

LIBRARY OF BENEFITS

 **THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA**

January 2012



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PART I - EXPLANATION OF BENEFITS

The School Board of Broward County, Florida (SBBC) provides a wide range of benefits to permanent employees. Premiums for the majority of benefits are paid in full by SBBC, while other benefits require employees to pay a portion of the premium through payroll deduction.

If you or your dependents are enrolled in medical, dental or vision insurance plans, your premium contribution for coverage **will generally be automatically paid through pre-tax reduction.**

SBBC offers different health care delivery systems...

MEDICAL PLANS

SBBC offers a variety of health plans and coverage levels for employees and their eligible dependents through Coventry Healthcare of Florida. You may choose from one of the following types of medical plans:

- High Option HMO Plan
- Low Option HMO Plan
- Consumer Driven Plan (PPO)
- High Option PPO Plan
- Kids Only HMO Plans

The **HMO** plans provide in-network benefits only. There is no reimbursement for services obtained from non-participating providers, with the exception of emergency care. There are no claim forms to file, annual deductibles, co-insurance or pre-existing limitations. Preventative care, routine physicals, and prescription drugs are covered after a minimum co-payment.

SBBC offers two HMO plans – the High Option HMO and the Low Option HMO. The benefits covered on both plans are the same; what differentiates the two plans are the co-payments you are required to pay when services are obtained. The co-payments on the Low Option HMO will be greater than the co-payments on the High Option HMO plan. Both the High Option HMO and the Low Option HMO plans are considered “open access” plans which means you are not required to select a Primary Care Physician (PCP) or obtain a referral to visit an in-network specialist. Though referrals are not required, prior authorization for select services is a requirement of the plans.

You may compare the two plans using the Schedule of Benefits located at end of the Medical section. A listing of the in-network providers as well as other plan features and benefits can be found by logging on to the Coventry Healthcare of Florida Website at www.chcflorida.com.

The **PPO** plans allow you freedom to select a provider of your choice. You may select a doctor or hospital from a list of participating providers (in-network) and receive your medical care at a cost savings or you may use a provider of your choice (out-of-network) and pay more for the cost of the services. There are deductibles, co-insurance and co-payments to satisfy.

SBBC offers two PPO plans – the Consumer Driven Health Plan and the High Option PPO plan. You may compare the two plans using the Schedule of Benefits located at end of the Medical section. A listing of the in-network providers as well as other plan features and benefits can be found by logging on to the Coventry Healthcare of Florida Website at www.chcflorida.com.

The **Kids Only HMO** medical plans are designed specifically for children and provide in-network benefits only. There is no reimbursement for services obtained from non-participating providers, with the exception of emergency care. Preventative care, routine physicals, and prescription drugs are covered after a minimum co-payment. Unlike the High and Low Option HMO's discussed above, the Kids plan are not considered "open access" plans and therefore require selection of a Primary Care Physician and referrals to visit a specialist. Prior authorization for select services is also a requirement of the plan. You may change your PCP for any reason at any time by contacting Coventry directly.

The District offers two Kids Plans – the Basic Kids Plan and the Enhanced Kids Plan. The benefits covered on both plans are the same; what differentiates the two plans are the co-payments, deductibles and co-insurance amounts you are required to pay when services are obtained. The Enhanced Kids Plan offers lower co-payments and no co-insurance or deductibles when compared to the Basic Kids Plan. The Basic Kids Plan provides for a lower monthly premium contribution.

You may compare the two plans using the Schedule of Benefits located at end of the Medical section. A listing of the in-network providers as well as other plan features and benefits can be found by logging on to the Coventry Healthcare of Florida Website at www.chcflorida.com.

Whichever plan(s) you choose, the District offers an annual Open Enrollment period during which you may change your choice of insurance plans and covered dependents. Dependent eligibility limitations apply.

Declination of Medical Coverage Opt-Out Program

You may elect to Opt-Out of medical insurance coverage ***at any time during the year*** provided you do not have any dependents covered by the School Board's medical insurance plan. The Opt-Out will go into effect the first day of the month following the date the **completed Declination of Medical Coverage Affidavit and required proof of other medical coverage is received by the Benefits Department.**

Those employees who have dependents in a School Board medical insurance plan may only Opt-Out during the annual Open Enrollment period unless there is a change in status. All changes must be in accordance with Internal Revenue Service regulations. For a detailed explanation of the Internal Revenue Service's rules for permitting a change in status, refer to Part III-Cafeteria Plan Guidelines.

In lieu of School Board medical coverage, you will receive \$750 **annually**, dispersed in per-paycheck increments.

You may download the Declination of Medical Coverage Affidavit from the Benefits Department Website at www.browardschools.com/benefits. Forms are located under the heading "Rates, Forms, Notices & Documents" located on the left side of the Website.

If you do not provide the completed Declination of Medical Coverage Affidavit and proof of other medical coverage, you will be automatically defaulted into the lowest cost health plan.

**Coventry Health Care of Florida, Inc.
Schedule of Benefits**



Coventry Health Care of Florida, Inc.
Schedule of Benefits
School Board of Broward County
High Option HMO Plan – 2012

Referrals are not required for Covered Services

Copayment Maximums: Individual / Family	\$1,264 / \$2,528
Lifetime Maximum Benefit	Unlimited
Major Copayment Provisions	Member Responsibility
PCP (Primary Care Physician) Office Visits includes Dermatology, Podiatry, OB/GYN & Chiropractic Services	\$10 copay per visit
Specialist Office Visits	\$30 copay per visit
Hospital Admission	\$150 copay per admission
Emergency Room (waived if admitted)	\$250 copay per visit
Convenience Care clinic Visits	\$10 copay per visit
Urgent Care Center Visits	\$10 copay per visit
Prescription Drugs*: Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)	Tier 1A - \$3 Tier 1B - \$10 Tier 2 - \$25 Tier 3 - \$40
Mail Order (MO) 90-day supply	Tier 1A - \$6 Tier 1B - \$20 Tier 2 - \$50 Tier 3 - \$80
Self-Injectables	Applicable Tier copay
Inpatient Hospital Services	Member Responsibility
Inpatient Hospital Facility Services (Room and Board)	\$150 copay per admission
Inpatient X-Rays Diagnostic Tests & Lab	No Additional Copay; Included in Inpatient Hospital admission
Operating and Recovery Room, Intensive and Special Care Units, General Nursing Care, Prescribed Drugs, Anesthesia	No Additional Copay; Included in Inpatient Hospital admission
In-Hospital Maternity Care (labor and delivery)	No Additional Copay; Included in Inpatient Hospital admission
Rehabilitative Services; Radiation Therapy and Chemotherapy	No Additional Copay; Included in Inpatient Hospital admission
Pre-Admission Testing	No Additional Copay; Included in Inpatient Hospital admission
Human Organ Transplants	No Additional Copay; Included in Inpatient Hospital admission
Inpatient Physician Services	Member Responsibility
Surgeon Services (including Asst. Surgeon)	No copay
Anesthesiologist Services	No copay
Specialist Consultation in Hospital	No copay
Other Physician Visits in Hospital	No copay
Outpatient Medical Care	Member Responsibility
PCP Office Visits	\$10 copay per visit
Specialist Office Visits	\$30 copay per visit
Routine Lab Tests, Radiology, Mammograms and Diagnostics Procedures and/or their interpretation ordered by the physician but performed at a separate lab or drawing station	No copay
Adult Preventive Care, including annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations	No copay
Child Preventive Care, including well child and well baby exams and immunizations	No copay
Bone Density Screenings	No copay
Outpatient Diagnostic Services (e.g., MRI, CT Scan, PET scan)	\$50 copay \$30 copay
• at the Hospital	
• at a Freestanding Facility	
Radiation and Chemotherapy	No copay
Maternity Prenatal/Postnatal Care	One time \$30 copay
Outpatient Hospital Surgery including physician and facility services	\$150 copay \$75 copay
• at the Hospital	
• at an Ambulatory Surgical Center	

Second Medical and Surgical Opinion <ul style="list-style-type: none"> Participating Provider Non-Participating Provider 	No copay 40% of Allowed Amount
Special Kinds of Care	Member Responsibility
Mental Health Care <ul style="list-style-type: none"> Inpatient Outpatient 	\$150 copay per admission \$10 copay per visit
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> Inpatient Rehabilitation and Detoxification Treatment Outpatient Rehabilitation Treatment 	\$150 copay per admission \$10 copay per visit
Emergency and Urgent Care <ul style="list-style-type: none"> Hospital Emergency Room – In Service Area (waived if admitted) Hospital Emergency Room – Outside Service Area (waived if admitted) In an Urgent Care Facility In a Physician's Office Ambulance Service to hospital 	\$250 copay per visit \$250 copay per visit \$10 copay per visit \$10 PCP; \$30 Specialist No copay
Skilled Nursing Facility Care Limitation: Up to 100 days per calendar year	No copay
Home Health Care (Unlimited visits)	\$10 copay per visit
Hospice Care Limitation: 210 days lifetime maximum	No copay
Dialysis Treatment	No copay
Insulin/Oral Agents:	\$25 brand copay per month
Diabetic Supplies:	No copay
Outpatient Physical, Speech and Occupational Therapy	No copay
Outpatient Cardiac and Respiratory Therapy	No copay
Durable Medical Equipment	No copay
Breast Prosthetics; Other External Orthotics and Prosthetics	No copay
Smoking Cessation Limitation: Prescriptions are for a 90-day supply once per calendar year, twice per lifetime	No copay
Hearing Aids	\$300 allowance per calendar year
Infertility Services Limitation: Coventry will pay 100% of first \$2,000 reasonable cost and 50% of reasonable cost thereafter up to a maximum of 3 cycles per member per lifetime <ul style="list-style-type: none"> Voluntary Counseling Infertility Diagnosis Testing Infertility Treatment - Artificial Insemination & In-Vitro Fertilization Injectable Drugs administered in the office 	No copay No copay No copay No copay
Family Planning <ul style="list-style-type: none"> Elective Abortion (Outpatient Hospital or Office) Elective Sterilization 	Not covered \$200 copay

*If you or your physician requests a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment. Tier 1A drugs are a select group of drugs available for a reduced copayment. A listing of Tier 1A (\$3 Generic) drugs can be found on the Coventry website. For Tier 1B drugs, refer to all other Tier 1 drugs not listed on Tier 1A. Prescription drug copays do not apply toward the annual copayment maximum.

PCP referrals are not required to obtain Covered Services, however certain Covered Services require Prior Authorization including Hospital and Skilled Nursing Facility confinements, Non-emergent transportation, Non-emergent Outpatient Hospital services, MRIs, CAT Scans, PET Scans, Hospice, Pain Management and Non-emergent Wound care procedures. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements.

Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

This schedule is provided for information only; it does not contain complete details of the Plan which are available only in the Certificate of Coverage and it does not constitute an Agreement.

This plan has exclusions and limitations and terms under which the plan may be continued in force or discontinued.



Coventry Health Care of Florida, Inc.
Schedule of Benefits
School Board of Broward County
Low Option HMO Plan – 2012

Referrals are not required for Covered Services

Copayment Maximums: Individual / Family	\$1,500 / \$3,000
Lifetime Maximum Benefit	Unlimited
Major Copayment Provisions	Member Responsibility
PCP (Primary Care Physician) Office Visits includes Dermatology, Podiatry, OB/GYN & Chiropractic Services	\$20 copay per visit
Specialist Office Visits	\$40 copay per visit
Hospital Admission	\$150/day for the first 5 days
Emergency Room (waived if admitted)	\$250 copay per visit
Convenience Care clinic Visits	\$20 copay per visit
Urgent Care Center Visits	\$20 copay per visit
Prescription Drugs*: Participating Pharmacy: 30-day supply at participating pharmacy (includes contraceptives)	Tier 1A - \$3 Tier 1B - \$10 Tier 2 - \$35 Tier 3 - \$50
Mail Order (MO) – 90-day supply	Tier 1A - \$6 Tier 1B - \$20 Tier 2 - \$70 Tier 3 - \$100
Self-Injectables	Applicable Tier copay
Inpatient Hospital Services	Member Responsibility
Inpatient Hospital Facility Services (Room and Board)	\$150/day for the first 5 days
Inpatient X-Rays Diagnostic Tests & Lab	No Additional Copay; Included in Inpatient Hospital admission
Operating and Recovery Room, Intensive and Special Care Units, General Nursing Care, Prescribed Drugs, Anesthesia	No Additional Copay; Included in Inpatient Hospital admission
In-Hospital Maternity Care (labor and delivery)	\$200 copay
Rehabilitative Services; Radiation Therapy and Chemotherapy	No Additional Copay; Included in Inpatient Hospital admission
Pre-Admission Testing	No Additional Copay; Included in Inpatient Hospital admission
Human Organ Transplants	No Additional Copay; Included in Inpatient Hospital admission
Inpatient Physician Services	Member Responsibility
Surgeon Services (including Asst. Surgeon)	No copay
Anesthesiologist Services	No copay
Specialist Consultation in Hospital	No copay
Other Physician Visits in Hospital	No copay
Outpatient Medical Care	Member Responsibility
PCP Office Visits	\$20 copay per visit
Specialist Office Visits	\$40 copay per visit
Routine Lab Tests, Radiology, Mammograms and Diagnostics Procedures and/or their interpretation ordered by the physician but performed at a separate lab or drawing station	No copay
Adult Preventive Care, including annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations	No copay
Child Preventive Care including well child and well baby exams and immunizations	No copay
Non-Preventive Bone Density Screenings	
• at Hospital	\$100 copay
• at Freestanding Facility	\$20 copay
Outpatient Diagnostic Services (e.g., MRI, CT Scan, PET scan)	
• at Hospital	\$75 copay
• at Freestanding Facility	\$50 copay
Radiation and Chemotherapy	\$20 copay per visit
Maternity Prenatal/Postnatal Care in physician's office	\$40 copay per visit

Outpatient Hospital Surgery including physician and facility services <ul style="list-style-type: none"> • at Hospital • at an Ambulatory Surgical Center 	\$250 copay \$100 copay
Second Medical and Surgical Opinion <ul style="list-style-type: none"> • Participating Provider • Non-Participating Provider 	\$20 copay per visit 40% of Allowed Amount
Special Kinds of Care	Member Responsibility
Mental Health Care <ul style="list-style-type: none"> • Inpatient • Outpatient 	\$150/day for the first 5 days \$20 copay per visit
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> • Inpatient Rehabilitation and Detoxification Treatment • Outpatient Rehabilitation Treatment 	\$150/day for the first 5 days \$20 copay per visit
Emergency and Urgent Care <ul style="list-style-type: none"> • Hospital Emergency Room – In Service Area (waived if admitted) • Hospital Emergency Room – Outside Service Area (waived if admitted) • In an Urgent Care Facility • In a Physician's Office • Ambulance Service to hospital 	\$250 copay per visit \$250 copay per visit \$20 copay per visit \$20 copay PCP; \$40 copay Specialist No copay
Skilled Nursing Facility Care Limitation: Up to 100 days per calendar year	No copay
Home Health Care (Unlimited visits)	\$10 copay per visit
Hospice Care Limitation: 210 days lifetime maximum	No copay
Dialysis Treatment	\$20 copay per visit
Insulin/Oral Agents:	\$35 brand copay per month
Diabetic Supplies:	No copay
Outpatient Physical, Speech and Occupational Therapy (Therapy must be completed within 90 days of first visit per episode of care) Limitation: 60 visits per calendar year combined	\$20 copay per visit
Outpatient Cardiac and Respiratory Therapy	\$20 copay per visit
Durable Medical Equipment	No copay
Breast Prosthetics; Other External Orthotics and Prosthetics	No copay
Smoking Cessation Limitation: Prescriptions are for a 90-day supply once per calendar year, twice per lifetime	No copay
Hearing Aids	\$300 allowance per calendar year
Infertility Services Limitation: \$6,000 lifetime maximum. Up to a maximum of 3 cycles per member per lifetime. <ul style="list-style-type: none"> • Voluntary Counseling • Infertility Diagnosis Testing • Artificial Insemination & In-Vitro Fertilization • Injectable Drugs administered in the office (subject to lifetime maximum) 	\$40 copay per visit \$40 copay per visit No copay No copay
Family Planning <ul style="list-style-type: none"> • Elective Abortion (Outpatient Hospital or Office) • Elective Sterilization 	Not covered \$200 copay

*If you or your physician requests a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment. Tier 1A drugs are a select group of drugs available for a reduced copayment. A listing of Tier 1A (\$3 Generic) drugs can be found on the Coventry website. For Tier 1B drugs, refer to all other Tier 1 drugs not listed on Tier 1A. Prescription drug copays do not apply toward the annual copayment maximum.

PCP referrals are not required to obtain Covered Services, however certain Covered Services require Prior Authorization including Hospital and Skilled Nursing Facility confinements, Non-emergent transportation, Non-emergent Outpatient Hospital services, MRIs, CAT Scans, PET Scans, Hospice, Pain Management and Non-emergent Wound care procedures. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements. Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

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CHC.SBBC.HMO.OA.LowOption (1/12)

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Schedule of Benefits
School Board of Broward County
High Option PPO Plan - 2012

	In-Network	Out-of-Network
Annual Deductible (Individual / Family) (per calendar year) <i>(Eligible deductible expenses apply toward both the participating and non-participating providers)</i>	\$250 / \$500	
Annual Out-of-Pocket Maximum (Individual / Family) (per calendar year) <i>(Excludes annual deductible and copays)</i>	\$1,000 / \$2,000	
Lifetime Maximum Individual Benefit	Unlimited	
Benefit Provisions	Plan Pays	
Physician's Office Visits (includes annual physical exam, maternity care, all radiology, lab, diagnostic tests, X-rays, MRI, etc, inside physician's office)	100% after \$15 copay	65% after deductible
Adult Preventive Care, including annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations	100%, NO deductible	65% after deductible
Child Preventive Care, including well child and well baby exams and immunizations	100%, NO deductible	65% after deductible
All Radiology, Lab, Diagnostic Tests, X-rays, MRIs, etc Outside Physician's office (Freestanding Facility)	100% after \$15 copay	65% after deductible
Hospital admission	85% after deductible	65% after deductible
Inpatient Hospital / Physician Services	Plan Pays	
Inpatient Hospital Facility Services <i>(includes room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants, maternity care)</i>	85% after deductible	65% after deductible
Pre-Admission Testing	100%, NO deductible	100%, NO deductible
Rehabilitative Services	85% after deductible	65% after deductible
Outpatient Medical Services	Plan Pays	
Convenience Care Clinic Visits	100% after \$15 copay per visit	65% after deductible
Allergy Injections	100%, NO deductible	65% after deductible
Non Preventive Bone Density Screenings <ul style="list-style-type: none"> at hospital at freestanding facility 	85% after deductible 100% after \$15 copay	65% after deductible 65% after deductible
Routine Mammography <i>(based on established guidelines)</i>	100%, NO deductible	100%, NO deductible
Outpatient Surgery <i>(includes physician and facility services)</i>	85% after deductible	65% after deductible
Outpatient Physical, Speech and Occupational Therapy <i>(Therapy must be completed within 90 days of first visit per episode of care)</i>	85% after deductible	65% after deductible
Outpatient Cardiac and Respiratory Therapy	85% after deductible	65% after deductible
Outpatient Radiation and Chemotherapy	85% after deductible	65% after deductible
Outpatient Dialysis Treatment	85% after deductible	65% after deductible
Non-surgical Spine and Back Treatment <i>Limitation: 20 visits per calendar year</i>	85% after deductible	65% after deductible
Second Medical and Surgical Opinion	100%, NO deductible	100%, NO deductible
Emergency and Urgent Care <ul style="list-style-type: none"> in hospital emergency room (waived if admitted) in urgent care facility in physician's office Ambulance service to hospital 	85% after \$100 copay 85% after \$15 copay 100% after \$15 copay 85% after deductible	85% after \$100 copay 65% after deductible 65% after deductible 65% after deductible
Family Planning <ul style="list-style-type: none"> Voluntary counseling Infertility diagnosis and treatment Elective Abortion Elective sterilization 	Not Covered Not Covered Not Covered 85% after deductible	 65% after deductible



Schedule of Benefits
School Board of Broward County
High Option PPO Plan - 2012

Mental Health, Alcohol & Substance Abuse Services		Plan Pays	
Mental Health Care <ul style="list-style-type: none"> Inpatient Treatment Outpatient Treatment 	85% after deductible	65% after deductible	
	\$15 copay	65% after deductible	
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> Inpatient detoxification and Rehabilitation Outpatient rehabilitation treatment 	85% after deductible	65% after deductible	
	\$15 copay	65% after deductible	
Other Covered Services		Plan Pays	
Home Health Care Limitation: 60 visits per calendar year	85% after deductible	65% after deductible	
Hospice Care Limitation: Unlimited	85% after deductible	65% after deductible	
Skilled Nursing Facility Care Limitation: 60 days per calendar year	85% after deductible	65% after deductible	
Insulin	Tier 1 - \$15 Tier 2 - \$25 Tier 3 - \$45	70% after deductible	
Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	No copay	70% after deductible	
Durable Medical Equipment	85% after deductible	65% after deductible	
External orthotics, prosthetics and breast prosthetics	85% after deductible	65% after deductible	
Hearing Aids \$300 allowance per calendar year	85% after deductible	65% after deductible	
Smoking Cessation Program Limitation: Prescriptions are for a 90-day period only once per year, twice per lifetime	100% for smoking deterrents in conjunction with smoking cessation program	Not Covered	
Services Provided by Rider or Endorsement		Plan Pays	
Prescription drugs: 30-day supply at participating pharmacy (includes contraceptives)*	Tier 1 - \$15 Tier 2 - \$25 Tier 3 - \$45	70% after deductible	
Mail Order: 90-day supply	Tier 1 - \$15 Tier 2 - \$25 Tier 3 - \$45	Not Covered	

*If a brand name medication is requested when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment.

Certain Covered Services require Prior Authorization, including Hospital and Skilled Nursing Facility confinements, Non-emergent transportation, Non-emergent Outpatient Hospital services, MRIs, CAT Scans, PET Scans, Hospice, Pain Management and Non-emergent Wound care procedures. If you do not obtain authorization for services which require a Prior Authorization, the benefit otherwise payable by Coventry is reduced by \$400. This additional out-of-pocket amount will not be used to satisfy Deductible, Coinsurance or Out-of-Pocket Maximum requirements. Please refer to the Certificate of Insurance for further details on Prior Authorization requirements.

All Out-of-Network services are subject to the Out-of-Network Deductible and applicable Coinsurance. In addition to the applicable Deductible and Coinsurance, Covered Persons who receive services from Non-Participating Providers shall be responsible for the difference between the Non-Participating Provider's bill and the Out-of-Network Rate.

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Schedule of Benefits
School Board of Broward County
Consumer Driven Plan – 2012

	In-Network	Out-of-Network
Up-Front Benefit Allowance <i>Applies to medical services received from participating providers only. Does not apply to member copays, mental and nervous benefits, alcohol and chemical benefits or Rx benefit</i>	\$500	N/A
Annual Deductible (Individual / Family) <i>Copayments do not apply.</i>	\$2,500 / \$7,500	\$5,000 / \$15,000
Annual Out-of-Pocket Maximum (Individual / Family) <i>Excludes deductibles and copayments</i>	N/A	\$4,000 / \$12,000
Lifetime Maximum Individual Benefit	Unlimited	
Benefit Provisions	Plan Pays	
Physician's Office Visits (includes maternity care, all radiology, lab, diagnostic tests, x-rays, MRI, etc, inside physician's office)	100% after \$20 copay PCP; \$35 copay Specialist	70% after deductible
Adult Preventive Care, including annual physical exams, annual well-woman exams, Pap smears, prostate cancer screening, colon cancer screening, eye exams, health education and counseling and immunizations	100%, NO deductible	70% after deductible
Child Preventive Care, including well child and well baby exams and immunizations	100%, NO deductible	70% after deductible
All Radiology, Lab, Diagnostic Tests, X-Rays, MRIs, etc Outside Physician's office (Freestanding Facility)	100% after deductible	70% after deductible
Hospital admission	\$100 copay per day for the first 5 days per admission after deductible	70% after deductible
Inpatient Hospital / Physician Services	Plan Pays	
Inpatient Hospital Facility Services (includes room and board, diagnostic tests, x-rays, operating & recovery room, intensive & special care units, general nursing care, anesthesia, prescribed drugs, radiation therapy & chemotherapy, surgeon services, anesthesiologist services, specialist consultation, physician visits, human organ transplants, maternity care, rehabilitative services)	\$100 copay per day for the first 5 days per admission after deductible	70% after deductible
Pre-Admission Testing	100% after deductible	70% after deductible
Outpatient Medical Services	Plan Pays	
Convenience Care Clinic Visits	100% after \$20 copay per visit	70% after deductible
Bone Density Screenings	100% after deductible	70% after deductible
Routine Mammography (based on established guidelines)	100%, NO deductible	100%, NO deductible
Allergy Injections	100% after \$5 copay	70% after deductible
Maternity Prenatal/Postnatal Services	100% after one time office visit copay	70% after deductible
Outpatient Surgery (includes physician and facility services)	\$50 copay after deductible	70% after deductible
Outpatient Non-Surgical Care	100% after deductible	70% after deductible
Outpatient Physical, Speech and Occupational Therapy (Therapy must be completed within 90 days of first visit per episode of care) Limitation: 20 visits each therapy type	100% after deductible	70% after deductible
Outpatient Cardiac and Respiratory Therapy	100% after deductible	70% after deductible
Outpatient Radiation and Chemotherapy	100% after deductible	70% after deductible
Outpatient Dialysis Treatment	100% after deductible	70% after deductible
Non-surgical Spine and Back Treatment Limitation: 20 visits per calendar year	100% after deductible	70% after deductible
Second Medical and Surgical Opinion	100% after deductible	70% after deductible
Emergency and Urgent Care		
• in hospital emergency room (waived if admitted)	100% after \$250 copay	70% after \$250 copay
• in urgent care facility	100% after \$35 copay	70% after deductible
• in physician's office	100% after \$20 copay PCP; \$35 copay Specialist	70% after deductible
• Ambulance service to hospital	100% after deductible	100% after deductible



Schedule of Benefits School Board of Broward County Consumer Driven Plan – 2012

Family Planning <ul style="list-style-type: none"> Voluntary counseling Infertility diagnosis and treatment Elective Abortion Elective sterilization 	Not Covered	
	Not Covered	
	Not Covered	
	\$50 copay after deductible	70% after deductible
Mental Health, Alcohol & Substance Abuse Services	Plan Pays	
Mental Health Care <ul style="list-style-type: none"> Inpatient Treatment Outpatient Treatment 	100% after \$100/day for the first 5 days per admission	70% after deductible
	100% after \$35 copay	70% after deductible
Alcohol and Substance Abuse Care <ul style="list-style-type: none"> Inpatient Detoxification Treatment Outpatient Detoxification Treatment 	100% after \$100/day for the first 5 days per admission	70% after deductible \$
	100% after \$35 copay	70% after deductible
Other Covered Services	Plan Pays	
Home Health Care Limitation: 40 visits per calendar year	100% after deductible	70% after deductible
Hospice Care Limitation: Unlimited	100% after deductible	70% after deductible
Skilled Nursing Facility Care Limitation: 30 days per calendar year	100% after deductible	70% after deductible
Insulin / Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	Tier 1 - \$15 Tier 2 - \$30 Tier 3 - \$55	70% after deductible
Durable Medical Equipment	100% after deductible	70% after deductible
External orthotics, prosthetics and breast prosthetics	100% after deductible	70% after deductible
Hearing Aids	Not Covered	Not Covered
Smoking Cessation Program	Not Covered	Not Covered
Services Provided by Rider or Endorsement	Plan Pays	
Prescription drugs: 30-day supply at a pharmacy (includes contraceptives)*	Tier 1 - \$15 Tier 2 - \$30 Tier 3 - \$55	70% after deductible plus \$15/\$30/\$55
Mail Order: 90-day supply at a participating pharmacy	Tier 1 - \$15 Tier 2 - \$30 Tier 3 - \$55	Not Covered

*If a brand name medication is requested when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment.

Certain Covered Services require Prior Authorization, including Hospital and Skilled Nursing Facility confinements, Non-emergent transportation, Non-emergent Outpatient Hospital services, MRIs, CAT Scans, PET Scans, Hospice, Pain Management and Non-emergent Wound care procedures. If you do not obtain authorization for services which require a Prior Authorization, the benefit otherwise payable by Coventry is reduced by \$400. This additional out-of-pocket amount will not be used to satisfy Deductible, Coinsurance or Out-of-Pocket Maximum requirements. Please refer to the Certificate of Insurance for further details on Prior Authorization requirements.

All Out-of-Network services are subject to the Out-of-Network Deductible and applicable Coinsurance. In addition to the applicable Deductible and Coinsurance, Covered Persons who receive services from Non-Participating Providers shall be responsible for the difference between the Non-Participating Provider's bill and the Out-of-Network Rate.

This schedule is provided for information only; it does not contain complete details of the Plan which are available only in the Certificate of Insurance and it does not constitute and Agreement.

This plan has exclusions and limitations and terms under which the plan may be continued in force or discontinued.



Coventry Health Care of Florida, Inc.
Schedule of Benefits
School Board of Broward County
Basic Kids Plan – 2012

Referrals are required for Covered Services

Individual Out-of-Pocket Maximum -	\$1,500
Lifetime Maximum Benefit	Unlimited
Annual Hospital Deductible (per calendar year): applies to all inpatient and outpatient services at hospital	\$300
Major Copayment Provisions	Member Responsibility
Primary Care Physician (PCP) office visits	\$15 copay per visit
Specialist office visits	\$30 copay per visit
Hospital admission	After Hospital Deductible: 20% Coinsurance
Emergency room (waived if admitted)	\$250 copay per visit
Convenience Care Clinic Visits	\$15 copay per visit
Prescription drugs:* 30-day supply at participating pharmacy	Tier 1 - \$7 Tier 2 - \$45 Not covered
Self-injectables (except for diabetes)	
Mail Order: 90 day supply	Tier 1 - \$7 / Tier 2 - \$45
Inpatient Hospital / Physician Services	Member Responsibility
Inpatient hospital facility services (room and board)	After Hospital Deductible: 20% Coinsurance
Inpatient x-rays, diagnostic tests & lab	After Hospital Deductible: 20% Coinsurance
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia	After Hospital Deductible: 20% Coinsurance
In-Hospital maternity care	Not covered
Rehabilitative Services Limitation: 30 days per calendar year	After Hospital Deductible: 20% Coinsurance
Radiation therapy and chemotherapy	After Hospital Deductible: 20% Coinsurance
Pre-admission testing	After Hospital Deductible: 20% Coinsurance
Surgeon services (including Asst. Surgeon)	After Hospital Deductible: 20% Coinsurance
Anesthesiologist services	After Hospital Deductible: 20% Coinsurance
Specialist consultation	After Hospital Deductible: 20% Coinsurance
Other physician visits	After Hospital Deductible: 20% Coinsurance
Human organ transplants	After Hospital Deductible: 20% Coinsurance
Outpatient Medical Services	Member Responsibility
Wellness care: preventive care, including physical exams, eye exams, health education and counseling and immunizations	No copay
Annual well-woman care, including Pap smears and Thin Prep Pap smears	No copay
Diagnostic procedures, tests, chest x-rays, blood tests, urinalysis, EKG's performed: • in a physician's office • at a separate facility	No additional copay No copay
Outpatient diagnostic services (MRI, CAT scans, etc) • at Hospital • at Freestanding Facility	After Hospital Deductible: 20% Coinsurance \$30 copay per visit
Outpatient Surgery (including physician and facility services) • at Hospital • at Ambulatory Surgical Center	After Hospital Deductible: 20% Coinsurance \$100 copay per visit
Prenatal & postnatal care in physician's office	Not covered
Radiation and chemotherapy • at Hospital • at Freestanding Facility	After Hospital Deductible: 20% Coinsurance \$30 copay per visit
Second medical and surgical opinion • Participating Provider • Non-Participating Provider	\$15 PCP/\$30 Specialist 40% of Allowed Amount
Non-Surgical Spine and Back services Limitation: 20 visits per calendar year	\$15 PCP/\$30 Specialist

Mental Health, Alcohol & Substance Abuse Services	Member Responsibility
Mental health care <ul style="list-style-type: none"> Inpatient Outpatient 	After Hospital Deductible: 20% Coinsurance \$30 copay per visit
Alcohol and substance abuse care <ul style="list-style-type: none"> Inpatient detoxification Outpatient rehabilitation treatment 	After Hospital Deductible: 20% Coinsurance Not covered
Special Kinds of Care	Member Responsibility
Emergency and urgent care <ul style="list-style-type: none"> In hospital emergency room (waived if admitted) In urgent care facility In physician's office Ambulance service to hospital 	\$250 copay per visit \$30 copay per visit \$15 PCP/\$30 Specialist No copay
Home Health Care Limitation: 60 visits per calendar year	No copay
Hospice Care	Not covered
Skilled Nursing Facility Care Limitation: 30 days per calendar year	\$25/day for the first 5 days per admission
Dialysis treatment (outpatient) <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	After Hospital Deductible: 20% Coinsurance \$30 copay per treatment
Insulin Diabetic supplies (includes glucose monitors, test strips, lancets, etc.)	\$7 copay per prescription \$7 copay per month
Outpatient physical, speech and occupational therapy (therapy must be completed within 90 days of first visit per episode of care) Limitation: 60 visits per calendar year, combined for all therapies <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	After Hospital Deductible: 20% Coinsurance \$30 copay per visit
Outpatient cardiac and respiratory therapy <ul style="list-style-type: none"> at Hospital at Freestanding Facility 	After Hospital Deductible: 20% Coinsurance \$30 copay per visit
Durable medical equipment; other external orthotics and prosthetics	No copay
Hearing Aids	\$300 allowance per year
Family Planning (Voluntary counseling, infertility diagnosis and treatment, elective abortion and elective sterilization)	Not covered
Dental care: Preventive dental (Oral exam, cleaning & bitewing x-rays including fluoride treatment for children sixteen (16) and under once every 6 months)	No copay
Vision care - at a participating Optometrist <ul style="list-style-type: none"> Refractive eye exams Eyeglasses 	\$15 copay per visit Negotiated fees available at participating providers

Coinsurance and Copayments apply toward the Out-of-Pocket Maximum.

* If you or your physician requests a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment. Prescription drug copays do not apply toward the annual out-of-pocket maximum.

Except for emergency care, services are covered only when provided or referred by a Coventry Health Care of Florida, Inc.(Coventry) primary care physician and/or approved in advance by Coventry Medical Management. Certain Covered Services require Prior Authorization including Hospital and Skilled Nursing Facility confinements, Non-emergent transportation, Non-emergent Outpatient Hospital services, MRIs, CAT Scans, PET Scans, Pain Management and Non-emergent Wound care procedures.

Please refer to the Certificate of Coverage for further details on Prior Authorization requirements. Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members.

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Coventry Health Care of Florida, Inc.
Schedule of Benefits
School Board of Broward County
Kids Enhanced Plan 2012

Referrals are required for Covered Services

Individual Out-of-Pocket Maximum	\$1,264
Lifetime Maximum Benefit	Unlimited
Major Copayment Provisions	Member Responsibility
PCP (primary care physician) office visits	\$15 copay per visit
Specialist office visits (Direct Access for all medical services provided by a general GYN & OB/GYN, excluding sub-specialty OB/GYN services)	\$15 copay per visit
Hospital admission	\$100 copay per day for the first 5 days
Emergency room (waived if admitted)	\$250 copay per visit
Emergency room visits by physician	\$15 copay per visit
Convenience Care Clinic Visits	\$15 copay per visit
Urgent care center visits	\$15 copay per visit
Prescription drugs*:	
30-day supply at participating pharmacy	Tier 1 - \$5 Tier 2 - \$5 Tier 3 - \$25
Self-Injectables	Applicable Tier copay
Mail Order	Tier 1 - \$5 / Tier 2 - \$5 / Tier 3 - \$25
Inpatient Hospital Services	Member Responsibility
Inpatient Hospital facility services (room and board)	\$100 copay per day for the first 5 days
Inpatient X-rays, diagnostic tests & lab	No additional copay; Included in Inpatient Hospital admission
Operating and recovery room, intensive and special care units, general nursing care, prescribed drugs, anesthesia	No additional copay; Included in Inpatient Hospital admission
In-Hospital maternity care (labor and delivery)	Not Covered
Short-term speech, physical, occupational and respiratory therapy	No additional copay; Included in Inpatient Hospital admission
Radiation therapy and chemotherapy	No additional copay; Included in Inpatient Hospital admission
Pre-admission testing	No additional copay; Included in Inpatient Hospital admission
Human organ transplants	No additional copay; Included in Inpatient Hospital admission
Inpatient detoxification	No additional copay; Included in Inpatient Treatment
Inpatient Physician Services	Member Responsibility
Surgeon services (including Asst. Surgeon)	No copay
Anesthesiologist services	No copay
Specialist consultation and other physician visits in hospital	No copay
Outpatient Medical Care	Member Responsibility
PCP office visits	\$15 copay per visit
Specialists office visits (Direct Access for all Medical Services provided by a general GYN & OB/GYN, excluding sub-specialty OB/GYN services)	\$15 copay per visit
Allergy Injections	\$15 copay per visit
Routine lab tests, radiology, mammograms and diagnostic procedures and/or their interpretation ordered by the physician but performed at a separate lab or drawing station	No copay per visit
Preventive care, including physical exams, eye exams, health education, counseling, hearing exams, and immunizations	No copay per visit
Well-woman care, including Pap smears and Thin Prep Pap smears	No copay per visit
Well-child care including immunizations, hearing and eye exams	No copay per visit
Outpatient diagnostic services (e.g., MRI, CT Scan, PET scan)	\$20 copay per visit
Radiation and chemotherapy	\$15 copay per visit
Prenatal & Postnatal care in physician's office	Not covered
Outpatient hospital surgery including physician and facility services	\$50 copay per visit
Ambulatory surgery including physician and facility services	\$50 copay per visit

Second medical and surgical opinion	Participating Provider: \$15 copay per visit; Non-Participating Provider: 40% of Allowed Amount
Non-Surgical spine and back services	\$15 copay per visit
Mental Health, Alcohol & Substance Abuse	Member Responsibility
Mental Health Care	
• Inpatient	\$100 copay per day for the first 5 days
• Outpatient	\$15 copay per visit
Alcohol and Substance Abuse Care	
• Inpatient rehabilitation treatment	\$100 copay per day for the first 5 days
• Outpatient rehabilitation treatment	\$15 copay per visit
Special Kinds of Care	Member Responsibility
Emergency and urgent care	
• In hospital emergency room - In service area (waived if admitted)	\$250 copay per visit
• In urgent care facility	\$15 copay per visit
• In physician's office	\$15 copay per visit
• Ambulance service to hospital	No copay
Home health care (20 visits per acute** episode)	\$15 copay per visit
Hospice care	Not covered
Skilled nursing facility care (up to 45 days per calendar year)	\$20 copay per day
Dialysis treatment	\$15 copay per visit
Insulin/oral agents	\$5 copay per prescription
Diabetic supplies	\$5 copay per prescription
Outpatient physical, speech or occupational therapy (Therapy must be completed within 90 days of first visit per episode of care)	\$ 5 copay per visit
Outpatient cardiac and respiratory therapy	\$15 copay per visit
Durable medical equipment	\$15 copay per item
Breast Prosthetics	\$15 copay per item
Other External Orthotics and Prosthetics	\$15 copay per item
Smoking Cessation (Prescriptions are for a 90-day supply once per year, twice per lifetime)	\$15 copay per visit
Hearing Aids	\$300 allowance per calendar year
Family Planning (Voluntary counseling, infertility diagnosis and treatment, elective abortion and elective sterilization)	Not covered
Dental Care Preventive dental (Oral exam, cleaning & bitewing x-rays including fluoride treatment for children sixteen (16) and under once every 6 months)	No copay
Vision Care	
• Routine vision and hearing screenings by PCP only (once per year)	\$0 copay
• Vision exam provided by a participating Optometrist (once per year)	\$3 copay
• Eyeglasses – 1 pair per year, single vision/bifocal, plastic or glass lenses, frames from the "Coventry Classic Selection" at a participating Vision provider.	\$10 copay
• Member may receive discounts on other items.	

* If you or your physician requests a brand name medication when a generic is available, you must pay 100% of the difference in price between the generic and brand name medication, plus the applicable brand copayment. Prescription drug copays do not apply toward the annual out-of-pocket maximum.

** Sudden onset of illness or injury, severe symptoms and of short duration.

Except for emergency care, services are covered only when provided or referred by a Coventry Health Care of Florida, Inc. (Coventry) primary care physician and/or approved in advance by the Coventry Medical Management. Coventry participating physicians and providers have contracted with Coventry to provide care to Coventry's members; they are not employees, agents, servants or representatives of Coventry. Certain Covered Services require Prior Authorization including Hospital and Skilled Nursing Facility confinements, Non-emergent transportation, Non-emergent Outpatient Hospital services, MRIs, CAT Scans, PET Scans, Pain Management and Non-emergent Wound care procedures. Please refer to the Certificate of Coverage for further details on Prior Authorization requirements. Services must be rendered within the Coventry network. Coventry participating physicians and providers have contracted with Coventry to provide care to our members

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CHC.SBBC.KIDS.HMO.SOB.ENH (1/12)

SBBC offers two types of dental plans to employees.

DENTAL PLANS

You may choose one of eight dental plans, offered by three dental carriers. The three dental carriers used by the District are Humana/CompBenefits, MetLife and SafeGuard, a MetLife Company.

The following carrier's offer **DHMO** (Dental Health Maintenance Organization) plans:

Humana/CompBenefits

MetLife/SafeGuard

DHMO plans provide in-network benefits only. You pre-select a general dentist from the network and visit that dentist for all dental services. There are typically no calendar year maximums, deductibles, waiting periods, or claim forms. Co-payments are required for certain procedures.

The District offers a Basic DHMO plan and an Enhanced DHMO plan. The difference between the Basic and the Enhanced plans are when using the services of a specialist. In the Basic DHMO plan, should you require the services of a specialist, you will receive a 25% discount from the dentists' usual and customary (U&C) fees. With the Enhanced DHMO, the co-payments listed in the Schedule of Benefits are the maximum fees that will be charged when visiting a specialist.

A complete listing, by carrier, of the co-payments associated with each procedure (Schedule of Benefits), can be found on the benefits Website, or on the specific carrier's Website. Additionally, a listing of the in-network providers can also be found on the specific carrier's Website.

On the next page is a DHMO Comparison chart which compares the four DHMO plans that are available. Additionally, a Procedure Cost Comparison chart, by carrier, provides a side by side comparison of select dental procedures. The plans are very similar, however, the providers within each network may differ.

DHMO COMPARISON

Plan Provisions	Humana/CompBenefits Must use in-network providers to obtain benefits		MetLife/SafeGuard Must use in-network providers to obtain benefits	
	Basic SBBC97	Enhanced FGC+B	Basic	Enhanced
Plan	None	None	None	None
Annual Deductible	None	None	None	None
Annual Benefit Maximum	U&C less 25%*	Listed co-payment	U&C less 25%*	Listed co-payment
Specialty Care	No	No	No	No
Referral to a Specialist Required	No	No	No	No
Diagnostic & Preventative Oral exams, cleanings, X-rays, topical fluoride treatments, etc.	Most services are covered at no charge.	Most services are covered at no charge.	Most services are covered at no charge.	Most services are covered at no charge.
Basic Services Fillings, root canals, periodontal scaling, oral surgery, extractions, etc.	Covered at the listed co-payment if performed by your general dentist.	Covered at the listed co-payment.	Covered at the listed co-payment if performed by your general dentist.	Covered at the listed co-payment.
Major Services Crowns, dentures, bridgework, etc.	Covered at the listed co-payment if performed by your general dentist.	Covered at the listed co-payment.	Covered at the listed co-payment if performed by your general dentist.	Covered at the listed co-payment.
Orthodontia (braces) Adult Orthodontia	25% Discount 25% Discount	Covered Covered	25% Discount 25% Discount	Covered Covered

This is a comparison only and not a complete summary of benefits. Exclusions and limitations apply.

**U&C refers to the usual and customary fees that are customarily charged for dental services by a participating dentist.*

DHMO PROCEDURE COST COMPARISON

Procedure	Humana/CompBenefits Must use in-network providers to obtain benefits		MetLife/SafeGuard Must use in-network providers to obtain benefits	
	Basic	Enhanced	Basic	Enhanced
Preventative 1110 Cleaning	\$0.00	\$0.00	\$0.00	\$0.00
Restorative				
2330 White Filling (front-1 surface)	\$0.00	\$12.00	\$0.00	\$0.00
2331 White Filling (front-2 surfaces)	\$0.00	\$20.00	\$0.00	\$0.00
2332 White Filling (front-3 surfaces)	\$0.00	\$25.00	\$0.00	\$0.00
2335 White Filling (front-4+ surfaces)	\$0.00	Not Covered	\$0.00	\$0.00
2391 White Filling (back-1 surface)	Not Covered	Not Covered	\$65.00	\$65.00
2392 White Filling (back-2 surfaces)	Not Covered	Not Covered	\$75.00	\$75.00
2393 White Filling (back-3 surfaces)	Not Covered	Not Covered	\$80.00	\$80.00
2790 Crown	\$185.00	\$185.00	\$185.00	\$185.00
Endodontics				
3320 Root Canal - Bicuspid	\$135.00	\$135.00	\$130.00	\$130.00
3330 Root Canal - Molar	\$175.00	\$175.00	\$175.00	\$175.00
Oral Surgery				
7220 Removal of Impacted tooth - soft tissue	\$25.00	\$25.00	\$20.00	\$20.00
7240 Removal of Impacted tooth - completely bony	\$75.00	\$75.00	\$75.00	\$75.00
Implants				
6010 Endosteal	25% Discount	25% Discount	25% Discount	\$1005.00
6040 Eposteal	25% Discount	25% Discount	25% Discount	\$1860.00

This is a comparison only and not a complete summary of benefits. Exclusions and limitations apply.

Basic Plans: Co-payments are applicable when treatment is performed by a General Dentist only.

Enhanced Plans: Co-payments are applicable when treatment is performed by a General Dentist or Specialist.

The following carrier's offer **PPO** (Preferred Provider Organization) dental plans:

Humana/CompBenefits

MetLife

The PPO plans offered by Humana/CompBenefits and MetLife allow you to choose an in-network or out-of-network dentist at the time you make your appointment. However, when using an out-of-network dentist, the level of coverage is reduced and your out-of-pocket expenses will increase.

A listing of the in-network providers can be found on the specific carrier's website. If your dental office does not file claims on your behalf you will be required to complete a claim form and submit it to the proper carrier in order to receive reimbursement.

Below is a PPO Comparison chart which compares the four PPO plans that are available. The plans are very similar, however, the providers within each network may differ.

PPO COMPARISON

Plan Provisions	Humana/CompBenefits In-network and Out-of-Network providers available.		MetLife In-network and Out-of-Network providers available.	
	Basic	Enhanced	Basic	Enhanced
Annual Deductible	\$25.00 In-network	\$25.00 In-network	\$25.00 In-network	\$25.00 In-network
Annual Benefit Maximum	\$50.00 Out-of-Network \$1,250	\$50.00 Out-of-Network \$2,000	\$50.00 Out-of-Network \$1,250	\$50.00 Out-of-Network \$2,000
Diagnostic & Preventative Oral exams, cleanings, X-rays, topical fluoride treatments, etc.	IN: 100%, no deductible OON: 90%, no deductible	IN: 100%, no deductible OON: 90%, no deductible	IN: 100%, no deductible OON: 90%, no deductible	IN: 100%, no deductible OON: 90%, no deductible
Basic Services Fillings, root canals, periodontal scaling, oral surgery, extractions, etc.	IN: 80%, after deductible OON: 70%, after deductible	IN: 80%, after deductible OON: 70%, after deductible	IN: 80%, after deductible OON: 70%, after deductible	IN: 80%, after deductible OON: 70%, after deductible
Major Services Crowns, dentures, bridgework, etc.	IN: 50%, after deductible OON: 40%, after deductible	IN: 50%, after deductible OON: 40%, after deductible	IN: 50%, after deductible OON: 40%, after deductible	IN: 50%, after deductible OON: 40%, after deductible
Orthodontia (braces)	Not Covered	Children and adult benefits available.	Not Covered	Children only, no adult benefits available.

*This is a comparison only and not a complete summary of benefits. Exclusions and limitations apply.
"IN" means In-network and "OON" means Out-of-network*

Below is an in-network versus out-of-network cost comparison.

In-Network vs Out-of-Network Savings Example

This hypothetical example shows how receiving services from an in-network dentist can save you money.

Out-of-network benefits are paid based on a Usual & Customary (U&C) charge. The U&C charge is based on the lowest of:

1. The Dentist's actual charge;
2. The Dentist's usual charge for same or similar services; or
3. The usual charge of most Dentists in the same geographic area for same or similar services

<p><i>Your Dentist says you need a Crown</i></p> <ul style="list-style-type: none"> • In-Network Fee: \$375.00 • U&C Fee: \$500.00 • Dentist's Usual Fee: \$600.00 			
IN-NETWORK When you receive care from an in-network dentist:		OUT-OF-NETWORK When you receive care from an out-of network dentist:	
Dentist's Usual Fee is:	\$600.00	Dentist's Usual Fee is:	\$600.00
The In-network fee is:	\$375.00		
Your Plan Pays: 50% X \$375	\$187.50	Your Plan Pays: 40% X \$500 U&C Fee	\$200.00
Your Out-of-Pocket Cost: (\$375 - \$187.50)	\$187.50	Your Out-of-Pocket Cost: (\$600 - \$200)	\$400.00
<p>In this example, you save \$212.50 (\$400.00 minus \$187.50) by using an In-network dentist.</p>			

- The amounts shown are for example purposes only – they do not reflect your exact cost for the procedure listed.
- This example assumes that your annual deductible has been met.

VISION PLANS

You will have the option to choose one of four vision plans as follows:

Humana/CompBenefits **Basic** Plan
Humana/CompBenefits **Enhanced** Plan
Solstice/Davis Vision **Basic** Plan
Solstice/Davis Vision **Enhanced** Plan

The plans offered by Humana/CompBenefits and Solstice/Davis Vision allow you to choose an in-network or out-of-network provider at the time you make your appointment. Selecting an in-network provider will provide you with the greatest amount of benefit under the plan. Choosing an out-of-network provider will still provide you with coverage; however, just at a reduced level.

A listing of the in-network providers can be found on the specific carrier's Website or by contacting customer service directly.

Humana/CompBenefits
www.compbenefits.com/custom/sbbc-vision
PH: 1-800-865-3676

Solstice/Davis Vision
www.solsticebenefits.com/sbbc
PH: 1-800-448-9679

No claim forms need to be completed if you seek services from an in-network provider; however, if you select an out-of-network provider, you will be required to complete a claim form and submit it to the proper carrier in order to receive reimbursement. Out-of-network claim forms may be downloaded from the carrier's Website listed above.

BENEFIT COMPARISON

Below is a comparison chart which compares select benefits across the four plans that are available. Additional benefits and specific plan provisions may be obtained by contacting customer service or logging on to the carrier's Web site. The plans are very similar; however, the providers within each network may differ.

	Humana/CompBenefits		Solstice/Davis Vision	
Benefit	Basic	Enhanced	Basic	Enhanced
Eye Exam	\$4	\$4	\$4	\$4
Lenses Including single vision, bifocal, trifocal or lenticular	\$10	\$10	\$10	\$10
Frames	\$80 Allowance	\$130 Allowance	\$75 Allowance + 20% off the balance or No charge to select from the Davis Vision Fashion Frame Collection	\$130 Allowance + 20% off the balance or No charge to select from the Davis Vision Fashion Frame Collection
Second pair of glasses	20% discount	20% discount	20% discount	20% discount
Contact Lenses	\$85 Allowance for exam and lenses	\$120 Allowance for exam and lenses	\$55 Allowance + 15% off the balance	\$90 Allowance + 15% off the balance
Mail order contact lenses	N/A	N/A	Available	Available
Laser Vision Correction	Available	Available	Available	Available
One Year Breakage Warranty	N/A	N/A	Available	Available

*This is a comparison only of **in-network** copayments and benefits and is not a complete summary of benefits. Exclusions and limitations apply.*

DEPENDENT AGE LIMITATIONS

Coverage is available for your eligible dependents up to the following age limitations:

<u>PLAN/CARRIER</u>	<u>MAXIMUM AGE</u>	<u>COVERAGE ENDS</u>
MEDICAL		
Coventry – Children under 26	26	End of the month after reaching age 26
Coventry – Children over 26* (Adult Dependent Coverage)	30	End of the year after reaching age 30
DENTAL		
Humana/CompBenefits	26	End of the month after reaching age 26
MetLife	26	End of the month after reaching age 26
MetLife/SafeGuard	26	End of the year after reaching age 26
VISION		
Humana/CompBenefits	26	End of the month after reaching age 26
Solstice/Davis Vision	26	End of the month after reaching age 26

* In order to add or continue coverage for your adult child, you must re-enroll your adult child in the plan by completing the Dependent Coverage Enrollment/Affidavit Form. The Adult Dependent Coverage premium is in addition to the premium you are currently paying.

MEDICAL PLAN DEPENDENT ELIGIBILITY

An eligible dependent is defined as:

SPOUSE: Your spouse is considered your eligible dependent for as long as you are lawfully married.

DOMESTIC PARTNER: Your Domestic Partner is eligible for coverage as long as he/she meets the requirements as set forth in the Domestic Partner Affidavit. The children of a Domestic Partner are eligible for coverage also.

CHILDREN: Children eligible for coverage include natural born children, stepchildren, adopted children and children you have been granted court ordered custody. Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.

NEWBORN CHILDREN: A natural born child, adopted child, the child of your Domestic Partner, or a child for whom you have been appointed legal guardian, who is born or becomes eligible, will be covered from the date of birth/event. Coverage is not automatic. You must complete a Change of Status Election form within 31 days of the event.

DISABLED CHILDREN: Disabled children may remain on the plan past the age limitation (age 26) providing proof of disability and dependency is provided.

ADULT CHILD: Florida Statute 627.6562(2) makes special provisions for a dependent adult child who has reached the age of 26 and becomes uninsured. This Florida law allows a dependent child to remain covered on the plan to the end of the calendar year in which age 30 is reached for the purpose of medical insurance. To add or continue your currently-enrolled adult child's coverage, you must re-enroll the adult child by completing the Dependent Coverage Enrollment/Affidavit Form. If you are covering other dependents on your plan, the adult dependent premium is in addition to the premium you are currently paying for your other dependents.

Eligible employees may enroll their Domestic partner...

DOMESTIC PARTNER PROGRAM

The School Board of Broward County, Florida (SBBC) recognizes our employees may establish and maintain important personal, emotional and economic relationships, living in a committed family relationship outside the bounds of traditional marriage. SBBC extends certain employee benefits to the Domestic Partners of their employees.

Employees eligible for Domestic Partner Benefits may include their eligible domestic partners as dependents under their SBBC medical, dental and/or vision insurance coverage. In accordance with Internal Revenue Service rules, domestic partners and their children will not be considered eligible dependents for purposes of Reimbursement Accounts and continuation of coverage (COBRA).

Eligibility:

- domestic partner must be a person of at least 18 years of age and not related to you by blood
- you both must live together in an exclusive, committed relationship and assume joint responsibility for your basic living expenses
- domestic partner must be your “sole spousal equivalent”
- you must share the same residence
- neither you or your domestic partner can be married, or have another domestic partner, or have had another domestic partner at any time during the 12 months preceding enrollment for health care benefits
- children of your domestic partner may be enrolled as your dependents if they are their natural children, stepchildren, legally adopted or foster children, and must meet the established requirements for enrolling unmarried dependent children
- if you are covering the children of your domestic partner, you must also cover your domestic partner
- you must submit a copy of each eligible child’s birth certificate, adoption agreement or proof of dependency

To enroll your domestic partner you **must** complete a Domestic Partner Affidavit and provide the required proof that you and your domestic partner live together and are financially interdependent. Log onto the Benefits Department Web site, www.browardschools.com/benefits to download the Domestic Partner Enrollment packet.

GROUP LIFE INSURANCE

Your Group Term Life Insurance amount is **125% of your basic salary**, rounded to the next higher \$1,000, if not an exact multiple of \$1,000. The **minimum** amount is \$7,000 and the **maximum** amount is \$50,000. In the event of your accidental death, the insurance is doubled.

Group Term Life Insurance for Paraprofessionals is **125% of your basic salary**, rounded to the next higher \$1,000, subject to a maximum of \$50,000 and a minimum of \$20,000.

The Life Insurance plan includes the following features:

- waiver of premium if disabled prior to age 60 or 24 months after age 60
- a living benefit rider (for the terminally ill)
- a conversion plan available upon separation
- optional enhanced coverage available under the Cafeteria Plan

The Certificate of Coverage for your life insurance policy is available to you online throughout the year. To print a copy, log onto www.browardschools.com/benefits. Click on the book titled “Life Insurance” to access the certificate.

The Living Benefit is available to employees who meet certain criteria.

Living Benefit Rider

The Living Benefit Rider (LBR) is an innovative feature, which allows an insured employee to apply for an accelerated death benefit. This benefit will be paid during his/her lifetime if the employee has a terminal condition, which is expected to result in death within twelve months. The maximum Living Benefit for which an employee can apply is 75% of his/her total life insurance amount. The amount paid under the Living Benefit Rider will reduce the Beneficiary Life Insurance benefit.

Conversion

You have the opportunity to convert to individual life insurance coverage if your insurance ends or it is reduced for any reason other than plan termination or if you fail to pay the required premium. If coverage is terminated, you will have 60 days to file an application to convert your coverage.

Disability Income replaces 60% of your monthly salary.

DISABILITY INCOME PLAN

- The School Board's Basic Disability Income Plan provides income protection in the event you should become totally disabled as a result of an illness or accidental injury. **The basic plan is offered at no cost to employees. Under this plan, income payments may continue for up to two years.**

The Basic Disability Income Plan **replaces 60% of your monthly salary** to a maximum monthly benefit of \$1,500.

The Basic Disability Income Plan contains the following guidelines:

- disability must be caused by an illness or accidental injury
- complications of pregnancy are covered
- continuous physician care is required
- benefit payments begin **after thirty consecutive days** of disability
- benefit payments may continue for up to two years
- monthly calculation of base salary will not include overtime or other extra pay
- benefits under the plan are subjected to income tax
- optional enhanced long term coverage available under the Cafeteria Plan

Under the Basic Disability Income Plan, your monthly benefits will be **reduced by the amount of other income benefits you receive**. Worker's Compensation, Social Security, other disability insurance and sick pay are considered income. The amount you receive from the SBBC as a disability benefit will not fall below a **minimum of \$100 per month**.

Retirement benefits are paid by the Board.

FLORIDA RETIREMENT SYSTEM

Prior to 2002, the Florida Retirement System (FRS) offered one retirement option: the FRS Pension Plan. It provided a retirement benefit based on years of service at retirement, employees' highest five years of pay and FRS membership class during the time an employee is with an FRS employer.

Today, employees have a choice to either participate in the FRS Pension Plan or participate in the FRS Investment Plan. The FRS Investment Plan lets the employee decide how to allocate employer and employee monthly contributions among one or more investment funds.

Both FRS options are funded by the School Board of Broward County, Florida and the employee. Located on the following page is a summary of the key differences between the FRS Pension Plan and the FRS Investment Plan.

In addition to the above information, the Florida Retirement System also offers individuals an opportunity to increase their retirement benefit by purchasing:

- prior service (as approved by the State of Florida, Division of Retirement)
- certain military service
- board approved leave of absence
- in-state and / or out-of state service (as approved by the State of Florida, Division of Retirement)

To obtain more information on the Florida Retirement System (FRS), you may contact the Benefits Department at 754-321-3100 or the Division of Retirement regarding the Pension Plan at 1-888-738-2252, the "My FRS Financial

	FRS Pension Plan	FRS Investment Plan
Plan type	Defined benefit retirement plan	Defined contribution retirement plan.
Who contributes	Monthly contributions are employer and employee paid.	Monthly contributions are employer and employee paid.
How it works	Monthly contributions based on a percent of salary and FRS membership class - paid to a trust fund for all FRS members. Benefits are based on a fixed formula determined by age, years of service, the average of the highest five (5) fiscal years salary (FRS enrollment prior to July 1, 2011) or eight (8) years (FRS enrollment on or after July 1, 2011), FRS membership class and payment option selected at retirement.	Monthly contributions based on a percent of salary and FRS membership class - paid to employees' accounts. Benefits are based on employees' account value (contributions plus investment earnings less expenses and losses).
Who invests	The state Board of Administration (SBA) invests the Pension Plan trust Fund by choosing investment strategies and investment firms.	Employees choose how contributions are allocated among various investment funds. The SBA chooses private investment firms to manage the investment funds.
Who assumes the investment risk and rewards	FRS and employers.	Employee
Other Factors influencing employees' benefit level	The length of an employee's FRS service is the most important, but so are other factors, including salary growth, FRS membership class, vesting, inflation and DROP participation.	
Vesting (benefit ownership)	After six (6) years of FRS service if enrolled prior to July 1, 2011 or eight (8) years if enrolled on or after July 1, 2011.	After one (1) year of FRS service.
Amount of benefit paid at retirement	Amount fixed by formula and employee's choice of payment option.	Amount based on employee's account value and employee's choice of payment option.
Will benefits continue to grow if employee changes employers?	Yes, if an employee moves to another public sector employer participation in the FRS. Otherwise, benefit is frozen until retirement.	Yes, employee's account can be left in the plan or rolled over to another retirement plan. Either way, employee's account remains invested.
Retirement income options	Monthly lifetime payments, guaranteed by the FRS. Benefit reduction for early retirement. Other lifetime options provide for payments to surviving beneficiary. Under current law, Cost of Living Adjustment (COLA) on benefits is 3% for FRS service earned prior to July 1, 2011. There is no COLA on FRS service earned on or after July 1, 2011.	Employee decides how and when the account balance is withdrawn after termination. Employee can use some or all of account to buy monthly lifetime payments guaranteed by a private sector insurance company Payments include survivor benefit options.
Deferred Retirement Option Program (DROP) participation	Employees are eligible to participate in DROP after reaching normal retirement eligibility.	Employees are not eligible to participate in DROP.

Guideline Line at 1-866-44-MYFRS regarding the Investment Plan or log onto www.myfrs.com.

CHANGING YOUR ELECTIONS

All changes must be in accordance with IRS rules as stated in the Cafeteria Plan Guidelines, Part III. When adding or deleting dependents through a family status change, (birth, adoption, legal guardianship, marriage, etc.) the Benefits Department must be notified, in writing, with proper documentation, within 31 days of the change. The employee must come into the Benefits Department to add the dependent (s).

Dependent coverage is generally prepaid a full month in advance. You are responsible for monitoring the dependent eligibility limitations of each plan you select.

DEPENDENT ELIGIBILITY

CONTINUATION OF COVERAGE

When you are not actively working and not earning a SBBC paycheck, it is **your responsibility** to arrange for continuation of your individual and/or dependent insurance coverage through the Benefits Department on **a pay-direct basis**.

If you are on an approved Family Medical Leave of Absence (FMLA), SBBC will continue to pay for your health insurance for up to 12 weeks. However, **you must arrange** with the Benefits Department to make payments for **any additional coverage** and for your **dependent coverage**.

Pre-Tax Retirement Savings plans are available through payroll reductions.

TAX SHELTERED ANNUITIES - 403(b) & 457(b) DEFERRED COMPENSATION PLAN

Participating in a retirement savings/investment plan, offers an employee the opportunity to establish another retirement fund in which he or she can draw from at the time of retirement. The contributions made to this retirement savings plan are employee funded and are available through payroll reduction.

The School Board of Broward County, Florida is a qualified tax-exempt organization covered under the Internal Revenue Code allowing you to accumulate money for your retirement in special tax-sheltered plans - 403(b) Tax Sheltered Annuities and 457(b) Deferred Compensation Plans.

These plans are **in addition** to your pension benefits under the Florida Retirement System. Social Security credits are not affected because they are determined by your gross earnings prior to contributions in these tax-advantaged accounts.

Contributions are excluded from your current taxable income and the interest earned or gained is credited to your account and is tax deferred until you begin to receive distributions. The IRS limits the maximum that you may contribute to a Tax Sheltered Plan in a given tax year. These limits are based on several factors including: established IRS contribution limits, years of service with your employer (only applies to 403(b) plans), and your age. You may participate in both a 403(b) Tax Sheltered Annuity and a 457(b) Deferred Compensation Plan at the same time.

Chart #1-Save 3% of Pay Each Year

Your Age	Your Pay (increased by 3% each year)	Amount Saved Per Year/Check	Your balance, If you earn 5% annually	Your balance, If you earn 7% annually
30	\$ 25,000	\$ 750	\$ 768	\$ 776
35	\$ 28,982	\$ 869	\$ 5,627	\$ 5,982
40	\$ 33,598	\$ 1,008	\$ 12,602	\$ 14,144
45	\$ 38,949	\$ 1,168	\$ 22,413	\$ 26,623
50	\$ 45,153	\$ 1,355	\$ 36,001	\$ 45,336
55	\$ 52,344	\$ 1,570	\$ 54,595	\$ 73,162
60	\$ 60,682	\$ 1,820	\$ 79,800	\$ 113,991
65	\$ 70,347	\$ 2,110	\$ 133,701	\$ 173,528

Chart #2-Save 7% of Pay Each Year

Your Age	Your Pay (increased by 3% each year)	Amount Saved Per Year/Check	Your balance, If you earn 5% annually	Your balance, If you earn 7% annually
30	\$ 25,000	\$ 1,750	\$ 1,792	\$ 1,809
35	\$ 28,982	\$ 2,029	\$ 13,128	\$ 13,958
40	\$ 33,598	\$ 2,352	\$ 29,404	\$ 33,003
45	\$ 38,949	\$ 2,726	\$ 52,297	\$ 62,119
50	\$ 45,153	\$ 3,161	\$ 84,003	\$ 105,853
55	\$ 52,344	\$ 3,664	\$ 127,289	\$ 170,711
60	\$ 60,682	\$ 4,248	\$ 186,198	\$ 265,978
65	\$ 70,347	\$ 4,924	\$ 265,302	\$ 404,898

The examples show the value in an account every five years, and assume the following:

- The employee begins investing at age 30
- Pay increases by 3% per year
- The employee saves 3% of pay (chart 1) or 7% of pay (chart 2)
- The employee works 35 years
- A rate of average return of either 5% or 7%

Note: This example is for illustration only. Other factors could change the value of the account. This chart is for general information and education purposes only. The information provided should not be construed as legal or tax advice. Please consult with your legal or financial advisor to determine the appropriateness of this article for your particular

circumstances. The SBBC assumes no responsibility or liability for the accuracy of the information provided.

It is never too late to start saving/investing for your future. Agents are available to meet with you at your convenience. They can provide you with a free personal consultation and discuss your retirement goals. To view a list of vendors, a Resource Guide to assist you when you are considering investing in a tax-sheltered annuity, and a Plan Charge Comparison, log on to www.browardschools.com/benefits. To enroll you need to contact the vendor of your choice directly.

PART II - CAFETERIA PLAN

WHAT IS A CAFETERIA PLAN AND WHO IS ELIGIBLE?

The Cafeteria Plan is a multiple part program that allows eligible employees reductions in taxes.

You can pay for certain expenses with “pre-tax” dollars.

The Cafeteria Plan, established under Internal Revenue Code Section 125, is an innovative way to save tax dollars while receiving additional benefits.

By participating in the School Board’s Cafeteria/Flex Plan, you can:

- pay for certain medical expenses and/or adult and child dependent care with pre-tax dollars
- choose enhanced/additional benefits from a “menu” of optional benefits
- save tax dollars

The plan is comprised of four main sections:

<u>Section 1</u>	Board Contributions to The Cafeteria Plan
<u>Section 2</u>	Pre-Tax Salary Reduction for Employee Paid Premiums (unless you request a waiver)
<u>Section 3</u>	Flexible Spending Accounts
<u>Section 4</u>	Additional Plan Benefits

All permanent employees are eligible...

ALL PERMANENT EMPLOYEES are eligible to receive benefits through the Cafeteria Flex Program, pursuant to applicable collective bargaining agreements.

Section 1

BOARD PAID CONTRIBUTIONS TO THE CAFETERIA PLAN

Board-paid contributions for eligible employees.

School Board Contribution

Under the terms of the collective bargaining agreements, the School Board provides a monthly contribution toward your Cafeteria Plan. Check your specific bargaining unit agreement to verify the specific benefit contribution.

If you do not choose to participate in the Cafeteria/Flex Plan, the School Board's contribution will be applied automatically to your salary. However, the Board's monthly contribution will be reduced by the appropriate income and Social Security taxes.

Section 2

PRE-TAX SALARY REDUCTION FOR EMPLOYEE PAID PREMIUMS

Insurance premiums are paid automatically through pre-tax salary reductions.

If you or your dependents are enrolled in medical, dental or vision insurance plans, your premium contribution for coverage will generally be automatically paid through salary reduction.

Section 3

FLEXIBLE SPENDING ACCOUNTS

"Flexible Spending" helps you save on taxes.

Flexible Spending Accounts (FSAs) let you pay eligible medical and dependent care expenses with pre-tax money. Flexible Spending Accounts feature:

- IRS-approved reimbursement of eligible expenses tax free
- per-pay-period deposits from your pre-tax salary
- savings on income and Social Security taxes

FSAs are optional: You may participate in one or both.

There are two separate FSAs: the **Medical Reimbursement Spending Account** and the **Dependent Care Spending Account**. The FSAs are optional; you may participate in one or both.

Medical Expense FSAs

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Medical Expense FSAs include:

- physician office co-payments
- eyeglasses and contact lenses
- prescription co-payments
- dental expenses not covered by the dental insurance company
- orthodontia

Dependent Care Expense FSAs

Dependent care expenses, whether for a child or an elder include:

- pre-school care
- before and after school care for children under age 13

- summer day camps
- care for elderly parents

For questions regarding eligible expenses contact Fringe Benefits Management Company at www.myfbmc.com or via telephone at 1-800-342-8017.

You decide the amount(s) you want to contribute.

HOW FLEXIBLE SPENDING ACCOUNTS WORK

You must first decide the **total amount** you want to put into your account(s) over the course of the **upcoming year**. This pre-tax deduction will be deposited into your FSA account(s). When you incur eligible expenses, you submit a claim for reimbursement. Your reimbursements will be made in tax-free dollars.

The Medical Reimbursement Spending Account allows you to pay for eligible medical expenses

MEDICAL REIMBURSEMENT SPENDING ACCOUNT

The Medical Reimbursement Spending Account reimburses you for many medical expenses that are not covered by insurance or any other plan. Additional information regarding eligible expenses may be found at www.myfbmc.com or by calling Fringe Benefits Management Company at 1-800-342-8017.

Most filled prescriptions are eligible for reimbursement, as long as you properly substantiate the expense. The IRS requires the complete name of all medicines and drugs to be obtained and documented on pharmacy invoices (including prescription number, date(s) of service and total dollar amount). The information must be included when submitting your request for reimbursement.

Orthodontia treatment designed to treat a specific medical condition is reimbursable if the proper documentation is provided:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service, the cost for the service

Additional details are available by contacting Fringe Benefits Management Company at www.myfbmc.com or by calling 1-800-342-8017.

Your Medical Expense FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying child
- your qualifying relative

Medical Reimbursement - avoid taxes on up to \$5,000 of income annually.

You may deposit a minimum of \$100 up to a maximum of \$5,000 into your Medical Reimbursement FSA annually. **In estimating how much you should contribute, consider the typical out-of-pocket medical expenses that you and your family incur during the year.** You might review your expenses from last year as a guide to what you can expect in the upcoming year. Again, calculate the expenditures so that your monthly deduction will match your estimated expenditures.

IMPORTANT: Be conservative when estimating your annual medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA account(s) after the plan year and any applicable grace period ends and all reimbursable requests have been submitted and processed, cannot be returned to you nor carried forward to the next plan year.

The Dependent Care Spending Account covers most expenses related to the care of eligible dependents.

DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account covers most of the expenses related to the care of an eligible dependent (child or elder) being taken care of while you and your spouse (if married) are working.

The FSA will reimburse you for the cost of care provided by someone other than your spouse or a dependent under age 19 for eligible dependents.

An “eligible dependent” may be a child, spouse or qualifying relative, who qualifies as your dependent for income tax purposes and has a specified family-type relationship with you. Additional details are available by contacting Fringe Benefits Management Company at www.myfbmc.com or by calling 1-800-342-8017.

You may deposit a minimum of \$100 up to a maximum of \$5,000 into your Dependent Care FSA annually. However, certain exceptions apply:

If you are married, filing a joint income tax return, and your spouse contributes to a dependent care FSA, your combined contributions for the year **cannot exceed \$5,000**

If you are married, filing a separate income tax return, you may only deposit **up to \$2,500** for the year

Dependent Care FSAs provide immediate tax savings.

Internal Revenue Service regulations state that you can use either the Dependent Care FSA or the Dependent Care Income Tax Credit, **but not both**. In order to determine whether it is better for you to use the FSA instead of the tax credit, you need to review your personal situation, (household income, marital status, and the amount of your eligible expenses). Before you make a decision about enrolling in the Dependent Care FSA, it might be a good idea to consult a tax advisor.

Claiming your tax advantaged dollars is easy.

FLEXIBLE SPENDING REIMBURSEMENTS

When you have incurred eligible medical or dependent care expenses, you may submit a claim for reimbursement to the Plan Administrator. Claim forms are available from the Benefits Department, or Fringe Benefits Management Company's Website, www.myfbmc.com. Simply fax or mail a correctly completed FSA Reimbursement Request form.

For the Medical FSA you should include the following:

- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided or

- an Explanation of Benefits (EOB) from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost

For the Dependent Care FSA you should include the following:

- the name, age and grade of the dependent receiving the service
- the cost of the service
- the name and address of the provider
- the beginning and ending dates of the service

Note**The expenses must have been incurred while you were employed by the School Board **and** a plan participant.

IMPORTANT: Be conservative when estimating your annual medical and/or dependent care expenses. IRS regulations state that any unused funds which remain in your FSA account(s) after the plan year and any applicable grace period ends and all reimbursable requests have been submitted and processed, cannot be returned to you nor carried forward to the next plan year.

...reimbursements are generally made within five days...

Reimbursements from the Medical and Dependent Care FSAs are generally made within five business days from the date the claim is received by the Fringe Benefits Management Company. You may enroll in Direct Deposit to expedite the time of your reimbursement. You will receive statements periodically showing the reductions paid in and any amounts reimbursed to you. If you have questions about your account balance or claims, contact Fringe Benefits Management Company at www.myfbmc.com or by calling 1-800-342-8017.

FSA Claims Submission

The IRS has added a “**grace period**” to your **Medical Expense** Flexible Spending Account. Your grace period ends on March 15th of the following year. During the grace period, you may incur expenses and submit claims for these expenses. Funds will be automatically deducted from the dollars in your account from the previous plan year. The “**grace period**” **does not apply** to the **Dependent Care** Flexible Spending Account.

For both the Medical Expense and Dependent Care Flexible Spending Accounts, you have a “run out period” for filing claims incurred during the previous plan year. The “run out period” extends until April 15th. YOU MUST SUBMIT YOUR CLAIMS NO LATER THAN APRIL 15, AFTER THE END OF THE PLAN YEAR, IN WHICH THE EXPENSES ARE INCURRED.

Section 4

ADDITIONAL PLAN BENEFITS

Enhanced Disability replaces 66.7% of your monthly income up to \$3,000.

LONG TERM DISABILITY INCOME ENHANCEMENT

SBBC's Long Term Disability Protection plan helps to provide financial security for you in the event of income loss due to an illness or accidental injury.

For many individuals, relying on the Board-paid Basic Disability Income Plan, which pays 60% of your salary for a two year period, **may not be enough** to ensure your essential living expenses will be covered.

The Enhanced Long Term Disability Plan replaces 66.7% of your regular salary with a maximum monthly benefit of \$3,000 per month. Benefit payments begin after you have been disabled for 30 days. Benefits will continue to age 65 as long as you are under the care of a licensed physician and remain totally disabled.

Payments will continue for as long as you remain totally disabled up to a maximum of five years, if disability occurs at age 60 or older.

MAXIMUM BENEFIT DURATION

Age (on the Date Disability Starts)	Maximum Benefit Duration
Under age 60	To age 65
Age 60 or older	5 years from end of the elimination period and the beginning of the benefit payment.

Enhanced Disability pays up to age 65.

Total Disability Defined

During the first two years of disability, the plan defines total disability as the inability to perform the essential duties of **your** occupation. Thereafter, total disability is defined as the inability to perform the duties of **any** occupation for which you are, or can become qualified for by training, education, or experience. Keep in mind, you **do not** have to be permanently disabled to qualify for benefits.

The Enhanced Disability Plan is available to **any** employee, pursuant to their union contract, who qualifies for the Basic Disability Plan and is subject to all other benefits and provisions as described for the Basic Disability Plan.

Under the Enhanced Disability Plan, your monthly benefits will be **reduced** by the **amount of other income benefits you receive**. Workers' Compensation, Social Security, other disability insurance and sick pay are considered income. The amount you receive from SBBC as a disability benefit will not fall below a minimum of \$100 per month.

No medical evidence is required.

Enhanced Coverage is Guaranteed

Under this plan, you will be accepted without evidence of good health. Pre-existing condition limitations may apply within the first year of coverage. This coverage is available only during initial enrollment and during subsequent Open Enrollment periods.

Cost of Your Enhanced Level Protection

The cost for this coverage will depend on your annual salary. The cost is considerably lower than an individual plan with similar benefits. Examples of costs are highlighted below. Premiums will be deducted from your paycheck. The rate is based on \$.257 per \$100 of your monthly covered salary.

Your Monthly Salary	Initial Benefit	Enhanced Benefit	Premium
\$833	\$500	\$555	\$2.31/MONTH
\$1,250	\$750	\$832	\$3.34/MONTH
\$2,500	\$1,500	\$1,655	\$6.42/MONTH
\$3,000	\$1,500	\$2,000	\$7.71/MONTH
\$4,500	\$1,500	\$3,000	\$11.56/MONTH

LIFE INSURANCE ENHANCEMENT

The Enhanced Life Insurance benefit is in addition to the Basic Life Insurance benefit. The coverage is affordable and convenient; premiums are remitted through payroll deductions. You are able to purchase additional group term life insurance at competitive rates.

Under the Cafeteria Plan, you may purchase additional amounts of life insurance:

Employees (other than the Para-professionals earning less than \$16,000) may choose an additional:

Option 1 – 125% of basic annual salary, rounded to the next highest \$1,000 or \$50,000, whichever is less.
(Para-professionals earning \$16,000 or less receive a minimum election of \$20,000 for Option 1)
The monthly cost is \$0.18 cents per \$1,000 of coverage.

Or

Option 2 – 250% of basic annual salary, rounded to the next \$1,000 or \$100,000 whichever is less.
(Para-professionals earning \$16,000 or less receive a minimum election of \$40,000 for Option 2)
The monthly rate is \$0.16 cents per \$1,000 of coverage

The Accidental Death and Dismemberment (AD&D) coverage is a Board-paid benefit that cannot be enhanced.

The Certificate of Coverage for your life insurance policy is available to you online throughout the year. To print a copy, log onto www.browardschools.com/benefits. Click on the book titled "Life Insurance" to access the certificate.

Medical Underwriting is required for late enrollment.

If you select Enhanced Life Insurance when you initially enroll for basic life insurance benefits, no medical evidence of insurability is required. If you do not select Enhanced Life Insurance at time of employment, you may only enroll during subsequent Open Enrollment periods, at which time evidence of insurability will be required if increasing two levels. During the annual Open Enrollment no evidence of insurability will be required if increasing only one level. Any employee increasing coverage due to certain family status changes is considered a late entrant into the plan. Satisfactory evidence of insurability will be required. (Refer to Cafeteria Plan Guidelines)

ENHANCED EXAMPLE(S)				
Value of Core Coverage	Value of Enhanced (x1)	Premium (x1)	Value of Enhanced (x2)	Premium (x2)
\$20,000	\$20,000	\$3.60/MONTH	\$40,000	\$6.40/MONTH
\$40,000	\$40,000	\$7.20/MONTH	\$80,000	\$12.80/MONTH
\$50,000	\$50,000	\$9.00/MONTH	\$100,000	\$16.00/MONTH

The IRS considers the value of group term life insurance in excess of \$50,000 as income to an employee. This concept is known as "imputed income." The value of the insurance is determined by calculating the amount of an employee's group term life insurance in excess of \$50,000, and multiplying that amount by an IRS factor based on the employee's age as of the last day of the calendar year (see table below).

The imputed income based upon the District's group term life insurance will be reported on each employee's Form W-2 as taxable wages. This may cause the taxable wage to be greater than the gross income on the employee's remuneration statement. Take for example, a 52 year old employee with \$80,000 of group term life insurance during calendar year 2008. Of that \$80,000, the value of \$30,000 (the amount in excess of \$50,000) is taxable to the employee. Under IRS rules, the value of that \$30,000 excess group term life insurance equals the difference between the value of that excess determined under the IRS table below, minus the actual after-tax deductions the employee makes for that coverage.

In this example, the imputed income would equal \$82.80

Here's how that \$82.80 was calculated. The employer multiplies the IRS factor applicable to a 52 year old (which is \$0.23) by 30 (the number of thousands of excess), and then multiplies that number by 12 (the number of months during the calendar year). So, $\$0.23 \times 30 \times 12 = \82.80 which is reported as NonCash Txbl Group Life on the employee's remuneration statement.

Since the employee did not have any after-tax deductions for that extra coverage, the \$82.80 is the imputed income and increases the Taxable Income on the remuneration statement and is reported on the W2 statement.

IRS TABLES

Age of Employee	Monthly cost per \$1,000 of Excess Coverage
Under 25	\$.05
25 to 29	\$.06
30 to 34	\$.08
35 to 39	\$.09
40 to 44	\$.10
45 to 49	\$.15
50 to 54	\$.23
55 to 59	\$.43
60 to 64	\$.66
65 to 69	\$1.27
70 and over	\$2.06

Any employee increasing coverage due to certain family status changes is considered a late entrant into the plan. Satisfactory evidence of insurability will be required. (Refer to Cafeteria Plan Guidelines)

CANCER/SPECIFIED DISEASE INSURANCE

Cancer/Specified Disease Protection is a supplemental insurance plan that pays in addition to other coverage if you are diagnosed with cancer or other specified diseases. The plan is designed to pay directly to you, unless assigned.

The plan helps you focus on care, addressing both direct and indirect medical expenses to help keep you financially secure.

Cancer/Specified Disease Insurance Highlights:

- Choice of daily hospital confinement benefit depending on the premium you pay
- Pays directly to you, unless assigned
- Pays in addition to any other insurance you may have including employer provided insurance
- Premium will be made using **pre-tax dollars under Internal Revenue Code, Section 125 for Cafeteria Plans**
- Portable when you leave employment
- Spouse and/or child coverage is available

Full information about your benefits and coverage is available through separate product brochures as provided by the insurance carriers.

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance provides a supplement to your income while you are hospitalized. Employees who are eligible receive a fixed daily benefit during the period of hospitalization resulting from a covered illness or accident. Benefits will begin the first day of hospital confinement. This supplemental income is in addition to other benefits being received.

Hospital Indemnity Insurance Highlights:

- Benefits are paid directly to the insured, unless assigned
- It is guaranteed renewable to age 65, subject to changes in premium by class
- Premium will be made using **pre-tax dollars under Internal Revenue Code, Section 125 for Cafeteria Plans**
- Pays in addition to other coverage, including Workers' Compensation
- Spouse and/or child coverage is available

Full information about your benefits and coverage is available through separate product brochures as provided by the insurance carriers.

This brochure highlights some features of the policies and riders, but is not the insurance contract.

PART III - CAFETERIA PLAN GUIDELINES

Plan elections are effective for the entire plan year and cannot be changed except as permitted below.

Changing your Elections

Cafeteria Plan elections made during the annual Open Enrollment period become effective January 1 of the upcoming year, and remain in effect for the entire calendar year. The School Board intends to provide you with the broadest ability to make mid-year election changes permitted in accordance with Internal Revenue Service (IRS) rules. To summarize those IRS rules, you cannot change your level of participation unless you experience one of the following events and notify the Benefits Department within 31 days of such event.

Change in Status. You may modify your Cafeteria Plan election for the remainder of the plan year if one of the following events affects the eligibility for coverage under the Plan for you, your spouse and/or dependent as long as your requested Cafeteria Plan change is "consistent with" the Change in Status:

- **Marital Status:** A change in your marital status, including marriage, death of a spouse, divorce or annulment.
- **Change in Number of Tax Dependents:** A change in the number of your dependents, including birth, death, adoption or placement for adoption.
- **Change in Status of Employment Affecting Coverage Eligibility.** A change in your employment status (or the employment status of your spouse or dependent) that affects the individual's eligibility under an employer's plan, such as commencement or termination of employment.

- **Gain or Loss of Dependent's Eligibility Status.** A gain or loss of eligibility status is an event that causes your dependent to satisfy or cease to satisfy coverage requirements under the plan, such as change in age, marital, employment or tax dependent status.
- **Change in Residence.** A change in your residence, and/or the residence of your spouse or dependent, such as moving outside the HMO service area.

As an example of the "consistency" requirement, let's assume you are married and elect "Employee Plus One" coverage beginning January 1, 2011. However, you and your spouse divorce on May 15, 2011. You may change your election under the Cafeteria Plan from "Employee Plus One" coverage to "Employee Only" coverage if you notify the Benefits Department by June 15, 2011. Your election to drop your former spouse from the plan and choose "Employee Only" coverage is "consistent" with your divorce.

Medicare, Medicaid or other governmental sponsored health coverage Entitlement: Gain or loss of Medicare or Medicaid by you, your spouse and/or dependent may allow you to drop or enroll the appropriate individuals in the Plan.

Judgment, Decree or Court Order: If a judgment, decree or order from a divorce, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child, you may change your election to provide coverage for the dependent child. If the order requires that another individual (such as your spouse or former spouse) cover the dependent child and provide 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.

Open Enrollment Under Other Employer's Plan: You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and (1) the other employer's plan has a different period of coverage than the School Board's Plan and (2) the other employer's plan permits mid-year election changes for this same event.

Enrollment Rights with a 60 day Notice Requirement: You may make an election change if you, your spouse and/or dependents lose eligibility under Medicaid or a state children's health insurance program (SCHIP), or become eligible for premium assistance under Medicaid or a SCHIP program. You must notify the Benefits Department within 60 days of such event.

Remember: You must give prompt notification in writing to the Benefits Department to make any of the above-described changes.

PART IV - VOLUNTARY SUPPLEMENTAL INSURANCE PLANS

The following Voluntary Supplemental Insurance Plans are fully paid by eligible employees and are available on a post-tax basis.

- Group/Individual Universal Life Insurance Plans
- Long-Term Care Insurance
- Prepaid Legal Insurance

GROUP/INDIVIDUAL UNIVERSAL LIFE INSURANCE PLANS

Group/Individual Universal Life Insurance enables you to prepare for you and your family's future without putting

a strain on your present budget. While your cash value is accumulating, you are protected by an immediate life insurance benefit.

Group/Individual Universal Life Insurance Highlights:

- Living Benefit Rider
- Additional rider benefits are also available
- Portable when you leave employment
- Spouse and/or child coverage is available

LONG-TERM CARE INSURANCE

Long-Term Care Insurance is the only type of coverage designed specifically to cover the costs associated with extended long-term Care. It lets you protect your savings and your independence. You'll get to choose the care you need and won't be dependent on others for financial help or to act as caregivers. Long-term care offers you comprehensive flexible coverage at an affordable price.

Long-Term care Insurance Highlights:

- Protects your savings, investments and independence
- Includes inflation protection
- Medicare does not cover some of the costs associated with long-term care
- Portable when you leave employment
- Allows comprehensive care choices
- Available to spouse, parents, grandparents, parent-in-laws, and grandparent-in-laws

PREPAID LEGAL INSURANCE

Prepaid Legal Insurance offers you quality attorney services at an affordable price. You will have a customer service hotline as well as toll-free attorney advice. Also, there is a nationwide attorney referral service available through your provider firm at no additional cost. As a member, you and your family can get the help you need without having to take time from your jobs.

Prepaid Legal Insurance Highlights:

- Will review and preparation
- Moving traffic violation representation
- Contract and document review
- Family law
- Your spouse and dependents
- Portable when you leave employment

Full information about your benefits and coverage is available through separate product brochures as provided by the insurance carriers.

This brochure highlights some features of the policies and riders, but is not the insurance contract.

PART V - EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (E.A.P.) is a confidential benefit program that utilizes a policy of support and assistance to all employees, whether or not job performance is being adversely affected. The E.A.P. operates in both a preventive and corrective mode for the total wellness of all School Board employees and their families. The philosophy underlying the function of the E.A.P. is that even the most effective employees may encounter obstacles that may, or do, impede efficiency and productivity. Employees are the District's most valuable resource, and the District offers assistance to employees to promote an optimum sense of well being and productivity.

The Employee Assistance Program may offer assistance to permanent employees and to their insured dependent family members. The assistance is beneficial for people that are directly or indirectly suffering from behavioral/medical problems that tend to jeopardize their physical or mental health, work satisfaction and/or continued employment. Behavioral/medical problems include but are not limited to:

- physical illness
- marital/family distress and conflicts
- emotional problems e.g. depression
- stress/anxiety
- bereavement/grief and loss
- eating disorders
- parenting issues
- interpersonal problems
- work related problems
- medical/pain management/coping with illness
- relationship problems
- alcohol and/or substance abuse or dependency

The Broward County School Board recognizes behavioral/medical problems as conditions that can often be successfully treated or resolved, especially when they are dealt with in the early developmental stages. For example, a certain amount of stress is inevitable and necessary, but high levels of stress are detrimental to one's health, overall well being and can impact work performance. High levels of stress can also create "burn-out" which may manifest itself in an individual's personal and/or professional life. However, much can be done to reduce the amount of stress in an individual's life and to reduce its impact.

The program goal is to help those individuals who develop such problems to:

1. gain a better understanding of the problem
2. learn about the services available
3. choose a plan of action

After providing an extensive intake assessment (a requirement of the insurance company), referral(s) to a psychotherapist and/or other appropriate community resources are made. We also obtain the necessary authorization numbers from the School Board insurance carrier who will pay for the ongoing therapy. Extensive case management is conducted to monitor and ensure the recommended service is being received.

CONFIDENTIALITY AND THE E.A.P.

Employee Assistance Program files are treated as medical/psycho/social files and as such are governed by the Federal Regulations on Confidentiality as described in 42 CFR Part 2. Information can only be released when clients give written consent or when the law requires (e.g. issues of abuse, threats to harm self or others, criminal investigation). The issue of confidentiality is of the highest importance to the E.A.P. staff as it allows the most effective use of essential services.

By calling us at 754-322-9900 you can access the services of the EAP and schedule an appointment.

PART VI- WELLNESS PROGRAM

The Wellness Program of the School Board of Broward County seeks to **improve the emotional and physical well-being of its employees through education, health screenings, and encouragement of healthy lifestyles**. Complimentary Wellness Seminars and screenings are provided on a variety of personal topics that can be requested through calling the Wellness Coordinator at 754-321-3100.

Topics include:

- Nutrition/Healthy Eating
- Fitness/Exercise (Interactive)
- Fast Food for Fast People
(Healthy cooking demonstration)
- Today's Top Health Threats
- The Importance of Sleep/Sleep Disorders
- Stress Reduction
- Disease Prevention
- Fad Diets
- Cancer Prevention
- Heart Disease
- Anti-Aging Myths and Methods
- Simple Choices to Assure a Healthy Lifestyle
- General Health and Wellness
- Time Management
- Asthma
- Diabetes
- Weight Management
- Cardiovascular Disease
- Conflict Management
- Smoking Cessation
- Migraines
- Walking
- Jazzersize www.jazzersize.com

Available Health Screenings:

(Available on Regular School Days or Teacher Work Days)

- Blood Pressure
- Cholesterol
- Hearing
- Vision
- Blood Sugar
- Skin
- Colon
- Body Mass Index
- Posture
- Mammogram Van (Minimum of 10 women)
- Bone Density
- Prostate (Once a year)

(Available on Regular School Days or Teacher Work Days)

- Flu Shots (Seasonal)

Weight Loss Programs:

- Weight Watchers (Minimum of 15 people)
www.weightwatchers.com
- The Weight Manager (Minimum of 8 people)
www.theweightmanager.com

This booklet covers some of the major highlights and provisions of the benefits available to The School Board of Broward County, Florida employees. It is not intended to replace the "Certificates of Coverage" provided by the carriers. The Board approved contracts and the Certificates of Coverage will serve as the final authority in determining benefits. Please read ALL material carefully. If you have any questions, please contact the Benefits Department at 754-321-3100 or you may contact the appropriate company directly.

If you have questions about the following benefit coverages, please refer to the listing delineated below for the appropriate company to contact:

MEDICAL

COVENTRY (In-House Representatives)

954-832-9061
(8:00am - 5:00pm)
1-800-547-0852

DENTAL

HUMANA/COMPBENEFITS

866-890-4464
954-527-4088

METLIFE

888-865-6878
954-321-6911

METLIFE/SAFEGUARD

800-936-5315
954-590-9560
954-308-5562

VISION

HUMANA/COMPBENEFITS VISION PLAN
SOLSTICE BENEFITS/DAVIS VISION

800-865-3676
800-448-9679
800-335-0771

LIFE

RELIANCE STANDARD LIFE INSURANCE

877-268-7606
954-846-7370

DISABILITY

THE PRUDENTIAL INSURANCE COMPANY

800-842-1718

FLEXIBLE SPENDING ACCOUNTS

FRINGE BENEFITS MANAGEMENT COMPANY

800-342-8017

CUSTOMER SERVICE
I N F O R M A T I O N

VOLUNTARY SUPPLEMENTAL INSURANCE

AMERICAN HERITAGE LIFE INSURANCE COMPANY

Cancer/Specified Disease, Hospital Indemnity,
and Individual Universal Life

954-485-9909

• **CNA INSURANCE**

Long Term Care

866-357-8482

• **ING EMPLOYEE BENEFITS**

Group Universal Life

954 485-9909

MASS MUTUAL LIFE INSURANCE COMPANY

Long Term Care

954 938-8800

PRE-PAID LEGAL SERVICES

Prepaid Legal Services

800 654-7757

407 657-1940

TEXAS LIFE INSURANCE COMPANY

Universal Life Plan

954 485-9909

U.S. LEGAL SERVICES, INC

Prepaid Legal Services

800 356-5297

954 485-9909

CUSTOMER SERVICE
I N F O R M A T I O N

Notice Of COBRA Continuation Coverage Rights

Introduction

As an employee of Broward County Public Schools you are covered under a group health plan (The Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the School Board of Broward County, FL, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Benefits Department, School Board of Broward County, 7770 W. Oakland Park Blvd., Sunrise, FL 33351. Supporting documentation is required to support the date and qualifying event.

How is COBRA Coverage Provided?

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

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

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice to: Benefits Department, School Board of Broward County, 7770 W. Oakland Park Blvd., Sunrise, FL 33351. Supporting documentation is required to support the date and qualifying event.

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information:

Broward County Public Schools
Attn: Benefits Department
7770 W. Oakland Park Blvd.
Sunrise, FL 33351
PH: 754-321-3100
FAX: 754-321-3280

Important Notice from The School Board of Broward County, Florida About Your Prescription Drug Coverage and Medicare

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

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current SBBC coverage will not be affected. The only way to drop the prescription coverage offered by The School Board of Broward County, Florida is to drop all of your medical coverage.

If you do decide to join a Medicare drug plan and drop your current SBBC healthplan coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information at 754-321-3100. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The School Board of Broward County, Florida changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

Date: October 1, 2011
Name of Entity/Sender: The School Board of Broward County, Florida
Contact-Position/Office: Michelle Johnson, Administrator IV
Address: 7770 W. Oakland Park Boulevard
Sunrise, Florida 33351
Phone Number: 754-321-3100



PROTECTING PRIVACY: VITAL FACTS

Privacy Officer - Contact Information

- Todd Sussman, LMHC, LMFT; Member: Int'l. Assoc. of Privacy Professionals
- (754) 321-1914 / Risk Management Department, KCW bldg.
- 600 SE 3rd Avenue, 11th Floor; Ft. Lauderdale, FL 33301
- todd.sussman@browardschools.com

HIPAA (Health Insurance Portability & Accountability Act)

- Federal law to protect privacy and increase security of health care information.

Protected Health Information (PHI)

Data maintained, transmitted, or received in any form or medium by a covered entity (SBBC) and its representatives that:

- Identifies an individual
- Relates to past, present, or future physical or mental health or condition of an individual
- Relates to provision of health care to an individual, including payment

PHI or Employment Record?

- PHI = Medical condition documented for billing purposes, transmitted by Benefits Department staff or Benefits Coordinator. Covered by HIPAA.
- Employment record = Medical condition written on doctor's note for employee's leave file, submitted by employee to Supervisor. Not covered by HIPAA.

HIPAA Authorization Form (Authorization for Release of Health Information)

The Benefits Department will not share your information (except for purposes of treatment, payment, day-to-day business operations and additional exceptions specified in the Notice of Privacy Practices) unless you sign an Authorization.

- Where to find it: From main page of SBBC website, click "Departments," then "Benefits," then "Rates, Forms & Documents." See top of the list (first link).
- Please forward signed forms to the Benefits Department for filing. The form expires three (3) years post-employment and must be retained for six (6) years after it was created or last in effect, whichever is later.



Notice of Privacy Practices (Health Plan)

- Includes SBBC's privacy practices, including uses and disclosures of PHI and individual's rights with respect to their PHI.
- Where to find it: From main page of SBBC website, click "Privacy Statements" link at the bottom of page, then click "Employee." The Notice is also provided in your Open Enrollment CD.

HIPAA Privacy Video

The District's 10-minute privacy awareness and training tool, with introduction by Superintendent Notter, features the basic requirements of HIPAA. All SBBC employees must view this video and sign an Employee Confidentiality Agreement.

- Where to find the video: This video is readily available from the District's streaming server at **<http://ets-tcs-admin>**. Type "privacy" in the search box and the video will appear.
- Where to find the Employee Confidentiality Agreement Form: This form was distributed to all Principals and Department Heads with a memo from Donnie Carter, most recently on August 21, 2009. It is also available from the District's website. Click "Departments," then "Risk Management," then "HIPAA" (under Quick Links), then "Employee Confidentiality Agreement."

Best Privacy Practices for District staff

- Keep all files containing employees' Benefits information in a locked file cabinet.
- Do not discuss someone's health information with others, including those in your department, without written authorization.
- When sending documents to the Benefits Department (i.e. HIPAA Authorization Forms), place them in a sealed envelope before putting in the pony interoffice envelope.
- Do not send e-mails containing health information unless the information is sent in a password-protected attachment.
- Avoid sending faxes containing health information. If a fax is necessary, do not leave outgoing faxes unattended at the fax machine. Confirm receipt by the recipient. Retrieve incoming faxes ASAP.

Visit our privacy website at **<http://www.broward.k12.fl.us/rmt/>**.
Under Quick Links, click "HIPAA."



Total Wellness