

Seminole County
Public Schools

2016 Employee Benefits & Enrollment Guide

be a success story



Table of Contents

Benefits Directory	3
Key Things to Know	4
Get Connected With Our Mobile App	6
Who's Eligible?	7
How to Enroll during Annual Enrollment	8
Health and Wellness Resources	12
Be a Savvy Healthcare Consumer	14
Become Engaged in Managing Your Health	15
Medical Plan: Cigna	16
Prescriptions: Cigna	21
Dental Plans: Assurant	23
Vision Plan: UnitedHealthcare	25
FSA: myCafeteriaPlan	27
HSA/HRA Cigna Choice Funds	31
Short-Term Disability/Long-Term Disability: Cigna	33
Long-Term Care: Unum	35
Cancer Insurance: Colonial	36
Hospital Indemnity Protection: Colonial	37
Accident Insurance: Colonial	38
Life Insurance: VOYA/Reliastar	39
Additional Life Insurance Rates	40
Approved LOA and Newborn Coverage	42
Retirement	43
Insurance Definitions	44
Beyond Your Benefits	46
Notice of Social Security Number Disclosure	50
Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice	51
Changing Your Coverage	52



be a success story

Benefits Directory

Medical and Prescription Plans

Cigna
Plan/Policy #3337309
1-800-244-6224
www.mycigna.com
Mycigna.com Help Desk 1-800-853-2713

Cigna Pre-enrollment Hotline

Medical & Pharmacy coverage 1-800-401-4041

Cigna Pre-enrollment Online

Plan Comparison Guide -

www.myCignaplans.com
Open Enrollment ID: SCPS2016
Password: cigna

Employee Assistance Program

Cigna 1-877-622-4327

Assurant Dental Insurance

Plan/Policy #I-453
Assurant PPO Network = Assurant Dental
Network 1-800-442-7742

Prepaid Network = Prepaid Dental Series
1-800-443-2995
www.assurantemployeebenefits.com

Buy-Up Vision Insurance

UnitedHealthcare
1-800-638-3120
www.myuhcvision.com

Flexible Spending Accounts

myCafeteriaPlan
1-800-865-6543
1-937-865-6502 (claims fax)
www.mycafeteriaplan.com

Short-Term & Long-Term Disability

Cigna
Plan/Policy #LK8316 (STD)
Plan/Policy #LK8317 (LTD)
1-800-362-4462
www.cigna.com

Disability in Lieu of Medical

Mutual of Omaha
Plan/Policy # GUG-6K71
1-800-877-5176

Life Insurance

VOYA/ReliaStar Life Ins Co
Plan/Policy #65741-7
benefits@scps.k12.fl.us

Accident, Cancer Insurance & Hospital

Indemnity

Colonial Life
1-800-325-4368
www.coloniallife.com

Long-Term Care Insurance

UNUM
Plan/Policy #067229
1-800-227-4165
www.unum.com

FRS (Florida Retirement System)

Janice Hickson
Retirement Specialist
1-407-320-0498
janice_hickson@scps.k12.fl.us
enrollment@frs.state.fl.us
1-850-488-4742 or 1-866-446-9377

SCPS Employee Benefits Department

For a Menu of Options:
1-407-320-0095
Fax: 1-407-320-0389

benefits@scps.k12.fl.us
beth_swallows@scps.k12.fl.us
diane_mason@scps.k12.fl.us
karen_milligan@scps.k12.fl.us, FBMC On-Site Representative
loyda_nieves@scps.k12.fl.us
mary_libersat@scps.k12.fl.us
mindy_hatcher@scps.k12.fl.us, Cigna On-site Representative
nicole_enright@scps.k12.fl.us
pam_dixon@scps.k12.fl.us, Cigna On-site Representative
wellness@scps.k12.fl.us

Additional Resources

TSA Consulting Group 1-888-777-5827
SCPS Help Desk 1-407-320-0350
COBRA: AON 1-800-368-3804

Key Things to Know

Dates to Remember:

Your Annual Enrollment dates are:

September 17, 2015, through October 30, 2015

Your Period of Coverage dates are:

January 1, 2016, through December 31, 2016

What's New?

- Seminole County Public Schools (SCPS) is excited to offer you a comprehensive annual enrollment experience with dynamic enrollment communications, including an interactive enrollment guide and benefits mobile app. This interactive enrollment guide features hyperlinks for quick access to helpful insurance carrier sites and videos for you to learn more about benefits programs. Navigational tabs are located along the bottom of this interactive guide for your convenience.
- Seminole County Public School's voluntary benefits are now administered by FBMC Benefits Management, Inc.
- **NEW for 2015:** Benefits Counselors will be available onsite at all locations. The Benefits Counselor will:
 - » Provide voluntary products benefits education and assist you with making your benefit elections
 - » Help you understand your benefit options
 - » Review your enrollment information
- Visit www.myenrollmentschedule.com/seminole or call 1-866-998-2915 to make an appointment to meet with a Benefits Counselor.
- The District will be offering two medical plans, the High Deductible Health Plan (HDHP) and the Open Access Buy-Up Plan.
- The employer paid plan will be the High Deductible Health Plan (HDHP).
- Each plan will use a different network of doctors. The High Deductible Health Plan uses the Cigna Local Plus network and the Open Access Buy-Up Plan will use the Cigna Open Access Plus Network.
- Tobacco users will be charged a \$500 annual surcharge.
- All employees can earn a \$750 incentive by completing the three (3) wellness activities. You must complete your wellness activities by August 31, 2015. Anyone with other medical coverage including Medicare, is not eligible for an HSA however they may participate in an HRA. See the HSA and HRA Cigna Choice Funds on Page 31 and 32.
- Download the SCPS mobile app at Apple or Google play stores and receive enrollment reminders, benefit products information, instructions on how to enroll and schedule an appointment with a Benefits Counselor.
- Upload your wellness success story on the new SCPS mobile app and you may be featured in next year's enrollment materials.

Earn your 2016 Incentives in three, easy steps:

1. Complete the Cigna online Health Assessment on www.myCigna.com.
2. Get an Annual Preventive Exam with your Primary Care Physician or OB/GYN.
3. Complete Biometric/Lab work at an onsite screening event or with your physician.

If you had labs done at a facility other than the District on-site screening, your physician will need to complete and sign the Cigna Wellness Screening form and send to Cigna between September 1, 2014 through August 31, 2015. The Cigna Wellness Screening form is located on [www.mycigna.com/Manage My Health](http://www.mycigna.com/ManageMyHealth) tab, Incentive Awards Program, Wellness Screening Form.

Key Things to Know

How to Waive the \$500 Tobacco Surcharge:

If you're a tobacco user and want to avoid the \$500 tobacco surcharge for Plan Year 2016, you must participate in one of the following programs:

- Six smoking cessation classes with On-site Health Coach OR
- Complete at least six telephonic Cigna coaching sessions of the "Quit Today" Lifestyle Management Program at 1-866-417-7848.
- Complete a six-week "I Quit Tobacco" class (one hour a week) or a two-hour class to quit smoking by calling AHEC at 1-877-252-6094. Submit your certificate of completion to the Employee Benefits Department at the Educational Support Center.

How To Enroll:

It is always in your best interest to meet with a Benefit Counselor to ensure you understand all relevant factors related to your insurance decisions. Your Benefits Counselor can help you fully understand your benefit changes and answer all your questions.

Step One – Visit **www.myenrollmentschedule.com/seminole** or call 1-866-998-2915 to make an appointment to meet with a Benefits Counselor.

Step Two – Meet with your Benefits Counselor to learn about what is changing and understand your options.

Step Three – Log in to the ESS website at www.scps.k12.fl.us. Click ePassport at the bottom of the page, login, then click ESS.

Enrolling in Colonial Life Insurance:

- A Colonial Life application may be required for new or replacement coverage.
- For the 2015 Annual Enrollment, a special underwriting offer has been negotiated for the Hospital Confinement Indemnity plan and the Accident plan; be sure you understand the Colonial Life advantages and if the offer applies to you .

- The Colonial Life Cancer insurance requires medical underwriting and carrier approval before a policy is issued.
- Access the Colonial Life enrollment site and complete the required enrollment documentation. This step should be completed with the assistance of your Benefit Counselor.

Enrolling in Unum Long-Term Care:

- Visit <http://unuminfo.com/scps/index.aspx> and click on the "Enrollment" tab to access the Enrollment Form.
- If you did not sign up for this benefit when you were first eligible, then you will have to provide Evidence of Insurability. Family members are required to provide Evidence of Insurability when they sign up for this plan.
- Click on the "Long-Term Care Insurance Application" to provide Evidence of Insurability.
- Mail your enrollment form and Evidence of Insurability to:
Unum Life Insurance Company of America
Attn: Group Long-Term Care Department
2211 Congress Street
Portland, ME 04122-2295

New Hires

New hires enrolling outside the annual enrollment period must enroll using a Colonial Life paper application not through the Colonial Life enrollment site. The application and HIPAA form can be found on the Employee Benefits Department website at scps.k12.fl.us/departments/employeebenefits or to obtain the required enrollment related documents contact your FBMC onsite representative.

Effective June 30, 2015, those employees who are employed in a contracted position for less than 30 hours per week, but at least fifty percent (50%) of a full-time position, the Board will offer to contribute fifty percent (50%) of an individual single premium of a health insurance plan.

Get Connected Through Our Mobile App



Download the new SCPS Benefits Mobile App.

Watch the “be a success story” video at www.fbmclearningcenter/seminole2016PY to learn how your story could be featured in next year’s enrollment materials.

Be sure to schedule an appointment to meet with your Benefits Counselor at www.myenrollmentschedule.com/seminole or call 1-866-998-2915.

You may also schedule your appointment through the mobile app.

Who's Eligible?

Eligibility

Health and benefit plans are available to all regularly appointed and elected employees of SCPS who are entitled to any or all of SCPS-provided benefits. Non-benefits eligible employees, such as OPS and substitute teachers, are not entitled to benefits.

Effective June 30, 2015, those employees who are employed in a contracted position for less than 30 hours per week, but at least fifty percent (50%) of a full-time position, the Board will offer to contribute fifty percent (50%) of an individual single premium of a health insurance plan.

Dependent Eligibility

If you wish, your dependents may also be covered under every benefit plan option that shows a premium amount for dependent coverage (refer to the rate charts that appear in this guide). You and your dependents must be enrolled in the same plan. Eligible dependents include:

- Legal spouse, as defined by federal law; and
- Children under age 26;
- MEDICAL - Your children up to age 26, regardless of marital status, financial dependency, residency with the eligible employee, student status, employment status, or eligibility for other coverage; coverage ends at the end of the calendar year in which they turn 26. In the state of Florida, dependent medical coverage is available up to age 30 if the dependent is unmarried, a Florida resident or a full-time student and uninsured. The dependent must maintain continuous service.
- DENTAL - Your children, up to age 26, regardless of marital status, financial dependency, residency with the eligible employee, student status, employment status, or eligibility for other coverage.
- VISION - Your children, up to age 26, regardless of marital status, financial dependency, residency with the eligible employee, student status, employment status, or eligibility for other coverage.

It is your responsibility to provide the Employee Benefits Department with proof of your dependents' eligibility, in the form of:

- Your most recent federal income tax return
- Court order specifying your responsibility to provide "group healthcare coverage" to your dependent children
- Copy of birth certificate, Social Security card or a marriage certificate.

It is important that you make your choices carefully, since changes can only be made during the annual enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change.

Terminations

If an employee terminates employment before the end of their contract date, coverage terminates the date employment ends. If an employee works through their contract date, their coverage ends based on the month determined by the contract language.

COBRA

Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health, dental and vision plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

How to Enroll During Annual Enrollment

www.scps.k12.fl.us



Before You Start Your Web Enrollment

Annual Enrollment is from September 17 - October 30, 2015. Please confirm on www.mycigna.com that you have completed all three activities in order to receive any incentives. Due to the changes in medical plans, you will need to elect a new plan for 2016. Be sure to review your benefits and submit. If you do not receive a confirmation page and number, you have NOT submitted completely.

How to Enroll Online

- 1 Go to www.scps.k12.fl.us, go to the bottom right of the main District page and click "ePassport". You will be redirected to the "ePassport page".



How to Enroll During Annual Enrollment

www.scps.k12.fl.us

2 Click on "Employee Self Service (ESS)" and login.

3 Enter your Employee ID & password.
If you forgot your password, click on "forgot my password" to immediately reset your password, or contact the help desk at: the_helpdesk@scps.k12.fl.us.

Seminole County Public Schools

Employee Self Service

Employee ID:

Password:

[Forgot my password](#)

Copyright © 2002, 2005, 2008, All rights reserved. PeopleSoft® is a registered trademark of PeopleSoft Corporation under the US Patent. Other names may be trademarks of their respective owners.

Seminole County Public Schools

Summer Karate Sports Camp

Hydrex Cloud

Passport

P O R T A L

4 Click "Self Service".

Menu - Classic

Select:

- SCPS
- Self Service
- Recovery
- Enterprise
- Worker
- Change My Password

Navigate to your self service information and activities.

5 Click "Benefits Enrollment".

Self Service

Navigate to your self service information and activities

Personal Information
Review and update your personal information.
[Personal Information Summary](#)
[My Profile](#)

Job Vacancies
[Latest Job Vacancies](#)
[Latest Job Vacancies](#)

Payroll and Compensation
Review your pay and compensation history. Update your direct deposit and other deduction or contribution information.
[View Paycheck](#)
[W-4 Tax Information](#)
[View W-2/W-2c Forms](#)
[W-2/W-2c Consent](#)

Employee Forms
[Request Leave of Absence](#)
[Travel Reimb. for In-County](#)
[Travel Reimb. for Out-County](#)
[2 More...](#)

Benefits
Review health, insurance, savings, pension or other benefits information. Review and update dependent and beneficiary personal information.
[Benefits Summary](#)
[Benefits Enrollment](#)
[Enroll in benefits.](#)

Evaluation
Review and acknowledge your evaluation information.
[Final Evaluation Summary](#)

6 Click "Select" to begin Annual Enrollment.

Benefits Enrollment
Jane Doe

After your initial enrollment, the only time you may change your benefit elections is during annual enrollment or have a qualified event.
The Information icon (i) provides you with additional information about your enrollment.
The Select button next to an event means it is currently open for enrollment.
Use the **Select** button to begin your enrollment.

Event Description	Event Date	Event Status	Job Title
Annual Enrollment	01/01/2015	Not Submitted	Job Title

After you use the Select button, it will take a few seconds for your benefits enrollment information to load.

7 Click "OK" to continue Annual Enrollment.

Benefits Enrollment
Open Enrollment
Jane Doe

You have already submitted your changes

How to Enroll During Annual Enrollment

www.scps.k12.fl.us

8

Answer ALL required questions, then complete all "EDIT" Sections. Flexible Spending Accounts must be re-enrolled in for the 2016 plan year or the funds will not be available. To qualify for Board Disability, you must submit a copy of your current insurance plan to the Employee Benefits Department.

Benefits Enrollment
Annual Enrollment
Jane Doe

Annual enrollment is your opportunity to review your current coverage and make changes for the upcoming plan year. To continue participating in the Flexible Spending Accounts program next year, you must re-enroll in this program during the Annual Enrollment period.

After the Annual Enrollment period ends, you are unable to make changes to your coverage UNLESS you experience a qualifying event and notify the Employee Benefits Department in writing within 30 days of the event. These changes are NOT automatic.

Important: Your enrollment will not be complete until you **SUBMIT** and your confirmation page is displayed with your changes.

Benefit Guide

The Benefit guide provides details about ALL benefits.

Enrollment Summary

	Full Cost	Paycheck	Before Tax	After Tax	Edit
Medical					
Current: Wellness Plan After Tax Empl Only					
New: Wellness Plan After Tax Empl Only	0.00	0.00		0.00	
Board Disability					
Current: Not Enrolled					
New: Not Enrolled					
Dental					
Current: Freedom Basic Dental Pre Tax Empl Only					
New: Freedom Basic Dental Pre Tax Empl Only	267.02	13.35		267.02	
Vision					
Current: Not Enrolled					
New: Not Enrolled					
Life (Board Paid)					
Current: Life: Salary X 1 + 0 : \$32,000					
Vision:					
Current: Not Enrolled					
New: Not Enrolled					
Life (Board Paid)					
Current: Life: Salary X 1 + 0 : \$32,000					
New: Life: Salary X 1 + 0 : \$32,000	0.00	0.00			
Employee Age Graded Life					
Current: Not Enrolled					
New: Not Enrolled					
Spouse Age Graded Life					
Current: Not Enrolled					
New: Not Enrolled					
Dependent Standard Life					
Current: Not Enrolled					
New: Not Enrolled					
Short-term Disability					
Current: Not Enrolled					
New: Not Enrolled					
Long-Term Disability					
Current: Waive/Terminate					
New: Waive/Terminate	0.00	0.00			
Cancer Base Policy					
Current: Not Enrolled					
New: Not Enrolled					
Accident Plan					
Current: Not Enrolled					
New: Not Enrolled					
Hospital Indemnity					
New: Waive/Terminate	0.00	0.00			
Cancer Base Policy					
Current: Not Enrolled					
New: Not Enrolled					
Accident Plan					
Current: Not Enrolled					
New: Not Enrolled					
Hospital Indemnity					
Current: Waive/Terminate					
New: Waive/Terminate	0.00	0.00			
Flex Spending Medical					
Current: Waive/Terminate					
New: Waive/Terminate	0.00	0.00		0.00	
Flex Spending Dependent Day Care					
Current: Waive/Terminate					
New: Waive/Terminate	0.00	0.00		0.00	

This table summarizes the estimated costs of your new benefit elections.

Election Summary

	Total	Paycheck	Before Tax	After Tax
Summary of estimated costs for new benefit elections:				
Costs:	267.02	13.35	267.02	0.00
Your Annual Costs	267.02	13.35	267.02	0.00

These costs do not include certain choices that are based on variable savings.

Submit

Select the **Submit** button to send your final elections to the Employee Benefits Department.

Important: Your enrollment will not be complete until you **SUBMIT** and your confirmation page is displayed with your changes.

Click "edit" to make changes.

9

Click "submit" once you have reviewed the costs summary.

How to Enroll During Annual Enrollment

www.scps.k12.fl.us

- 10 Click "submit" for final submission. If the submit button is NOT selected, your changes will NOT process completely.

Benefits Enrollment
Submit Benefit Choices
Jane Doe

You have almost completed your enrollment. If you have no further changes, select the **Submit** button at the bottom of this page to finalize your benefit elections.

Select the **Cancel** button if you are not ready to submit your elections and wish to return to the Enrollment Summary.

You may save your elections on each page and return to the Enrollment Summary as many times as you'd like until your enrollment deadline.

Once your enrollment is processed, you will not be able to make any further benefit changes until the next Annual Enrollment period unless you have a qualifying event as defined by the IRS.

Authorize Elections

By submitting your benefit elections you are authorizing the District to take deductions from your paycheck to pay for your benefit costs. You are also authorizing the District to send the necessary personal information to your selected providers to initiate and support your coverage.

Select the **Submit** button to send your final elections to the Employee Benefits Department.

Select the **Cancel** button if you are not ready to submit your elections and wish to return to the Enrollment Summary.

- 11 Print this page for your records!
Please note: you are able to make changes up until October 30th, no later than 11:59 p.m.

Benefits Enrollment
Submit Confirmation
Jane Doe

Your benefit elections have been successfully submitted on Wed, July 8, 2015 03:57 PM to the Employee Benefits Department.
Your confirmation number is **20591**. Please note this number or Print this page for your records.

Your new election summary for the 2016 benefit year:

Medical :	Wellness Plan After Tax Empl Only
Dental :	Freedom Basic Dental Pre Tax Empl Only
Life :	Life: Salary X 1 + 0 : 32000
Long-Term Disability :	Waive/Terminate
Hospital Indemnity :	Waive/Terminate
Flex Spending Medical :	Waive/Terminate
Flex Spending Dependent Day Care :	Waive/Terminate

"If enrolled in any benefit requiring an application, deductions will begin once approval is received."

PS: If you have added dependents for the first time, proof of marriage and/or birth certificates and social security card need to be sent to the Employee Benefits Department by August 16, 2015. (Please include Employee ID)

You will receive notification from the Employee Benefits Department after the closing of annual enrollment when confirmation statements are available on-line.
To return to the Benefits Enrollment page, use the **OK** button.

- 12 Click "OK" to return to the beginning.

- 13 Once you Click "OK" you are redirected to this page which brings you back to the beginning. "Submitted" will be displayed, once confirmation page was reached.
Then, sign out once completed.

Benefits Enrollment
Jane Doe

After your initial enrollment, the only time you may change your benefit elections is during annual enrollment or have a qualifying event.
The Information icon (i) provides you with additional information about your enrollment.
The Select button next to an event means it is currently open for enrollment.
Use the **Select** button to begin your enrollment.

Event Description	Event Date	Event Status	Job Title	
Annual Enrollment	01/01/2015	Submitted	Job Title	<input type="button" value="Select"/>

After you use the **Select** button, it will take a few seconds for your benefits enrollment information to load.

- 14 An e-mail will be sent to you once your Confirmation Statement is available on the ESS.

SEMINOLE COUNTY PUBLIC SCHOOLS
CONFIRMATION OF 2015 ELECTIONS - Annual Enrollment

Jane Doe
123 Benefits Lane
Lake Mary, FL 32746-6139

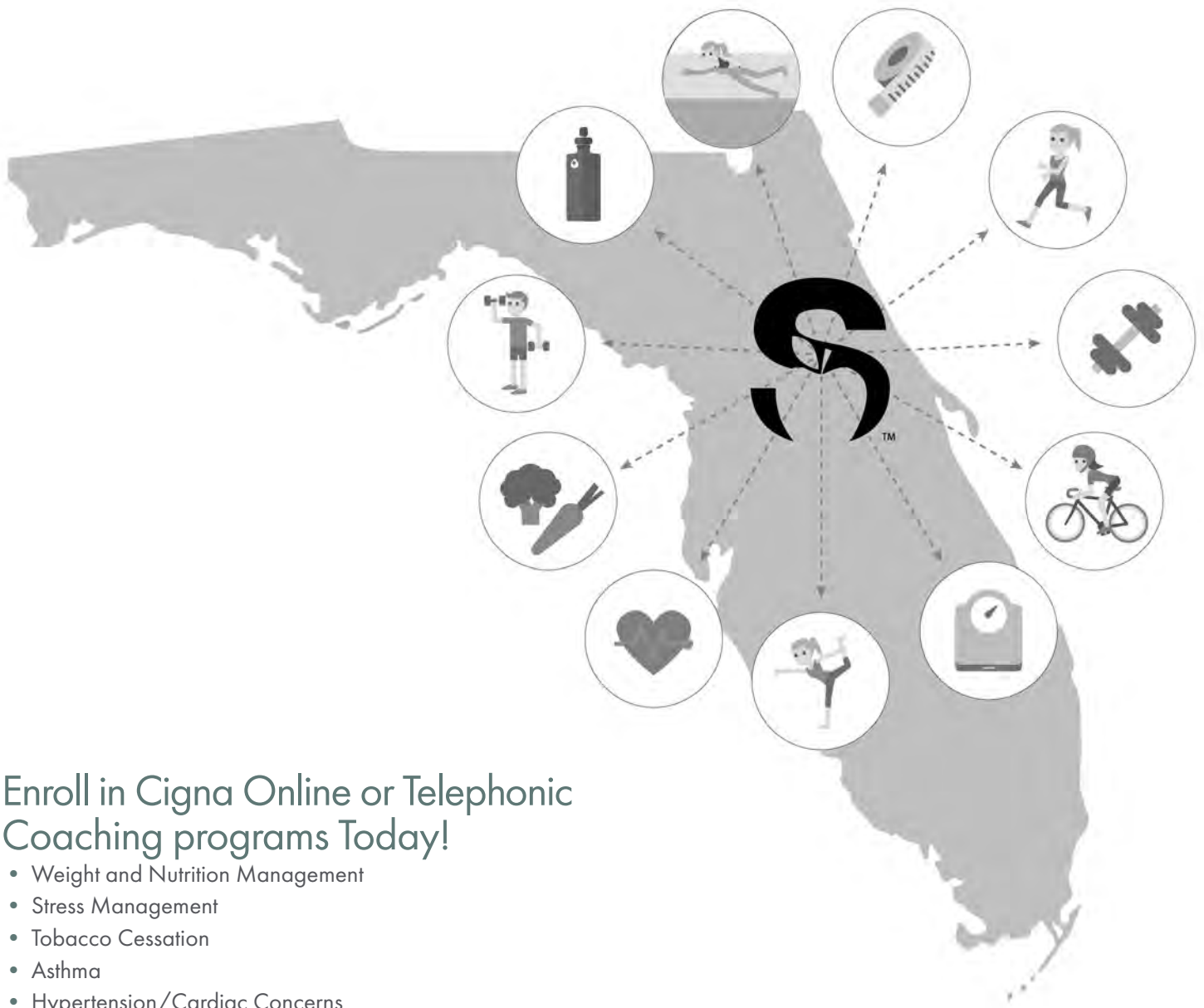
Employee ID: 123456
Department: Department
Job Code: Job Title

Effective Date: 01/01/2015

This statement confirms your benefit election for the plan year beginning January 01, 2015.
These benefits will remain in effect for the 2015 Plan Year, unless you notify the Employee Benefits Department of a qualifying event.
If an error has been made in the recording of your elections, please email Benefits@scps.k12.fl.us. (Discrepancies must be submitted by November 28, 2014 @ 4:00pm)

YOUR BENEFIT CHOICES	Benefit Option	Coverage
Medical	Wellness Plan After Tax	Coverage/None
Dental	Freedom Basic Dental Pre Tax	Employee Only
Life	Board Paid Life Insurance	Employee Only

Health and Wellness Resources



Enroll in Cigna Online or Telephonic Coaching programs Today!

- Weight and Nutrition Management
- Stress Management
- Tobacco Cessation
- Asthma
- Hypertension/Cardiac Concerns
- Anxiety/Depression
- Diabetes
- Lower Back Pain and more!

Call the number on the back of your Cigna ID card to enroll or log onto www.mycigna.com and enroll in online coaching via "My Health Assistant" (under the "Manage My Health" tab).

Health and Wellness Resources

Tips to Better Manage Your Health:

Create an account on www.mycigna.com. By doing so, you will have access to:

- Find in-network doctors and medical facilities
- Order ID Cards
- Manage and track your medical and pharmacy claims
- Take a Health Assessment
- Track your wellness activities
- See cost estimates for medical procedures that are completely tailored to your medical plan's current deductible, coinsurance and out-of-pocket maximum.
- Use the prescription drug price quote tool to compare prices between Cigna Home Delivery and our network of retail pharmacies to help ensure you're getting the best price possible. You can also use the tool to find lower-cost alternatives to your current prescriptions.
- Investigate health improvement programs for weight loss, exercise, smoking cessation, stress reduction, aging, etc.
- Compare quality of care ratings for doctors and hospitals.
- Access a variety of health and wellness tools and resources.
- When seeing your physician, confirm they have your updated information on file.
- Group policy number
- Individual identification number
- Complete any physician-recommended exams and lab work based on age, sex, and family history.
- Keep a record of all communication with your insurance carriers or healthcare providers. Include the date and time of any conversation and the name of the person with whom you spoke.

Take advantage of Cigna's Employee Assistance Program!

Cigna's EAP services offer you access to a wide range of health and well-being information — seven days a week, 24 hours a day. Using one, toll-free phone number, you can speak with registered nurses and master's level counselors who can help with almost any problem ranging from medical and family matters to personal legal, financial and emotional needs.

If face-to-face resources are more appropriate for your situation, a Cigna EAP representative can refer you to local, in-person support. Counselors also can refer you to a wide range of national and community resources. Call Cigna's EAP for:

- Childhood illnesses
- Minor illnesses and injuries
- Medication safety
- Relationship problems
- Choosing appropriate medical care
- Work-related stress
- Emotional distress
- Personal legal and financial issues

Engage in a Wellness Committee

Each District location is unique. As a result, the wellness program at each location needs to be specific to that team's needs. Improve the health of the staff and the students at your site by engaging in your wellness committee. See your site's Wellness Champion for details.

Be a “Savvy” Healthcare Consumer

Lower Your Out-of-Pocket Expenses!

1. **Stay in network.** Save big when you use a doctor, hospital or facility that’s part of the Cigna network. Chances are, there’s a network doctor or facility in your neighborhood. Log onto www.mycigna.com and use the “Find a Provider” search. It’s easy to find quality, cost-effective care right where you need it. In fact, one thing you won’t find is higher costs.
2. **Ask before you go.** Your primary care doctor may be in your plan’s network, but that doesn’t mean everyone and everywhere they refer you to is as well. When your doctor gives you a referral, don’t be afraid to ask if the facility, lab or specialist is in your plan’s network. If you don’t, you may unintentionally go out of network and be surprised by a higher bill than expected. You can always log onto www.mycigna.com to check if providers are in your network or call the number on the back of your ID card for help.
3. **Use Cost Transparency Tools on www.mycigna.com.** Compare out-of-pocket estimates – specific to your coverage plan – for actual treatment and procedure costs. And, out-of-pocket estimates calculate your deductible, the percentage you pay (coinsurance) and any account balances on that given day. Estimates show both doctor and facility fees in one place, allowing you to more accurately compare total costs of treatment before choosing your doctor and where to receive care.
 - » Average urgent care center cost*: \$135
 - » Average hospital ER cost: \$1,553
4. **Use an urgent care center.** If you need medical attention but it’s not serious or life threatening, you may not have to go to an emergency room (ER). An urgent care center provides quality care like an ER, but can save you hundreds of dollars. Visit an urgent care center for things like minor cuts, burns and sprains, fever and flu symptoms, joint or lower back and urinary tract infections.
 - » Average urgent care center cost*: \$135
 - » Average hospital ER cost: \$1,553
5. **Go to a convenience care clinic.** Need to see your doctor but can’t get an appointment? Try going to a convenience care clinic. You’ll get quick access to quality and cost-effective medical care. A convenience care clinician can treat you for sinus infections, rashes, earaches, minor burns and other routine medical conditions. You can find convenience care clinics in grocery stores, pharmacies and other retail stores.
 - » Average convenience care clinic cost: \$58
 - » Average ER cost: \$1,553
6. **Stick with lower-cost in-network labs.** If you go to a national lab such as Quest Diagnostics® or Laboratory Corporation of America® (LabCorp), you can get the same quality service and save up to 84 percent.** Even though other labs may be part of the Cigna network, you’ll often get even bigger savings when you go to a national lab. And with hundreds of locations nationwide, they make it easy to get lab services at a lower cost.
7. **Consider Cigna Home Delivery Pharmacy.** Home Delivery is designed especially for individuals who take prescription medications on a regular basis, such as those used for diabetes, asthma, heart conditions, high blood pressure, birth control and more. Get a 90-day supply for a two-month Copay. You can also get a 90-day supply at Publix or Walmart for the same Copay. Reminder service to refill or take your medication available at www.cigna.com/CoachRx. Cigna pharmacists are available 24/7, 365 days a year at 1-800-285-4812. Manage your medication on www.mycigna.com: compare medication prices, check order status, order refills and review number of refills remaining.
8. **Ask for Generics.** When prescribed a medication, ask your doctor if a generic version is available. Generics are always priced at a lower cost than brand name medications.
9. **Visit independent radiology centers.** If you need a CT scan or MRI, you could save hundreds of dollars by going to an independent radiology center. These centers can provide you with quality service like you’d get at a hospital, but usually at a lower price.

	CT	MRI
» Average radiology center costs:	\$445	\$725
» Average outpatient hospital costs:	\$1,384	\$1,668
10. **Choose the right place for your colonoscopy, GI endoscopy or arthroscopy.** When you choose to have one of these procedures at an in-network freestanding outpatient surgery center, you could save hundreds of dollars. These facilities specialize in certain types of outpatient procedures, and offer quality care, just like a hospital, but at a lower cost to you.
 - » Average outpatient surgery center: \$959
 - » Average hospital cost: \$2,548

* Cost estimates are national 2012 averages of participating facilities; actual cost may vary by location, facility, and the type or level of services received.

** Savings estimate is based on an internal Cigna national study of 2012 lab utilization data, costs and discounts. Savings will vary.

Become Engaged in Managing Your Health

1. **Be your own health advocate and work with a health coach!** Call the number on the back of your Cigna ID card to enroll in telephonic health coaching. Coaching is available for a variety of health conditions including: diabetes, COPD, hypertension, asthma, depression, anxiety, weight management, stress management, tobacco cessation, and more. You will receive one-on-one wellness coaching with the same health advocate who has convenient evening and weekend hours available for appointments. Each program is easy to use, free to you, and available where and when you need it.
2. **Improve Your Health Online!** Complete health coaching online via "My Health Assistant" on www.mycigna.com. You choose the goals and track your own progress! "My Health Assistant" gives you friendly reminders and encouragement. You can adjust your plan and change activities as you go. It's flexible and fit, just for you! Powered by WebMD, "My Health Assistant" delivers a robust and personalized coaching experience that can build habits and lay the groundwork towards achieving your goals.
3. **Complete your Health Risk Assessment.** The Cigna Health Risk Assessment, located on www.mycigna.com is an easy-to-use questionnaire about your health and well-being. It produces a personal report that includes suggestions for health screenings, provides a snapshot of overall health, identifies preventable and common conditions and recommends steps for improvement. This confidential, online questionnaire will give you a better understanding of your health today and teach you simple steps for improving your health in the future.
4. **Understand your medical and pharmacy plan.** Visit www.mycigna.com to enroll in health coaching programs, track your claims, stay updated on your deductible and out-of-pocket max amounts, print ID cards, find in-network providers/facilities, compare quality of care ratings for doctors and hospitals, access a variety of health and wellness resources, and use the cost-transparency tools to find the cost of medical procedures, surgeries, and prescriptions. The website, www.mycigna.com, is your personal healthcare portal – the site is completely customized to YOU!
5. **Utilize your health dashboard.** Your "Health Dashboard" on www.mycigna.com shows your personalized health information on one page - such as goals, next steps, status and biometrics. The information is presented in simple ways making it easy for you to know your "numbers" and understand what to do next. The Dashboard links you to personally relevant information and tools - connecting you quickly and easily!

Medical Plan: Cigna



What's Changing?

- The District will be offering two medical plans, the High Deductible Health Plan (HDHP) and the Open Access Buy-Up Plan.
- The employer paid plan for employee only coverage will be the High Deductible Health Plan (HDHP).
- Each plan will use a different network of doctors. The High Deductible Health Plan uses the Cigna Local Plus network and the Open Access Buy-Up Plan uses the Cigna Open Access Plus Network.
- Tobacco users will be charged a \$500 annual surcharge if they do not participate in a smoking cessation program.
- All employees can earn a \$750 incentive award by completing the three (3) wellness activities.
- Effective June 30, 2015, those employees who are employed in a contracted position for less than 30 hours per week, but at least fifty percent (50%) of a full-time position, the Board will offer to contribute fifty percent (50%) of an individual single premium of a health insurance plan.

Disability Coverage in Lieu of Medical Coverage

If you have medical coverage elsewhere, such as under your spouse, you can waive the SCPS paid medical plan and receive a disability benefit. This benefit is provided through Mutual of Omaha and pays you a flat weekly benefit if you are disabled for an extended period of time and under a physician's care. In order to be eligible for this plan, you MUST show proof of other coverage such as a copy of an ID card.

After you are disabled for seven continuous days, you will receive a flat \$300 weekly benefit for a maximum of 104 weeks. This benefit offsets with the Cigna group disability plan, as well as any other income you receive such as retirement. Additionally since it is paid for by SCPS, your benefit will be taxed. To file a claim, call 1-800-877-5176.

Medical Plan Rates: Cigna

High Deductible Health Plan (HDHP) Rates WITHOUT a Cost Share

EMPLOYEE 20 DEDUCTION	HIGH DEDUCTIBLE PLAN (WITHOUT TOBACCO SURCHARGE)	HIGH DEDUCTIBLE PLAN (\$500 TOBACCO SURCHARGE APPLIED)
SINGLE	\$0.00	\$25.00
EMPLOYEE SPOUSE	\$453.51	\$478.51
EMPLOYEE CHILD(REN)	\$371.06	\$396.06
FAMILY	\$824.57	\$849.57

Open Access Buy-Up Plan Rates WITHOUT a Cost Share

EMPLOYEE 20 DEDUCTION	OPEN ACCESS BUY-UP (WELLNESS INCENTIVES NOT MET)	OPEN ACCESS BUY-UP WITH WELLNESS INCENTIVES MET	OPEN ACCESS BUY-UP (\$500 TOBACCO SURCHARGE APPLIED) WELLNESS INCENTIVES NOT MET	OPEN ACCESS BUY-UP (\$500 TOBACCO SURCHARGE APPLIED) WELLNESS INCENTIVES MET
SINGLE	\$62.50	\$25.00	\$87.50	\$50.00
EMPLOYEE SPOUSE	\$526.54	\$489.04	\$551.54	\$514.04
EMPLOYEE CHILD(REN)	\$442.17	\$404.67	\$467.17	\$429.67
FAMILY	\$906.21	\$868.71	\$931.21	\$893.71

Tobacco Surcharge = \$500 Annually

Medical Plan Rates: Cigna

HDHP Cost Share Rates

EMPLOYEE 20 DEDUCTION	HIGH DEDUCTIBLE PLAN (\$500 TOBACCO SURCHARGE APPLIED)	HIGH DEDUCTIBLE PLAN (WITHOUT TOBACCO SURCHARGE)
SINGLE	\$231.15	\$206.15
EMPLOYEE SPOUSE	\$684.66	\$659.66
EMPLOYEE CHILD(REN)	\$602.20	\$577.20
FAMILY	\$1,055.71	\$1,030.71

Open Access Buy-Up Cost Share Rates

EMPLOYEE 20 DEDUCTION	OPEN ACCESS BUY-UP PLAN (WELLNESS INCENTIVES NOT MET)	OPEN ACCESS BUY-UP PLAN WITH WELLNESS INCENTIVES MET	OPEN ACCESS BUY-UP PLAN (\$500 TOBACCO SURCHARGE APPLIED) WELLNESS INCENTIVES NOT MET	OPEN ACCESS BUY-UP PLAN (\$500 TOBACCO SURCHARGE APPLIED) WELLNESS INCENTIVES MET
SINGLE	\$242.18	\$223.43	\$267.18	\$248.43
EMPLOYEE SPOUSE	\$706.22	\$687.47	\$731.22	\$712.47
EMPLOYEE CHILD(REN)	\$621.85	\$603.10	\$646.85	\$628.10
FAMILY	\$1,085.89	\$1,067.14	\$1,110.89	\$1,092.14

Cost Sharing for part-time employees at least .50 FTE but less than 1.00 FTE except for grandfathered employees as per contract language.

Tobacco Surcharge = \$500 Annually

Medical Plan Benefit Summary: Cigna

BENEFIT SUMMARY	HDHP WITH HEALTH SAVINGS ACCOUNT	OPEN ACCESS BUY-UP PLAN
EMPLOYEE ONLY ANNUAL / 20 PAY COST	\$0	\$1,250 / \$62.50 per 20 pay
WELLNESS INCENTIVE RECEIVED WHEN ALL 3 WELLNESS ACTIVITIES ARE MET	HSA OR HRA (if applicable) District Contribution \$750/EE, \$500/ Spouse	\$750 District Credit toward Employee Cost
TOBACCO USE SURCHARGE (ANNUAL)	\$500 / \$25 per 20 pay	\$500 / \$25 per 20 pay
NETWORK	Local Plus	Open Access Plus
WELLNESS ACTIVITIES QUALIFICATION PERIOD	September 1, 2014 through August 31, 2015	September 1, 2014 through August 31, 2015
PLAN DESIGN		
INDIVIDUAL DEDUCTIBLE	\$1,500	\$500
FAMILY DEDUCTIBLE	\$3,000 ^A	\$1,500 ^B
DEDUCTIBLE APPLICATION (*)	Medical & Rx	Medical Only
COINSURANCE (PLAN AND MEMBER % OF ALLOWED COST)	80%/20%	80%/20%
PREVENTIVE SERVICES	100% Covered	100% Covered
PRIMARY CARE PHYSICIAN	20%*	\$25 Copay
SPECIALISTS	20%*	\$50 Copay
URGENT CARE	20%*	\$50
INPATIENT HOSPITAL	20%*	20%*
OUTPATIENT SERVICES	20%*	20%*
EMERGENCY ROOM	20%*	\$250 Copay
MRI, PET, & CT	20%*	20%*
MINOR RADIOLOGY	20%*	20%*

*Deductible must be met before the Plan Shares cost of Services.

A - Collective, 1 or more family members.

B – 3 Family members must each meet individual deductible.

Medical Plan Benefit Summary: Cigna

BENEFIT SUMMARY	HDHP WITH HEALTH SAVINGS ACCOUNT	OPEN ACCESS BUY-UP PLAN
PHARMACY		
PREVENTIVE MEDICATIONS ^c	No Deductible; Copays Apply	Copays Apply
GENERIC - RETAIL	\$7*	\$7
BRAND (30-DAY) - RETAIL	\$30*	\$30
RETAIL 90 GENERIC/BRAND (90-DAY PUBLIX, WALMART)	\$14/\$60*	\$14/\$60*
SPECIALTY - RETAIL	\$75*	\$75
MAIL ORDER RX CIGNA HOME DELIVERY	Not Mandatory	Not Mandatory
GENERIC/BRAND	3 Month Fill for 2 Copays*	3 Month Fill for 2 Copays*
OUT OF POCKET MAXIMUM		
INDIVIDUAL MEDICAL/RX (INCLUDES DEDUCTIBLE)	\$5,500	\$6,400
FAMILY MEDICAL/RX (INCLUDES DEDUCTIBLE, NON-COLLECTIVE)^d	\$11,000	\$12,800
RX	Included in OOP Max	Included in OOP Max
VISION: ANNUAL EXAM	\$20	\$20
CONVENIENCE CARE CLINIC	20% after deductible	\$25

NOTE: These plans do not include out of network coverage.

*Deductible must be met before the Plan Shares cost of Services.

C - Go to Employee Self Service/Benefits/Benefit Summary Resources for the list of PPACA and Cost Share Preventative Medications

D - Non-Collective: Each family member will meet the individual out-of-pocket maximum, not to exceed two members.

Prescriptions: Cigna

Your Copayments

	RETAIL PHARMACY - 30-DAY SUPPLY	HOME DELIVERY + RETAIL 90 90-DAY SUPPLY
GENERIC (1ST TIER)	\$7.00	\$14.00
BRAND NAME PREFERRED (2ND TIER)	\$30.00	\$60.00
BRAND NAME NON-PREFERRED (3RD TIER)	Not Covered	Not Covered
SPECIALTY (RETAIL)	\$75.00	

Cigna administers the prescription drug benefit program. When you select any of the medical plans offered, you are automatically enrolled in the prescription drug benefit program. Listed in the table above are the Copayments you will pay depending on where you get your prescriptions filled.

Cigna has a national network of pharmacies that include major retail chains, such as CVS, Costco, Sam's Club, Medicine Shoppe, Winn Dixie, K-Mart, Target & Wal-Mart – to name a few. To locate a participating pharmacy, you may use www.cigna.com or call 1-800-Cigna24.

Prescription Drug List

Your plan's drug list contains generic drugs and a wide range of preferred brand-name drugs that have been approved by the US Food and Drug Administration (FDA). Prescription drugs are chosen to be included on the prescription drug list because they are safe, effective and save money.

The list of drugs covered under the plan is reviewed periodically.

PLEASE NOTE: The drugs on the prescription drug list can change during the plan year and as a result could change your Copayment.

Non-preferred brand-name medications are not covered under your plan.

COVERAGE CONSIDERATIONS: There are certain cost containment features of your prescription plan of which you should be aware. They include Prior Authorization, Drug Quantity Management and Step Therapy. The drugs that are subject to these considerations may change from time to time.

PRIOR AUTHORIZATION: Certain drugs require prior authorization. This means that either you or your doctor must get approval from Cigna before a prescription can be filled under the benefit plan.

DRUG QUANTITY MANAGEMENT: This program is designed to limit medications for both quantity and days supply based on safe prescribing guidelines from the FDA. Prior authorizations may be required for some of these medications where applicable.

STEP THERAPY/SPECIALTY STEP THERAPY: In some cases, the plan requires you first try certain drugs to treat your medical condition before another drug is covered for that condition. This includes both Specialty and non-specialty medications.

Tips to better managing your Prescriptions:

Create an account on www.myCigna.com or download the myCigna Smart Phone App. By doing either, you will have access to:

- Check order status
- Order available medications
- Utilize the Price Quoting Tool
- Order ID cards
- Locate a participating pharmacy in your area

How to Use Cigna's Pharmacy

Maintenance Drugs and Home Delivery

If you or a covered family member receive a prescription for a maintenance medication (any long-term medications taken for 90 days or more, such as cholesterol, blood pressure, diabetes, oral contraceptives, etc.), you can obtain a 30-day fill for the retail Copayments listed on the previous page.

Maintenance medication must be dispensed through the Cigna Home Delivery Pharmacy or use the retail 90 option at Publix and Walmart. Convenient delivery of your covered maintenance medications is available to your home or other specified address with Cigna Home Delivery. Please remember that prescriptions are dispensed for the exact quantity prescribed by your physician. The mail order Copay is charged for prescriptions that are dispensed for any quantity over a 31 day supply.

Filling Prescriptions via Home Delivery

Once you have obtained a prescription from your physician for a 90-day supply with refills, send it along with a home delivery form and your payment to Cigna Home Delivery Pharmacy. Your medication should ship to you within seven to ten days from the time Cigna Home Delivery Pharmacy receives your order. You may also call the Cigna Home Delivery Pharmacy at 1-800-285-4812 or request Cigna contact your physician for new prescriptions.

Ordering refills can be done at www.mycigna.com, via the phone, the mail or via Cigna Home Delivery Pharmacy Quick Fill program.

Mail order saves you and the plan money. You will receive a 90-day supply for what you would pay for a 60-day supply.

IMPORTANT NOTE:

IF MEDICATION IS TAKEN	QUANTITY TO PRESCRIBE	REFILLS
1 TIME A DAY	90	3
2 TIMES A DAY	180	3
3 TIMES A DAY	270	3

Please remember that prescriptions are dispensed for the exact quantity prescribed by your physician.

Prescription Savings

Many pharmacies now offer discount prescriptions—often even lower than your Copay. Below are just a few of the current discounts offered:

- Publix: a variety of oral antibiotics for FREE
- Target: over 300 generics for only \$4
- Wal-Mart: \$4 for a 30-day supply and \$10 for a 90-day supply of some generic medications
- basic

Dental Plans: Assurant



Your dental coverage is provided by Assurant Employee Benefits.* You have three plans to choose from to fit the needs of you and your family. The Prepaid 225 Plan offers benefits through a network of participating Plan Dentists. You must receive all your dental care from participating Plan Dentists. You and each covered dependent must select a participating General Dentist as your primary dentist. This plan has no annual maximum, no deductible, and covers orthodontia even for adults. Treatments you receive from your selected Plan Dentist will be provided at reduced fees called copayments. The Prepaid 225 Plan is the lowest cost per payroll deduction.

There are two PPO plans from which you can choose. In network, your Routine Dental Cleanings are covered at 100% once in any 6-month period (subject to frequency limitations). Both of the PPO plans have a Calendar Year Maximum of \$1,250 and include the Preventive Max Waiver (PMW) feature which means that benefits paid for Type I Preventive Services will not be applied to the Calendar Year Maximum. The PPO plans allow you to have access to the Assurant® Dental Network* providers and take advantage of their fee discounts. Treatment is available from dentists who do not participate in the network, but their fees are subject to a Maximum Allowable Charge (MAC). The allowable amount for non-participating dentists is based on 20% off the 80th percentile of usual and customary. You will be responsible for fees in excess of the MAC. There can be significant out-of-pocket expenses if a non-participating dentist is chosen. Plan frequencies, limitations, and waiting periods apply to the PPO plans.

DENTAL INSURANCE: Employee Contribution Rates (20 Payroll Deductions)

FREEDOM PREFERRED PLAN W/ PMW (LOW OPTION)	
EMPLOYEE ONLY	\$13.94
EMPLOYEE + ONE	\$26.10
EMPLOYEE + FAMILY	\$44.66
FREEDOM PREFERRED PLAN W/ PMW (HIGH OPTION)	
EMPLOYEE ONLY	\$20.77
EMPLOYEE + ONE	\$38.72
EMPLOYEE + FAMILY	\$65.57
PREPAID 225 PLAN	
EMPLOYEE ONLY	\$8.47
EMPLOYEE + ONE	\$13.86
EMPLOYEE + FAMILY	\$22.95

*Assurant Employee Benefits is the brand name used for prepaid dental products administered and provided by Union Security Insurance Company and for insurance products underwritten and issued by Union Security Insurance Company. Assurant® Dental Network includes dentists contracted with Dental Health Alliance, LLC® (DHA®) and dentists under access arrangements with other PPO dental networks.

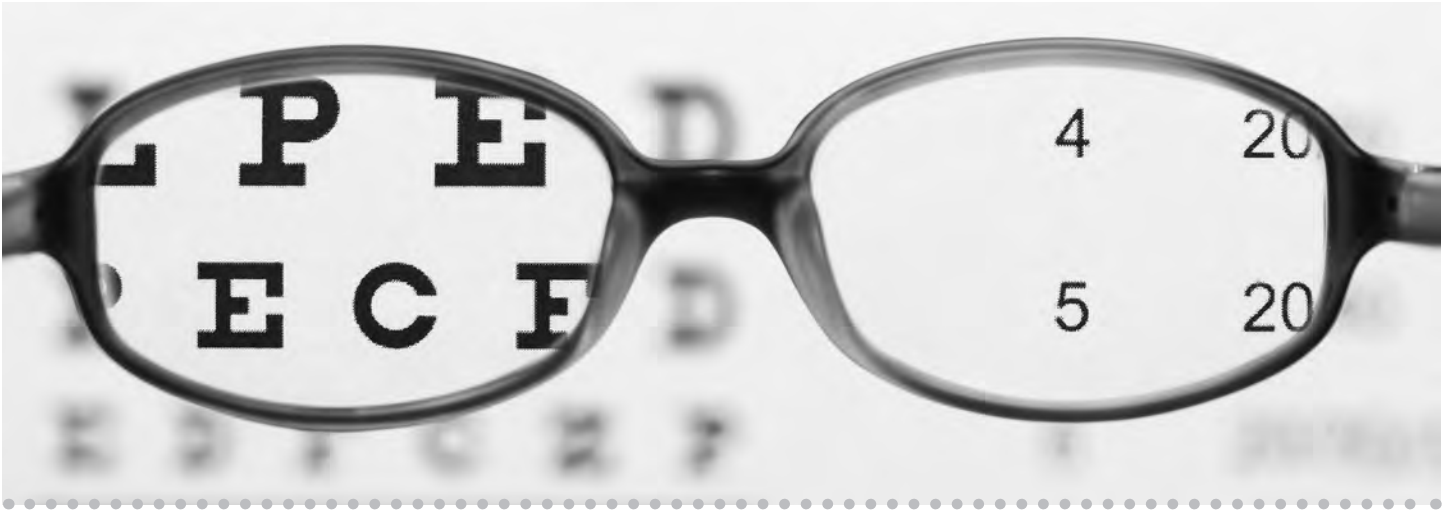
Dental Plans: Assurant

Visit the web site at www.assurantemployeebenefits.com, register in Online Advantage (the online tool for managing your dental benefits) and have access to your personal plan information, search for participating dentists, and find other information related to your overall dental health. To search for participating dentists, click on "Find a Dentist" under the Resource header. For the PPO plans, choose the Assurant® Dental Network. For the Prepaid 225 Plan, select "Florida" under the DHMO/Prepaid Dental Plans, then select the Prepaid Dental Series (Florida only).

	PREPAID 225 PLAN (COPAY ONLY PLAN)	FREEDOM PREFERRED PLAN W/ PMW (LOW OPTION)		FREEDOM PREFERRED PLAN W/ PMW (HIGH OPTION)	
	IN-NETWORK COVERAGE ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE SERVICES (CLEANINGS, FLUORIDE TREATMENT FOR CHILDREN, ETC.)	See Copayment List located on Employee Benefits Website	* Covered in Full	You pay 10% (Balance Billing may occur)	* Covered in Full	You pay 10% (Balance Billing may occur)
BASIC SERVICES (Restorative, Endodontics, Fillings)	See Copayment List located on Employee Benefits Website	You pay 10% after deductible	You pay 30% after deductible (Balance Billing may occur)	You pay 10% after deductible	You pay 30% after deductible (Balance Billing may occur)
MAJOR SERVICES (Perio, Crowns, Bridges, Dentures)	See Copayment List located on Employee Benefits Website	You pay 70% after deductible	You pay 90% after deductible (Balance Billing may occur)	You pay 40% after deductible	You pay 60% after deductible (Balance Billing may occur)
DEDUCTIBLE (Waived for Preventive)	Not applicable	\$50 per person	\$50 per person	\$50 per person	\$50 per person
MAXIMUM ANNUAL BENEFIT (Amount is combined for in & out of network)	Not applicable	\$1,250 per person	\$1,250 per person	\$1,250 per person	\$1,250 per person
ORTHODONTICS (Child and Adult)	See Copayment List located on Employee Benefits Website	Not Covered	Not Covered	Lifetime maximum: \$1,000 (For children under the age of 19)	Lifetime maximum: \$1,000 (For children under the age of 19)

*Oral evaluations and routine dental cleanings are covered once in any 6-month period. Plan frequencies, limitations and waiting periods apply.

Vision Plan: UnitedHealthcare



The voluntary vision coverage is provided by UnitedHealthcare Vision. This plan is separate from the vision benefits available under your medical plan with Cigna. The voluntary vision plan gives you coverage for the hardware that helps you see better like glasses or contacts. Contacts can be purchased in lieu of glasses.

To see a list of participating providers for this plan go to: www.myuhcvision.com or call 1-800-638-3120. The system will inform you of the providers located within 30 miles of your home. ID cards are not provided; therefore once you select a provider, simply call their office and make your appointment. Make sure you identify yourself as a UnitedHealthcare vision participant in the Seminole County Public Schools program and give the provider your Social Security number and birth date. (If you wish to select a doctor for your dependents, you must provide their date of birth as well).

Tips to better managing your vision benefits:

- Create an account on www.myuhcvision.com. By doing so, you will have access to:
 - » Search for doctors near you
 - » Print an ID card, as United Healthcare Vision does not supply cards
 - » Review benefit details

As a reminder, your Cigna medical plan has a vision benefit so you can get your eyes examined every year (\$20 copay). If you have good eye sight and do not need glasses or contacts to see better, then your medical plan provides you coverage to have your eyes examined to ensure they stay healthy.

Vision Plan: UnitedHealthcare

VISION INSURANCE: Employee Contribution Rates (20 Payroll Deductions)

EMPLOYEE	EMPLOYEE + 1 DEPENDENT	EMPLOYEE + 2 OR MORE DEPENDENTS
\$4.37	\$7.01	\$10.11

EMPLOYEE	IN-NETWORK BENEFITS	OUT-OF-NETWORK REIMBURSEMENT PLAN
OFFICE VISIT Copay (COVERED ONCE EVERY 12 MONTHS)	\$10 Eye Exam Copayment	\$35 Eye Exam Optometrist or Ophthalmologist
LENSES (COVERED ONCE EVERY 24 MONTHS)	\$10 Materials Copayment Progressive lenses available at a discount Polycarbonate lenses covered	\$20 Single vision \$40 Bifocal \$60 Trifocal \$60 Lenticular
FRAMES (COVERED EVERY 24 MONTHS)	\$50 Wholesale Frame Allowance Up to \$130.00 Retail Frame Allowance.	\$35
CONTACT LENSES (COVERED ONCE EVERY 24 MONTHS)	Covered Selection Contacts Up to 6 boxes Non-selection Contacts Up to \$150	Elective: Up to \$150.00 Medically Necessary: Up to \$175.00

Flexible Spending Accounts: myCafeteriaPlan

Current Participants

Your current card will be replenished if enrolled in the new plan year. New cards are provided for new enrollees or expiring cards. For replacement or additional cards prior to the card expiration date, \$5 will be charged by Visa/Mastercard to the participant. All eligible employees will have the opportunity to participate in a Flexible Spending Account (FSA) program administered through myCafeteriaPlan on the Open Access Buy Up Plan only. The plan covers your dependents even if they are not covered under the SCPS medical plan.

What is a Flexible Spending Account?

A Flexible Spending Account, also known as Section 125 Cafeteria Plan, allows participants to set aside pre-tax dollars to be used to pay for various out of pocket medical expenses, and dependent care expenses.

What are the types of Flexible Spending Accounts?

A Medical FSA is used to pay for medical expenses that you or your dependents incur even if they are not enrolled in the SCPS medical plan. You also have a dependent care flexible account. This account is for DAYCARE expenses ONLY and cannot be used for medical expenses.

FSA SAVINGS EXAMPLE		
	WITHOUT A FLEX PLAN	WITH A FLEX PLAN
Salary	\$ 700.00	\$ 700.00
FSA Election	\$0.00	\$25.00
Taxable Income	\$ 700.00	\$675.00
Income Tax	\$ 105.00	\$ 101.00
State Tax	\$56.00	\$54.00
Social Security Tax	\$53.00	\$51.00
Income After Taxes	\$486.00	\$469.00
Medical Premium	\$10.00	
Medical Expenses	\$5.00	
Dependent Care	<u>\$10.00</u>	<u>\$0.00</u>
Take Home Pay	\$461.00	\$469.00
Net Increase		\$8.00
Pay Periods		x 52
Annual Increase		\$416.00

Flexible Spending Accounts: myCafeteriaPlan

How Does a Flexible Spending Account work?

First, you must estimate the amount of out-of-pocket expenses you feel you may incur in the upcoming year. This amount will be your election amount. Your election amount is divided by the frequency of pay periods. This amount is then deducted from your paycheck each pay period on a pre-tax basis. You will receive a debit card for the FSA, which is the most convenient way to receive reimbursement.

Simply swipe your debit card at your providers office, pharmacy, hospital, daycare provider, etc. at the time of service and your claim will be paid instantly. It is important when you are utilizing the debit card to still ask for and keep an itemized receipt on file. You may still receive a letter from myCafeteriaPlan requesting this receipt for IRS documentation purposes. Even if you use the debit card, YOU are ultimately responsible to the IRS for documentation (i.e. a receipt). YOU are required to keep it and submit it so the plan is compliant with government regulations.

The Use It or Lose It Rule

Section 125 Flexible Spending Plans are governed by the “use it or lose it” rule, whereby, any amounts remaining at the end of the year are forfeited due to IRS regulations. **All claims must be submitted no later than 90 days after the end of the plan year. For the plan year 2016, claims that happen (incurred) January 1, 2016 through December 31, 2016, you have until March 31, 2017 to file the claim.**

Retirees

If you retire during the plan year, please remember you have 30 days from your retirement date to submit claims that were incurred through your employment termination date.

How Much Can I Contribute annually to the FSA Plan?

- Medical Flexible Spending: \$250 Minimum/\$2,500 Maximum
- Dependent Care Flexible Spending: \$5,000 maximum per household.

What if I don't substantiate my claims?

Please make note that when you use the debit card, you still must keep all of your receipts. myCafeteriaPlan may contact you and ask that you provide them with a copy of a receipt to substantiate a claim. Failure to provide this information to them in a timely manner will result in the deactivation of your debit card. If the substantiation is still not received, then SCPS may be required by the IRS to payroll deduct the unsubstantiated claim amount from your paycheck on an after-tax basis. Note that if you enroll in this product, you are agreeing to these terms.

Important Notice

Please remember if you are enrolling in the HDHP, you are not eligible to have a Flexible Spending Account.

Medical FSA Overview

There are at least two significant ways to benefit from a Flexible Spending Account. The first is by taking advantage of the tax savings. By reducing your gross income, you pay less in taxes, take home more pay and have the freedom to choose how your money is used.

The second benefit is the “cash flow” increase built into the Medical FSA (not the dependent day care FSA). This means that no matter how much money you have actually contributed to the plan at any given point, you can still be reimbursed up to your entire annual election. So a major medical expense at the beginning of the claim period can be reimbursed even though few, if any, deposits have been made into the account at that time. This applies to the medical FSA only.

Medical FSA Claims Reimbursement

Through myCafeteriaPlan, you have a variety of ways to choose from to get reimbursed for your claims: debit card, online submission, fax, mail or mobile App.

Debit Card

You will receive a debit card, which is the most convenient way to receive reimbursement. Simply swipe your debit card at your provider’s office, pharmacy, hospital, etc. at time of service and your claim will be paid instantly. It is important when you are utilizing the debit card to still ask for and keep an itemized receipt on file. You may still receive a letter from myCafeteriaPlan requesting this receipt for IRS documentation purposes. Even if you use the debit card, YOU are ultimately responsible to the IRS for documentation (i.e., a receipt). YOU are required to keep it and submit it so the plan is compliant with government regulations.

Please be advised that if you do not respond to myCafeteriaPlan’s request for an itemized receipt, your card and your account will be SUSPENDED. In addition, you will be payroll deducted for the unsubstantiated amount on an after tax basis.

Online

You can submit your claims online at www.mycafeteriaplan.com. To login to your account, go to www.mycafeteriaplan.com. There you will be prompted to create a username and password for returning visits to this site. Once you are logged in, you will be prompted to change your password and verify your personal information. You can also check your account balance(s) and see the status of any claims you have submitted.

Fax, E-mail or Mail

You are also able to submit your claims via fax at 937-865-6502 or by mail to:

myCafeteriaPlan

ATTN: Claims Department

432 East Pearl Street,

Miamisburg, OH 45342

Mobile App

myCafeteriaPlan On-the-go™ App allows you to easily check your balances, file claims* and send pictures of receipts using an iPhone, iPod Touch, iPad, or Android-powered device.

Medical FSA Eligible Expenses:

The following is a partial list of expenses that are reimbursable tax-free with a Medical FSA. For a complete list, visit the IRS’s website at www.irs.gov and search for Section 213 expenses.

Acupuncture (if medically necessary)

Ambulance service

Chiropractic care

Contact lenses (corrective)*

Diagnostic tests

Doctor’s fees

Drugs (prescription only**)

Experimental medical treatment (only if referred by a physician)

Eyeglasses

Hearing aids & exams

Injections and Vaccinations

Optometrist fees

Orthodontic treatment*

Prescription drugs to alleviate nicotine withdrawal symptoms

Smoking cessation programs/treatments

Transportation for local medical care

Wheelchairs

X rays

* To be eligible for reimbursement, some treatments, prescription drugs, or services deemed cosmetic in nature require written proof of medical necessity from your healthcare provider.

** Not all drugs requiring a prescription are approved by the IRS as eligible for reimbursement.

Dependent Day Care FSA Overview

Below is a list of expenses that qualify for reimbursement from the Dependent Day Care Account. Generally, eligible expenses include the cost of childcare for dependents under age 13 or care for a disabled spouse or dependent that allows you – or you and your spouse – to work. You'll also find examples of expenses that do not qualify for reimbursement because they are not considered legitimate deductions for federal income tax purposes. To make sure your situation and the type of care being provided meet IRS requirements, refer to IRS Publication 503. Please note this account operates differently than the medical FSA.

Funds in this account are only available for reimbursement as they are accumulated via payroll deductions, it does not have the same cash flow increase as the medical FSA. For example, if you have an annual election of \$1,000 (\$50 per paycheck), the full \$1,000 is NOT available on January 1st. Only the amount that has been deducted from your paycheck is available for reimbursement. So, by the end of January you will have \$100 to be reimbursed from. Keep this in mind if you are enrolling in this plan. You will also receive a debit card for this account as well. You will only be able to "swipe" the debit card for the amount that has been payroll deducted. Be sure to keep your receipts with your tax records and provide them if requested.

Eligible Dependent Day Care Expenses:

- After school care
- Fees paid to a childcare center or day care camp that comply with all applicable state and local regulations if providing care for more than six children
- Full amount paid to a nursery school, even though the cost may include lunch and education services
- Fees paid to a baby-sitter in or outside your home
- Fees paid to a relative who provides dependent care services, other than your spouse, your child under age 19 or a dependent you claim for federal income tax purposes
- Fees paid to a housekeeper or cook who also is responsible for providing care for an eligible dependent
- Fees paid to a nurse or home healthcare agency for care for your spouse or legal dependent who is physically or mentally incapable of self-care
- Legally mandated amounts paid on behalf of the provider – Social Security (FICA), federal (FUTA) and state (SUTA) unemployment taxes

Ineligible Dependent Day Care Expenses:

- Food, clothing and education
- Transportation to and from the place where dependent care services are provided
- Fees paid for a childcare center that provides care for more than six children but does not comply with all applicable laws
- Expenses for which a federal childcare tax credit is taken or which are claimed under the Healthcare Account Search fees for a dependent care provider

Medical HSA: Cigna Choice Funds

Giving you more of what you want

Healthcare costs are rising, and there's no sign of them slowing down anytime soon. Fortunately, there are plans that can help you take control of your health – and your costs. They're called account-based plans.

These plans offer you a typical medical plan at a higher deductible – the amount you pay before your plan starts to pay – but with a health account to help with the cost of meeting that deductible.

Cigna Choice Funds

These account-based plans give you access to useful information that will help you make the best choices – for you and your family. With Cigna Choice Fund®, you're given the freedom to seek care from a large network of licensed doctors, hospitals and other healthcare professionals.

Choose to see doctors who participate in the Cigna network and take advantage of discounted rates on care. Choose to see a doctor outside the network and you can still use your health savings account to pay for the cost of rates on covered services, but you'll typically pay more and it will not apply to your deductible or out-of-pocket maximum.

What is a health savings account?

The Cigna Choice Fund Health Savings Account (HSA) provides a healthcare plan with a tax-free* health savings account you establish through your employer with HSA Bank. Both you and your employer may contribute to your account, up to the current federal limit.

The money in your HSA belongs to you. You decide how you want to pay for your healthcare expenses.

Whether you use the money in your account or other personal money, your next step is to meet your deductible (the amount you pay before your plan starts to pay). Once you do, you pay coinsurance (a percentage of the cost) for your covered expenses and the plan pays the rest.

How it Works:

- Your tax-free health savings account is opened. You, your employer or both may contribute to your account.
- You can choose to participate in investment options when your balance reaches \$2,000. You can save for future medical costs or opt to invest your funds. You can use your account to pay for eligible healthcare expenses.
- Use your debit card, checkbook, auto pay or online bill pay to reimburse your healthcare expenses.
- Take the account with you when you leave the plan, change jobs or retire.
- You're protected by an annual, out-of-pocket maximum limit on how much you pay.
- HSA accounts are available if you, the employee, are not covered under an Flexible Spending Account, and you are enrolled in the High Deductible Health Plan.

* HSA contributions and earnings are not subject to federal taxes and not subject to state taxes in most states. Contact your professional tax advisor about details for your specific state.

Medical HRA: Cigna Choice Funds

What is a health reimbursement account?

The Cigna Choice Fund Health Reimbursement Account (HRA) provides a healthcare plan with a health reimbursement account funded by your employer to help pay for some of the costs of covered expenses, including healthcare expenses and prescription drugs.

Your HRA consists of three components:

1. A Health Account
2. Your share of the costs
3. A Cigna Health Plan

Your HRA can be used to pay 100% of your eligible healthcare expenses until the money is used up.

Money that you don't use during the plan year may be rolled over to the next year and added to your employer's annual contribution if you re-enroll in the account. This reduces your share of the deductible (the amount you pay before your plan starts to pay) in the next year. If you leave the plan or your employer, your account stays behind.

There's no question that Cigna Choice Fund gives you more flexibility. But you'll also be glad to know that when you choose Cigna Choice Fund you're able to more effectively control your healthcare expenses without sacrificing important care. And with today's increasing healthcare costs, that's something we can all appreciate.

Who is eligible for and HSA and HRA?

Anyone with other medical coverage including Medicare, is not eligible for an HSA however they may participate in an HRA.

For more information regarding HSAs and HRAs, consult with your tax advisor, or visit www.IRS.gov.

Short-Term and Long-Term Disability: Cigna

Think of disability coverage as insurance for your paycheck. A disability can put your life on hold while you recover. Unfortunately, expenses such as your mortgage or rent, utility and grocery bills are not put on hold.

Disability insurance provides you with a stable source of income that can help carry you and your family financially through this time. Short-Term Disability covers you for up to 26 weeks. Should your disability take longer than this to recover from, then your claims would transition to Long-Term Disability (if you are enrolled in it). These are two separate policies and you do not have to purchase both of them. It is recommended that the deductions for these plans come out of your check AFTER tax. If you choose to have your deductions on a pre-tax basis, your benefit will be considered taxable income. Please note this benefit does not pay if you are out on a worker's comp claim or receiving sick or vacation time.

STD Employee Contribution Rates (20 Payroll Deductions)

BI-WEEKLY EARNINGS	WEEKLY BENEFIT	DEDUCTION	BI-WEEKLY EARNINGS	WEEKLY BENEFIT	DEDUCTION
Less than \$508	\$100	\$4.52	\$1,570 - \$1,999	\$500	\$22.69
\$508 - \$841	\$200	\$9.19	\$2,000 - \$2,333	\$600	\$27.22
\$842 - \$1,175	\$300	\$13.58	\$2,334 - \$2,687	\$700	\$31.76
\$1,176 - \$1,569	\$400	\$18.10	\$2,688 or higher	\$800	\$36.29

SHORT-TERM DISABILITY HIGHLIGHTS	
BENEFIT AMOUNT	You can select your benefit in increments of \$100. Your maximum benefit amount is determined by your salary.
BENEFIT MAXIMUM	\$820
BENEFIT DURATION	26 weeks
ELIMINATION PERIOD	14 calendar days
MAXIMUM BENEFIT PERIOD	26 weeks
BENEFIT OFFSETS	Including but not limited to sick pay, retirement (401(k) & pension), workers' compensation, social security & other group disability plans like the Mutual of Omaha policy

Short-Term and Long-Term Disability: Cigna

LTD Employee Rate (20 Payroll Deductions) \$6.57

LONG-TERM DISABILITY HIGHLIGHTS	
BENEFIT AMOUNT	60% of your monthly earnings
BENEFIT MAXIMUM	\$5,000 per month
BENEFIT DURATION	age 65/Graded ADEA
ELIMINATION PERIOD	180 calendar days
MAXIMUM BENEFIT PERIOD	To age 65/Graded ADEA as stated above. Benefits are paid on a graded scale if the employee becomes disabled after age 62.
BENEFIT OFFSETS	Including but not limited to sick pay, retirement (401(k) & pension), workers' compensation, social security & other group disability plans like the Mutual of Omaha policy

Long-Term Care: Unum

Long-Term Care is care that isn't covered by any medical or disability income insurance, or by Medicare. Long-Term Care is needed when you or a family member (spouse, parents, grandparents, in-laws, etc.) become unable to care for themselves on their own and require help doing the everyday things we all take for granted, such as: dressing, eating and bathing. This can happen as a result of a stroke, accident or illness.

Seminole County Public School's Long-Term Care coverage can provide an important financial resource if you or a family member faces a debilitating accident or illness. Through SCPS, you have the opportunity to purchase Long-Term Care coverage with UNUM through easy, after-tax, payroll deductions. This group policy offers you and your family the ability to take advantage of group rates. If you did not sign up for this benefit when you were first eligible, then you will have to provide Evidence of Insurability. Family members are required to provide Evidence of Insurability when they sign up for this plan. You have the ability to pay for you and your spouse's coverage via payroll deductions. Your other family members will be billed directly by UNUM.

What does it cover?

Just as it sounds, Long-Term Care is about needing care for lengthy periods of time, either in your home or in a facility that provides Long-Term Care services. Long-Term Care coverage

can help cover the cost of care in a variety of places, a few of which are:

- Your own home
- An assisted living facility
- A nursing home
- Adult Day Care

Why does it pay to enroll now?

You may need Long-Term Care at any age whether you're 27 or 72. Accidents and sudden illness can happen at any age, to anyone, regardless of how well you take care of your health. UNUM rates are based on your age at the time your coverage becomes effective. By enrolling now, your monthly rate is the lowest it will ever be. The younger you are when you enroll, the lower your rate will be for as long as you continue your coverage. Remember, you can only buy this insurance before you need it. Waiting to enroll could mean you may risk losing the ability to qualify for coverage.

NOTE: This plan does not have an accumulated cash value. If you terminate your coverage, there is not a cash surrender value. This plan will require medical underwriting if you enroll after your initial eligibility period. If you are interested in enrolling, please contact the FBMC representative at 1-407-320-0364 in the Employee Benefits Department.

Visit <http://unuminfo.com/scps/index.aspx> for more details, including a cost calculator.

LONG-TERM CARE BENEFIT HIGHLIGHTS	
MONTHLY BENEFIT AMOUNT	Available in increments of \$1,000 with \$2,000 as the minimum and \$6,000 as the maximum
ELIMINATION PERIOD	90 days
BENEFIT DURATION	Choose 3 year, 6 year or lifetime
FACILITY BENEFIT	Receive 100% of the benefit if receiving care at an approved facility such as a nursing home
HOME HEALTH BENEFIT	Receive 75% of the benefit if receiving approved home care
WHO IS ELIGIBLE FOR COVERAGE	You, your spouse, parents, grandparents, aunts, uncles, siblings, children over the age of 18 and in-laws
ADDITIONAL PLAN FEATURES	Inflation protection available on some plans. ALL plans are indemnity reimbursement which means you do not need to submit receipts.

Cancer Insurance: Colonial

Cancer Insurance

If diagnosed with cancer, would you have the money to cover any of the following?

- Loss of wages or salary
- Deductibles and coinsurance
- Experimental treatments
- Travel expenses
- Home healthcare needs
- Childcare expenses

Colonial Life & Accident Insurance Company's Cancer insurance helps guard against financial difficulties if you or a loved one is diagnosed with cancer.

Plan Features:

1. Annual cancer screening benefit of \$100 (per person, per year)
2. Pays benefits to help with the cost of cancer treatment
3. Hospital confinement benefit and chemotherapy and radiation benefits
4. Pays regardless of any other insurance you have with other companies
5. Benefits paid directly to you unless you specify otherwise
6. Guaranteed renewable as long as premiums are paid when due
7. You can take your coverage with you even if you change jobs or leave your employer

Also included is an initial diagnosis rider; this rider pays a lump sum of \$2,000 for the initial (first) diagnosis of internal (not skin) cancer per adult and \$3,500 per child.

Cancer Security Highlights

ANNUAL CANCER SCREENING	\$100 (Paid only once)
SKIN CANCER INITIAL DIAGNOSIS	\$300 for skin cancer (once per lifetime)
CHEMOTHERAPY & RADIATION BENEFIT	\$300 per day for approved treatments (maximums apply)
HOSPITAL CONFINEMENT	\$300 a day for the first 30 days

Rates for Cancer Insurance and the initial diagnosis rider based on 20 payroll deductions:

EMPLOYEE ONLY	ONE-PARENT FAMILY	FAMILY
\$17.34	\$19.80	\$29.40

All policy premiums are 100% employee paid.

NOTE: Benefits are not payable until after the first 30 days following the coverage effective date.

The rates provided are for illustration purposes only and may vary based on plan design.

This policy and the rider have exclusions and limitations. For cost and complete details of the coverage, see your Benefits Counselor. Coverage may vary by state and may not be available in all states. Applicable to policy form C1000 (including state abbreviations where used) and applicable to rider form R-C1000-Indx (including state abbreviation where used).

Hospital Indemnity Protection: Colonial

Hospital Confinement Indemnity Insurance

How will you pay for what your health insurance won't?

Colonial Life & Accident Insurance Company's Hospital Confinement Indemnity insurance can help protect you against those out-of-pocket expenses related to a covered accident or covered sickness.

Plan Features:

- Lump-sum hospital confinement benefit of \$1,000; payable per confinement
- Includes outpatient surgical procedure benefit; calendar year maximum is \$1,500
- Annual wellness test benefit is included; maximum of one test per calendar year for named insured only coverage or maximum of two tests per calendar year for all covered persons combined. Fifty dollars paid only once a year.
- Rehabilitation unit confinement benefit of \$100 per day; maximum of 15 days per confinement with a 30-day maximum per covered person per calendar year.
- A waiver of premium benefit is available after 30 continuous days of the named insured's hospital confinement.
- Coverage options for you, your spouse and eligible dependent children.

Rates for Hospital Confinement Indemnity Insurance and based on 20 payroll deductions:

AGE	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Age 17 - 24	\$9.81	\$18.66	\$16.59	\$23.04
Age 25-29	\$10.95	\$20.16	\$17.67	\$24.66
Age 30 - 34	\$10.59	\$19.92	\$17.07	\$24.48
Age 35 - 39	\$10.35	\$19.83	\$16.41	\$24.36
Age 40 - 44	\$10.89	\$21.21	\$16.83	\$25.77
Age 45 - 49	\$12.24	\$24.03	\$17.91	\$28.71
Age 50 - 54	\$13.68	\$27.27	\$19.35	\$31.89
Age 55- 59	\$15.54	\$31.56	\$21.39	\$36.15
Age 60 - 64	\$18.60	\$37.92	\$24.54	\$41.64
Age 65 - 69	\$22.92	\$43.95	\$27.54	\$48.48
Age 70 - 74	\$25.32	\$51.51	\$31.32	\$56.10

All policy premiums are 100% employee paid.

The rates provided are for illustration purposes only and may vary based on plan design.

The rates provided are for illustration purposes only and may vary based on plan design. This policy has exclusions and limitations. For cost and complete details of the coverage, see your Benefits Counselor. Coverage may vary by state and may not be available in all states. Applicable to policy number MB3000-FL.

Accident Insurance: Colonial

Accident Insurance

Accidents happen in places where you and your family spend the most time – at work, in the home and on the playground – and they are unexpected. How you care for them shouldn't be.

Colonial Life & Accident Insurance Company's Accident Insurance is designed to help you fill some of the gaps caused by increasing deductibles, Copayments and out-of-pocket costs related to a covered accidental injury. The benefit to you is that you may not need to use your savings or secure a loan to pay expenses. Many levels and options are available for you, your spouse and eligible dependent children. Plus you'll feel better knowing you can have greater financial security.

This benefit does not require underwriting approval though an application must be completed as indicated on Page 5. A policy will not be issued without the applications.

Plan Features Include Benefits for:

- On & Off-Job Benefits
- Initial Care, Including Emergency Room Treatment
- Common Accidental Injuries
- Surgical Care
- Transportation and Lodging Assistance
- Accident Hospital Care
- Follow-Up Care
- Accidental Death and Dismemberment
- Catastrophic Accident
- Issue Age is 0-80

Accident Plan Highlights

EMERGENCY ROOM VISIT	\$150.00
HOSPITAL ADMISSION DUE TO AN ACCIDENT	\$750
FOLLOW-UP DOCTOR VISIT	\$50
BROKEN OR FRACTURED BONES	Varies \$75

Rates For Accident Insurance Based On 20 Payroll Deductions:

EMPLOYEE ONLY	EMPLOYEE AND SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
\$10.80	\$14.40	\$18.00	\$21.60

All policy premiums are 100% employee paid.

The rates provided are for illustration purposes only and may vary based on plan design.

This policy has exclusions and limitations. For cost and complete details of the coverage, see your Benefits Counselor. Coverage may vary by state and may not be available in all states. Applicable to policy form ACCPOL-FL. This is not an insurance contract only actual policy provisions will control.

Life Insurance: VOYA/Reliastar

Board Paid Basic Life Insurance

Board paid (Basic) Life and Accidental Death & Dismemberment (AD&D) Insurance is provided by VOYA/ReliaStar Life Insurance Company at no cost to the employee. Life Insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at Seminole County Public Schools. AD&D Insurance is equal to your Life Insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits for certain injuries. It is important to keep your beneficiary information updated. Please refer to your certificate of coverage for more details.

PLAN FEATURES	BENEFIT AMOUNT
BOARD PAID (BASIC) LIFE INSURANCE	One times your annual salary up to \$150,000 (minimum \$25,000)
ACCIDENTAL DEATH AND DISMEMBERMENT	One times your annual salary up to \$150,000 (minimum \$25,000)
BENEFIT REDUCTION SCHEDULE (OCCURS AT THE POLICY ANNIVERSARY DATE OF JANUARY 1ST)	Age 65, insurance reduces to 65% of the original amount; Age 70, insurance reduces to 50% of the original amount; Age 75, insurance reduces to 35% of the original amount

Additional Life & AD&D Insurance

Employees have the opportunity to elect additional voluntary Life and Accidental Death & Dismemberment Insurance. This will provide an additional Life Insurance benefit for yourself, your spouse and/or your dependent child(ren). Contributions for these premiums are 100 percent employee paid. If you waive voluntary life coverage when you are initially eligible, you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date. Please allow four to six weeks for underwriting approval. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results which is determined by your health status. ***This benefit does not continue when you retire.***

PLAN FEATURES	BENEFIT AMOUNT
EMPLOYEE LIFE INSURANCE	Available in increments of \$10,000 not to exceed four times (4X) your annual salary to a maximum benefit of \$300,000. New hires are eligible to purchase the lesser of two times (2X) your annual salary or \$100,000 on a guaranteed issue basis if you are under the age of 65 at time of purchase. If you are over the age of 65, please consult the certificate of coverage or contact the Employee Benefits Department.
SPOUSE LIFE INSURANCE	You may also purchase Supplemental Term Life Insurance for your spouse in \$10,000 increments up to a maximum of \$150,000. The amount you can purchase for your spouse cannot exceed 50% of the Employee Basic & Supplemental Term Life Insurance amounts combined.
DEPENDENT CHILD(REN) LIFE INSURANCE	This benefit provides coverage for all eligible dependent children, regardless of how many. You have three options to choose from: \$2,000, \$5,000 and \$10,000, per deduction.
BENEFIT REDUCTION SCHEDULE (OCCURS AT THE POLICY ANNIVERSARY DATE OF JANUARY 1ST)	Age 65, insurance reduces to 65% of the original amount; Age 70, insurance reduces to 50% of the original amount; Age 75, insurance reduces to 35% of the original amount

Additional Life Insurance Rates

Payroll deductions are based on 20 pays. Rates are dependent upon your age and your spouse's age on the effective date of coverage. **Please note that if you move up to the next age bracket, your payroll deduction will change in January following your birthday.**

Dependent Child(ren) Life Rates

\$2,000	\$0.48
\$5,000	\$1.20
\$10,000	\$2.40

Rates for Life Insurance based on 20 payroll deductions:

Ages	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	>70
\$10,000	\$0.24	\$0.30	\$0.50	\$0.95	\$1.67	\$2.64	\$4.58	\$5.48	\$10.62	\$18.72
\$20,000	\$0.48	\$0.60	\$1.00	\$1.90	\$3.34	\$5.28	\$9.16	\$10.96	\$21.24	\$37.44
\$30,000	\$0.72	\$0.90	\$1.50	\$2.85	\$5.01	\$7.92	\$13.74	\$16.44	\$31.86	\$56.16
\$40,000	\$0.96	\$1.20	\$2.00	\$3.80	\$6.68	\$10.56	\$18.32	\$21.92	\$42.48	\$74.88
\$50,000	\$1.20	\$1.50	\$2.50	\$4.75	\$8.35	\$13.20	\$22.90	\$27.40	\$53.10	\$93.60
\$60,000	\$1.44	\$1.80	\$3.00	\$5.70	\$10.02	\$15.84	\$27.48	\$32.88	\$63.72	\$112.32
\$70,000	\$1.68	\$2.10	\$3.50	\$6.65	\$11.69	\$18.48	\$32.06	\$38.36	\$74.34	\$131.04
\$80,000	\$1.92	\$2.40	\$4.00	\$7.60	\$13.36	\$21.12	\$36.64	\$43.84	\$84.96	\$149.76
\$90,000	\$2.16	\$2.70	\$4.50	\$8.55	\$15.03	\$23.76	\$41.22	\$49.32	\$95.58	\$168.48
\$100,000	\$2.40	\$3.00	\$5.00	\$9.50	\$16.70	\$26.40	\$45.80	\$54.80	\$106.20	\$187.20
\$110,000	\$2.64	\$3.30	\$5.50	\$10.45	\$18.37	\$29.04	\$50.38	\$60.28	\$116.82	\$205.92
\$120,000	\$2.88	\$3.60	\$6.00	\$11.40	\$20.04	\$31.68	\$54.96	\$65.76	\$127.44	\$224.64

Additional Life Insurance Rates

Rates for Life Insurance based on 20 payroll deductions:

Ages	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	>70
\$130,000	\$3.12	\$3.90	\$6.50	\$12.35	\$21.71	\$34.32	\$59.54	\$71.24	\$138.06	\$243.36
\$140,000	\$3.36	\$4.20	\$7.00	\$13.30	\$23.38	\$36.96	\$64.12	\$76.72	\$148.68	\$262.08
\$150,000	\$3.60	\$4.50	\$7.50	\$14.25	\$25.05	\$39.60	\$68.70	\$82.20	\$159.30	\$280.80
\$160,000	\$3.84	\$4.80	\$8.00	\$15.20	\$26.72	\$42.24	\$73.28	\$87.68	\$169.92	\$299.52
\$170,000	\$4.08	\$5.10	\$8.50	\$16.15	\$28.39	\$44.88	\$77.86	\$93.16	\$180.54	\$318.24
\$180,000	\$4.32	\$5.40	\$9.00	\$17.10	\$30.06	\$47.52	\$82.44	\$98.64	\$191.16	\$336.96
\$190,000	\$4.56	\$5.70	\$9.50	\$18.05	\$31.73	\$50.16	\$87.02	\$104.12	\$201.78	\$355.68
\$200,000	\$4.80	\$6.00	\$10.00	\$19.00	\$33.40	\$52.80	\$91.60	\$109.60	\$212.40	\$374.40
\$210,000	\$5.04	\$6.30	\$10.50	\$19.95	\$35.07	\$55.44	\$96.18	\$115.08	\$223.02	\$393.12
\$220,000	\$5.28	\$6.60	\$11.00	\$20.90	\$36.74	\$58.08	\$100.76	\$120.56	\$233.64	\$411.84
\$230,000	\$5.52	\$6.90	\$11.50	\$21.85	\$38.41	\$60.72	\$105.34	\$126.04	\$244.26	\$430.56
\$240,000	\$5.76	\$7.20	\$12.00	\$22.80	\$40.08	\$63.36	\$109.92	\$131.52	\$254.88	\$449.28
\$250,000	\$6.00	\$7.50	\$12.50	\$23.75	\$41.75	\$66.00	\$114.50	\$137.00	\$265.50	\$468.00
\$260,000	\$6.24	\$7.80	\$13.00	\$24.70	\$43.42	\$68.64	\$119.08	\$142.48	\$276.12	\$486.72
\$270,000	\$6.48	\$8.10	\$13.50	\$25.65	\$45.09	\$71.28	\$123.66	\$147.96	\$286.74	\$505.44

Approved LOA and Newborn Coverage

Board-Approved Leave of Absence

While on a Board approved leave of absence, you may continue your insurance. **The category of leave (Family Medical Leave, sick leave with or without pay, etc.) will dictate whether you are required to pay for your benefits including any current Board contributions to medical and life insurance.** You must contact your FTE clerk for information concerning your leave options prior to any inquiries to the Employee Benefits Department.

Billing

Billing statements will be sent monthly and will be based on the number of missed checks/deductions during this period. You may choose to voluntarily terminate your insurance while on leave, by submitting termination notification to the Employee Benefits Department **in writing**. Otherwise, payment must be received by the posted monthly due date. Premiums not received by the due date will cause your coverage to be terminated.

If you terminate coverage while on leave, you may re-enroll in coverage when you return from leave. An enrollment form must be completed and received by the Employee Benefits Department within 30 days of the date you return to work. The effective date of all plans will be the first of the month following 30 days of continuous service.

Employees on leave of absence are held accountable to wellness activities just like active employees. If an employee wants to receive incentives for the next plan year, the wellness activities must be met. Contact your assigned Benefit Specialist prior to or returning from a leave of absence.

Coverage for Newborns

A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium. Your Dependents will be insured only if you are insured.

To permanently add your newborn to your policy, you must submit an enrollment form to the Employee Benefits Department no later than 60 days from the date of birth. Additionally, a copy of the birth certificate and the newborn's Social Security number is required to be submitted to the Employee Benefits Department within 30 days of the birth. Once the baby is enrolled in your plan, you CANNOT drop their coverage until the next annual enrollment. Due to IRS Section 125 rules and SCPS procedures, you need a qualifying event to make changes outside of annual enrollment. If you want the baby to be covered under your spouse's group insurance plan, then you will need to add the baby to his or her plan at the time of birth. Newborns will not be added if you fail to notify the Employee Benefits within 60 days from the date of birth.

PLEASE NOTE: If you add the newborn to both you and your spouse's plan, there is NO qualifying event that will allow you to drop the newborn from your coverage, so the newborn will continue to be on both of your plans and you will continue to be charged the premium. You will not be able to drop coverage until the next annual enrollment. The purchase of an individual policy does not constitute a qualifying event.

Cigna Healthy Pregnancy, Healthy Babies Program – 1-800-615-2906

This program is designed to help you and your baby stay healthy during your pregnancy and in the days and weeks following your baby's birth. And, you will get rewarded for a good decision. When you participate and complete the program you'll be eligible to receive a \$150 award if you enroll by the end of your first trimester; or \$75 award if you enroll by the end of your second trimester. Simply call in to join this program.

Retirement

Have you given much thought to your financial security? Regardless of the stage in your career, whether you are just starting out or getting ready to retire, you should have a financial plan that will support you through the duration of your life.

In addition to the FRS pension plan, you are eligible to participate in a voluntary 403(b) and/or a 457(b) plan. These plans can help build your financial security and provide funds for retirement.

To participate, you will decide how much of your gross salary you would like to contribute. These contributions are on a pre-tax basis, which will reduce your taxable income. The taxes on your contributions and any earnings are delayed until you withdraw the money at retirement or upon separation of service.

Florida Retirement System (FRS) –

1-866-446-9377 or 1-850-488-4742

The Florida Retirement System offers two retirement plans, the FRS Pension Plan and the FRS Investment Plan. On your date of hire, you are automatically enrolled in the FRS Pension Plan. You have up to five months from your date of hire to choose whether to stay in the Pension Plan or change to the FRS Investment Plan. After that period, you will have one other opportunity to change plans (a second election) anytime during your FRS career.

The District contributes the majority of your FRS retirement plan savings. In addition, a mandatory three percent pre-tax contribution is directed from your paycheck into your retirement account regardless of the plan you choose.

You are vested in the FRS Investment Plan after one (1) year of service. Your benefit is based on how much money is contributed to your account and how well that money grows over time when invested. You decide how much risk to take by allocating your account balance among professionally managed investment funds. You can be conservative or aggressive. When you retire you are able to take your benefit in a single payment, in multiple payments over time, in guaranteed monthly payments for life, or any combination. DROP is not available.

Employees hired July 1, 2011, or after are vested under the FRS Pension Plan after you have COMPLETED eight (8) years of CREDITABLE service. Vesting refers to your earned right to receive a retirement benefit when you reach normal or early retirement age, even though you may have terminated employment before that age. Normal retirement is 65 years of age OR 33 years of service regardless of age. If you have at least eight years of creditable service but have not reached your normal retirement age, as described above, you can take early retirement. Your benefit will be reduced five percent for each year you are under normal retirement age. If you are a rehired employee who has Pension Plan service prior to July 1, 2011, you will vest in your benefit after six years of FRS service and your normal retirement age is 62.

Enrollment 403(b) & 457(b) Plans

If you would like to enroll in the SCPS supplemental retirement plans 403(b) or 457(b), you will need to choose an authorized SCPS investment provider(s). A current list of these authorized providers, agents and forms are located on the SCPS website at www.scps.k12.fl.us/benefits/mainmenu. Look for tax sheltered information. The same information is also available on TSA Consulting Groups website at <https://www.tsacg.com> or by calling 1-888-777-5827.

Insurance Definitions

ADMINISTRATIVE SERVICES ONLY (ASO) - SELF-FUNDED: Your employer is exclusively liable for all of the financial (claims and related expenses) and legal aspects of your group benefits plan.

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

BENEFIT YEAR: The 12-month cycle during which the benefits expenses that you incur, and that are covered by the insurance plan, count toward your annual or calendar-year deductible.

CAFETERIA PLAN: A reimbursement plan governed by IRS Section 125 which allows employees to contribute a certain amount of their gross income to a designated account or accounts before taxes are calculated.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COPAY: A capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COBRA: The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80 percent of the allowable charge, with the covered person responsible for the remaining 20 percent. The 20 percent amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

EVIDENCE OF INSURABILITY (EOI): Medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

EXPLANATION OF BENEFITS (EOB): A document produced by your medical insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a medical claim processed on your behalf.

FLEXIBLE SPENDING ACCOUNT (FSA): One of a number of tax-advantaged financial accounts that can be set up through a cafeteria plan by an employee to pay for eligible medical and dependent day care expenses on a pre-tax basis.

HEALTH ASSESSMENT: A physician collects, validates, and analyzes your biometric information in order to make a judgement about your health status and life processes.

HEALTH REIMBURSEMENT ACCOUNT (HRA): an IRS approved, employer-funded, tax-advantaged employer health benefit plan that reimburses employees for out-of-pocket medical expenses and individual health insurance premiums.

Insurance Definitions

HEALTH SAVINGS ACCOUNT (HSA): A savings account used in conjunction with a high-deductible health insurance policy that allows users to save money tax-free against medical expenses.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP): A health insurance plan with lower premiums and higher deductibles than a traditional health plan.

IN-NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

OUT-OF-NETWORK: The use of healthcare providers who have not contracted with the health plan to provide services.

OUT-OF-POCKET MAXIMUM: The total amount a covered person must pay before his or her benefits are paid at 100 percent for the remainder of the plan year. Deductible, copayments, and coinsurance apply towards the maximum out-of-pocket.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional healthcare providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PRIMARY CARE PHYSICIAN (PCP): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PROTECTED HEALTH INFORMATION (PHI): Any information about health status, provision of healthcare, or payment for healthcare that can be linked to a specific individual. This is interpreted rather broadly and includes any part of a patient's medical record or payment history.

Beyond Your Benefits

TAXABLE BENEFITS AND THE IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any payments received under the plan will be taxed on a pro-rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcares you incur, if these premiums were paid with pre-tax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

According to IRS regulations, you can pay life insurance premiums tax free on your first \$50,000 of life insurance. You must pay tax on premiums for coverage exceeding \$50,000.

LIFE INSURANCE PREMIUMS AND THE IRS

According to IRS regulations, you can pay premiums on a pre-tax basis, for the first \$50,000 of life insurance. However, you must pay tax on any coverage exceeding \$50,000 (which includes your School Board-provided \$10,000) with after-tax money.

SOCIAL SECURITY

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call Customer Care Center at 1-855-5MY-DCPS (1-855-569-3277) for an approximation.

DISCLAIMER - HEALTH INSURANCE BENEFITS PROVIDED UNDER HEALTH INSURANCE PLAN(S)

Health Insurance benefits will be provided not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s) and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies and procedures from time to time adopted.

FBMC PRIVACY NOTICE

This statement applies to products administered by FBMC Benefits Management, Inc. FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal and sometimes, sensitive information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended. FBMC's privacy statement is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services.

FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally vary depending on the products or services you request and may include:

Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.

Responses from you and others such as information relating to your employment and insurance coverage.

Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.

Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under Federal Law you have certain rights with respect to your protected health information.

You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information.

We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.

IV. We limit how, and with whom, we share customer information.

We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Beyond Your Benefits

NOTICE OF ADMINISTRATOR'S CAPACITY

This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder and the insurer:

1. Contract Administrator. FBMC Benefits Management (FBMC) has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.
2. Policyholder. This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. Insurer. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for a prescribing a length of stay not in excess of the above periods.

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and Copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

- The dependent child's change in college enrollment must meet the following requirements:
- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.

The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING PATIENT PROTECTION RIGHTS

The Seminole County Public Schools group health plan does not require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician.

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010. You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the Plan's network. The healthcare 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 or notifying primary care provider or Plan of treatment decisions. If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the insurer.

Beyond Your Benefits

MEDICARE NOTICE

You must notify Seminole County Public Schools when you or your dependents become Medicare eligible. Seminole County Public Schools is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Creditable Coverage Notice below.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

Seminole County Public Schools The Employee Benefits Department 400 East Lake Mary Blvd. Sanford, FL 32773

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by Medicare 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. 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. Your company has determined that the prescription drug coverage offered by their carrier's Benefits Plan 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. If 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 November 15th through December 31st. 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next Annual Enrollment period.

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 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 one percent 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 percent 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 November to join.

MEDICARE PRESCRIPTION DRUG COVERAGE OPTIONS

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. 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, visit Social Security at www.socialsecurity.gov, or call 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 (penalty).

Beyond Your Benefits

EARLY RETIREE REINSURANCE PROGRAM NOTICE

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of healthcare benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, Copayments, deductibles, co-insurance, or other out-of-pocket costs. If the plan chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

FAMILY MEDICAL LEAVE ACT

Please be advised that Seminole County Public Schools is required to offer its employees protection under the Family Medical Leave Act (FMLA). FMLA guarantees eligible employees 12 weeks of unpaid leave each year for a serious illness, to care for a seriously ill family member, and upon the birth or adoption of a child. In addition, new amendments in the last few years extended FMLA to certain military-related situations. Your health benefits will continue to be paid by the Board during an FMLA approved leave and when you return from a leave, you will return to the same or a substantially equivalent job that you had prior to your approved leave.

THE SECURITY OF YOUR INFORMATION (HIPAA)

Any protected health information (PHI) you share with your employer is kept in a secure manner under the Health Insurance Portability & Accountability Act (HIPAA). All files whether paper or electronic are kept confidential, secure and are only accessible by a select few employees.

CLAIM ADMINISTRATION, PHARMACY BENEFIT ADMINISTRATION, HEALTH SAVINGS ACCOUNT BANKING AND ADDITIONAL SERVICES

a. While this Agreement is in effect, CHLIC shall, consistent with, the claim administration policies and procedures then applicable to its own healthcare insurance business (i) receive and review claims for Plan Benefits; (ii) determine the Plan Benefits, if any, payable for such claims; (iii) disburse payments of Plan Benefits to claimants in accordance with Most Favored Nation Status; and (iv) provide in the manner and within the time limits required by Applicable Law, notification to claimants of (a) the coverage determination or (b) any anticipated delay in making a coverage determination beyond the time required by Applicable Law. In addition, CHLIC shall provide other services as listed in this Agreement and all attachments including Exhibit B.

b. Following (i) termination of this Agreement, except pursuant to Section 1 (iii); (ii) termination of a Plan benefit option or (iii) termination of eligible Members, if the required fees have been paid in full, if any, CHLIC shall process Run-Out Claims for the applicable Run-Out Period (Refer to Schedule of Financial Charges for applicable fees and Run-Out Period). At the termination of any applicable Run-Out Period, CHLIC shall cease processing Run-Out Claims and, subject to the requirements of Section 6.b, make all relevant records in its possession relating to such claims reasonably available to Employer or Employer's designee. CHLIC is not required to provide proprietary information to Employer or any other party unless required by Applicable Law.

c. Employer hereby delegates to CHLIC the authority, responsibility and discretion to determine coverage under the Plan based on the eligibility and enrollment information provided to CHLIC by Employer. Employer also hereby delegates to CHLIC the authority, responsibility and discretion to i) make factual determinations and to interpret the provisions of the Plan to make coverage determination on claims for Plan Benefits, (ii) conduct a full and fair review of each claim which has been denied as required by ERIS, (iii) decide level one mandatory appeals of "Urgent Care Claims" (as that term is defined under ERISA), and (iv) conduct both mandatory levels of appeal determinations for all "Concurrent", "Pre-service" and "Post-service" claims (as those terms are defined under ERISA) and notify the Member or the Member's authorized representative of its decision. Employer will ensure that all summary plan description materials provided to Members reflect this delegation.

d. In addition to the basic claim administrative duties described above, CHLIC shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B. All services identified in this Agreement shall be provided by CHLIC.

FUNDING AND PAYMENT OF CLAIMS

a. CHLIC, on behalf of Employer shall establish a Bank Account, and maintain the Bank Account an amount sufficient at all times to fund checks written on it for the following (collectively "Bank Account Payments"): (i) Plan Benefits, (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account and (iii) any sales or use taxes, or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (i) capitated (i.e. fixed Per Member) payments and pay-for-performance incentive payments to Participating Providers; (ii) amounts owed to CHLIC; and (iii) amounts paid to CHLIC's affiliates and/or subcontractors for, among other things, network access or in- and out-of-network healthcare services/ products provided by Members. CHLIC may credit the Bank Account with payments due Employer under a stop loss policy issued by CHLIC or an affiliate.

b. CHLIC, as agent for the Employer, shall make Bank Account Payments from the Bank Account, in the amount CHLIC reasonably determines to be proper under the Plan and/or under this Agreement.

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall notify Employer of such insufficiency and shall cease to process claims for Plan Benefits.

APPEAL PROCESS

Appeal Level 1 - Appeal to Cigna is to abide by external review results. Appeal can go to litigation.

Appeal Level 2 - External Review (OCA language) External review is through Cigna's three reviewing agencies, as indicated by AC.

Notice of Social Security Number Disclosure

Chapter 2007-251 Laws of Florida, requires agencies to notify individuals of the purpose(s) that require the collection of Social Security numbers. Seminole County Public Schools collects Social Security numbers (SSNs) for the following purposes:

- The Internal Revenue Service and Social Security Administration require a Social Security number on a Form W-4, that is used to determine how much federal withholding tax is to be collected and Federal Insurance Contribution Act (FICA) tax on wages paid and later reported in a W-2 Wage and Tax Statement.
- The Internal Revenue Service requires a Taxpayer Identification Number on Form W-9 which could be a Social Security or an Employer Identification number that could be used to generate a 1099 Miscellaneous Income Statement based on expenditures processed through accounts payable. Vendors with Social Security numbers are captured in the Vendor Application process.
- The SAP Human Resources/Finance software program requires use of Social Security numbers as the primary personal identification of employees for wages, leaves, payroll deductions, etc.
- Social Security numbers are also used as identifiers for processing fingerprints with the Federal Bureau of Investigation and the Florida Department of Law Enforcement.
- Social Security numbers are required by the Florida Agency for Workforce Innovation to report wages on a quarterly basis to determine unemployment taxes due to the state by Seminole County Public Schools.
- Social Security numbers are requested by the National School Lunch Act from parents on the free or reduced price meal application and household verification process as part of determining a family's eligibility for their child(ren) for free or reduced price meals.
- Social Security numbers for employees, retirees and dependents are required for enrollment in health insurance, life insurance, and other miscellaneous insurances.
- Social Security numbers are used by the Florida Department of Education as a standardized identification number for the required reporting of yearly certification and training information.
- Social Security numbers are required by the Florida Division of Retirement to report earnings used to document creditable years of service in the Florida Retirement System.
- Social Security numbers are used by the Florida Department of Education as a standardized identification number to track students from year to year and when they move from one school or county to another. Social Security numbers are used for students in grades 10 through 12 as identifiers for colleges and scholarship programs such as Bright Futures. For students in grades Pre-Kindergarten through 12, Social Security numbers are used as identifiers for enrollment and attendance, funding reports (such as FTE), tracking of achievement gains, and standardized testing such as FCAT. Student Social Security numbers are included in all Florida Department of Education required reporting.
- For adult students and approved GED Exit Option students taking the GED exam for graduation purposes, Social Security numbers are used by the Florida Department of Education as a standardized identification number to track students.
- Social Security numbers are used in the Magnet Web application.
- Student Social Security numbers are also used to report to the State Department of Licenses that students have passed the written test and completed the Drinking and Driving course requirement for their Restricted Driver's License.

The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator, Cigna at 1-800-CIGNA24, for more information.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:

- 48 hours following a vaginal delivery OR 96 hours following a cesarean section.
- Determination of when the hospital stay begins is based on the following:
 - » For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
 - » For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

Changing Your Coverage

Changing your Coverage during the Plan Year

Within **30 days** of a qualifying event, you must submit an Enrollment Form and supporting documentation. Upon the approval of your election change request, your existing coverage will be stopped or modified (as appropriate). However, if your election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal. For more information, refer to the "Appeal Process" section on Page 49. Visit www.myFBMC.com for information on rules governing periods of coverage and IRS Special Consistency Rules.

CHANGES IN STATUS:	
Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment.
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.
SOME OTHER PERMITTED CHANGES:	
Coverage and Cost Changes*	Plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Annual Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Annual Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: the other employer's plan has a different period of coverage (usually a plan year) or the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Expense FSA plan.

† Does not apply to a Dependent Care FSA plan.

Notes

Notes



FBMC

BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
To reach the SCPS Employee Benefits Department,
call 1-407-320-0389.

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

© FBMC 2015