Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG)

CERTIFICATE RIDER

No. CR7BIASO4-4

Policyholder: Miami-Dade County Public Schools

Rider Eligibility: Each Employee as reported to the insurance company by your Employer

Policy No. or Nos. 3332199-OAP10

EFFECTIVE DATE: April 1, 2012

You will become insured on the date you become eligible, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above.

Shermona Mapp, Corporate Secretary

GM6000 R 7 CEP

THE SCHEDULE — **Open Access Plus Medical Benefits** — section in your certificate is changed to read as attached.

THE SCHEDULE — **Prescription Drug Benefits** — section in your certificate is changed to read as attached.

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Open Access Plus Medical Benefits

The Schedule

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 16 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to 62.5 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	90%	70% of the Maximum Reimbursable Charge

Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by the Insurance Company. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.	Not Applicable	110%
Calendar Year Deductible		
Individual	$250 per person	$750 per person
Family Maximum	$500 per family	$1,500 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.		

Out-of-Pocket Maximum		
Individual	$2,000 per person	$3,500 per person
Family Maximum	$4,000 per family	$7,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		
Primary Care Physician's Services		
Primary Care Physician's Office visit	No charge after $20 per office visit copay	70% after plan deductible
Surgery Performed In the Physician's Office	No charge after the $20 PCP per office visit copay	70% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $20 PCP per office visit copay	70% after plan deductible
Allergy Treatment/Injections	No charge after either the $20 PCP per office visit copay or the actual charge, whichever is less	70% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No charge	70% after plan deductible

Specialty Care Physician Services **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.		
Office Visits Consultant and Referral Physician's Services	No charge after the $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Surgery Performed by a Specialist in the Physician's Office	No charge after the $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Second Opinion Consultations performed by a Specialist (provided on a voluntary basis)	No charge after the $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Allergy Treatment/Injections performed by a Specialist	No charge after the $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Allergy Serum (dispensed by the Specialist in the office)	No charge	70% after plan deductible
Preventive Care		
Routine Preventive Care to age 16	No charge	70% no plan deductible
Immunizations	No charge	70% no plan deductible
Routine Preventive Care for 16 and over)	No charge	In-Network coverage only
Well Woman	No charge	70% after plan deductible
Immunizations	No charge	In-Network coverage only
Mammograms		
Preventive Care Related Services (i.e. "routine" services)	No charge	No charge
Diagnostic Related Services (i.e. "non-routine" services)	No charge	70% after plan deductible
PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	No charge	70% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	70% after plan deductible

Inpatient Hospital - Facility Services	90% after plan deductible	70% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services – Hospital Based Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	90% after plan deductible	70% after plan deductible
Outpatient Facility Services – Non Hospital Based (free standing clinic)	$100 per visit copay, then 100%	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% (PCP), 90% (CCN) or 90% (Non-CCN) after plan deductible	70% after plan deductible
Inpatient Hospital Professional Services		
Surgeon	90% (CCN) or 90% (Non-CCN) after plan deductible	70% after plan deductible
Radiologist Pathologist Anesthesiologist	90% after plan deductible	70% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge	70% after plan deductible

Emergency and Urgent Care Services		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay
Hospital Emergency Room	No charge after $300 per visit copay*	No charge after $300 per visit copay*
JMH facilities (Memorial, North South & Cedars/UM Hospital)	No charge after $150 per visit copay*	No charge after $150 per visit copay*
	*waived if admitted	*waived if admitted
Outpatient Professional services (radiology, pathology and ER Physician)	No charge	No charge
Urgent Care Facility or Outpatient Facility	No charge after $70 per visit copay	No charge after $70 per visit copay
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	No charge
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge	No charge
Convenience Care Clinics	No charge after $20 copay	No charge after $20 copay
Ambulance	No charge after $50 per trip copay	No charge after $50 per trip copay
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 90 days combined	90% after plan deductible	70% after plan deductible
Laboratory - includes pre-admission testing		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Outpatient Hospital Facility	No charge	70% after plan deductible
Independent Lab Facility	No charge	70% after plan deductible

Radiology Services (i.e. X-rays) - includes pre-admission testing		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Outpatient Facility – Hospital Based	90% after plan deductible	70% after plan deductible
Independent X-ray Facility	100% after $100 copay per visit	70% after plan deductible
Radiological Imaging (i.e. MRIs, MRAs, CAT Scans amd PET Scans) The scan copay/deductible applies per type of scan per day		
Physician's Office Visit	No charge after $100 scan copay	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility – Non Hospital Based (free standing clinic)	No charge after $100 scan copay	70% after plan deductible
Outpatient Facility – Hospital Based	90% after plan deductible	70% after plan deductible
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 40 days per therapy Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab	No charge after the $70 per visit copay or the actual charge, whichever is less **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	70% after plan deductible
Chiropractic Care Calendar Year Maximum: 30 days		
Physician's Office Visit	No charge after the $70 per visit copay or the actual charge, whichever is less **Note:** X-rays covered at $100 copay	70% after plan deductible
Home Health Care Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as medically necessary)	90% after plan deductible	70% after plan deductible

Hospice		
Inpatient Services	90% after plan deductible	70% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	90% after plan deductible	70% after plan deductible
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	90% after plan deductible	70% after plan deductible
Outpatient	90% after plan deductible	70% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either a PCP or Specialist depending on how the provider contracts with the Insurance Company.	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Subsequent Prenatal Visits and Postnatal Visits	No charge	70% after plan deductible
Obstetrical/Midwifery – Physician's Delivery Charges (i.e. global maternity fee	90% after plan deductible	70% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	90% after plan deductible	70% after plan deductible

Abortion Includes elective and non-elective procedures		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Surgical Facility – Hospital Based	90% after plan deductible	70% after plan deductible
Outpatient Surgical Facility – Non-Hospital Based (free standing clinic)	$100 per visit copay, then 100%	70% after plan deductible
Physician's Services	90% (CCN) or 90% (Non-CCN) after plan deductible	70% after plan deductible
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	In-Network coverage only
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.		
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals)		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	In-Network coverage only
Inpatient Facility	90% after plan deductible	In-Network coverage only
Outpatient Facility – Hospital Based	90% after plan deductible	In-Network coverage only
Outpatient Facility – Non-Hospital Based (free standing clinic)	$100 per visit copay, then 100%	In-Network coverage only
Physician's Services	90% (CCN) or 90% (Non-CCN) after plan deductible	In-Network coverage only

Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination. Surgical Treatment: Limited to procedures for the correction of infertility (excludes In-vitro, GIFT, ZIFT, etc.)		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	In-Network coverage only
Inpatient Facility	90% after plan deductible	In-Network coverage only
Outpatient Facility – Hospital Based	90% after plan deductible	In-Network coverage only
Outpatient Facility – Non-Hospital Based (free standing clinic)	$100 per visit copay, then 100%	In-Network coverage only
Physician's Services	90% (CCN) or 90% (Non-CCN) after plan deductible	In-Network coverage only
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	In-Network coverage only
Inpatient Facility	100% at Lifesource center, otherwise 90% after plan deductible	In-Network coverage only
Physician's Services	100% at Lifesource center, otherwise 90% (CCN) or 90% (Non-CCN) after plan deductible	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible

External Prosthetic Appliances Calendar Year Maximum: Unlimited	90% after plan deductible	70% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility – Hospital Based	90% after plan deductible	70% after plan deductible
Outpatient Facility – Non-Hospital Based (free standing clinic)	$100 per visit copay, then 100%	70% after plan deductible
Physician's Services	90% (CCN) or 90% (Non-CCN) after plan deductible	70% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within one month of an injury to sound, natural teeth.		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility – Hospital Based	90% after plan deductible	70% after plan deductible
Outpatient Facility – Non-Hospital Based (free standing clinic)	$100 per visit copay, then 100%	70% after plan deductible
Physician's Services	90% (CCN) or 90% (Non-CCN) after plan deductible	70% after plan deductible

Bariatric Surgery **Note:** Subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Physician's Office Visit	No charge after the $20 PCP or applicable $50 CCN or $70 Non-CCN Specialist per office visit copay	In-Network coverage only
Inpatient Facility	90% after plan deductible	In-Network coverage only
Outpatient Facility – Hospital Based	90% after plan deductible	In-Network coverage only
Outpatient Facility – Non-Hospital Based (free standing clinic)	$100 per visit copay, then 100%	In-Network coverage only
Physician's Services	90% (CCN) or 90% (Non-CCN) after plan deductible	In-Network coverage only
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient	90% after plan deductible	70% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	$20 per visit copay	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Substance Abuse		
Inpatient	90% after plan deductible	70% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	$20 per visit copay	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

Retail Prescription Drugs	**The amount you pay for each 31-day supply**	**The amount you pay for each 31-day supply**
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $15 copay	50%
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $40 copay	50%
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50%, subject to a minimum of $100 and a maximum of $150, then the plan pays 100%	50%
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		
Mail-Order Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $30 copay	In-network coverage only

Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $80 copay	In-network coverage only
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50%, subject to a minimum of $200 and a maximum of $300, then the plan pays 100%	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		