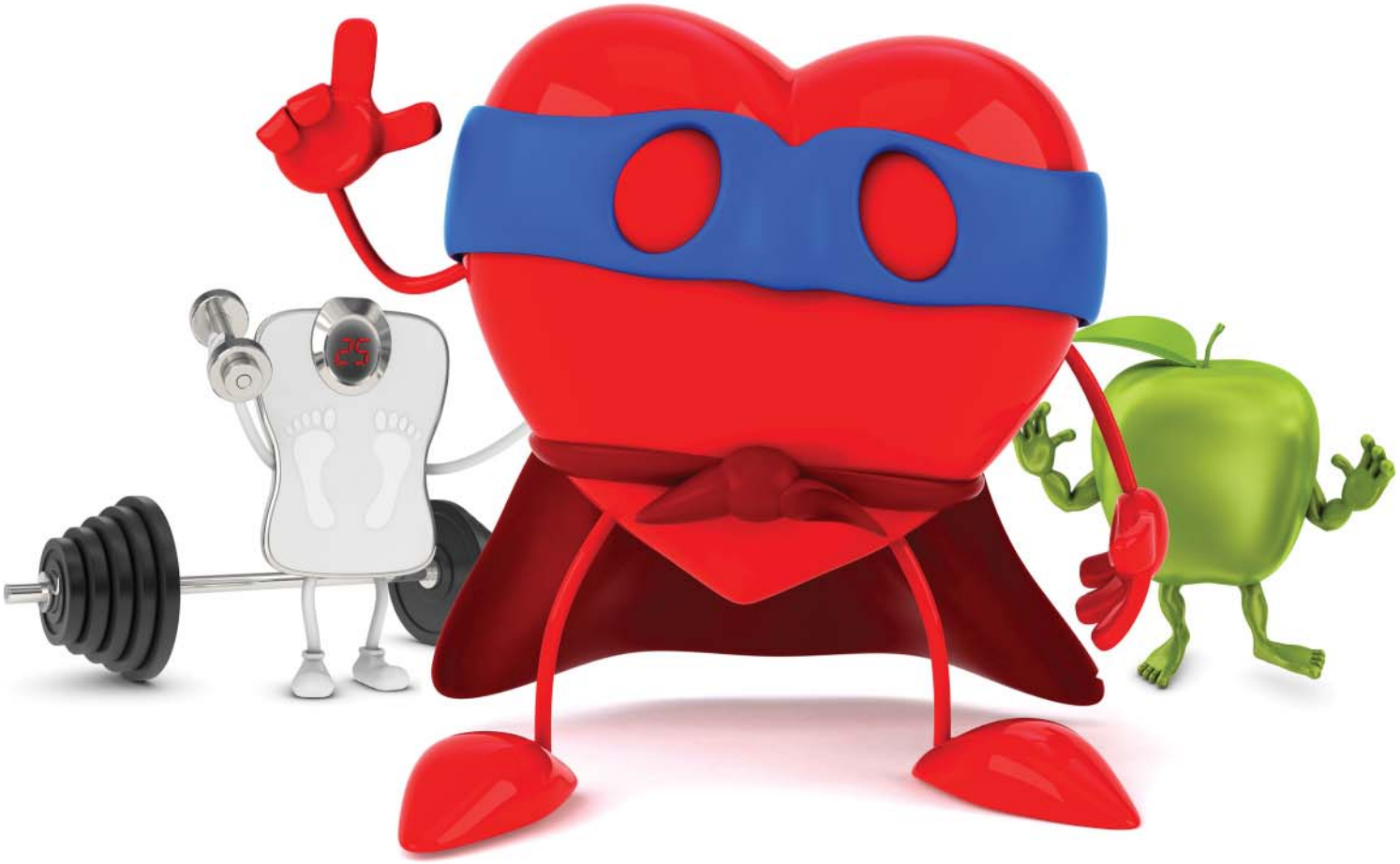
Benefits Guide

The Wellness Crusaders and their Adventures for Health

Volume: 2016 - 2017



Superintendent's Message

Dear District Employees,

Great school systems are built with great people. We are fortunate that the Osceola School District is built on a strong foundation based on talented employees and students; a supportive and effective School Board; and an engaged community. Together, our work for this upcoming school year will focus on opportunities to strengthen our district in ways that exemplify excellence in all that we do. To that end, I am extremely grateful for the passion and expertise that each of you bring to the table every day in our schools and departments.

The Osceola County School Board and I are committed to creating a culture of health and wellness throughout our district that both decreases the risk of disease and enhances the quality of life of all our employees. I am excited to share in this guide an overview of the benefit plans for 2016 – 2017. Please take your time to read and discuss this material with your family as you consider the options available. I know how important these programs are to each and every one of us.

The comprehensive benefit plans and options the district offers are designed to provide you and your family members with protection and give you the peace of mind to know that if illness or injury occurs, you have coverage. The Osceola County School Board spends millions of dollars on these programs every year, and is pleased to continue that investment in our employees.

The School Board has also made a significant investment for our employees towards our brand new Center for Employee Health. The district has partnered with Florida Hospital to manage and staff this facility with the purpose of providing high-quality services to you and your family members. The Center provides primary care, physical therapy, occupational health services, x-ray, nutritional counseling, and many common generic mediations at no cost to employees. We are looking to expand the facility to include other needed areas, including diabetes care, heart health, and other types of healthcare education. All of these services are designed around the goal of helping you and your dependents and our retirees achieve better overall health and wellbeing. If you have not visited the Center yet, please call and arrange a time to come in to meet the staff and view the facility.

Thank you for your continued contribution and efforts to help all of our students succeed. Our success as a district must build upon our continuing efforts to help students reach higher than they ever thought possible by enhancing the health, happiness, and motivation of our employees.

Best wishes for an outstanding 2016-2017 school year.

Dr. Debra Pace
Superintendent

This guide is a summary of the benefit programs offered through the School District of Osceola County for the plan year October 1, 2016 through September 30, 2017. The contents summarize the key features of each plan. Complete details are provided in plan documents, policy guidelines, and insurance contracts that legally govern the operation of each plan. If there is a discrepancy between this guide and the official plan documents, the plan documents will prevail.

What's Inside

Open Enrollment

August 31 to
September 14, 2016

Benefits Effective:

October 1, 2016

Plan Year:
October 1, 2016 to
September 30, 2017

See page 4 for new hire eligibility.

Open Enrollment 2016-2017

August 31, 2016- September 14, 2016

Benefit Changes

Good News! There are no new benefit changes this year that would require you to re-enroll. All benefit plan premiums, except Dental, will stay the same. There is a premium reduction for both Dental PPO plans now offered by Delta Dental.

Once again this year, all benefits information will be available online. To save printing cost and a few trees, paper Guides will not be available. So be sure to log onto Benefits Corner and to the District's Web site to review the Benefit Guide: *http://osceolaschools.net/departments/benefits*

Pharmacy Changes - Pending Ratification

Exclusion of CVS and Walgreens

Walgreens and CVS (and their smaller affiliate pharmacies) will no longer be part of your pharmacy network. They'll be considered out-of-network pharmacies. If you – or a covered person within your plan – continue to use Walgreens, CVS, or their affiliates, you will not have coverage for your prescriptions as there is no out of network coverage. For continued coverage in-network, you will need to switch to a participating pharmacy. All you need to do is to contact your doctor's office and tell them which pharmacy you'd like to use. They will transfer the prescription for you. You still have many pharmacy choices, from local pharmacies and grocery stores to retail chains and wholesale warehouse stores— places where you may already shop! You may also fill your prescriptions through Cigna Home Delivery Pharmacy℠. To find out which pharmacies are in the network, please visit *http://www.cigna.com/pharmacy-networks/pharmacy-network-1*

Step Therapy

Your pharmacy benefit is now subject to Step Therapy -- a prior authorization program. This means that certain medications in the Step Therapy program need approval by Cigna before they're covered under your plan. In Step Therapy, you need to try the most cost-effective and appropriate medications available before more expensive brand name medications are approved for coverage. Typically, these are generics or lower-cost brands. Generic medications have the same strength and active ingredients as brand name medications – but often cost much less – in some cases, up to 80–85% less! See page 14 for details.

Specialty Prescriptions

Specialty prescriptions will now require refills through Cigna Specialty Pharmacy Services mail order. Under your Cigna prescription drug plan, you and your family members will be able to go to your retail pharmacy for two fills of your specialty medication. After that, your specialty medications will only be covered when you use Cigna Specialty Pharmacy Services. See page 14 for details.

Dental Benefits

Delta Dental is our new dental insurance company beginning October 1st, 2016. Along with this change, there are exciting new enhancements to each benefit plan and, for both of the PPO plans, a reduction in premium. See page 18 for details.

All other benefits

All other benefits remain the same for the 2016-2017 plan year. However, if you want to contribute to an FSA, you will have to log on and elect your contribution amount for the new plan year. Your election for Flexible Spending Accounts does not roll over per IRS guidelines.

If I have questions, whom do I talk to?

Don't fret, Benefit Counselors are back! The District has again partnered with Worksite Communications to provide one-on-one benefit counseling to all of our employees. The counselor will meet with each employee on an individual basis to discuss the plans, enroll in benefits and verify dependent eligibility. Schedule your 30-minute appointment online at *www.myenrollmentschedule.com/osceola* or by calling *866-998-2915.*

Who needs to enroll?

All employees must meet with a Benefits Counselor to complete their benefits enrollment, verify dependent eligibility, assign an emergency contact and update beneficiary information. Scheduling your appointment in advance will enhance your enrollment experience and minimize time required to complete your enrollment. Be sure to make your 30-minute appointment with Worksite Communications online at *www.myenrollmentschedule.com/osceola* or by calling *866-998-2915* to ensure you do not miss your opportunity to enroll.

If employees enroll on their own through the benefits enrollment system or just continue enrollment for their current dependents, they are still required to provide the required documentation to a Benefits Counselor. **Failure to provide appropriate documentation will result in cancellation or non-enrollment of dependent coverage retroactive to the beginning of the 2016-2017 plan year.**

Open Enrollment 2016-2017 (continued)

August 31, 2016- September 14, 2016

Dependent Verification Process- new for 2016

During this year's open enrollment period, the District will also conduct verification of dependents enrolled in our medical, dental and/or vision insurance plans. To ensure our records are accurate and that benefit dollars are spent appropriately, **ALL** employees with dependent coverage or employees that wish to have his/her dependents visit the Center for Employee Health will be required to provide documentation of their dependents' eligibility even if the dependent was previously covered and documentation was previously provided.

Benefit Counselors from Worksite Communications will conduct the verification process during the open enrollment period. The Benefit Counselors will be responsible for meeting with employees to confirm their dependent's eligibility status. Employees with dependents will receive notification instructing them to bring the required documentation to their enrollment meeting. See page 5 for a list of eligible dependents and coverage age maximums.

What documents do I need to verify my dependent's eligibility?

The following documents meet the criteria for verification of dependent eligibility:

1. **Spouse** - Original or copy of government issued Marriage Certificate
2. **Birth Child** - Original or copy of government issued Birth Certificate that shows proof of relationship
3. **Step Child** - Original or copy of government issued Birth Certificate that shows proof of relationship **AND** Marriage Certificate to child's parent
4. **Adopted Child** - Legal Adoption records naming employee as parent. If the spouse (not employee) is the adoptive parent, a Marriage Certificate is required.
5. **Child born outside of the USA** - Naturalization papers that show proof of relationship
6. **Legal Guardianship** - Original or copy of government issued Birth Certificate **AND** Court order naming employee as legal guardian. If the spouse (not employee) is the guardian, a Marriage Certificate is Required. Educational guardianship is not sufficient documentation.
7. **Grandchild (newborn to 18 months of age)** - Original or copy of government issued Birth Certificate that shows proof of relationship **AND** Original or copy of government issued Birth Certificate of covered dependent birth parent who is also enrolled in the plan. If a grandchild is older than 18 months, Legal Guardianship must be obtained and provided in order to remain on the plan.
8. **Disabled Adult Child** - Original or copy of government issued Birth Certificate that shows proof of relationship **AND** Physician's Statement *OR* Social Security Disability Papers.
9. **Domestic Partner** - Notarized written Domestic Partner declaration **AND** two documents showing proof of joint financial and joint residency (see page 6 for the District Domestic Partner School Board Rule).
10. **Domestic Partner's Child** - Original or copy of government issued Birth Certificate that shows proof of relationship. Domestic Partner must also be enrolled.

IMPORTANT: You will need to provide originals or copies of the required verification documentation when you are meeting with the Benefits Counselor. The Counselor will not be collecting your documents, they will review and return back to you during your enrollment session.

Emergency Contact and Beneficiary Collection- new for 2016

During enrollment, Benefit Counselors will be collecting emergency contact and beneficiary information from all employees. Please bring two emergency contact and beneficiary names and phone numbers to your enrollment session.

Effective Dates

As a SDOC benefits-eligible employee, you are eligible for the plans described in this Guide.

- Medical Insurance
- Medical Insurance Opt-Out Credit
- Dental
- Vision
- Wellness Incentive
- Flexible Spending Accounts
- Employee Assistance Program
- Life Insurance
- Disability Insurance
- Tax-Sheltered Annuities
- Universal Life with Long Term Care
- Accident Insurance

Effective Dates for New Employees

All benefited staff — Your benefits are effective the first of the month after your date of hire.

Note: If your potential effective date has passed, you have not yet enrolled and are still within your enrollment period, *insurance is effective the day of enrollment.*

Take Action to Avoid Default Coverage

If you do not enroll in benefits by the appropriate deadline, you will automatically be enrolled in the LocalPlus Plan (employee-only) and Board-paid Term Life Insurance. You will not be able to re-enroll until the next Open Enrollment unless you experience an IRS qualified change-in-status event (see page 8).

New Employee Enrollment Process

1. **Learn and Plan:** Read this Guide and use the resources and tools available to you.
2. **Enroll:** As soon as you are cleared for employment,* log onto the benefits enrollment system and enroll for your benefits. Refer to the Benefits Enrollment System Step-by-Step Instructions section of this Guide for detailed instructions (See page 35).

You have two weeks to enroll in benefits from the date you are cleared.*

* ***Your facility secretary will notify you as soon as you are cleared for employment.***

Open Enrollment Effective Date

All changes made during Open Enrollment are effective from October 1, 2016 through September 30, 2017.

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Proof of dependent status (legal guardianship or adoption, for example) is required to enroll eligible dependent children.

Eligible dependents are defined as:

- your legal spouse as defined under Federal law (Marriage Certificate required)
- eligible dependent children include:
  - your own children
  - legally adopted children
  - stepchildren
  - a child for whom you have been appointed legal guardian
  - a child for whom the court has issued a Qualified Medical Child Support Order requiring you or your spouse to provide coverage
  - a dependent of a currently enrolled dependent (e.g., your grandchild) may be enrolled in a health plan for a period of 18 months from birth

Covering Dependent Children

The following criteria do not apply to adult dependent children who are mentally or physically incapable of supporting themselves. These children may qualify for coverage at any age by virtue of their incapacitation, as long as they became incapacitated prior to age 26 or 30.

Medical Plan Coverage

Through Age 26

Under the Patient Protection and Affordable Care Act (PPACA), you may cover your eligible adult dependent children up to age 26, regardless of marital, financial, or student status (this does not include spouses of adult children).

Age 26 Through 30

Florida law allows employees enrolled in a District-sponsored medical plan to cover their adult dependent children, age 26 through age 30 (benefits terminate on their birthday). To qualify for this extended coverage, your adult dependent child must meet **all** of the following eligibility criteria. Your adult dependent child must:

- Be unmarried and have no dependent children of his or her own,
- Be a resident of the state of Florida or a full-time or part-time student, and
- Have no medical insurance as a named subscriber, insured enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan; or not be entitled to benefits under Title XVII of the Social Security Act.

Other Plans Offering Dependent Coverage (Dental, Vision, and Life Insurance)

Dependent eligibility varies by plan. Please refer to the summary plan descriptions for specific information on each plan.

- **Dental and Vision.** Coverage will cease at the end of the year in which your enrolled dependent children or domestic partner children reach age 26. Florida over age dependent law does not apply.
- **Accident:** Unmarried and dependent children can be covered up to age 26
- **Universal LifeEvents:** Children can be covered up to age 18, (full-time student/dependent up to age 24)

Do Not Enroll Ineligible Dependents

Enrolling a dependent who is not eligible for coverage or failing to remove a dependent who has become ineligible for any District benefit plan in a timely manner is a violation of District policy and will lead to disciplinary action, including possible termination.

If you violate District policy, the District may seek reimbursement from you (even if you no longer work for the District) for any and all benefits paid under the plan on behalf of the ineligible dependent, plus any costs and attorney fees associated with obtaining reimbursement.

Special Enrollment Rights

If you decline coverage for yourself and any eligible dependents, including your spouse, because you and/or your dependents are covered under another major medical plan, you may be able to enroll yourself and/or your dependents in a District medical plan if you lose eligibility under the other plan. An individual policy is not considered a major medical plan. For more information, please see page 8 for Section 125 and Benefit Changes or contact the Benefits Specialist assigned to your facility at 407-870-4899.

Domestic Partners and their dependents

It is the policy of the School District to offer benefits to domestic partners and their dependent children. Domestic partners are defined to be two individuals of the same or opposite gender who reside together with the intent of a committed relationship that meet the criteria listed below to qualify for Domestic partnership Benefits. This declaration does not affect Federal or State laws, and is subordinate to such laws concerning common law marriages, real and personal property rights, wills and estates, child custody, taxes, etc.

The following criteria must be met to be considered for domestic partnership benefits. The partners must declare:

A. The employee and his/her partner are each other's sole and exclusive domestic partner and they mutually intend to remain so indefinitely.

B. The employee and his/ her partner reside together in a common residence and at the time of the declaration, must have previously resided together on a continuous basis for the preceding twelve (12) months and intend to continue that arrangement.

C Both the employee and his/ her partner are at least 18 years of age and mentally competent to consent to a contract.

D. The employee and his/ her partner shall have the responsibility for a significant measure of each other's common welfare and financial obligations.

E. The employee and his/ her partner are not married to or domestic partners as defined herein, with anyone else and have not been so during the preceding twelve (12) months prior to the declaration.

F. The employee and his/ her partner are not related by blood to a degree of closeness that would prohibit legal marriage in the State of Florida (i.e. siblings or first cousins).

All employees wishing to claim domestic partnership benefits must execute a written declaration, acknowledging the above listed criteria and submit the necessary and appropriate paperwork as requested by the School District to substantiate their eligibility. Proof of eligibility shall require a minimum of two (2) documents/instruments showing joint residency and joint financial responsibility. Subsequent declarations with a different partner are not eligible for consideration until at least twelve (12) months have elapsed since the previous declaration has been terminated by the School District. If, after the initial declaration, the criteria changes for domestic partnership benefits, the employee shall promptly submit any new documentation necessary to comply with the new policy.

A qualified domestic partner and dependent children may be eligible for group insurance coverage for Medical, Dental, Vision and Universal Life Insurance.

All employees who qualify for this benefit recognize and acknowledge that IRS regulation does not recognize domestic partners as the equivalent of spouses. As such, payroll deductions cannot be made on a pretax basis and those employees shall have to pay income tax on the imputed value of the domestic partnership benefit. Employees are encouraged to seek tax advice from a qualified tax accountant.

If an employee terminates his/her employment with the School District, the domestic partner and dependent children are eligible for COBRA coverage for Medical, Dental and Vision coverage.

A domestic partnership shall be considered automatically terminated in the event that one of the domestic partners, marries, remarries, dies or enters into a domestic partnership with another. In those instances where a domestic partnership dissolves, the date of termination shall be the date of the event the eligibility is lost, not the date of notice to the School District. Within 30 days of that date, the employee is required to complete and file with the School District's Risk & Benefits Management Department a Notice of Termination of Declaration of Domestic Partnership.

Domestic partners have the obligation to and shall within thirty (30) days of the date of which the domestic partnership no longer meets the eligibility criteria file with the School District's Risk & Benefits Management Department a Notice of Termination of Domestic Partnership. Failure to timely report and file the Notice of Termination of Domestic Partnership is a violation of District policy and will lead to disciplinary action, including possible termination.

If the employee fails to comply with the policies of the domestic partnership benefits, the District may seek reimbursement from the employee (even if the employee no longer works for the District) for any and all benefits paid under the plan on behalf of the ineligible dependent, plus any costs and attorney fees associated with obtaining reimbursement.

Domestic Partners and their dependents

Medical Coverage Taxation Examples

If your domestic partner does not qualify as your tax dependent, the IRS requires that the "fair market value" of your domestic partner's health coverage, minus any post-tax contributions made by you, be included in your gross income and subject to federal tax as well as being reported as taxable earnings on your W-2 Form. This "taxable imputed income" is the amount that the School Board pays towards the Domestic Partner's coverage.

1. Employee + Domestic Partner

The employee adds a Domestic Partner on the Local Plus plan.

Domestic Partner Fair Market Value	$7,240.32
Domestic Partner After Tax Premium	-$ 5,500.00
Taxable Imputed income	$1,740.32

Since the District is paying $1,740.32 per year for medical coverage for the Domestic Partner, this amount must be reported as imputed income on the employee's W-2 and the employee will pay taxes on this amount. It will be added to the employee's taxable wages.

2. Employee + Employee's Child(ren) + Domestic Partner

The employee adds a Domestic Partner on the Local Plus plan.

Domestic Partner Fair Market Value	$7,240.32
Domestic Partner After Tax Premium	-$ 5,500.00
Taxable Imputed income	$1,740.32

Since the District is paying $1,740.32 per year for medical coverage for the Domestic Partner, this amount must be reported as imputed income on the employee's W-2 and the employee will pay taxes on this amount. It will be added to the employee's taxable wages. The employee pays for their child(ren)'s premium as pre-tax.

3. Employee + Domestic Partner + Domestic Partner's Child(ren)

The employee adds a Domestic Partner and Domestic Partner's Child(ren) on the Local Plus plan.

Domestic Partner and Child(ren) Fair Market Value	$10,257.12
Domestic Partner +DM Child(ren) After Tax Premium	-$ 8,040.00
Taxable Imputed income	$2,217.12

Since the District is paying $2,217.12 per year for medical coverage for the Domestic Partner and the Domestic Partner's child(ren), this amount must be reported as imputed income on the employee's W-2 and the employee will pay taxes on this amount. It will be added to the employee's taxable wages.

4. Employee + Employee's Child(ren) + Domestic Partner + Domestic Partner's Child(ren)

The employee adds a Domestic Partner and Domestic Partner's Child(ren) on the Local Plus plan..

Domestic Partner and Child(ren) Fair Market Value	$8,748.72
Domestic Partner +DM Child(ren) After Tax Premium	-$ 6,770.00
Taxable Imputed income	$1,978.72

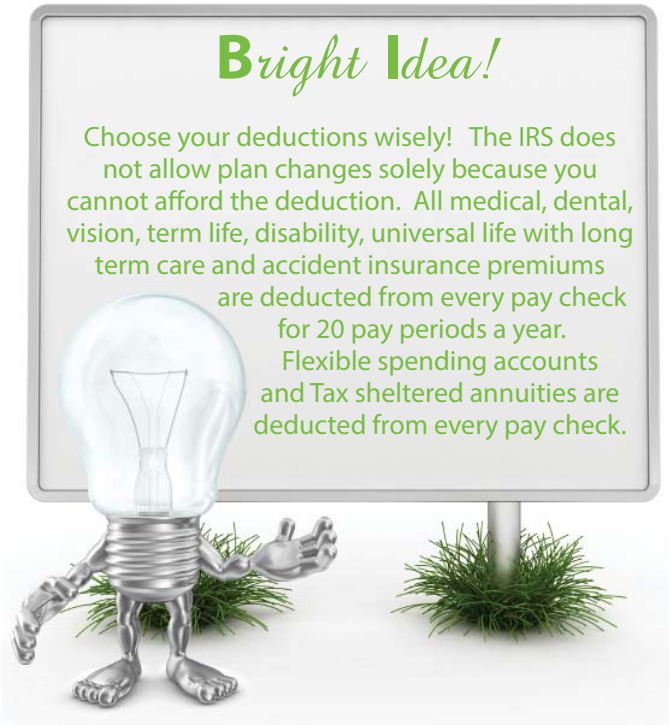
Since the District is paying $1,978.72 per year for medical coverage for the Domestic Partner and the Domestic Partner's child(ren), this amount must be reported as imputed income on the employee's W-2 and the employee will pay taxes on this amount. It will be added to the employee's taxable wages. The employee pays for their child(ren)'s premium as pre-tax. Note that in this situation the child premium is split equally.

Note: *The example above uses the LocalPlus default plan. Each of the medical plans will have its own imputed income computation.*

Section 125 and Benefit Election Changes

Under Section 125 of the Internal Revenue Service (IRS) code, you are allowed to pay for certain group insurance premiums using pretax dollars. This means your premium deductions are taken before federal income and Social Security taxes are calculated. Depending on your tax bracket, your savings could be significant.

However, you must make your benefit elections carefully, including the choice to waive coverage, because IRS regulations state that your pretax elections will remain in effect until the next annual open enrollment period, unless you experience an IRS-approved qualifying change in status. Qualifying change-in-status events include, but are not limited to:



- Marriage, divorce, or legal separation*
- Death of spouse or other dependent
- Birth or adoption of a child
- A spouse's employment begins or ends (must have coverage from previous employer)
- A dependent's eligibility status changes due to age, student status, marital status, or employment
- You or your spouse experience a change in work hours that affect benefits eligibility
- You relocate into or outside of your plan's service area
- Voluntary or involuntary loss of other qualifying coverage or gaining other group coverage
- Your eligible child(ren) lose coverage under a federal or state-sponsored health program

* ***Legal separation is not recognized in Florida.***

Please note that your qualified status change must be consistent with the event. For example, if you get married, you can add your spouse to your current medical coverage, but you cannot switch medical plans. **You must notify Risk and Benefits Management within 30 days of your qualified status change.**

Effective Date Following a Qualifying Event

Your benefits effective date following a qualified status change is the first month after paperwork is received and online enrollment is completed. Birth or adoption of a child will be effective the date of birth or date of placement for adoption.

Adding Newborn(s) or Adopted Child(ren)

In accordance with ***Florida Statute 627.6575 Coverage for newborn children***, children added after birth or adoption will have 30-days coverage without an additional premium. However, the plan co-insurance and deductibles still apply.

If a child is not enrolled within thirty-one (31) days from the date of birth, but is enrolled within 60 days from the date of birth by written notification, coverage for the newborn child will become effective from the date of birth. Any premiums due must be paid retroactive to the date of birth for coverage to be effective.

Medical Benefits

The School Board contributes $6,398 annual for benefits including the new Center for Employee Health. That's above and beyond your regular salary or hourly wage. With those dollars we are able to continue to offer medical plans that focus on our employees' and dependents' health with integration with wellness.

You can choose between three medical plan options: the *LocalPlus plan*, the *Wellness LocalPlus* plan and the *Wellness Open Access Plus* plan. All plans offer comprehensive medical coverage, however, each plan provides coverage in a different way. Be sure to review the Medical Benefits Plan Comparison Chart on page 12-13 to help you decide which plan is right for you.

1. LocalPlus Plan

No Premiums for Employee-Only Coverage!

The LocalPlus plan is one of the two "free" plans. If you elect employee-only coverage, you will have no payroll deductions for medical insurance. This is also the plan that you will default into (employee-only coverage) if you do not actively enroll, so it is recommended that you review the plans carefully and make an informed decision.

The LocalPlus plan gives you the flexibility to visit any provider (doctor or facility) within Cigna's LocalPlus network, including specialists, without the need for a referral.

With this plan, you must meet a deductible first then pay 30% co-insurance of the discounted network charges for all doctors and procedures. Also, the pharmacy deductible is waived when you are purchasing generic medication.

Keep in mind that there is no out-of-network coverage under this plan except in the case of a true emergency; you will pay the full amount if you use out-of-network providers.

**** Please read page 14 to understand your prescription drug coverage under the LocalPlus Plan.***

2. Wellness LocalPlus Plan

No Premiums for Employee-Only Coverage!

The Wellness LocalPlus plan is the second of the two "free" plans. If you elect employee-only coverage, you will have no payroll deductions for medical insurance.

The Wellness LocalPlus plan gives you the flexibility to visit any provider (doctor or facility) within Cigna's LocalPlus network, including specialists, without the need for a referral.

One of two Copay plans! With this plan, you DO NOT need to meet a deductible unless you're having a procedure/visit outside your doctor's office. Co-pays for your **primary care physician are $30** per visit and **specialists are $35 per visit**. Also, the pharmacy deductible is waived when you are purchasing generic medication.

Although dependent premiums for the Wellness LocalPlus plan are slightly higher than the LocalPlus plan, the coverage is better. The deductibles and the maximum out-out-of pocket is the lowest when comparing all three plans.

Visit the Center for Employee Health for your primary care needs. In most cases, there is no out-of-pocket cost to the employee. See page 44 for details.

Doc. Broc

**** Please read page 14 to understand your prescription drug coverage under the Wellness LocalPlus.***

Medical Benefits (continued)

3. Wellness Open Access Plus Plan

Buy-up plan - $45 per pay period for Employee Only Coverage

The Wellness Open Access Plus plan is the buy-up plan. If you elect employee-only coverage, you will have a $45 payroll deduction for medical insurance ($45 per pay, 20 times a year). You're paying an employee premium because of the choice of a bigger network and out of network coverage.

The Wellness Open Access Plus plan gives you the flexibility to visit any provider (doctor or facility) within Cigna's Open Access Plus network, including specialists, without the need for a referral. With the Wellness Open Access Plus plan, you can also use out-of-network providers although the benefit is not as good (more expensive and can involve balance billing from your doctor).

One of two Copay plans! With this plan, you DO NOT need to meet a deductible unless you're having a procedure/visit outside your doctor's office. Co-pays for your in-network **primary care physician are $35** per visit and **specialists are $50 per visit**. Also, the pharmacy deductible is waived when you are purchasing generic medication.

Since this plan has a larger network and offers out-of-network coverage, premiums are the highest for both the employee and dependents.

* ***Please read page 14 to understand your prescription drug coverage under the Wellness Open Access Plus Plan.***

What is the LocalPlus Network?

The LocalPlus network is a narrower network made up of high quality physicians and facilities in our area. Visit *www.cigna.com* and search for providers in the "LocalPlus" network. You may access the LocalPlus network in any area of the country where it exists. In service areas where the LocalPlus Network is not available, you can access doctors and hospitals in our national Away From Home (Open Access Plus) Network and receive coverage at the in-network level. Emergency care is always covered as in-network. Your doctor must specifically be listed under Cigna's LocalPlus network, not just take Cigna insurance.

But wait, I have a child going to school in another state where there is no LocalPlus network. What do I do?

We have you covered. A dependent who does not live in the LocalPlus service area can use an Open Access Plus provider while out of the LocalPlus area. When they return, say while home for the summer, they will need to use LocalPlus health care professionals. Feel free to call Cigna at 1-800-244-6224 if you have any concerns or questions about where LocalPlus is available.

What is the Open Access Plus Network?

The Open Access Plus network Cigna's broader and nationwide network of doctors, facilities and hospitals. Visit *www.cigna.com* and search for providers in the "Open Access Plus" network.

Do I need Out-of-Network Coverage?

Maybe, but highly unlikely. You may use out-of-network providers only if you purchase the Wellness Open Access Plus Plan (all other plans do not include out-of-network coverage) but make sure it's something you need. Your expenses with out-of-network providers will be significantly higher than if you used an in-network provider because typically, an out-of-network provider's fees will be higher than the negotiated fees charged by in-network providers. In addition to paying a higher amount of coinsurance, you can also be billed for the difference between what the plan pays and what the out-of-network provider charges. This is called "balance billing", and these amounts do not count towards your out-of-pocket maximums.

Medical Benefits (continued)

Medical Premiums per pay check (20 pay checks per year).

Premiums are collected per pay over 20 pays October 1 through September 30th regardless of what pay cycle you elect.
Monthly premiums in blue below are for demonstration/budget purposes only.

	1. LocalPlus		2. Wellness LocalPlus		3. Wellness Open Access Plus	
	Per Pay	*Per Month (10 months)*	*Per Pay*	*Per Month (10 months)*	*Per Pay*	*Per Month (10 months)*
Employee Only	$0.00	*$0.00*	$0.00	*$0.00*	$45.00	*$90.00*
Employee + Spouse	$275.00	*$550.00*	$335.00	*$670.00*	$410.00	*$820.00*
Employee + Child(ren)	$127.00	*$254.00*	$145.00	*$290.00*	$200.00	*$400.00*
Employee + Family	$402.00	*$804.00*	$480.00	*$960.00*	$610.00	*$1,220.00*
Half Family Primary	$127.00	*$254.00*	$145.00	*$290.00*	$200.00	*$400.00*
Half Family Secondary	$0.00	*$0.00*	$0.00	*$0.00*	$0.00	*$0.00*
Each Adult Dependent child age 26-30	$275.00	*$550.00*	$335.00	*$670.000*	$410.00	*$820.00*

Half-Family Status

If you and your spouse work for SDOC, are both eligible for benefits and have children, your status is considered "Half-Family." If you choose family coverage under one of the medical plans, only one spouse will have a payroll deduction for medical insurance. The spouse who is designated as "Primary" (for insurance purposes) will have the premiums deducted from his or her pay; the employee designated as "Secondary" will be covered under the Primary's medical plan. Note that this feature does not apply to employees with spouses in other school districts or government offices.

Job Share

Employees classified as Job-Share pay half the Board contribution ($159.95) plus the premium listed based on your choice.

Medical Plan Comparison Chart

	1. LocalPlus*	2. Wellness LocalPlus*
Network *(List of Doctors)*	LocalPlus*	LocalPlus*
	Default Plan, Coinsurance Plan	Copay and Coinsurance Plan
Individual deductible	$500	$350
Family Deductible	$1,000	$700
Coinsurance Level	30%	25%
Individual Maximum Out of Pocket	$6,300	$4,700
Family Maximum Out of Pocket	$12,600	$9,400
Primary Care Physician Visits (PCP)	30% after deductible	$30 copay, no deductible
Specialist Office Visits	30% after deductible	$35 copay, no deductible
Convenient Care Center	30% after deductible	$30 copay, no deductible
Urgent Care Center	30% after deductible	25% after deductible
Emergency Room	30% after deductible	25% after deductible
Hospital Services	30% after deductible	25% after deductible
Outpatient Services	30% after deductible	25% after deductible
Lab and X-ray		
• Physician's office	30% after deductible	$30 PCP or $35 Specialist copay
• Independent Lab	30% after deductible	25%, no deductible
• All other facilities	30% after deductible	25% after deductible
Maternity		
• Initial visit to confirm pregnancy	30% after deductible	$30 PCP or $35 Specialist copay
• Global Maternity Fee[1]	30% after deductible	25% after deductible
• Physician's office visit (in addition to Global Maternity fee at OB/GYN or Specialist)	30% after deductible	$30 PCP or $35 Specialist copay
• Delivery -- Facility (Inpatient Hospital or Birthing Center)	30% after deductible	25% after deductible
Preventive Care • well-baby, well-child, well-woman and adult preventive care • Immunizations - All ages • Pap, PSA Tests	Free	Free
Mammograms	First Mammogram free per year - screening or diagnostic Then, 30% after deductible	First Mammogram free per year - screening or diagnostic Then, 25% after deductible
Advance Imaging (CT, MRI, PET)[2]	30% after deductible	25% after deductible
Out of Pocket Maximum	Includes Deductibles and Copays	Includes Deductibles and Copays
Lifetime Maximum	Unlimited	Unlimited
Pre-certification requirements[4]	Coordinated by your physician	Coordinated by your physician

* ***You must use providers within the LocalPlus Network. There are no benefits for out-of-network unless it is a true emergency.***

1 *Includes all routine prenatal visits , Routine postpartum visits, Physician's Delivery Charges, Management of hospital observation for up to 48 hours for the evaluation of latent phase of labor or uterine contractions w/o cervical dilatation, Admission to the hospital, All medical services required for prep and delivery*

2 *Advanced radiological imaging (MRI, CAT Scan, PET Scan, etc.); outpatient facility charges, independent lab and X-ray facility.*

Medical Plan Comparison Chart (continued)

3. Wellness Open Access Plus	
Open Access Plus	Out of Network
Copay and Coinsurance Plan	
$500	$1,000
$1,000	$3,000
30%	50%
$5,000	$10,000
$10,000	$30,000
$35 copay, no deductible	50% after deductible
$50 copay, no deductible	50% after deductible
$35 copay, no deductible	50% after deductible
30% after deductible	50% after deductible
30% after deductible	50% after deductible
30% after deductible	50% after deductible
30% after deductible	50% after deductible
$35 PCP or $50 Specialist copay 30%, no deductible 30% after deductible	50% after deductible 50% after deductible 50% after deductible
$35 PCP or $50 Specialist copay 30% after deductible $35 PCP or $50 Specialist copay 30% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible
Free	50% after deductible[3]
First Mammogram free per year - screening or diagnostic Then, 30% after deductible	First Mammogram free per year- screening or diagnostic Then, 50% after deductible
30% after deductible	50% after deductible
Includes Deductibles and Copays	Includes Deductibles and Copays
Unlimited	Unlimited
Coordinated by your physician	Member's responsibility[5]

3 Out-of Network Deductible waived on preventive care for children under age 16

4 Required for all inpatient admissions and selected outpatient procedures and diagnostic testing. Contact Cigna at 1-800-244-6224 to confirm if authorization is required for individual services

5 Subject to penalty, reduction of benefit, or denial of claim for noncompliance.

After You Enroll in a Cigna Medical Plan

Cigna ID Card

Once you enroll in a medical plan, you will automatically receive an ID card from Cigna. Carry it with you at all times and present it whenever you visit a medical provider or pharmacy. This will help ensure that your claim is handled properly. To order a new ID card, contact Cigna Member Services at 1-800-244-6224 (1-800-Cigna24) or online at mycigna.com.

Cigna Member Services 1-800-244-6224

For answers to plan questions, members and their physicians should contact Cigna Member Services at 1-800-244-6224 (1-800-Cigna24) available 24/7 365 days per year. Please have your Cigna ID Card handy when you call.

Register at mycigna.com

Once you enroll in a medical plan, be sure to register at mycigna.com. You and your covered dependents can have individualized log-ins. (See page 16 for details)

Prescription Benefits

When you enroll in any of the Cigna medical plans you receive prescription benefits through the **Cigna Pharmacy Network Prescription Drug Plan.** There are no out-of-network prescription benefits, so be sure to use one of the pharmacy providers listed on this page, or use Cigna's home-delivery pharmacy for maintenance (ongoing) prescriptions.

How the Prescription Drug Plan Works

- You are automatically enrolled in the prescription drug plan when you enroll in any of the Cigna medical plans.
- The prescription drug plan has a deductible. However, it is waived if you are filling generic medications.
- When you have prescriptions filled at a network pharmacy, you pay a preset copay for generic and preferred drugs.
- If you use non-preferred or specialty drugs, you will pay a percentage of the negotiated rate (see chart below), up to the per-prescription cap.

  Because you always pay less for the generic version of a drug, ask your doctor to write your prescription for the generic (if available).
- If you are enrolled in any of the Cigna medical plans:
  - Any copays and coinsurance you pay for non-preferred and specialty drugs is applied toward your plan's out-of-pocket maximum.

Cigna Pharmacy Network

The following chain pharmacies are included in the Cigna pharmacy network:

- Publix
- Costco
- Medicine Shoppe
- K-Mart
- Walmart
- Winn Dixie

Exclusion of CVS and Walgreens

Walgreens and CVS (and their smaller affiliate pharmacies) will no longer be part of your pharmacy network. They'll be considered out-of-network pharmacies. If you – or a covered person within your plan – continue to use Walgreens, CVS, or their affiliates, you will not have coverage for your prescriptions as there is no out of network coverage. For continued coverage in-network, you will need to switch to a participating pharmacy. All you need to do is to contact your doctor's office and tell them which pharmacy you'd like to use. They will transfer the prescription for you. You still have many pharmacy choices, from local pharmacies and grocery stores to retail chains and wholesale warehouse stores— places where you may already shop! You may also fill your prescriptions through Cigna Home Delivery PharmacySM. To find out which pharmacies are in the network, please visit *http://www.cigna.com/pharmacy-networks/pharmacy-network-1*

Step Therapy

Step Therapy is a prior authorization program. This means that certain medications in the Step Therapy program need approval by Cigna before they're covered under your plan. In Step Therapy, you need to try the most cost-effective and appropriate medications available before more expensive brand name medications are approved for coverage. Typically, these are generics or lower-cost brands. Generic medications have the same strength and active ingredients as brand name medications – but often cost much less – in some cases, up to 80–85% less!

How Step Therapy works

When you fill a prescription for a Step Therapy medication, we'll send you and your doctor a letter that lets you

	1. LocalPlus		2. Wellness LocalPlus		3. Wellness Open Access Plus	
	30-day Supply	*90-day Supply*	*30-day Supply*	*90-day Supply*	*30-day Supply*	*90-day Supply*
Generic	$20 copay	$55 copay	$15 copay	$40 copay	$15 copay	$40 copay
Preferred drug	$45 copay	$130 copay	$35 copay	$100 copay	$35 copay	$100 copay
Non-preferred drugs	50% up to $150*	50% up to $445*	45% up to $100*	45% up to $295*	45% up to $100*	45% up to $295*
Specialty drugs	75% up to $250*	75% up to $745*	55% up to $200*	55% up to $595*	55% up to $200*	55% up to $595*
Pharmacy Deductible	$200 (waived for generics)		$50 (waived for generics)		$50 (waived for generics)	

* *Cap per prescription.*

Prescription Benefits (continued)

know the steps you need to take before you refill your medication. This may include trying a generic or lower-cost alternative, or asking Cigna to approve coverage of your medication. At any time, if your doctor believes an alternative medication isn't right for you due to medical reasons, he or she can request prior authorization for continued coverage of a Step Therapy medication.

Are you taking a Step Therapy medication?

You should take a look at your prescription drug list on myCigna.com. If there's a (ST) symbol listed next to your medication, then it's part of the Step Therapy program.

Home-Delivery Prescriptions

Cigna Home Delivery Pharmacy is part of your prescription benefits. Cigna Home Delivery Pharmacy provides a cost-effective way for you to obtain maintenance drugs (prescription medication you and/or your covered dependents take on an ongoing basis).

Benefits of Home Delivery

- FDA-approved medications
- Verification of every order by a licensed pharmacist
- Standard delivery to your home or other preferred address at no additional cost
- 90-day supply reduces out-of-pocket expenses and trips to a retail pharmacy
- Refill reminders so you don't forget to reorder

To learn more about Cigna's home-delivery program, call 1-800-835-3784 toll-free or visit ***www.mycigna.com***. To switch your current prescription, call Cigna Home Delivery Pharmacy toll-free at 1-800-285-4812, Option 1, and an associate will contact your prescriber to request a new prescription under Cigna Home Delivery.

Specialty Prescriptions

Your health condition deserves special care, and making sure you get the medication you need is a critical part of that care. That's why Cigna Specialty Pharmacy Services℠ makes it easier to get the specialty medications you take to help treat and control your health condition. Under your Cigna prescription drug plan, you and your family members will be able to go to your retail pharmacy for two fills of your specialty medication. After that, your specialty medications will only be covered when you use Cigna Specialty Pharmacy Services.

Cigna Specialty Pharmacy Services offers you more than just your medication

- 24/7 access to customer service and pharmacists to help answer any questions
- Condition specific support and therapy management
- Convenient delivery right to your door or preferred location
- Helpful coaching and reminder services
- Supplies like tape, bandages, sharps collectors, swabs, etc.
- Access to educational materials and more
- Discreet packaging at no additional cost to protect quality and privacy
- Financial assistance for costly medications

Ordering is as easy as 1, 2, 3

1. Have your medication, doctor's information and credit card information ready.
2. Call 1.800.351.3606.
3. We'll contact your doctor and coordinate any necessary benefit approvals.

If you are currently filling a specialty drug at a retail pharmacy, you will receive a letter explaining the transition as well as the benefits of using Cigna Specialty Pharmacy Services. A follow up call from Cigna Specialty Pharmacy Services will also be made to answer any questions and help with the transition.

Cigna Resources

As a Cigna medical plan participant, you have access to these programs, features, and resources.

Health Information 24/7

What do you do when your child spikes a fever in the middle of the night? Or when you go jogging and twist your ankle? Don't worry, wonder or wait whenever there's a question about health just call the Health Information Line and talk directly with a specialist trained as a nurse, 24 hours a day, 7 days a week.

You can also listen to hundreds of our latest Podcasts on almost any health topic to help you stay informed about your health. Dial the toll-free number on your Cigna ID card and speak one-on-one with a specialist trained as a nurse for personalized attention and help answering your health questions.

Call 1.800.CIGNA24 (1.800.244.6224) or Visit myCigna.com for more information.

Free Lifestyle Management Programs

Whether you're looking for help with weight, tobacco or stress management, Cigna's Lifestyle Management Programs are easy to use, available where and when you need it, and are always at no cost to you. All the programs can be used online, over the phone – or both.

WEIGHT MANAGEMENT: Manage your weight using a non-diet approach. Get support to help build your confidence, become more active, eat healthier and change your habits.

TOBACCO: Tobacco cessation program helps you get and stay tobacco free. Develop a personal quit plan that's right for you.

STRESS MANAGEMENT: Stress management program helps you understand the sources of your stress and learn coping techniques to manage stress both on and off the job.

Call or go online for easy enrollment: 1.866.417.7848 or visit www.myCIGNA.com and enter your User ID and Password.

mycigna.com

mycigna.com is your personalized website that provides tools to help you better understand your benefits and manage your overall health and well-being. Both you and your covered dependents can create individual log ins. With *mycigna.com* you have the ability to:

- View your claims and benefits.
- Complete a brief questionnaire with the Health Assessment tool.
- Get information on health conditions, health and wellness, first aid, and medical exams through Healthwise, an interactive library.
- Use the pharmacy tools to:
  - Check prescription drug costs.
  - Use DrugCompare to look at condition-specific drug treatments.
  - Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.
- Through Select Quality Care, learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.
- Use the Online Provider Directory to find hospitals that rank highest for certain procedures and conditions.

Cigna Mobile App

Download the Cigna mobile App from the Apple Store™ or Google Play. Your log in is the same as your mycigna.com log in.

Access health care professional directory

- Search for a doctor or health care facility from the Cigna national network and compare quality-of-care ratings. Access maps for instant driving directions

ID cards

- Quickly view ID cards (front and back) for entire family. Easily print, email or scan right from smartphone

Claims

- View and search recent and past claims. Bookmark and group claims for easy reference

Drug search

- Look up and compare actual costs at over 60,000 pharmacies nationwide. Find closest pharmacy location using GPS. Research medications and dosages. Speed-dial Cigna Home Delivery Pharmacy℠.

Account balances

- Access and view health fund balances. Review plan deductibles and coinsurance

Health wallet

- Store and organize all important contact info for doctors, hospitals and pharmacies. Add health care professionals to contact list right from a claim or directory search

Medical Insurance Opt-Out Credit

"Opting out" means you may choose to decline medical coverage for yourself and your family. Only employees who are covered under another medical plan, either as a dependent or through individually acquired coverage, can select this option. For example, you might consider opting out of medical insurance if your spouse has elected family medical coverage through his or her employer, or if you are covered under another medical plan.

You may opt out only when: enrolling for the first time as a new employee; as a current employee during Open Enrollment for the next plan year, or when you have an approved qualifying change in status. Your opt-out election will remain in effect through September 30, 2017 unless you or a qualified dependent experience an approved qualifying change in status event.

The Benefits of "Opting Out"

When you opt out, you will receive up to a $750 annual credit which you may apply toward voluntary pretax benefits, such as dental employee-only coverage, vision employee-only coverage, a Flexible Spending (FSA), and disability insurance. (**This is not a cash payout and can be used only for eligible expenses.** Although you cannot use credit dollars to pay for dental and vision coverage for your dependents, you can elect dependent coverage and pay for it through your own pretax payroll deductions.)

If you do not purchase voluntary pretax benefits or have a remaining balance after choosing voluntary pretax benefits using your credit, the money will automatically be deposited into a Health Care FSA that the District sets up for you. You can be reimbursed from your Health Care FSA for eligible expenses not covered by a health plan. Please see page 26 for more information about the Health Care FSA.

Dental Benefits

Delta Dental is the new dental benefits company beginning October 1, 2016. The SDOC offers District employees a choice of the three Delta Dental dental plans described in this Guide. Delta Dental covers most preventive and restorative procedures. Orthodontia is also covered, but varies by plan. See the Dental Plan Comparison Chart on the next page to determine which plan best fits your and your family's needs. Keep in mind that the dental plan year is calendar based - January 1-December 31. That means deductibles and maximums are recalculated every year.

DeltaCare® USA Dental HMO

When you enroll in the DeltaCare USA Dental HMO, you and your covered family members can access the dental care you need through DeltaCare USA's network of quality dentists. Each covered family member can choose their own general dentist from the network. You will need a referral from your general dentist to see any specialist, such as an endodontist, oral surgeon, pediatric dentist, or orthodontist.

DeltaCare USAFeatures and Benefits

- No deductible. No dollar maximums. No claim forms to file. No waiting periods for coverage.
- Reduced rates on all covered services.
- Full Disclosure Copays on all services
- Coverage for most preventive services at no charge.
- Up to four cleanings per year: two at no charge; two additional at low cost for adults and children.
- Discounts on complex procedures.
- Specialty care provided at the same fee as general care with an approved referral.
- Orthodontic benefits for adults and children.
- Teeth whitening covered.

Delta Dental PPO℠

When you enroll in the Delta Dental PPO, you and your covered family members can access the dental care you need through Delta Dental's network of quality dentists. You can visit any dentist, both in- and out-of-network, but you will pay less when you use an in-network provider. You do not need a referral to see a specialist.

Delta Dental PPO High Option and Low Option

You can choose either the High Option or Low Option PPO. Your premiums are higher in the High Option plan, but services are generally covered at a higher percentage.

PPO Features and Benefits

- Visit any dentist, in or out of Delta Dental's preferred provider network.
- No referral required to see a specialist.
- $2,000 Annual Maximum Benefit - new for 2016!
- Replacement of Missing Teeth are covered benefits - new for 2016!
- Composite fillings covered - new for 2016!
- Visit a network dentist for maximum savings.
- In network or not, you'll be reimbursed for all or part of your costs for covered procedures, up to your annual $2,000 maximum, after meeting your deductible or satisfying any waiting periods.
- Orthodontic benefits for children ages 19 or younger.
- Implants covered at 50%.
- Enhanced benefits for pregnant enrollees. This coverage includes an additional exam, cleaning or periodontal procedure as needed, once pregnancy is confirmed.

Dental Premiums - 20 Pays

	HMO		PPO			
			Low Option		High Option	
	Rate per Pay	Opt-Out Credit Rate*	Rate per Pay	Opt-Out Credit Rate*	Rate per Pay	Opt-Out Credit Rate*
Employee	$ 8.35	$ 0.00	$10.67	$ 0.00	$17.47	$ 0.00
Employee + One	$14.62	$ 6.27	$21.87	$11.20	$35.81	$16.90
Employee + Family	$22.97	$14.62	$38.26	$27.59	$62.64	$45.17

* *This is the premium you will be responsible for if you elect the Medical Insurance Opt-Out Credit and Dental Coverage. See page 17 for more information*

The Dental Plan Year is based on a calendar year: January 1st to December 31st.

Dental Plan Comparison Chart

The Dental Plan Year is based on a calendar year: January 1st to December 31st.

Benefit	HMO*	PPO			
		PPO High Option		PPO Low Option	
Annual Deductible (Calendar Year)	None	$50 per subscriber; $150 per family; does not apply to Class I care		$50 per subscriber; $150 per family; does not apply to Class I care	
Annual Maximum	None	$2,000 per covered person		$2,000 per covered person	
Class I • Diagnostic & Preventative	In-Network	In-Network	Out-of-Network**	In-Network	Out-of-Network***
Semi-Annual Cleaning (2 cleanings/calendar year)	No charge	No charge	No charge	20%	20%
Sealants	$5	No charge	No charge	20%	20%
X-Rays (Bitewings and Full Mouth)[1]	No charge	No charge	No charge	20%	20%
Fluoride Application	No charge	No charge	No charge	20%	20%
Office Visit Fee	$5	N/A	N/A	N/A	N/A
Class II • Basic Restorative Care					
Periodontal Maintenance Cleanings	$30 for 2 cleanings per year (add'l $55)	20% for 4 cleanings per year		40% for 4 cleanings per year	
Amalgam Fillings	$10-$20 (depending on complexity)	20%	20%	40%	40%
Surgical Extraction of Impacted Teeth	$45-$100 (depending on complexity)	20%	20%	40%	40%
Class III • Major Restorative Care					
Crowns[2]	$145 - $340†	50%	50%	50%	50%
Dentures[3]	$210 - $360†	50%	50%	50%	50%
Bridges[2]	$235 - $360†	50%	50%	50%	50%
Implants[2]	Not covered	50%	50%	50%	50%
Class IV • Orthodontics					
Dependent Children[3]					
• Evaluation	$0	50%	50%	50%	50%
• Orthodontic Treatment (24 month routine)	$1,900	50%	50%	50%	50%
Adults[4]					
• Evaluation	$0	Not covered		Not covered	
• Orthodontic Treatment (24 month routine)	$2,100	Not covered		Not covered	
Lifetime Orthodontic Maximum	N/A	$1,000		$1,000	

* *You must use a participating general dentist or be referred to a specialist*

** *Coverage based on Program Allowance, based on payment at 70th percentile*

*** *Coverage based on contracted fees for the PPO Network*

† *Delta Dental's copays Include lab fees*

1 *Bitewings: Dental HMO: unlimited; PPO: 1 per year. Full mouth: Dental HMO 1 every 2 years; PPO's 1 every 5 years.*

2 *Dental HMO one every 5 years (Implants not covered). PPO One every 5 years.*

3 *HMO: replacement only after 5+ years; PPO: 1 in 5 years. PPO up to age 19.*

4 *Once per lifetime.*

Note: This is only a brief summary of the plans and is intended for comparison purposes only. Please contact Delta Dental Insurance Company. This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, Please reference your Evidence of Coverage, Certificate of Coverage or Summary Plan Description.

Choosing a Dental Plan

Does the PPO offer any discounts on non-covered services or services above plan maximum?

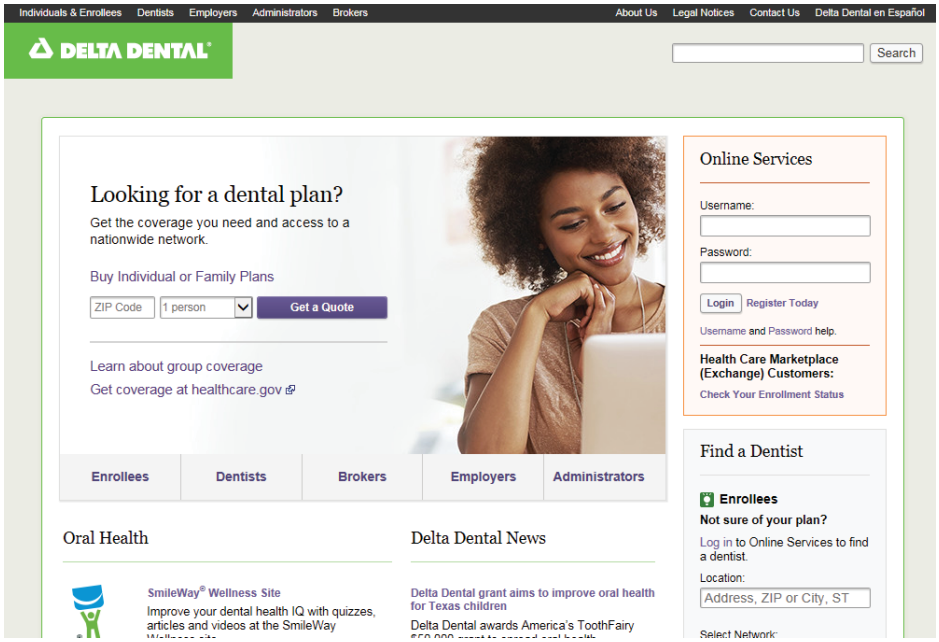
Yes. Delta Dental's negotiated fees with PPO (in-network) dentists extend to services not covered under your plan and services received after your plan maximum has been met. If you receive services from a PPO dentist that are not covered under your plan, you are only responsible for the dentist's PPO (in-network) fee.

Can I find out what my out-of-pocket expenses will be before receiving a service?

Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. Delta Dental recommends that you request a pre-treatment estimate from your dentist for services in excess of $300 (This often applies to services such as crowns, bridges, inlays, and periodontics.) To receive a free pre-treatment estimate, simply have your dentist submit a request for pre-treatment estimate to Delta Dental. You and your dentist will receive a benefit estimate for most procedures while you're still in the office, so you can discuss treatment and payment options, and have the procedure scheduled. Actual payments may vary depending upon plan maximums, deductibles, frequency limits, and other conditions at time of payment.

Find a Provider

As you consider enrolling in one of the new Delta Dental dental options, consider if your current provider is in the Delta Dental network or locate a provider near you.



For the DeltaCare USA HMO:

- Go to ***www.deltadentalins.com***
- On the right side menu under "Find a Dentist," add your location: Zip Code or City and State.
- Then under Select Network use the drop down menu to select Deltacare USA.
- You can then click Search to search all providers within your zip code or you can enter the dentist's name, practice name, etc.. Hit Search and view your results. Once you click on Search, you can refine your search results.

For the Delta Dental PPO:

- Go to ***www.deltadentalins.com***
- On the right side menu under "Find a Dentist," add your location: Zip Code or City and State.
- Use the drop down menu to select Delta Dental PPO.
- You can then click Search to search all providers within your zip code or you can enter the dentist's name, practice name, etc.. Hit Search and view your results. Once you click on Search, you can refine your search results.

How do I get credit for my deductible and plan year maximum?

Delta Dental will honor deductibles that have already been paid if the prior carrier provides the necessary data. If deductible data is not available Delta Dental will accept the enrollee's explanations of benefits statements (EOBs) from the prior carrier. To receive credit for deductibles and annual maximums, enrollees can request their dentist to submit their most recent benefits statement from their prior carrier when submitting their first Delta Dental claim. This information will be entered into Delta Dental's system.

Vision Benefits

The SDOC offers you the option of purchasing vision insurance through Humana Specialty Benefits. When you enroll, you will choose a provider from the Humana Specialty Benefits network at ***www.humanavisioncare.com.*** Present your ID card you will be receiving once enrolled to your provider at the time of service to receive the negotiated rates.

Vision Care Premiums - 20 Pays

	Rate per Pay
Employee	$3.85
Employee + Family	$11.77
Employee Opt-Out*	$0.00
Employee + Family Opt-Out*	$7.92

* *This is the premium you will be responsible for if you elect the Medical Insurance Opt-Out Credit and Vision Coverage. See page 17 for more information.*

Features and Benefits

- Eye health examinations, frames, glasses, or contacts based on the service frequency shown in the chart.
- LASIK surgery discount.
- Preferred member pricing for other frame and lens options.
- If you purchase eyeglasses or contact lenses from a Humana Specialty Benefits network eye doctor during the same year you had an eye exam, you will receive:
  - a 20% discount on a second pair of eyeglasses.
  - a 15% discount on your contact lens fitting fee.

If you have questions, call the Humana Specialty Benefits Customer Care Department at 1-866-537-0229 or visit ***www.humanavisioncare.com***.

	Vision Care Services	
Benefit	**In-Network**	**Out-of-Network**
Vision Exam	$10 copay	$35 reimbursement after copay
Materials Copay	$15 copay for lenses / frames	
Standard Lenses		
• Single Vision	Covered in full after copay	$25 reimbursement after copay
• Bifocal	Covered in full after copay	$40 reimbursement after copay
• Trifocal	Covered in full after copay	$60 reimbursement after copay
Frames	$50 wholesale allowance**	$50 reimbursement after copay
Contact Lenses		
• Electives	Select brands: Covered at 100%* Outside brands: $120 allowance	$120 allowance
• Medically Necessary (pre authorization required)	Covered at 100%	$210 allowance
Frequency		
• Exams	Every 12 months	
• Lenses or Contact Lenses	Every 12 months	
Frames	Every 24 months	
Other services		
• Lasik	Special rates and discounts available when benefits accessed through preferred providers	

* *Visitint, Ciba, Optima 38, Wesley Jensen - D2T4* ** *$100-$150 retail equivalent*

Life Insurance

Term Life and Accidental Death and Dismemberment (AD&D) Insurance

The District provides employees with basic group term life and AD&D insurance in the amount of one times your annual salary at no cost to you. An additional one times your annual salary in Board-paid life insurance is provided to employees whose pay is based on 10+ years experience.

Note that Professional Support employees earning less than $20,000 per year receive benefits based on the previously negotiated contract — see chart below.

Professional Support Staff *(non-instructional)* Negotiated Board-Paid Term Life Insurance Schedule

Annual Earnings (contract)	Amount of Life Insurance
$9,999 or less	$10,000
$10,000 - $14,999	$15,000
$15,000 - $19,999	$20,000
$20,000 or more	One times Annual Salary Rounded to the next $1,000

Designating a Beneficiary

You must designate a beneficiary when you first become eligible for life insurance coverage. You should review and update your beneficiary elections during each year's Open Enrollment. Your beneficiary designation for basic and optional life insurance may be changed at any time, either through the Online Enrollment System or by contacting R&BM for a form.

Note: If you designate a trust or a trustee, you must have a written trust agreement. If you designate a minor (a person who is not of legal age), it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid. This means there will be a legal expense for the beneficiary and a delay in payment. Please take this into consideration when naming your beneficiary.

Optional (Supplemental) Life Insurance

You can elect an additional one or two times annual salary in term life and AD&D insurance as a new employee without having to provide evidence of insurability (EOI). If you decide to increase your Optional Life Insurance during Open Enrollment you must submit an EOI form. MetLife will send you a pre-filled form once Open Enrollment ends for you to answer and return. MetLife will inform you if your increase has been approved.

Special Computation for Bus Drivers: There is a special computation for bus drivers based on actual time worked during the previous two pay periods, plus credit for extended routes. For example, your salary for a five-hour guarantee route bid is $15,000. If you win a bid for an extended route/field trip that pays an additional $15,000, your life insurance will be based on a $30,000 annual salary.

Life Insurance (continued)

MetLife Advantages℠

MetLife Advantages℠ is a comprehensive suite of valuable services that offers easy access to resources that can make a difference in your life. Whether you are faced with personal challenges or need planning support, you will find the assistance you need to get back on your feet and plan ahead.

Comfort and Guidance for Challenging Times

- Grief Counseling provides you, your dependents and your beneficiaries with up to 5 confidential counseling sessions per event to help cope with a loss — no matter the circumstances — whether it's a death, an illness, a divorce, losing a pet or even a child leaving home.
- Delivering the Promise provides valuable support and assistance at the time of a claim. Specialists help beneficiaries and their families identify eligible benefits, file insurance claims, and identify local resources, including grief counseling services and government agencies.
- Total Control Account helps your beneficiaries manage life insurance proceeds through a life settlement option that provides easy and immediate access to their funds.
    - Death claim proceeds are paid via an interest-bearing account with draft-writing privileges.
    - Relieves beneficiaries of the need to make immediate decisions about what to do with a lump-sum check, while giving them the flexibility to access funds as needed and earn interest on the proceeds as they assess their financial situation.

Professional and In-person Resources When It Matters

- Face-to-Face Will Preparation gives you or your spouse/domestic partner access to MetLife's face-to-face legal services to prepare a Will, Living Will, or Power of Attorney. In addition, you may access an attorney as many times as you need to make updates to these documents. Reimbursement is also available for out-of-network attorneys with set fees. (Participation in Optional Life Required)
- Face-to-Face Estate Resolution Services provides your beneficiaries and executors/administrators access to face-to-face legal representation for probating your and your spouse's/domestic partner's estates.
- WillsCenter.com helps you or your spouse/domestic partner prepare a Will, Living Will, Power of Attorney and HIPAA Authorization form on your own, at your own pace, 24 hours a day, 7 days a week.
- Special Needs Planning, offers services and guidance to help navigate the maze of legal and financial complexities when planning for the future financial well-being of your dependent with special needs.
- Funeral Planning Guide acts as a useful guide for your final wishes by documenting important financial information and decisions now so that your loved ones and beneficiaries have them later.
- retirewise® is a four-part workshop series that offers you comprehensive retirement education with the option to meet with a local financial professional to discuss your specific circumstances and individual goals.

Range of Solutions for Continuing Workplace Coverage

- Coverage for active and retired employees
- Services for workplace transitions
    - Portability provides the option to "port" or take your coverage with you if you become separated from or leave your company — a valuable feature in today's ever changing world.
    - Transition Solutions offers insurance and other financial products and services to help you and your family better prepare for your future in response to benefit changing events.

For more information on these programs please call **MetLife at 1-800 638-6420** or vist **www.metlife.com/mybenefits**

Disability Insurance

Have you ever thought about how your family would manage if an accident or major illness kept you from working for an extended period? Most people would have a hard time getting by without a regular paycheck. Disability insurance replaces a portion of your income if you are unable to work due to illness or injury. SDOC offers optional disability insurance through Aetna Educator Disability Plans. You can choose from two options: Platinum or Gold. Your premiums will be based on the level of protection you select available on the Benefits Enrollment System.

Eligibility

All benefited employees are eligible for this plan. If you are absent from work due to injury, illness, temporary layoff or leave of absence on your effective date of coverage, coverage will begin on the date you return to active employment.

Underwriting Guidelines

New Hires. First of the month coincident with or next following date of enrollment, if done within 30 days of your date of hire to sign up for coverage without having to provide Evidence of Insurability (answers to health questions). However, the full amount of coverage you select is subject to the 3/12 pre-existing condition limitation.

Currently Insured Employees. You can increase your level of coverage during Open Enrollment. Evidence of Insurability (answers to health questions) is not required. However, the additional coverage you select is subject to the 3/12 pre-existing condition limitation.

Late Entrants. Employees who do not sign up for coverage during their new hire period or the most recent Open Enrollment must wait until the next Open Enrollment to elect coverage. Evidence of Insurability (answers to health questions) is not required at the time you elect coverage. However, the full amount of coverage you select is subject to the 3/12 pre-existing condition limitation.

3/12 Pre-existing Condition Limitation

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

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

Benefit Amount

You can purchase a monthly benefit in $100 units, starting at a minimum of $200, up to $66^{2}/_{3}$ percent of your monthly earnings, with a maximum monthly benefit of $7,500.

Elimination Period

The elimination period is the length of time of continuous disability due to sickness or injury that you must wait before you are eligible to receive benefits. You choose an elimination period. The elimination period options are 14, 30, 60, 90 or 180 days.

If you select an elimination period of 30 days or less and are admitted to a hospital as a result of your disability, benefits will begin immediately and the remainder of the elimination period will be waived.

Waiver of Premium

Once you have received disability payments for 90 consecutive days, you do not have to continue paying disability premiums for as long as you are receiving disability payments under the plan.

Medical Treatment Benefit

A Medical Treatment Benefit will be paid when you receive treatment by a doctor as a result of sickness or injury, provided no other benefits are payable under the plan as a result of the condition for which the treatment was rendered.

The Medical Treatment Benefit will be the doctor's actual charge for services rendered, up to a maximum benefit of $50 for sickness or $100 for injury.

No benefit will be paid unless you are personally seen and treated by a doctor and the treatment is not for routine medical examinations or dental work.

No more than one benefit will be paid for the same or related condition unless your treatment dates are separated by 14 consecutive days. This benefit will not be paid more than four times per calendar year.

Disability Insurance (continued)

Monthly Hospital Indemnity Benefit

A Monthly Hospital Indemnity Benefit equal to two times the gross disability payment will be paid beginning on the first day of inpatient hospital confinement if you:

- are receiving or are entitled to receive disability payments under the plan; or
- have not completed the elimination period but would be entitled to receive disability payments under the plan upon completion of the elimination period.

The maximum Hospital Indemnity Benefit is 90 days. This benefit is paid instead of the disability monthly payment and it counts toward the maximum period of disability payment

Survivor Benefit

Your eligible survivor will be paid a lump sum benefit equal to three times the gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is no estate. In this case, no payment will be made.

Accelerated Survivor Benefit

Under certain conditions, an Accelerated Survivor Benefit may be paid to you if you are terminally ill. It is payable in a lump sum equal to three times the gross disability payment. An election to receive the Accelerated Survivor Benefit will result in the Survivor Benefit not being paid when you die.

Accidental Death and Dismemberment

An Accidental Death and Dismemberment payment will be made according to the Covered Losses and Benefit Amounts listed below if:

- death occurs within 90 days from the date of the accident; or
- the accidental bodily injury(ies) results in one or more covered losses within 90 days from the date of the accident

Covered Loss	Benefit Amount
Life	The Full Amount
One Hand or One Foot	One-Half of the Full Amount
Sight of One Eye	One-Half of the Full Amount

The Full Amount is 10 times the gross disability payment. The most that will be paid for any combination of covered losses from any one injury is the Full Amount.

Duration of Benefits

The duration of benefits depends on the plan you choose, as shown in the chart below.

Platinum Plan		Gold Plan	
Your duration of benefits is based on your age when the disability occurs as shown below:		Your duration of benefits is based on your age when the disability occurs and whether the disability is due to a covered injury or sickness, as shown below:	
Age at Disability	Platinum Duration of Benefits	Age at Disability	Gold Duration of Benefits
Your duration of benefits for injury or sickness is:		**Your duration of benefits for injury only is:**	
Less than age 60	To age 65, but not less than 5 years	Less than age 60	To age 65, but not less than 5 years
Age 60-64	5 years	Age 60-64	5 years
Age 65-69	To age 70, but not less than 1 year	Age 65-69	To age 70, but not less than 1 year
Age 70 and over	1 year	Age 70 and over	1 year
		Your duration of benefits for a sickness only is:	
		Less than age 65	5 years
		Ages 65-68	To age 70, but not less than 1 year
		Age 69 and over	1 year

Flexible Spending Accounts (FSAs)

Keep more of what you earn. The **Health Care FSA** and **Dependent Care FSA,** allow you to pay for certain eligible health and/or dependent care expenses using pretax dollars. This means that you will pay less in taxes and have more money to spend and save.

When you enroll in a flexible spending account, you specify the dollar amount you'd like to direct into your account from each paycheck, up to the annual maximum. You make deposits to your account through tax-free payroll deductions. You then use the money in the account to pay for your eligible health or dependent day care expenses. Cigna administers SDOC's flexible spending accounts.

Be sure to carefully estimate your FSA contribution amount. Any unused dollars in your account(s) at the end of the plan year may be forfeited (see page 27 FSA Carryover).

Annual FSA Contribution Amounts Limits

Type of FSA Account	Limits
Health Care FSA *(eligible health care expenses)*	$240 minimum up to $2,500 maximum
Dependent Care FSA* *(eligible day care and adult or elder care)*	Up to $5,000 if single or married filing a joint tax return Up to $2,500 if married filing an individual tax return

* You may be required to file Form 2441 with your annual income tax return. This form provides information about the person or organization providing the dependent care services.

You cannot transfer money between accounts. You'll need to carefully calculate the amount you plan to contribute to your FSA(s). Any unused dollars in your account(s) at the end of the plan year will be forfeited.

Health Care Flexible Spending Account

Account Number 3198508

Health Care FSA reimburses you for eligible medical, dental, or vision expenses for you, your spouse, or your eligible dependents. You can use it to pay for certain medical expenses not covered by another insurance plan for anyone you claim as a dependent on your tax return.

When you enroll in a Health Care FSA, your account is prefunded up to the amount you elect to contribute for the entire year. So even if you incur eligible expenses before the account is fully-funded, you can "spend" up to your total plan-year election before the funds are actually deducted from your paycheck and deposited into your account. Your Health Care FSA contributions will continue to be deducted from your paycheck throughout the year.

Accessing the Money In Your Health Care FSA

You will receive a Cigna HealthCare Visa Flexible Spending Account debit card when you enroll in a Health Care FSA. You can use your debit card to pay for eligible health care goods and services at the point of purchase. Funds will automatically be deducted from your Health Care FSA, reducing your account balance. The debit card eliminates your need to submit reimbursement requests.

Use your FSA debit card at all providers who accept Visa, including physicians, dentists, vision providers, hospitals, and pharmacies. Note that there is no Personal Identification Number (PIN) associated with the debit card. Always select "credit" when doing a transaction.

Flexible Spending Accounts (FSAs) (continued)

Cigna medical plan participants do not need to submit receipts for:

- Medical coinsurance at doctor's offices
- Medical coinsurance at a hospital or outpatient facility
- Pharmacy copays and coinsurance (if purchasing multiple prescriptions, have each prescription run as a separate transaction)

Cigna will mail a notice to your home address requesting documentation for expenses that cannot be substantiated electronically. If you do not provide necessary documentation after three notices, your debit card will be suspended until you provide the requested documentation.

Reimbursements

If you have an FSA debit card and use it, you do not need to submit reimbursement requests. If you don't have an FSA debit card or if you have one and do not use it, you must submit a reimbursement claim form (available on ***www.mycigna.com***) and attach all itemized receipts from the service provider. Receipts must include:

- Name of employee or dependent.
- Dates of service.
- Charges incurred.
- Explanation of Benefits (EOB).
- Note that canceled checks, bank card receipts, credit card receipts, and credit card statements are not acceptable forms of documentation.

Submit your claim form and all supporting documentation via mail or a dedicated claims fax line (which ensures confidentiality) to the address or fax number on your claim form.

Direct Deposit of Reimbursement Checks

You can choose to have your reimbursement checks direct deposited into your personal checking account. Log into your *mycigna.com* account and follow the instructions on screen. You will need your bank routing number and account number. Plan ahead, it takes 20 days to verify the account information before deposits can begin.

Information About Weight-Loss and Smoking Cessation Programs

The IRS now allows prescribed smoking cessation programs to be reimbursable under a Health Care FSA, even if there is no specific illness.

Expenses incurred for weight-loss programs and special foods may only be reimbursable if the treatment is prescribed by a physician as medically necessary to prevent, treat, mitigate, or alleviate a specific, objectively diagnosable medical defect or illness (i.e., hypertension, arteriosclerosis, or diabetes). If the special food is a substitute for the patient's normal diet, it is reimbursable only to the extent that the cost exceeds the cost of a normal diet.

FSA Carryover

The U.S. Department of the Treasury modified how flexible spending accounts work. You may be able to carry up to $500 into the next year's FSA. In order to be eligible for the carry over, you must enroll in an FSA for the subsequent year. If you terminate your FSA, all funds not spent will be forfeited and will not carry over. So, plan carefully.

Dependent Care Flexible Spending Account

When you enroll in a Dependent Care FSA, you can set aside money to pay for eligible non-medical **dependent day care expenses** for your children and/or elderly parents so you and your spouse can go to work. Examples of eligible expenses include a child care or adult care center, a nursery school, summer day camp, or a caregiver for an elderly or incapacitated dependent.

Eligible Expenses

Under IRS rules, dependent care must be provided by a person with a Social Security number or by a dependent care facility with a Taxpayer Identification number. Dependent care provided by any sitter who you or your spouse claim as a dependent on your tax return cannot be reimbursed through your Dependent Care FSA. This includes dependent care services provided by your children or stepchildren under age 19.

When estimating your dependent care expenses, do not include vacation time or sick time during which you or your spouse will not be at work or at school – even if you must pay your day care provider to hold your dependent's space. This is not an eligible expense under IRS regulations.

How it Works

When you enroll in the Dependent Care FSA, you will need to submit reimbursement claims to Cigna. Unlike a Health Care FSA, your Dependent Care FSA is not prefunded. This means that you will be reimbursed only up to the balance in your account

Flexible Spending Accounts (FSAs) (continued)

at the time you submit your claim. If your claim amounts to more than your account balance, the unreimbursed portion of your claim will be tracked by Cigna. You will automatically be reimbursed as additional deductions are deposited into your account, until your entire claim is paid out.

Note: Because of the way the District payroll deductions are taken and the fact that you must pay the day care provider before receiving reimbursement, you will experience a negative cash flow during the first month of the plan year. In subsequent months, the reimbursement from the previous month's deduction can be used to pay the day care provider for the current month.

Reimbursements

To obtain reimbursement from your dependent care FSA, complete a claim form (available at ***www.mycigna.com***) and attach itemized receipts that include:

- The dependent's name(s).
- The period during which the services were rendered.
- The name, address, and Taxpayer ID or Social Security number of the individual or organization providing services.
- Alternatively, if the above information is documented on the reimbursement form, you can have the provider sign the reimbursement form in place of a receipt.
- Note that canceled checks, bank card receipts, credit card receipts, and credit card statements are not acceptable forms of documentation.

Submit your claim form and all supporting documentation via mail or the dedicated claims fax line (which ensures confidentiality) to the address or fax number on your claim form.

Direct Deposit of Reimbursement Checks

You can choose to have your reimbursement checks direct deposited into your personal checking account. Log into your *mycigna.com* account and follow the instructions on screen. You will need your bank routing number and account number. Plan ahead, it takes 20 days to verify the account information before deposits can begin.

How Much Can I Save?

The actual amount you save will vary by the amount you contribute, how much you earn, and your tax-filing status and exemptions. In the following examples, Maria, Lisa, and Alex are all in the same tax bracket, but each contributes different amounts to their FSA(s).

Maria Saved $280

She contributed:

Health Care FSA	$1,000
Dependent Care FSA	$0
Total Contributions	$1,000
Her Tax Bracket*	x 28%
Savings	$280

Maria can make a car payment with her savings.

Lisa Saved $1,526

She contributed:

Health Care FSA	$450
Dependent Care FSA	$5,000
Total Contributions	$5,450
Her Tax Bracket*	x 28%
Savings	$1,526

Lisa's savings equaled one of her mortgage payments.

Alex Saved $700

He contributed:

Health Care FSA	$2,500
Dependent Care FSA	$0
Total Contributions	$2,500
His Tax Bracket*	x 28%
Savings	$700

Alex saved enough to pay for a new personal computer.

** Federal income tax + Social Security*

Tax-Sheltered Annuities

SDOC offers employees the opportunity to contribute to a 403(b) Tax Sheltered Annuity. Tax Sheltered Annuities are a type of retirement plan that is available to public education employees. These tax-free plans enable you to save money for retirement. This plan is optional and is offered in addition to your Florida Retirement System retirement benefits.

Following are examples of the types of investment vehicles to which you can contribute:

- **Fixed-Interest and Variable Annuities.** Annuities are sold only by life insurance companies. Fixed interest annuities usually provide protection of principal and a current interest crediting rate. Variable annuities usually offer a fixed interest account along with separate accounts that are invested in bond and/or equity markets.
- **Service-Based Mutual Funds and Custodial Accounts.** These products are offered by investment management companies and brokerage firms. Investment portfolios can include funds from a single fund family or a custodial platform that spans several fund families on a single statement.
- **No-Load/Low-Fee Mutual Funds.** No-load funds are described as investments with no sales fees on the market-based mutual funds offered. Ongoing investment management fees are charged to the funds selected. The no-sales fee/low-asset management fee offerings are good for those individuals who do not want to work with an investment advisor.

Select a Board-Approved Company & Agent

Visit the Benefits section of the District's web site for an up-to-date listing of agents who can assist you in selecting the product that helps you reach your financial goals. You must contact an approved company and agent to enroll in or change your Tax-Sheltered Annuity.

Once you have reviewed all your options with an agent and you are ready to enroll, the agent will send your Salary Reduction Form to Risk and Benefits Management. There are a few investment companies that do not require you to work with agents, so the Salary Reduction Form is also available on Benefits Corner.

Canceling Your Contribution

You must complete a Salary Reduction Form and submit it to Risk and Benefits Management prior to the payroll in which you want your contributions to end. Your agent can help you complete this form or you can download and print one from Benefits Corner or the Risk and Benefits Management website.

SDOC Board Approved Tax Sheltered Annuity Companies

403(b)/403(b)(7) Accounts

Ameriprise Financial	1-800-862-7919
*MetLife	1-800-560-5001
Pacific Life	1-800-722-2333

403(b)/403(b)(7) Accounts and 457(b) Deferred Compensation Plans

*AIG/VALIC	1-800-369-0314
American Century	1-800-345-3533
*AXA Equitable	1-800-628-6673
Fidelity Investments	1-800-343-0860
Great American (GALIC)	1-800-854-3649
*Horace Mann Company	1-800-999-1030
*VOYA Retirement Plans (formerly ING)	1-800-584-6001
The Legend Group	1-800-749-4221
*Life Ins. Of Southwest (LSW)	1-800-579-2878
Lincoln Investment Planning	1-800-242-1421
*Oppenheimer Funds	1-800-525-7040
*Plan Member Services	1-800-874-6910
Security Benefit Group/NEA	1-888-222-3003

**Also offer ROTH 403(b)*

Trustmark Accident Insurance and Universal LifeEvents® Insurance

The District has partnered with Trustmark Insurance Company to bring you two voluntary benefits that can build on the benefits provided by the District, giving you added protection that you and your family may need. You can use Trustmark voluntary benefits as planning tools to help you make educated choices for your financial future.

Accident Insurance

In the absence of a major illness, accidents can create your biggest exposure to out-of-pocket costs before your deductible is met -- especially if you have active children.

Trustmark Accident insurance helps you offset the cost of unexpected bills related to covered accidents that occur every day - on the playground, in the home, even on the job. Benefits for initial care, injuries and follow-up care are paid directly to you.

Life Insurance and Long-term Care

Trustmark Universal LifeEvents® insurance helps provide financial protection for your family if something happens to you. It offers a combination of permanent life insurance plus Living Benefits for long-term care, so you're covered for both in one affordable and portable plan. Life insurance builds cash value over time that you can borrow against later. Family coverage is also available.

Trustmark Accident Insurance

Trustmark Accident insurance is designed to cover unexpected expenses that result from all kinds of covered accidents on or off the job, even sports related and household ones. It provides cash benefits to cover things in addition to your health insurance. Benefits are paid directly to you without any restrictions on how you can use them, in addition to any other coverage you have.

- *Guaranteed Issue* – no medical questions to answer, but your spouse must answer a disability question to qualify for the plan.
- *Guaranteed Renewable* – as long as premiums are paid.
- Rates don't increase and benefits don't decrease because of age.
- *Family Coverage* – apply for your spouse, children and dependent grandchildren.
- *Portability* – take your coverage with you at the same premium even if you change jobs or retire.
- *Convenient Payroll Deduction* – no bills to watch for, no checks to mail. A direct bill option is available when you change jobs or retire.

Accident Insurance - 20 Pays

	Rate per Pay
Employee	$10.40
Employee + Spouse	$16.08
Employee + Children	$24.75
Employee + Family	$30.43

Trustmark Accident Insurance Schedule of Benefits[1]

Initial Care

Hospital Benefits	
Admission Benefit (per admission)	$3,200
Confinement Benefit (per day up to 365 days)	$500
ICU Benefit (per day up to 15 days)	$1,000
Emergency Room Treatment	$150
Ambulance	
Ground	$600
Air	$2,500
Initial Doctor's Office Visit	$200
Lodging (per night up to 30 days per accident)	$200
Surgery Benefit	
Open, abdominal, thoracic	$2,000
Exploratory	$200
Blood, Plasma and Platelets	$600
Emergency Dental Benefit	
Extraction	$150
Crown	$450

Follow-Up Care

Accident Follow-Up Treatment	$200
Physical Therapy	
Up to six visits per person per accident	$100
Appliance	$250
Transportation	
100+ miles, up to three trips	$600
Prosthetic Device or Artificial Limb	
More than one	$2,000
One	$1,000
Skin Grafts	25% of burn benefit

Accidental Death

Employee	$100,000
Spouse[2]	$50,000
Child	$25,000

Accidental Death – Common Carrier

Employee	$200,000
Spouse[4]	$100,000
Child	$50,000

Injuries

Fractures	
Open reduction	up to $15,000
Closed reduction	up to $7,500
Chips	25% of closed amount
Dislocations	
Open reduction	up to $12,000
Closed reduction	up to $6,000
Laceration	$50-$1,000
Burns	
Flat amount for:	
Third-degree 35 or more sq. in.	$25,000
Third-degree 9-34 sq. in.	$4,000
Second-degree for 36% or more of body	$2,000
Concussion	$200
Eye Injury	
Requires surgery or removal of foreign body	$400
Ruptured Disc	$1,000
Loss of Finger, Toe, Hand, Foot or Sight	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	$40,000
Loss of one hand, foot or sight of one eye	$20,000
Loss of two or more fingers, toes or any combination of two or more losses	$4,000
Loss of one finger or one toe	$2,000
Tendon/Ligament/Rotator Cuff Injury	
Repair of more than one	$1,500
Repair of one	$1,000
Exploratory surgery without repair	$200
Torn Knee Cartilage	$1,250
Exploratory surgery	$200

Wellness Benefit

Two per person annually	$100
Routine physicals, immunizations and health screening tests. 60-day waiting period applies.[3]	

1 Benefits are payable only as the result of a covered accident. Benefits may vary by state and additional benefits may be available in some states. Most benefits are paid once per person per covered accident unless otherwise noted.
2 In some states, spouse, domestic partner or civil union partner.
3 Your policy/group certificate will contain specific covered conditions and exact terms and conditions

Trustmark Universal LifeEvents

How does LifeEvents work?

LifeEvents combines two important benefits into one affordable product.

permanent life insurance
+ long-term care
LifeEvents

With LifeEvents, your benefits may be paid under the Accelerated Death Benefit Insurance Rider, under the Long-Term Care Insurance Rider, or as a combination of both. Let's take a closer look.

Accelerated Death Benefit Insurance Rider

Most people buy life insurance for the financial security of the death benefit. And it's easy to see why. A death benefit puts money in your family's hands quickly when they need it most. It's money they may use any way they want to help cover short- and long-term expenses like these:

- Funeral costs
- Rent or mortgage payments
- College tuition for children or grandchildren
- Debt
- Retirement and more

Long-Term Care Insurance Rider[1]

This benefit makes it easy to accelerate the death benefit to help pay for home healthcare, assisted living, nursing care and adult day care services when you are chronically ill, should you or your covered spouse ever need them.

It pays a monthly benefit equal to 4 percent of your death benefit for up to 25 months.

Benefit Restoration Insurance Rider

Restores the death benefit that is reduced by the Long-Term Care Insurance Rider, so your family receives the full death benefit amount when they need it most.

Features you'll appreciate

Lifelong protection – Provides coverage that will last your lifetime.

Family coverage – Apply for your spouse even if you choose not to participate. Dependent children and grandchildren may be covered under a Universal Life certificate.

Accelerated Death Benefit Insurance Rider – Accelerates up to 75 percent of your death benefit if your doctor determines your life expectancy is 24 months or less.

Guaranteed renewable – Guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all certificates in your class changes.

The LifeEvents Advantage

LifeEvents is unique. It's designed to match your needs throughout your lifetime, so you have the benefits you need, when you need them most. See for yourself:

Working years

LifeEvents pays a higher death benefit during working years when expenses are high and your family needs maximum protection. Then at age 70, when expenses typically reduce, LifeEvents reduces the death benefit amount to better fit your needs; however, your benefits for the Long-Term Care Insurance Rider never reduce.[1]

Throughout retirement

LifeEvents pays a consistent level of benefits during retirement, which is when you may be susceptible to becoming chronically ill and may need long-term care services.

Let's see LifeEvents in action

(Example: 35-year-old, $8/week premium, $75,000 benefit)

Before Age 70		Age 70+	
Death Benefit	$75,000	LTC Benefit	$75,000
LTC Benefit	$75,000	Death Benefit*	$25,000

*Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 64 and under.

Separately priced benefits:

Children's term life insurance rider – Covers newborns through age 23.

EZ Value – Automatically raises your benefits to keep pace with your increasing needs, without additional underwriting.

1The Long-Term Care (LTC) Insurance Accelerated Death Benefit Rider is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services, and to qualify for benefits you must be chronically ill. Pre-existing condition limitation may apply. Please consult your certificate for complete details.

Enrollment for Newly Hired Employees

You must use the Benefits Enrollment System to enroll in your benefits. To help you navigate the system, enrollment instructions begin on page 35.

New Employee Enrollment

After attending your Benefits Orientation, you will receive a call from your school or facility secretary clearing you for employment and letting you know you are now able to enroll in benefits using the Benefits Enrollment System. Emails will also be sent to your District email address reminding you to enroll. It is vital that you check your email for updates from Risk & Benefits Management. Contact your supervisor if you do not receive your District e-mail log-in and password within a week after you are cleared for employment.

If you do not log on and enroll in benefits by your deadline, you will automatically be enrolled in the following plans.

Medical Insurance: LocalPlus Plan, employee-only coverage.
Life Insurance: Board-Paid Term Life Insurance.

All elections (active and default) are final and cannot be changed until the next Open Enrollment unless you experience an IRS qualifying event (see page 8).

Enrollment Deadline and Effective Dates

Enrollment Deadline

Your enrollment deadline is two weeks from the date you are cleared for employment. Your school or facility secretary will notify you when you are cleared.

Effective Dates

All benefited staff — Your benefits are effective the first of the month after your date of hire.

***Note:** If your potential effective date has passed, you have not yet enrolled and are still within your enrollment period, *insurance is effective the day of enrollment*.

Dependent Verification

New hires must furnish proper documentation to verify dependent eligibility see page 3 for a list of required documents.

Open Enrollment for Current Employees

August 31, 2016 to September 14, 2016
For the Plan Year October 1, 2016 – September 30, 2017

You must make your benefit elections for the new plan year during Open Enrollment. Your elections will be effective from October 1, 2016 to September 30, 2017. You cannot change your benefits during the year unless you experience an IRS qualifying event (see page 8).

You must use the Benefits Enrollment System to enroll by 4:30 p.m. on September 14, 2016. After that time, you will be locked out of the system.

If you were hired after June 30, 2016 the elections you made as a new hire will remain in effect through September 30, 2017. You will not be able to log onto the enrollment system during Open Enrollment or change your elections unless you experience a qualifying event (see page 8).

How to Enroll -- Benefits Counselor

All locations will have Benefit Counselors on site for in person individually scheduled meetings. During your 30 minute scheduled appointment, the Benefits Counselor will:

- Review your enrollment information and make benefit election changes
- New! Verify eligible dependents (see page 3 for details)
- New! Emergency Contact and Beneficiary Collection (see page 3 for details)
- Confirm your benefit elections through the Enrollment System
- Educate you on Guaranteed Issue limits available on Trustmark Voluntary Benefits - Accident Insurance and Universal Life Insurance with Long Term Care (see pages 30-32)

If employees enroll on their own through the benefits enrollment system or just continue enrollment for their current dependents, they are still required to provide the required documentation to a Benefits Counselor. **Failure to provide appropriate documentation will result in cancellation or non-enrollment of dependent coverage retroactive to the beginning of the 2016-2017 plan year.** But remember, if you want to continue or elect one or both Flexible Spending Account you must re-enroll per IRS guidelines. All your current elections (except FSAs) will automatically roll over and remain in effect from October 1, 2016 through September 30, 2017.

Schedule an Appointment

Schedule your appointment online at *www.myenrollmentschedule.com/osceola* or *by calling 866-998-2915*. You will receive a reminder email the day before your appointment.

Please make sure that you make an appointment to meet with an onsite Benefits Counselor to ensure enrollment is properly completed. The Benefits Counselor will also enter you into the Wellness Promotions where you can win prizes and gift cards! If you have questions about the enrollment process or scheduling please call 866-998-2915.

Benefits Enrollment System Step-by-Step Instructions

On the following pages are step-by-step enrollment instructions, along with screen shots to help you become familiar with the system.

New Employee Enrollment

Go to *http://benefits.osceola.k12.fl.us*.

1. Your User ID is your 9-digit Social Security number without dashes (e.g., 123456789).
2. Your password will be your date of birth in CCYYMMDD format (for example, if your date of birth is December 3, 1967, you would enter: 19671203).
3. Be sure to make your benefits decisions before you log into the system. Once you confirm your elections, you will be locked out from making further changes.
4. Make sure you complete your enrollment by the deadline noted in your initial email, or you will default into the Plus In-Network Plan and Board-Paid Term Life Insurance, which may or may not be the best plans for you. Go to *http://benefits.osceola.k12.fl.us*.

Open Enrollment

Go to *http://benefits.osceola.k12.fl.us*.

1. Your User ID is your 9-digit Social Security number without dashes (e.g., 123456789).
2. Your password will be your date of birth in CCYYMMDD format (for example, if your date of birth is December 3, 1967, you would enter: 19671203).

Enrollment Instructions

1. Visit *http://benefits.osceola.k12.fl.us* from any computer that has Internet access.
2. Once in the system, click on the *Begin Open Enrollment* button. You will be directed to view each benefit option, one-by-one. Click on the *Save* and *Back* arrows to move from step to step. **(Caution! Do not use your browser's Back and Forward buttons. This will cause your data to become corrupt.)**
3. Make your selections.
4. Review your selections and make sure they are correct before you confirm your choices. Once you reach the last step and confirm your choices, your choices are final and you will be locked out from making any changes.
5. Confirm your elections and print a copy for your records. It is important to keep a copy of this verification as proof of your elections. (Set your printer settings to "landscape" to ensure all data gets printed.)

All elections are final and cannot be changed until the next Open Enrollment for the next plan year unless you experience an IRS qualifying event (see page 8).

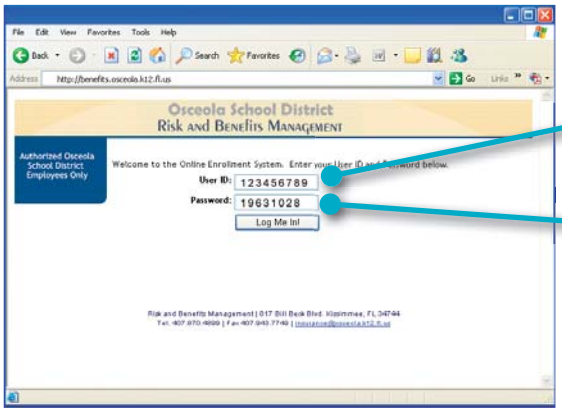
Enrollment Instructions (continued)

ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

SAVE FOR LATER

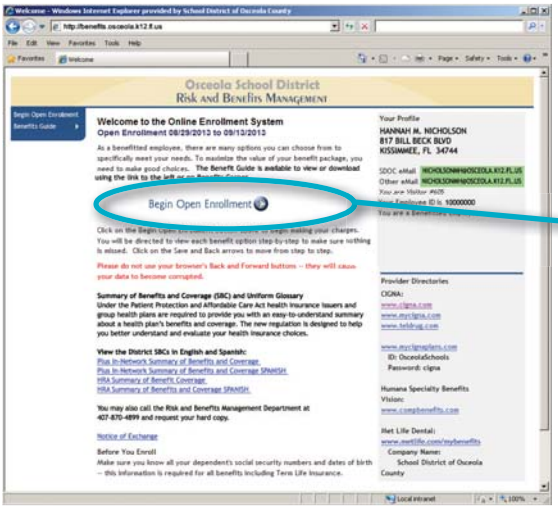
Screen Shots

Benefits Enrollment Instructions



Log-In

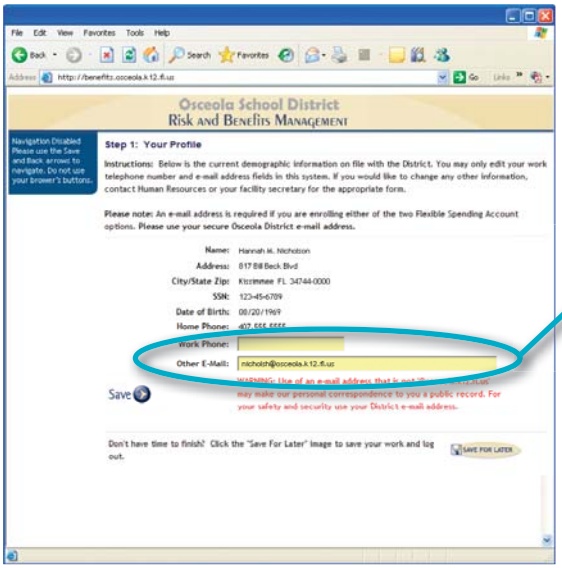
- Visit *http://benefits.osceola.k12.fl.us*
- Your Social Security number is your User ID (no dashes). Example: An employee with a Social Security number of 123-45-6789 would enter the number as 123456789.
- Your date of birth is your password (CCYYMMDD). Example: An employee with a birth date of October 28, 1963 would enter 19631028.



Welcome Screen

- When you first enter the system, you will see a welcome screen. During Open Enrollment or as a new hire, you'll see a ***Begin Open Enrollment*** arrow in the middle of the screen. Click this to begin making your changes.

- Review each screen and make your elections. If you need to log out and come back at a later time, you can save your changes by using the *Save for Later* button at the bottom of the screen.



Profile

- The **Profile** screen allows you to view your current address, telephone number and email address. To change your home address, contact your facility secretary or Human Resources for the appropriate form.
- Update your email address in the space provided.

  TIP: Your District email address is secure. Enter this email address instead of one outside the network.
- Click the *Save* arrow to continue to the next step.

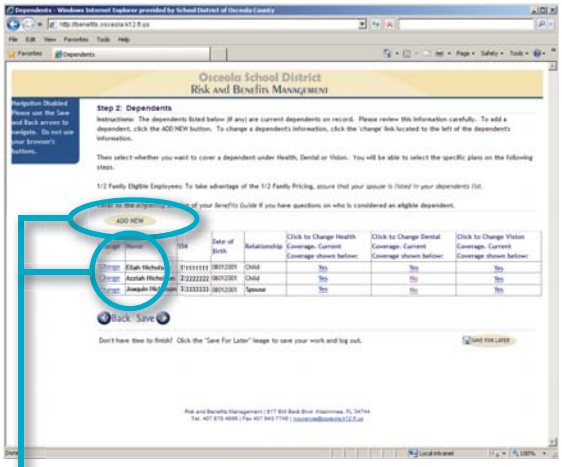
Enrollment Instructions (continued)

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots

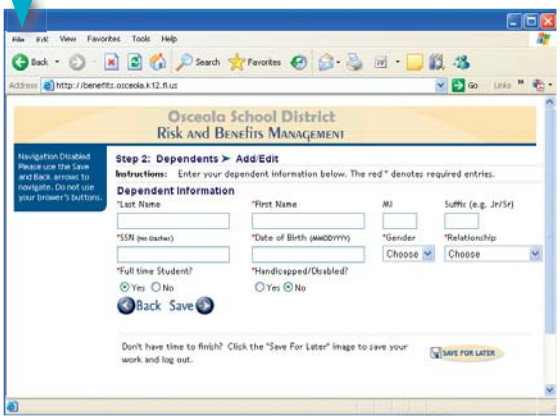
Benefits Enrollment Instructions

Dependents



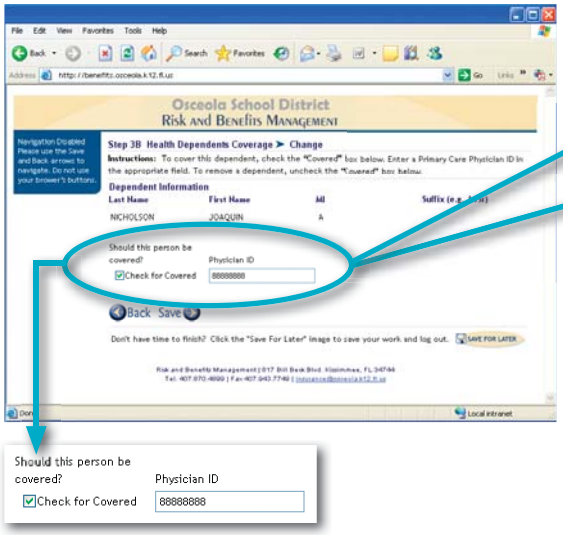
- You can add, but not delete, those eligible dependents you want to cover under the plans that offer dependent coverage. Click the *Add New* button to add a new eligible dependent. Click the "Change" link located to the left of a dependent's name to change his/her information. You only need to enter dependent information one time. Then, select whether you would like to cover each dependent under Health, Dental and Vision insurance.

  TIP: You are not allowed to delete dependents from this screen. If you entered information by mistake, contact Risk & Benefits Management to correct the mistake.



- Enter or edit your dependents' demographic information
- Use the *Save* arrow to advance to the next step. You will be able to select the specific plans on the following steps.

  TIP: You are required to enter your dependents' Social Security numbers and dates of birth for the plans under which they are being covered. Collect this information before you begin the process.

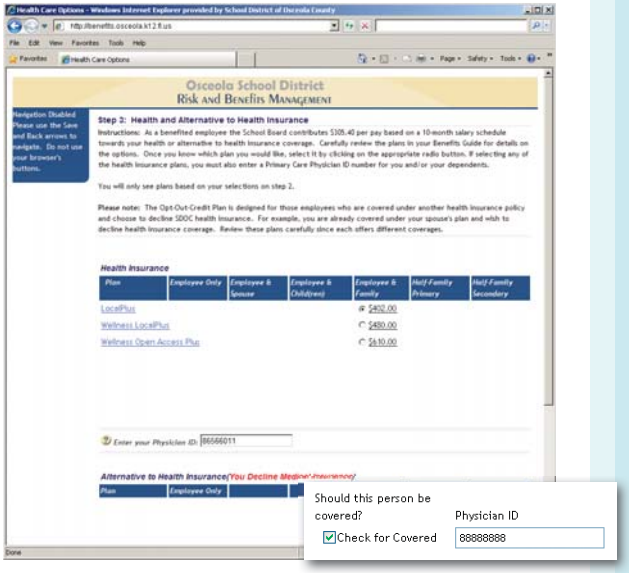
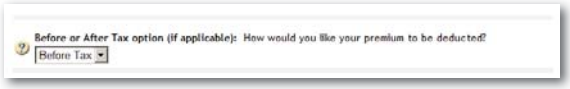
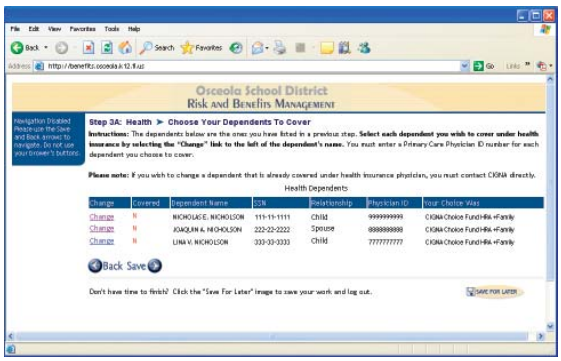


- To cover or drop a dependent under each option click the Yes/No link to the right of the dependent's relationship.
- To cover a dependent, click the "Check for Covered" box you will need to repeat this step for each plan.
- To drop a dependent, uncheck the "Check for Covered" box.
- Click the *Save* arrow to continue to the next step.

Enrollment Instructions (continued)

ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

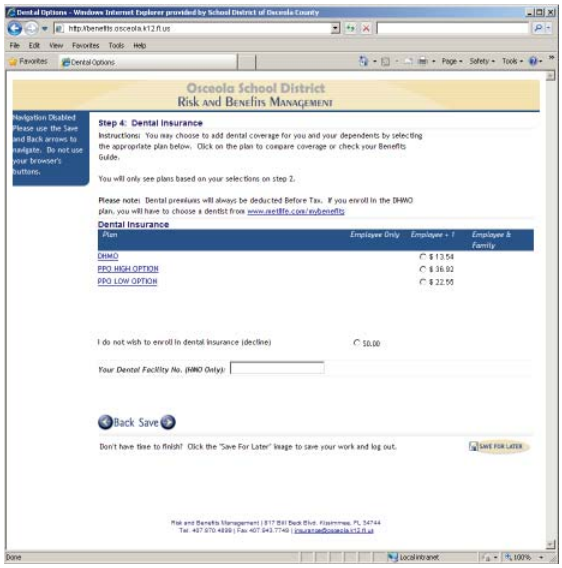
SAVE FOR LATER

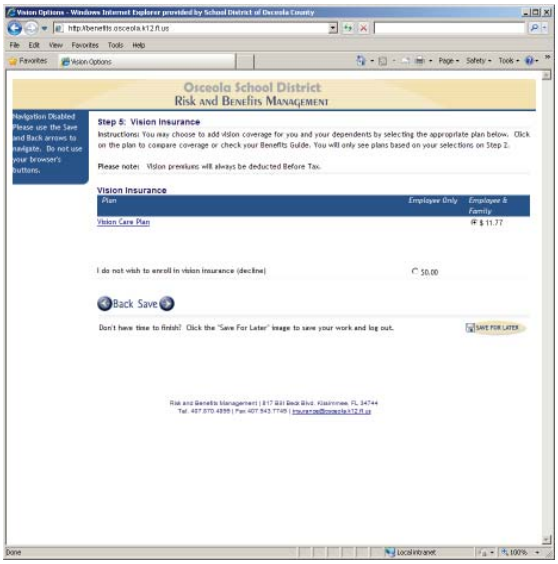
Screen Shots	Benefits Enrollment Instructions
	**Health Insurance and Opt-Out Credit** • Choose your Health Insurance plan or Opt-Out Credit here. You will only see the plans and premiums you qualify for based on your selections in Step 2. For example, if you did not add your spouse on the *Dependents* screen, you will not have the option of choosing coverage for your spouse. To make the dependent coverage option available, return to the *Dependents* screen and add your spouse (or other eligible dependents) to your list. **TIP:** Half-Family option is available only when the spouse's information you entered on the Dependent step matches another SDOC benefits-eligible employee.
	• Before you hit Save, select whether you want your deductions taken *Before Tax* or *After Tax*. Before Tax means you would like your deductions taken out before your income and Social Security taxes are calculated and deducted, reducing the amount of income taxes you pay. *After Tax* means you want your deductions taken out after your income and Social Security taxes have been deducted. For more information, speak with your personal accountant or tax attorney. **TIP:** Be sure to scroll down to see all your options. • If you enroll in the Opt-Out Credit you will be directed to an added step in which you must provide information about your primary insurance coverage (coverage you have through a spouse's employer or other source not connected with the District). If you enter a District group number, the page will display an error until you adjust your information.
	• If you select dependent coverage for a plan, your dependent list will display to confirm your earlier choices. If you make any changes on this step, you will be redirected back to Step 2. Otherwise, you will click *Save* to move on to the *Dental* step. • The Covered column shows the dependents you are covering. "Y" for Yes displays in black text; "N" for No displays in red text.

Enrollment Instructions (continued)

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots





Benefits Enrollment Instructions

Dental Insurance

- The **Dental Insurance** screen lets you choose which dental insurance, if any, you would like to select or drop.
- You will only see plans and premiums you qualify for based on your selection in Step 2. So, if you did not add a spouse under your *Dependents* step, for example, you will not have the option of choosing this coverage for a spouse. (To make the options available, return to the *Dependents* step and add that dependent to your list.)

  TIP: Before or After-Tax option. Dental premiums are always deducted before taxes. That is why there is no Before or After-Tax option.

Vision Insurance

- The **Vision Insurance** screen lets you choose which vision insurance, if any, you would like to select or drop.
- You will only see plans and premiums you qualify for based on your selection in Step 2. So, if you did not add a spouse under your *Dependents* step, for example, you will not have the option of choosing this coverage for a spouse. To make the options available, return to the *Dependents* step and add that dependent to your list.

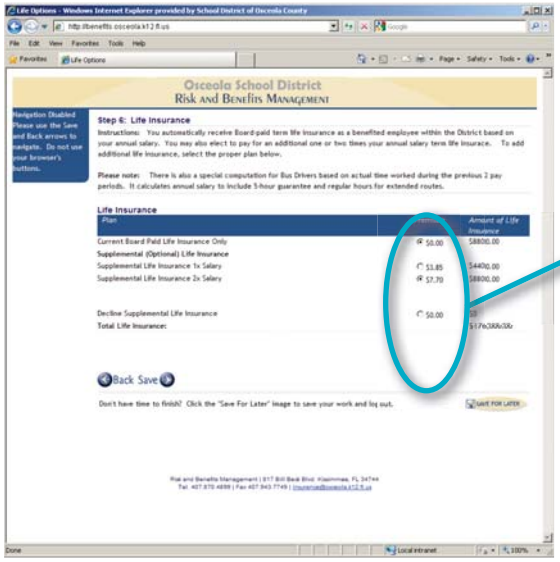
  TIP: Before or After-Tax option. Vision premiums are always deducted before taxes. That is why there is no Before or After-Tax option.

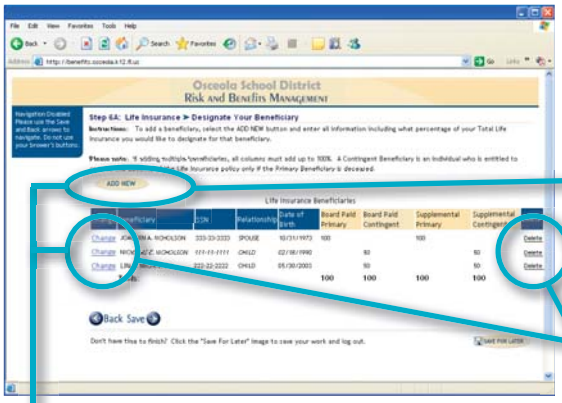
Enrollment Instructions (continued)

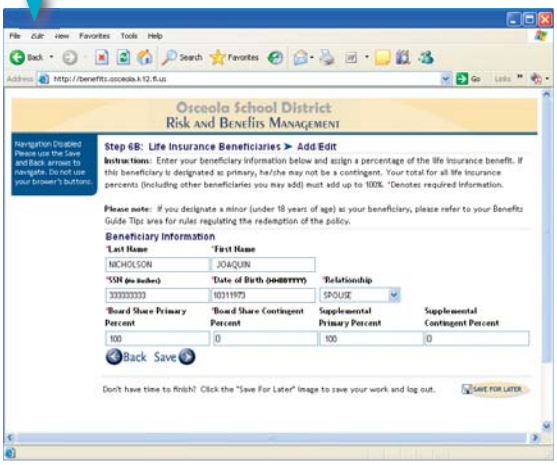
ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

SAVE FOR LATER

Screen Shots







Benefits Enrollment Instructions

Life Insurance

- The **Life Insurance** screen lets you choose how much *Term Life Insurance* you want to purchase, if any, and designate your beneficiary for both Board-Paid and any *Supplemental (Optional) Life Insurance* you purchase.
- Use the radio buttons to make your selection.
- Once you make your selections, the total Life Insurance benefit will be displayed. As a new hire, the amount is automatically approved. When increasing coverage during Open Enrollment your selection is not automatically approved until you complete an Evidence of Insurability form. Once open enrollment ends, expect the form for your completion in the mail from MetLife. Your change will not become effective until R&BM receives approval from the insurance carrier. You must acknowledge you are aware of this by clicking the check box before proceeding.
- After clicking the *Save* arrow, you will be directed to the Designate Your Beneficiary step. All District employees must designate a Board-Paid beneficiary. You will also need to designate a beneficiary for Supplemental (Optional) Life Insurance if you elect this coverage.
- To add a beneficiary, click the *Add New* button, then enter the information in the fields provided, as well as the percentage of life insurance you would like to direct to that beneficiary. You can designate as many beneficiaries as you'd like for each category; make sure each column adds up to 100%.
- To change a beneficiary, click the "Change" text to the left of the beneficiary's name, then edit necessary fields and assign a percentage of the life insurance benefit to that beneficiary.
- To remove a beneficiary, click *Delete* to the far right of the beneficiary's name.
- Click the *Save* arrow to continue to the next step.

TIP: A Contingent Beneficiary is a person(s) you name to receive the life insurance benefit in the event that your primary beneficiary(ies) is (are) no longer alive. Example: You name your spouse as your primary beneficiary and your children as the contingents. If you and your spouse both die, the children would receive the life insurance benefit. If your spouse is still alive, he/she will be the one receiving the benefit. Naming a contingent beneficiary is not required, but is recommended.

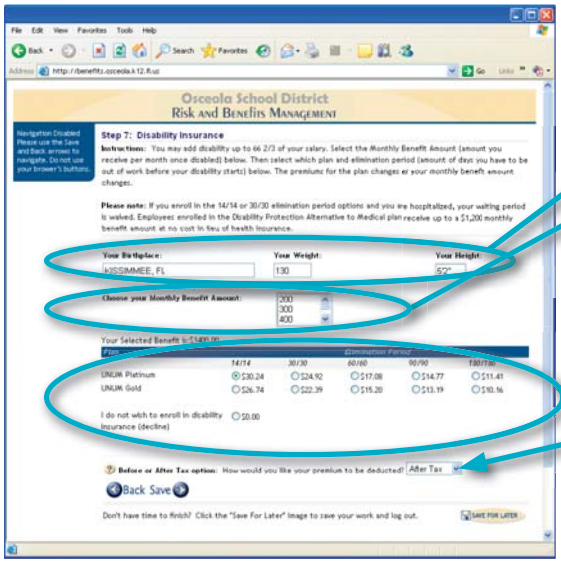
Enrollment Instructions (continued)

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots

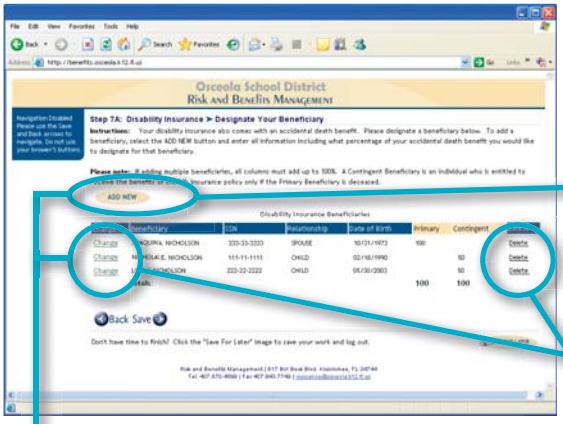
Benefits Enrollment Instructions

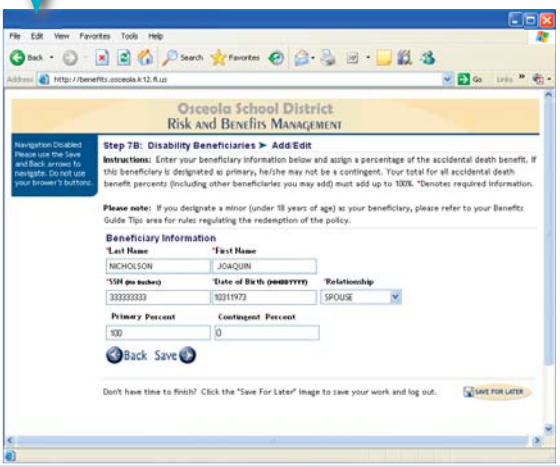
Disability Insurance



- The **Disability Insurance** screen lets you choose how much disability insurance you want to purchase.
- You must enter your birth place and height and weight.
- Then select the monthly benefit you want to purchase (the amount of money you would receive each month if you were disabled). The menu only shows the maximums you are eligible for.
- Then select the elimination period (the number of days you have to wait for benefits to begin once disabled) for the plan you want (Platinum or Gold — you cannot enroll in both).
- Finally, you must select whether you want your disability premiums deducted from your paycheck before or after taxes are calculated and deducted from your paycheck.

  TIP: Remember, if you select before tax and you are disabled, your disability benefit will be taxed. Most likely, the tax savings on your premium will be significantly less than the taxes you would pay on a disability benefit.





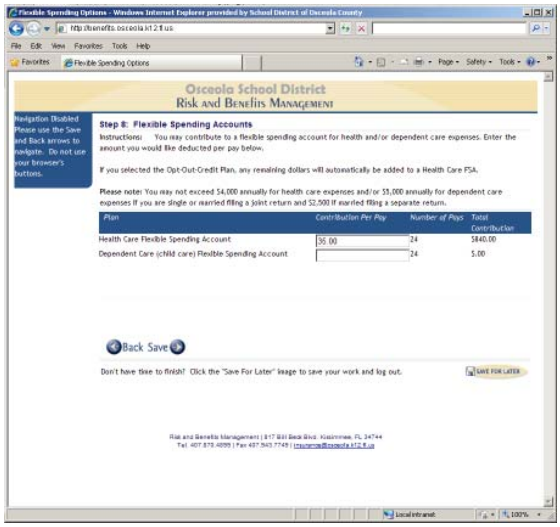
- When you elect disability coverage, you automatically receive Accidental Death and Disability coverage. This coverage requires you to designate a beneficiary (for the accidental death benefit), so you will be navigated to the *Designate Your Beneficiary* step.
- To add a beneficiary, click the *Add New* button, then enter all information in the fields provided, along with the percentage of your benefit you would like to direct to that beneficiary. You can designate as many beneficiaries as you'd like for each category; make sure each column adds up to 100%.
- To change a beneficiary, click the "Change" text to the left of the beneficiary's name. Then edit the necessary fields and assign the percentage of your benefit you would like to direct to that beneficiary.
- To remove a beneficiary, click the "Delete" text to the far right of the beneficiary's name. If you are enrolled in the Opt-Out Credit, amounts highlighted in Pink will be at no cost to you but will be deducted from the $750 available in the fund. Those highlighted in White, you will have to pay the full cost of the premiums.

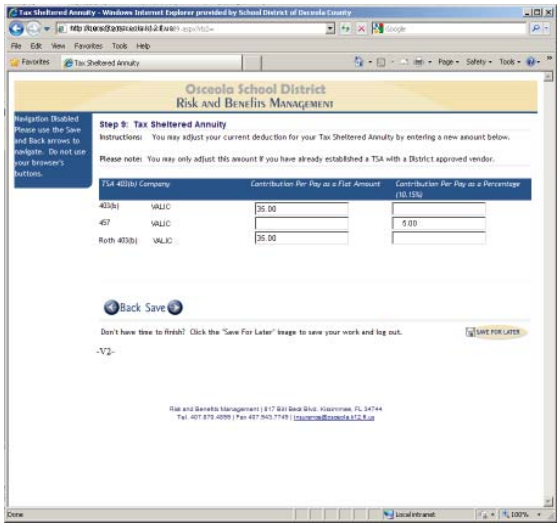
Enrollment Instructions (continued)

ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

SAVE FOR LATER

Screen Shots





Benefits Enrollment Instructions

Flexible Spending Accounts

- The **Flexible Spending Accounts** screen lets you enter the amount you would like to contribute from each paycheck to your Health Care FSA and/or your Dependent Care (Day Care) FSA.
- Enter the per-pay amount you would like directed into either of the two plans.
- Your annual amount will be calculated based on the number of pays you have already elected. If you are enrolled in the Opt-Out Credit, any remaining balance applied to your Health Care FSA will display on the screen.
- If you do not want an FSA, click *Save* to skip this step.
- Click the *Save* arrow to continue to the next step.

  TIP: Be sure you enroll in the right FSA. If you want only the Health Care FSA, do not enter an amount under the Dependent Care FSA as this premium cannot be reimbursed.

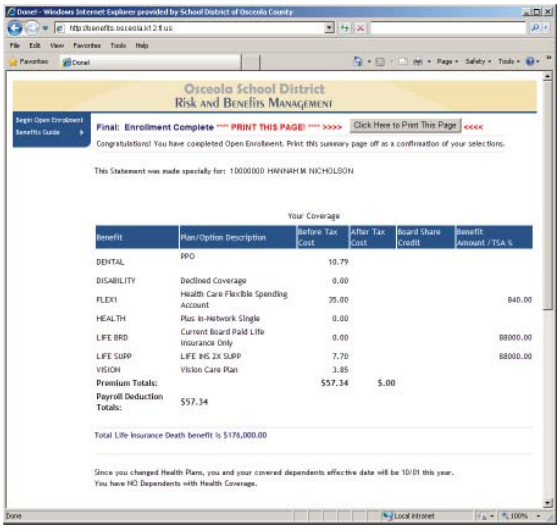
Tax Sheltered Annuity

- Employees who currently have a TSA can increase or decrease their current deduction. To suspend a current deduction a Salary Reduction Form must be submitted, see Page 29 for instructions. Employees who do not have a TSA must contact an approved agent or company to open a TSA, see Page 29.
- Enter your contribution amount in the appropriate field.
- Click the *Save* arrow to continue to the next step.

Enrollment Instructions (continued)

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots



Benefits Enrollment Instructions

Enrollment Complete

- The **Enrollment Complete** step shows the deductions you chose, the amount of life insurance you elected, your covered dependents (if any), and your beneficiaries.
- Use the *Back* arrow if you need to make any changes.
- Confirm your elections and print a copy for your records. It is important to keep a copy of this verification as proof of your elections. Set your printer settings to "Landscape" to ensure all data gets printed.
- You can enter the Enrollment System multiple times during Open Enrollment. Your elections become final when the System closes on September 13, 2013 at 4:30 p.m.
- Click the *Save* arrow to complete the process.

At the close of Open Enrollment, your elections are final and cannot be changed until the next Open Enrollment period unless you experience an IRS qualifying event (see page 8).

Employee's Responsibilities

You are responsible for:

1. Reading this benefits guide thoroughly and prior to enrolling in benefits.
2. Making informed decisions when you enroll or decline enrollment.
3. Reviewing your paycheck stub when your benefits become effective and verifying that your deductions are for the benefits you elected.
4. Notifying the Risk & Benefits Management department within 60 days of your benefits effective date if the premiums for benefits you elected are not being deducted from your paycheck, or the deduction amounts are not correct.
5. Enrolling only eligible dependents, as described in the "Dependent Eligibility" section on page 5.
6. Notifying the Risk & Benefits Management department within 30 days of the date a covered dependent no longer meets dependent eligibility requirements.

Center for Employee Health

Call 407-483-5757 or visit SDOCEmployeeHealthCenter.net

The School District has partnered with Florida Hospital to provide an onsite Center for Employee Health.

The Center provides services you would normally receive at your primary care physician's office and urgent care clinic in addition to health services that focus on improving your health. Services include primary care, urgent care, preventive care, occupational health, workers' compensation, physical therapy, nutritional counseling, prescription medications, and x-rays.

Monday - Friday 7 a.m. to 7 p.m.
Saturday 8 a.m. - Noon

Located at 831 Simpson Rd., Kissimmee, FL 34744 (next to TECO)

What services does the Center provide?

Primary Care/Urgent Care

- Men's and Women's Specific Health Care
- Chronic Disease Management
- Complete Annual Physicals
- School and Sports Physicals
- Flu Vaccines and Immunizations
- Health Screening and Testing
- Laceration care

Physical Therapy

- Orthopedic Conditions
- Low Back Pain

Medical Nutrition Therapy

- One-on-one consultations for individualized nutrition and lifestyle plans
- 8 week Weight Management Program
- Group Nutrition Classes

Occupational Health

- Drug and Alcohol Testing
- Workers' Compensation

On-Site Prescription Dispensing

On-Site X-Ray and EKG

Ask Erin

Staffed by our partners at Florida Hospital, all your protected health information is kept strictly confidential. That's why Florida Hospital has provided a Communications Liaison, Erin Lysik, who is available to answer all your questions concerning the Center. Simply email Erin at AskErin@FLHosp.org.

Be sure to look for Erin at your location. She's out and about visiting all worksites to ensure you are not only educated on the Center's offerings but to help you navigate this exciting benefit.

FLORIDA HOSPITAL

How do I make an appointment?

Call 407-483-5757 or visit SDOCEmployeeHealthCenter.net to schedule your appointment.

Center for Employee Health (continued)

Call 407-483-5757 or visit SDOCEmployeeHealthCenter.net

Meet Our Providers

Dr. Scott Wiltz, M.D.:

Dr. Wiltz earned his Doctorate of Medicine from Louisiana State University and completed his Family Medicine Residency at Eglin Air Force Base. He is certified in Advanced Life Support in Obstetrics, Advanced Cardiac Life Support, Neonatal Resuscitation, Pediatric Advanced Life Support, Advanced Trauma Life Support, and the S.T.A.B.L.E. Program. Dr. Wiltz is currently serving as a Fellow for the American Academy of Family Medicine. He is a member of the American Academy of Family Physicians, Uniformed Services Academy of Family Physicians and the Society of Teachers of Family Medicine.

Dr. Nikita Shah, D.O.:

Dr. Shah earned her Doctorate of Osteopathic Medicine from Lake Erie College of Osteopathic Medicine, completed her Family Medicine Residency at Florida Hospital East Orlando in August and joined our team in September. She is an active member of the American Academy of Pain Management as well as the American Academy of Family Physicians. Dr. Shah is certified in Pediatric Advance Life Support, Basic Life Support, and Advanced Cardiac Life Support.

Jenny Santos, PA-C:

Jenny Santos, PA-C completed her Master's in Physician Assistant Studies from Nova Southeastern University. She is currently certified by the National Commission on Certification of Physician Assistants and holds additional certifications in Pediatric Advance Life Support, Basic Life Support, and Advanced Cardiac Life Support. Santos is an active member of the American Academy of Physician Assistants as well as the Florida Academy of Physician Assistants.

Julie Canada, ARNP-C:

Julie Canada earned her Masters in Nursing at Valparasio University, Indiana. She then went on to complete her doctorate studies at the University of Central Florida. Currently certified by the American Academy of Nurse Practitioners, she also holds certifications in Digital Retinal Screening, Diabetes Master Clinician, Aesthetic Medicine and D.O.T Physical Assessments.

Dr. Jonathan Schwartzman, D.O.:

Dr. Schwartzman earned his Doctorate of Osteopathic Medicine from Western University of Health Sciences and completed his Family Practice Residency at Florida Hospital. Dr. Schwartzman is Board-Certified in Family Practice; adult and pediatric-trained. He is an active member of the American Osteopathic Association and is certified in Basic Life Support.

Dr. Brent Ellis, M.D.:

Dr. Ellis earned his Doctorate of Medicine from Loma Linda University and completed his Internship and Residency at Florida Hospital. He is pediatric and adult-trained; Board-Certified with the American Board of Family Practice.

Jason Cirolia, PT, DPT:

Jason Cirolia earned his Doctorate in Physical Therapy from the University of Central Florida. He then completed his Military Musculoskeletal Residency at Baylor University. Jason is a current member of both the American Physical Therapy Association and the Florida Physical Therapy Association.

Brittany Graves MS, RD, LDN:

Brittany graduated from Illinois State University while earning her Bachelors and Masters of Science for Food, Nutrition and Dietetics and completing her dietetic internship. She is a registered dietitian/licensed nutritionist. Over the past 10 years Brittany has been working as a Clinical Dietitian in a hospital and worked several years as an outpatient dietitian.

Center for Employee Health
In Partnership with Florida Hospital

Captain Pep and the Wellness Crusaders

Captain Pep and the Wellness Crusaders are here to help guide everyone through an adventure for better health. Your journey starts now! Teaming up with 4theHealthofit!, the Wellness Crusaders are your superheroes in wellness. Their goal is to encourage employees and dependents to seek preventive health care, participate in health screenings, and make moderate improvements in health habits. The team understands that wellness is more than just fitness, weight-loss, or disease management; rather it is an individual's overall wellbeing. When individuals feel their best, they perform their best. Health improvement doesn't have to be difficult or time consuming and, it can be fun. The district is committed to helping employees and their dependents make informed decisions around their health while offering rewards unlike any other.

Whenever you see one of the superheroes, pay attention! They are dedicated to better health, educating employees, great rewards, and a stronger, more productive staff. It all starts right now with Captain Pep and the Wellness Crusaders!

4 the Health of It!

Your health and wellness is very important to the School District of Osceola County. The District's worksite wellness program, called ***4theHealthofIt!***, is designed to help you make small, but meaningful lifestyle changes that add up to big health rewards.

The program's activities are intended to help you enhance your health and wellness, reduce your risk for certain chronic diseases, and have fun in the process. By applying these 4 simple steps, you can lead a healthier lifestyle and help to prevent chronic diseases.

Recognized by the American Heart Association as a *Fit-Friendly Worksite*, *4theHealthofit!* continues to add programs every year. The following pages highlight many educational and fitness programs as well as on-site testing available to employees throughout the school year. We hope you come join us on your adventure to health!

the 4 Health of it!

The School District of Osceola County, FL

1 Eat smart
·watch your portion size

2 Move more, sit less
·30 minutes most days of the week

3 Relax, don't stress
·take deep breaths and time for yourself

4 Get regular check-ups
·practice preventive care, see your doctor

Employee Wellness Program
Providing tools and education to help
employees live a healthier lifestyle.

What do I do if I have questions about programs offered or want to enroll?

You can contact:

Anabell Blanner, Cigna Wellness 407-870-4840; Email: CignaW@osceola.k12.fl.us

4 the Health of It! Wellness Programs

Preconception Care

Are you trying to have a baby or are just thinking about it? It is never too early to start planning the most exciting adventure of your life. Employee Wellness now offers a FREE Preconception Educational Booklet with important information about your first preconception visit, prenatal care, tests for reproductive health, folic acid, and the steps you need to take for a healthier you and a baby to be. Also available to you is FREE guidance on maternity and newborn length of stay, Family Medical Leave Act Eligibility and other beneficial medical resources you will want to get familiarized with before you decide to become pregnant.

Healthy Pregnancy Healthy Babies

The Healthy Pregnancy Healthy Babies Program is designed for District employees and their spouses who are currently pregnant and want to learn more about achieving a healthy pregnancy and delivering a healthy baby. This program offers guidance in prioritizing healthy pregnancy actions while providing critical answers for both planned and unplanned pregnancies.

You can enroll in the program at any time throughout your pregnancy. Our program is free of charge and in order to be eligible for the cash incentives, you must complete the steps listed on the To-Do-List and submit the information for verification.

Below is the cash incentive you can qualify to receive based on the stage of your pregnancy that you joined the program:

Enrollment into the program before the *12th week of pregnancy*	up to $150 worth of incentives
Enrollment into the program *between the 12th and 23rd week*	up to $100 worth of incentives
Enrollment into the program *after the 23rd week*:	up to $50 worth of incentives

Some other perks of the program include free access to a certified health and wellness coach, a registered nurse and a fun baby shower hosted for you and your partner!

In order to be eligible for the cash incentives, you must complete the steps listed on the To-do list, attend a child birth class, and submit the information for verification. This program is free of charge to eligible participants.

New! TeachWell™

The average length of a career of a teacher today is under five years. Teachers today are facing a personal energy crisis like never before. TeachWell™ is program (the first of its kind) to treat our teacher burnout and student achievement issues at the root: the health and happiness of our teachers.

This six week online course (with optional face-to-face components) will be offered though Moodle for teachers and professional staff who: feel burned out at the end of a work day; feel ill-equipped to manage their personal stress and work stress; feel unhappy, stressed, depressed, drained, or frustrated during their work days; or would be interested in improving the learning environment in their classrooms.

Energy is our most critical asset and more often than not, it is our fastest depleted resource. Energy must be managed effectively in a classroom to ensure the teachers are able to perform at their best in order to create the best possible learning environment for students. How do we do this? Energy is improved through emotional health and wellbeing (positive outlook, positive self-efficacy, etc. a strong sense of purpose and work/life balance), sustainable and healthy eating habits for maximum energy and focus, a strong resilience to stress, and mindful movement throughout the day, including a healthy exercise routine. The TeachWell™ program will help you learn the skills necessary to maximize energy, engagement, and resilience.

4 the Health of It! Wellness Programs (continued)

On-site Flu Shot Clinics

Prevent seasonal flu and get vaccinated! The flu is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs. Some of the most common signs and symptoms of flu include but are not limited to headaches, runny or stuffy nose, fever, muscle or body aches, cough and sore throat. It's important to note that not everyone with flu will have a fever.

The single best way to prevent the flu is to get a flu vaccine each season. That is why 4theHealthofit! wants to take a proactive approach to help improve its employees' health by offering every year onsite flu shot clinics.

This year's flu vaccination will begin soon after the flu vaccine is available. However, getting vaccinated even later can be protective, as long as flu viruses are circulating.

Stay tuned to the announcement for our 2016-2017 onsite flu shot clinics schedule.

Health Kiosks

High blood pressure usually has no warning signs or symptoms, so many us of don't realize we have it. A way to know your blood pressure numbers is to regularly measure it by utilizing the school district health kiosks.

Be proactive with your health and take control over it! Measuring your blood pressure is quick and painless and can help you identify other health problems or one on the horizon.

There are twelve health kiosks located throughout the School District, one at each high school, the District Administration Center, Ross Jeffries Service Center, and all three Transportation Centers. These interactive bilingual health kiosks can help you manage most vital statistics. The kiosks are fully automatic and can measure blood pressure, heart rate, body weight, and body mass index (BMI), in just minutes. You can also upload your glucose and pedometer readings.

Another convenient feature is the ability to use the barcode from your employee badge to record readings and to create a personal and confidential health record with an account at Lifeclinic.com. You can log-on *Lifeclinic.com* and generate reports to share with your physician.

Girls' Getaway Weekend

Join Employee Wellness for a fun filled girls' getaway weekend! The weekend features workshops on women wellness topics and lots of fun-filled girlie activities. This is a celebration of a successful school year, stress buster and a fun time with your work friends. NO BOYS ALLOWED! Date TBA.

Guys Night Out

Join Employee wellness for a guy's only night out with your work buds. This will be a fun-filled afternoon and evening with "It's a man world " workshops followed by a round trip coach ride to local sporting event, all- inclusive tailgate party with all you can eat food, game tickets, commemorative gift and door prizes! NO GIRLS ALLOWED! Date TBA.

4 the Health of It! Wellness Programs (continued)

Onsite Mammograms

4theHealthofit! recognized that today's woman is a multitasker. With that in mind, we've partnered with Florida Hospital to make it easier for the women of the District to improve their health by bringing onsite mammograms right to their worksite.

- Screening mammograms will be read by a breast imaging sub-specialized radiologist within two to ten days after your exam.

- If you brought your physician prescription, the report will be delivered to your doctor within two to ten days.
- Whether you brought a prescription or not, you will receive a letter within 30 days of your exam with the results in clear and simple language.
- All reports are available at any Florida Hospital or FRi location after ten days of your exam.
- If a follow-up appointment is needed, please call 407.303.1615, or go online to FloridaHospitalFRi.com, unless instructed differently.

Below you will find the mammogram schedule for the 2016-2017 school year.

Call 407.303.1615 for a reservation

Mammogram Schedule

Location	Date
Center for Employee Health	June 30, 2016
Center for Employee Health	July 27, 2016
St. Cloud High School	August 31, 2016
Osceola High School	September 7, 2016
Center for Employee Health	September 21, 2016
Center for Employee Health	October 14, 2016
Celebration High School	October 19, 2016
Center for Employee Health	November 19, 2016
Horizon Middle School	November 30, 2016
Harmony High School	December 1, 2016
Center for Employee Health	December 7, 2016
Ross E. Jeffries	December 8, 2016
Harmony Community School	January 23, 2017
Bellalago Charter School	January 24, 2017
Center for Employee Health	January 28, 2017
Discovery Intermediate School	January 30, 2017
Neptune Middle School	January 31, 2017

4 the Health of It! Wellness Programs (continued)

Mammogram Schedule (continued)

Location	Date
East Lake Elementary School	February 1, 2017
Michigan Avenue Elementary School	February 10, 2017
Boggy Creek Elementary School	February 13, 2017
Mill Creek Elementary School	February 16, 2017
Chestnut Elementary School for Science and Engineering	February 17, 2017
Administration Center and Gateway High School	February 20, 2017
Center for Employee Health	February 25, 2017
Hickory Tree Elementary School	March 1, 2017
Koa Elementary School	March 2, 2017
St. Cloud Middle School	March 10, 2017
Narcoossee Elementary and Narcoossee Middle School	March 29, 2017
Kissimmee Elementary School and Kissimmee Middle School	March 30, 2017
Partin Settlement Elementary School	March 31, 2017
Poinciana Academy of Fine Arts	April 6, 2017
Center for Employee Health	April 8, 2017
St. Cloud Elementary School	April 14, 2017
Westside K-8 School	April 18, 2017
Denn John Middle School	April 20, 2017
Center for Employee Health	April 26, 2017
Parkway Middle School	May 3, 2017
Liberty High School	May 4, 2017
Center for Employee Health	May 10, 2017
Thacker Avenue Elementary School	May 18, 2017
Sunrise Elementary School	May 19, 2017
Center for Employee Health/TECO/PATHS/ALCO	May 20, 2017
New Beginnings	May 24, 2017
Poinciana High School	May 25, 2017
Center for Employee Health	June 28, 2017
Center for Employee Health	July 19, 2017

How will my SDOC medical plan pay for a screening mammogram?
Employees and dependents covered under SDOC's medical plans receive one mammogram per year without a copay.

It has not been exactly 365 days since my last mammogram.
Under SDOC's insurance, you may receive one screening mammogram per year; it does not have to be exactly 365 days.

I opt-out of the District's medical plan, can I still get my mammogram?
Most other insurances accepted. Call 407-303-1615 for specifics.

4 the Health of It! Wellness Programs (continued)

The Right Direction Program

This online resource is available to employees and their family members that are dealing with depression and emotional health. This website provides tools that will raise your awareness about stress and depression, demystify the signs and symptoms and treatments, and give you the information you need to get help. When you're dealing with stress and depression, you may feel like you're "in a fog." When you utilize "Right Direction" this can be your first step on the path to brighter, clearer days!

Visit: ***http://www.rightdirectionforme.com/***

Colorectal Cancer Campaign

Did you know that colorectal cancer is the third most common type of cancer in the United States? However, according to the Centers for Disease Control and Prevention (CDC) 60% of colorectal cancer deaths could be prevented if all men and women ages 50 years and older were screened routinely.

In an effort to prevent colorectal cancer, 4theHealthofit! in partnership with Cigna provides a colon cancer screening program for the school district employees that are covered under the school medical benefit plan. Employees ages 50-64, who have not had or are overdue for a colorectal cancer screening, will be offered during the month of March the option to request an at-home screening test called the InSure® Fecal Immunochemical Test (FIT). The InSure® FIT™ is an easy to complete colorectal cancer screening test recommended by the American Cancer Society (ACS).

What are your risks?

- Age – 90% of colorectal cancer cases occur in people ages 50 or older
- Family history of polyps or colon cancer
- A personal history of colon polyps, chronic inflammatory bowel disease or colon cancer
- Lifestyle issues such as tobacco use, obesity and physical inactivity

Don't take a chance on your health or your life. Getting tested is the most important step you can take to help prevent colorectal cancer.

"I don't have symptoms."

Fact: Colorectal cancer doesn't always cause symptoms, especially early on.

" It doesn't run in my family."

Fact: Most colorectal cancers occur in people with no family history.

4 the Health of It! Wellness Programs (continued)

Yoga

Join 4theHealthofit! for YOGA starting back again early fall 2016! This 50-minute class is designed for those new to yoga or those that are interested in a foundational class. Classes include entering, warm-ups, asana/yoga pose practice, relaxation and breathing techniques.

Some of the benefits include but are not limited to strengthening and toning of your body, increase in vitality and flexibility and the creation of a calming effect to help you release stress.

You will be required to transition up and down from the floor and need to bring to class a yoga mat or large towel, water, and comfortable clothing. It is recommended that you don't eat a heavy meal at least two hours before the class.

Location and Time To Be Announced in the Fall

Transportation Transformation

Lessen the sedentary nature of your job!

We understand that as a bus driver you deal with several competing and conflicting demands every day such as driving congested streets, keeping to a timetable and working odd shift times. Fortunately, Employee Wellness is offering you the opportunity to make it easy for you to stay healthy.

Join Transportation Transformation Fitness program for a chance to get healthier, at your own pace, when it fits into your schedule, and at a level of participation that fits your lifestyle. Designed to improve your cardiovascular endurance and strength!

Who: All Transportation staff members!
When: Mondays, Wednesdays and Fridays from 9 a.m. to 10 a.m.
Where: Simpson Road Bus Center - PA Room
401 Simpson Road Kissimmee, FL 34744

Wellness Calendar

Be sure to check the Wellness Calendar frequently for added classes and resources. Visit http://www.osceolaschools.net/departments/risk_and_benefits_management click on 4theHealthofit! then the Wellness Calendar.

Leave of Absence

Going on a leave of absence? You can keep your District benefits while on a District-approved leave.

Paying Premiums

Employees who are granted a Leave of Absence (LOA) may elect to continue coverage through the District. Employees will be responsible for paying the full cost of premiums. This includes Board-Paid Health and Life Insurance, medical dependent coverage, supplemental life insurance, dental, vision, disability insurance, flexible spending account contributions, Accident Insurance and LifeEvents.

An employee on leave must pay their benefit premiums directly to the Risk and Benefits Management office. Premiums are due by the first of every month (with a 10-day grace period). Failure to pay premiums by the end of the grace period will result in termination of benefits.

A Leave at the End of the School Year

Employees who are granted a Leave at the end of the school year will continue to have Board-Paid benefits until July 19th. Employees will then be responsible for paying all premiums, including the Board-Paid portion, from July 19th to continue coverage.

A Leave During the School Year

Employees who are granted a Leave during the school year will be responsible for paying all premiums, including the Board-Paid portion, from the date the Leave begins.

Family Medical Leave Act (FMLA)

Eligibility

FMLA requires SDOC to provide up to 12 weeks of unpaid, **job-protected leave** to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for the District for at least one year, and have worked for 1,250 hours over the previous 12 months. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Your Rights Under FMLA

- 12 weeks maximum duration
- Job protection
- Continuation of Board-Paid benefits. (Employee is responsible for optional benefits including dependent coverage, life insurance, dental, vision, disability insurance, flexible spending account and Trustmark product contributions.)

FMLA Approved Circumstances

- Birth of a child
- Adopting a child or becoming a foster parent
- To care for the employee's seriously ill spouse, child or parent
- An employee's serious health condition
- To care for a covered service member who is recovering from a serious illness or injury sustained in the line of active duty.
- Any "qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

An eligible employee may also take up to 26 workweeks of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. The "single 12-month period" for military caregiver leave is different from the 12-month period used for other FMLA leave reasons. See Fact Sheets 28F: Qualifying Reasons under the FMLA and 28M: The Military Family Leave Provisions under the FMLA.

Under some circumstances, employees may take FMLA leave on an intermittent or reduced schedule basis. That means an employee may take leave in separate blocks of time or by reducing the time he or she works each day or week for a single qualifying reason. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operations. If FMLA leave is for the birth, adoption, or foster placement of a child, use of intermittent or reduced schedule leave requires the employer's approval.

Requesting FMLA Leave

An employee should contact their facility secretary or Benefits Specialist when foreseeable within 30 days in advance to obtain an FMLA application. Physician-documented proof (medical certification form) of birth or illness is required for all FMLA-designated leaves. Once FMLA is approved, a letter detailing your rights and responsibilities will be mailed to the employee.

Please note, FMLA is a federally mandated leave. If an employee is absent for three consecutive days due to an eligible FMLA circumstance and meets the criteria for the FMLA, they will be notified in writing by a Benefits Specialist. An application and physician certification will be sent to the employee to complete and return to Risk & Benefits Management.

Family Medical Leave Act (continued)

Important Information About FMLA

- FMLA is an unpaid leave. Employees can choose to use accrued paid vacation or personal leave, which will run concurrent with the FMLA leave.
- FMLA may run concurrent with a worker's compensation absence when the injury is one that meets the FMLA criteria for a "serious health condition."
- An eligible employee is entitled to take up to 12 weeks for FMLA leave in a "rolling" calendar year. So, when an employee requests FMLA leave, leave eligibility is determined by counting back 12 months from the date the leave is requested. If you have incurred a leave during the 12 months, your FMLA will be reduced by the time previously used.
- If an employee is receiving a paycheck during the FMLA, their benefit premiums will be deducted from their checks. *If the employee is not receiving a paycheck, premiums for optional insurance are due on the missed pay period.* If the employee does not make the premium payment within 30 days of the missed pay period, the District will terminate the optional benefits. However, an employee can arrange to pay their premiums when they return to work by contacting their Benefits Specialist.

Health Stat:
23 million Americans have type 2 diabetes.
Another 79 million Americans are pre-diabetic.
7 million Americans have diabetes and don't know it.

Doc. Broc

- The District may recover premiums for Board-paid insurance if the employee fails to *return to work for 30 days* and terminates his/her employment except due to: his/her own serious health condition, circumstances beyond his/her control, denial of restoration due to key employee status.
- If both husband and wife work for the District, FMLA limits the Leave that may be taken to a combined total of 12 workweeks during any 12-month period if the Leave is taken for birth or placement for adoption or foster care. This limitation does not apply to Leave taken:
  - to care for the other spouse who is seriously ill and unable to work.
  - to care for a child with a serious health condition.
  - for his or her own serious illness.
- For Leaves due to serious health conditions, a periodic status report will be required.
- Upon return to work, the employee who was on FMLA due to a personal illness will be required to provide *a fitness-for-duty notice from his/her physician. If the fitness-for-duty documentation is not provided, the employee may not return to work.*
- Employees on FMLA for maternity may extend the Leave beyond six weeks to the full 12 FMLA weeks.

For questions about FMLA, contact Risk and Benefits Management at 407-870-4899.

COBRA Continuation of Coverage

An employee's insurance coverage ceases on the last day worked for the School District of Osceola County. The District's COBRA administrator will mail a written notice to each terminated employee describing the employee's rights and obligations under COBRA.

Through federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may choose to continue coverage by paying the full monthly premium cost plus an administrative charge of 2%. Each individual who is covered by an SDOC plan immediately preceding the employee's COBRA event has independent election rights to continue his or her health, dental, and/or vision coverage.

The right to continuation of coverage ends at the earliest when:

- You, your spouse, or dependents become covered under another group health plan; or, you become entitled to Medicare
- You fail to pay the cost of coverage
- Your COBRA Continuation Period expires

Who Can Continue Coverage?

COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." Depending on the type of qualifying event, a qualified beneficiary can be a covered employee, a covered employee's spouse and/or a covered employee's dependents who were covered by one of the SDOC Health Plans the day before a qualifying event.

Definition of Qualified Beneficiaries

The following individuals can become qualified beneficiaries under COBRA:

- an employee
- a former employee
- the spouse of any of the above
- the dependent child(ren) of any of the above

COBRA Participants With FSAs

COBRA participants who have a Health Care FSA can elect to continue their FSA, only if their annual contributions exceed the amount that has been reimbursed to them (there is still money in their FSA) at the time they terminate. If there is still money in the account, the COBRA participant would be able to continue their FSA through the end of the calendar year. Contributions would be paid by the FSA participant directly to the FSA administrator. If you do not elect COBRA for your FSA, you may only be reimbursed for expenses incurred prior to your termination date up to the amount you contributed within 60-days of date of termination.

Life Insurance Portability

MetLife's Group Term Life insurance provides an option to port your coverage after termination or retirement.

What happens to your coverage if you leave your job or retire? You can continue your coverage, at group rates, when the coverage would otherwise end.

- Your coverage maximum amount is generally limited to the amount you had at the time group benefits terminated and may vary, depending on the type of coverage you had.
- The combination of all your MetLife group life insurance and accidental death and dismemberment (AD&D) plans cannot exceed $800,000.
- You can apply for more coverage than you already have if you wish to complete evidence of insurability, which includes a medical history from or a physical exam. This can be ported up to $2,000,000 if the employee chooses to do, with evidence of insurability.

How do you port? At the time of separation you will automatically receive information in the mail from MetLife with your options.

Keep Your Address Current

It's important to keep the plan administrator and SDOC informed of yours and your qualified beneficiary's address since all notices are mailed to a home address.

Maximum COBRA Continuation

Loss of Coverage is Due to	For You	For Your Covered Spouse	For Your Covered Child(ren)
Your employment ending for any reason (except gross misconduct) or your hours are reduced so you are no longer eligible for medical, dental, vision, and the health care flexible spending account	18 months	18 months	18 months
You or your covered spouse or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event, or becomes disabled during the first 60 days of COBRA continuation	29 months	29 months	29 months
Your death	—	36 months	36 months
Your divorce or legal separation	—	36 months	36 months
You become entitled to Medicare	—	36 months	36 months
Your covered child no longer qualifies as a dependent	—	—	36 months

End-of-School-Year Insurance End Dates

The following scenarios explain how benefits are affected when an employee terminates employment at the end of their current contract.

You will not lose your benefits at the end of the current contract if:

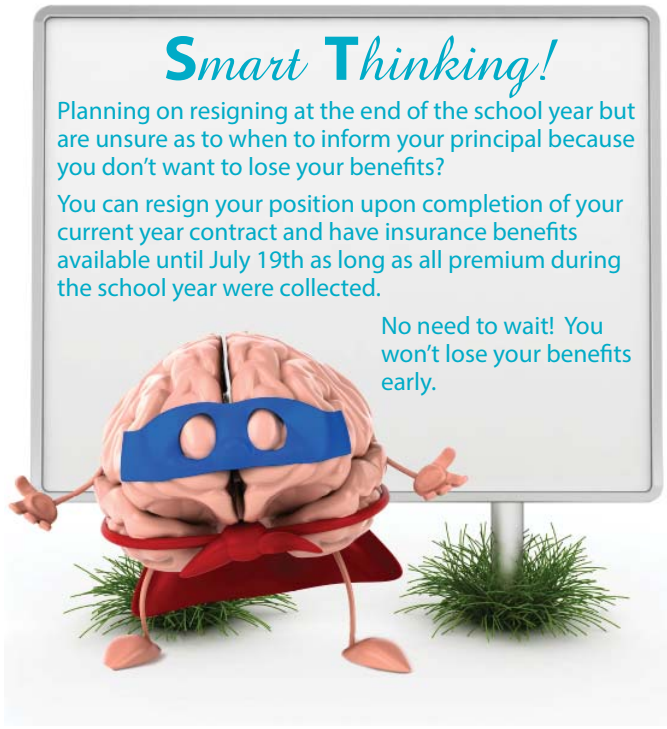
1. You resign at the end of the current contract. If you would have been reappointed for the coming year, but you know you will not be returning for the new contract year, you can resign your position now and have insurance benefits available to you until *July 19th, 2017*.
2. You would have been reappointed; however, a position is not available due to a reduction in force. *Benefits will terminate July 19th, 2017*.
3. You are granted a Leave of Absence (LOA) for the coming year. Your benefits continue until July 19th, 2017. Employees on LOAs then have the option of keeping their benefits during the leave. A letter detailing insurance options will be sent to the LOA employee automatically.
4. You retire at the end of your current contract. Your benefits will remain in effect until August 1, 2017; retirees then have the option of keeping their benefits. A letter detailing insurance options will be sent to the retiree automatically.

Your benefits will terminate immediately if:

1. You resign your position before the end of your current contract. Your insurance benefits will terminate on your last day.
2. Your employment is terminated by the District (except for RIF employees as noted in 2 above) at the end of your current contract. Your insurance benefits will terminate the day your contract ends as follows:
   - 187 & 188 Day Employees – May 30, 2017
   - 196 & 197 Day Employees – May 31, 2017
   - 200 Day Employees – June 6, 2017
   - 217 Day Employees – June 12, 2017
   - 230 Day Employees – June 20, 2017
   - 11 Month "A" Employees – June 20, 2017
   - 11 Month "B" Employees – June 27, 2017
   - 12 Month Employees – June 30, 2017

If an Action Form is submitted terminating your employment and you later secure a position for the coming year, you are considered a new hire and may be required to work a probationary period in your new position.

Your school/worksite will inform you of your employment status. Insurance benefits will remain in effect for all other employees.



Medical Exclusions, Expenses Not Covered and General Limitations

- Expenses for supplies, care, treatment, or surgery that are not Medically necessary.
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program other then Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be: not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; or not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan or; the subject of an ongoing phase I, II, or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- For or in the connection with treatment of the teeth or periodontium unless such expenses are incurred for (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; includes dental implants in conjunction with accidental injury to sound, natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery; or (d) charges made by a Physician for any of the following Surgical Procedures; excision of epulis; excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other then the one who extracted the tooth); intraoral drainage of acute alveolar abscess with cellulities; alveolectomy; gingivecomy, for gingivitis or periodontitis; unless otherwise specified as covered in the Schedule.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

Medical Exclusions, Expenses Not Covered and General Limitations (continued)

- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, garter belts, corsets, dentures.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition other than dental implants in conjunction with accidental injury to sound, natural teeth.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formula except for infant formula needed for the treatment of inborn errors of metabolism.
- For charges which would not have been made if the person had no insurance.
- To the extent that they are more than Maximum Reimbursable charges.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.
- Massage therapy.
- Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails, However, services associated with foot care for diabetics and peripheral vascular disease are covered when Medically Necessary.
- Expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- Charges made by any covered provider who is a member of your family or your Dependent's family.
- To the extent of the exclusions imposed by any certification requirement shown in this plan.
- Illness or injury to which a contributing cause was the commission of, or attempted commission of, an act of aggression or a felony, or participating in a riot by the Covered Person, as documented through the School District.
- Hospitalization primarily for X-ray, laboratory, diagnostic study, physical therapy, hydrotheraphy, medical observation, convalescent or rest cure, or any other medical examination or test not connected with an actual illness or injury.

Annual Notices

This section contains important information about your benefits and rights. Please read the following pages carefully and contact Risk and Benefits Management with any questions you have.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, *provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.*

Effective April 1, 2009, a special enrollment period provision is added to comply with the requirements of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. If you or a dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, *you must enroll within 60 days after the date eligibility is lost*. If you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, *you must enroll within 60 days after you or your dependent is determined to be eligible for State premium assistance.* Please note that premium assistance is not available in all states.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit *www.healthcare.gov*.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial *1-877-KIDS NOW* or *www.insurekidsnow.gov* to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you *must request coverage within 60 days of being determined eligible for premium assistance.* If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling toll-free *1-866-444-EBSA (3272)*.

Florida Medicaid
Website: *https://www.flmedicaidtplrecovery.com/*
Phone: *1-877-357-3268*

To see which other states participate in the premium assistance program, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
Website: *www.dol.gov/ebsa*
Phone: *1-866-444-EBSA (3272)*

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Website: *www.cms.hhs.gov*
Phone: *1-877-267-2323, Menu Option 4, Ext. 61565*

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses; and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Annual Notices (continued)

Section 111 Secondary

Effective January 1, 2009 Group Health Plans are required by the Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. This mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help to establish who pays first. The mandate requires Group Health Plans to collect additional information such as social security numbers for all enrollees, including dependents aged six months or older. Please be prepared to provide this information during enrollment in the Benefits Enrollment system.

Patient Protection

If the Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

HIPAA Privacy Act Legislation

SDOC and your health insurance carrier(s) are obligated to protect your confidential protected health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. SDOC and your health insurance carrier(s) are required to notify you and your beneficiaries about our policies and practices to protect the confidentiality of your protected health information. A copy of SDOC privacy policy can be found on *http://osceolaschools.net/departments/risk_and_benefits_management* or you may request a copy from Risk & Benefit Management.

Newborn's Act

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

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

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

Continued coverage for up to one year for a dependent child who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the plan year beginning October 1, 2016 and ending September 30, 2017. The election may be renewed for subsequent plan years.

Questions about this Notice should be directed to the Risk and Benefits Management Department, The School District of Osceola County, FL 831 Simpson Rd. STE 100., Kissimmee, FL 34744, or by telephone at 407.870.4899.

Annual Notices (continued)

Medicare Part D Notice

Important Notice from School District of Osceola County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with School District of Osceola County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and

Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. School District of Osceola County has determined that the prescription drug coverage offered by Cigna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current School District of Osceola County coverage will not be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current School District of Osceola County coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with School District of Osceola County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription

Drug Coverage…Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through School District of Osceola County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Annual Notices (continued)

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

The School District of Osceola County, FL
Risk and Benefits Management
831 Simpson Rd. STE 100
Kissimmee, FL 34744-5328
407.870.4899

Rates at a Glance

Medical Premiums per pay check (20 pay checks per year)

	1. Local Plus	2. Wellness Local Plus	3. Wellness Open Access Plus
Employee Only	$0.00	$0.00	$45.00
Employee + Spouse	$275.00	$335.00	$410.00
Employee + Child(ren)	$127.00	$145.00	$200.00
Employee + Family	$402.00	$480.00	$610.00
Half Family Primary	$127.00	$145.00	$200.00
Half Family Secondary	$0.00	$0.00	$0.00
Each Adult Dependent child age 26-30	$275.00	$335.00	$410.00

Half-Family Status -- If you and your spouse work for SDOC, are both eligible for benefits and have children, your status is considered **"Half-Family."** So, if you choose family coverage under one of the medical plans, only one spouse will have a payroll deduction for medical insurance. Note that this feature does not apply to employees with spouses in other school districts or government offices.

Job Share -- Employees classified as Job-Share pay half the Board contribution ($159.95) plus the premium listed based on your choice.

Medical Insurance Opt Out Credit Plan -- If you decline medical coverage, you will receive an annual credit that can be applied towards dependent dental or vision coverage. See premiums outlined below

Dental Premiums - 20 Pays - beginning 10/01/2016

	HMO		PPO			
			Low Option		High Option	
	Rate per Pay	Opt-Out Credit Rate*	Rate per Pay	Opt-Out Credit Rate*	Rate per Pay	Opt-Out Credit Rate*
Employee	$ 8.35	$ 0.00	$10.67	$ 0.00	$17.47	$ 0.00
Employee + One	$14.62	$ 6.27	$21.87	$11.20	$35.81	$16.90
Employee + Family	$22.97	$14.62	$38.26	$27.59	$62.64	$45.17

* *This is the premium you will be responsible for if you elect the Medical Insurance Opt-Out Credit and Dental Coverage. See page 17 for more information*

Vision Care Premiums - 20 Pays

	Rate per Pay
Employee	$3.85
Employee + Family	$11.77
Employee Opt-Out*	$0.00
Employee + Family Opt-Out*	$7.92

* *This is the premium you will be responsible for if you elect the Medical Insurance Opt-Out Credit and Vision Coverage. See page 17 for more information.*

Accident Insurance - 20 Pays

	Rate per Pay
Employee	$10.40
Employee + Spouse	$16.08
Employee + Children	$24.75
Employee + Family	$30.43

Term Life Insurance: Premiums are based on your salary or salary schedule. Visit the Benefits Enrollment System for specific rates.

Disability: Premiums are based on Monthly Benefit Amount and elimination period selected. Visit the Benefits Enrollment System for specific rates.

Flexible Spending Account: Deductions are based on elected amount of contribution as well as pay cycles. Visit the Benefits Enrollment System to compute your exact deduction.

Tax Sheltered Annuity: Minimum contribution of $13 per pay, not to exceed your Maximum Allowable Contribution as defined by the IRS.

Universal Life with Long Term Care: Premiums are based on your age, tobacco usage and amount of coverage selected. See Benefit Counselor to assist with specific rates.

Frequently Used Telephone Numbers and Websites

CIGNA Member Services	1-800-244-6224
CIGNA Online Provider Directory	www.cigna.com
mycigna.com	www.mycigna.com
CIGNA Technical Support	1-800-284-8346
Onsite CIGNA Representative - *Donna Laica*	407-870-4900; Internal Extension 67559 Email: cignarep@osceola.k12.fl.us
CIGNA Home Delivery Pharmacy (Mail Order)	1-800-835-3784 www.mycigna.com
CIGNA Behavioral Health	1-800-274-4573 www.cignabehavioral.com
Delta Dental *Dental*	Delta Care USA Dental HMO: 1-800-422-4234 PPO: 1-800-521-2651 www.deltadentalins.com
MetLife - *Life Insurance*	www.metlife.com/mybenefits 1-800-838-6420
Humana Specialty Benefits *Vision*	1-866-537-0229 www.humanavisioncare.com
Aetna *Disability*	1-888-266-2917 www.aetna.com
Trustmark - *Universal Life and Long -Term Care* - *Accident Insurance*	1-800-918-8877
Flexible Spending Accounts - *CIGNA HealthCare*	1-800-244-6224 www.mycigna.com
Worker's Compensation - *Keith Skipper*	407-870-4057; Email: workcomp@osceola.k12.fl.us Internal Extension 67598
COBRA Administrator *Discovery Benefits*	1-866-451-3399 *Then, Option 1 and Option 2*
Johns Eastern Company, Inc.	1-800-749-3044
Florida Retirement System	1-866-446-9377 myFRS.com
4theHealthofit! - *Anabell Blanner, Cigna Wellness*	Email: wellness@osceola.k12.fl.us 407-870-4840; Email: CignaW@osceola.k12.fl.us
Risk and Benefits Management	407-870-4899 benefits.osceola.k12.fl.us Email: Insurance@osceola.k12.fl.us
Worksite Commmunications	1-866-998-2915 myenrollmentschedule.com/osceola

Visit the Benefits Enrollment System at *benefits.osceola.k12.fl.us*

Risk and Benefits Management
The School District of Osceola County, Florida
Student Achievement - Our Number One Priority
831 Simpson Rd. STE 100 • Kissimmee, FL 34744-5328