YOUR GUIDE TO

YOUR BENEFITS

2019 - 2020

The School District of Osceola County

SUPERINTENDENT'S MESSAGE

Dear School District of Osceola County Employees,

Your hard work and dedication to the district and our students are undeniable. Similarly, your enthusiasm is recognized and appreciated each and every day.

Our school system is built around passion and a fundamental belief in our talented employees and students, supportive School Board, and engaged community. Your School Board, Superintendent, and district and school leaders share a deep commitment to health and supporting you as you engage daily with our students. The Osceola County School Board continues to make a significant investment in providing benefit options to meet your and your family's needs.

Your voices were heard, and we are thrilled to share some exciting updates for our 2019-2020 year. We are pleased to announce that the district has contracted with RosenCare Solutions to operate the Center for Employee Health, effective October 1, 2019. After listening to feedback from our employees concerning the Center, the School Board believes RosenCare is the proper community partner to service district employees and their families. In the upcoming months, you and your covered dependents will see a change in the focus of the Center from an acute care clinic to an all-inclusive medical home. The Center will continue to offer physical and occupational therapy, nutrition counseling, onsite x-rays, and many more of the services you would normally receive at your primary care physician's office. We also are continuing to offer eCare so you can access health care for minor concerns using the eCare app with extended hours and a low copay of only $25.

In addition to the Center for Employee Health, you will see some changes that outline our stronger focus on wellness, including the wellness incentive in conjunction with our medical plan detailed in this guide. Also, Humana will be the new dental carrier beginning October 1st. Both the DHMO and PPO plans offer richer preventive benefits, as well as some coverage enhancements for each individual plan. We encourage you to review your benefit options carefully to make the best decisions for you and your family.

I cannot close this letter without mentioning wellbeing. Taking care of yourself first improves your ability to do what you feel most passionate about, which is taking care of our students. The district offers many resources to support your physical and mental wellbeing. Please take advantage of these benefits as you continue to make good health a priority.

Thank you for your continued support and contribution to our district's success, and very best wishes for the coming school year.

Dr. Debra P. Pace
Superintendent

This guide is a summary of the benefit programs offered through the School District of Osceola County for the plan year October 1, 2019, through September 30, 2020.

The contents summarize the key features of each plan. Complete details are provided in Plan Documents, policy guidelines, and insurance contracts that legally govern the operation of each plan. If there is a discrepancy between this guide and the official Plan Documents, the Plan Documents will prevail.

CONTENTS

RECORD YOUR CHOICES

Keep a note of your elections as you read through the guide and use this list when you select your benefits online.

Medical:

Plan type

- ☐ Local Plus
- ☐ Local Plus Wellness
- ☐ Enhanced Local Plus
- ☐ Enhanced Local Plus Wellness
- ☐ Open Access Plus
- ☐ Open Access Plus Wellness

Coverage level

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Half Family Primary
- ☐ Half Family Secondary
- ☐ Adult Dependent Child Aged 26-30

Healthcare FSA:

☐ $ _____ per pay

Dependent Care FSA:

☐ $ _____ per pay

Disability insurance:

Monthly benefit amount $ _____

- ☐ 14 days
- ☐ 30 days
- ☐ 60 days
- ☐ 90 days
- ☐ 180 days

Dental:

Plan type

- ☐ DHMO
- ☐ PPO - High
- ☐ PPO - Low

Coverage level

- ☐ Employee
- ☐ Employee + One
- ☐ Employee + Family

Vision:

- ☐ Employee
- ☐ Employee + Family

☑ Basic Life and AD&D Insurance: $0

Supplemental Life Insurance:

- ☐ None
- ☐ 1x annual salary
- ☐ 2x annual salary

Accident insurance:

- ☐ Employee
- ☐ Employee + Spouse
- ☐ Employee + Children
- ☐ Employee + Family

Tax Sheltered Annuities:

☐ $ _____ per pay

! Happy with your choices? To enroll go to https://osceolaschools.net/benefits.

MEDICAL RATES **AT A GLANCE**

Great news! The Board contribution increased by $428 this year.

When selecting your benefits, it's important to consider the coverage you need to meet you and your family's needs. To help you make your elections, we've included all the detail you'll need regarding your benefits throughout this guide.

So you can understand how the different benefits will impact your paycheck, we've also included a summary of the per paycheck rates for our key benefits here, based on 20 paychecks per year.

Medical:

	Local Plus	Local Plus Wellness	Enhanced Local Plus	Enhanced Local Plus Wellness
Employee Only	$25.00	$0.00	$50.00	$25.00
Employee + Spouse	$375.00	$325.00	$435.00	$385.00
Employee + Child(ren)	$202.00	$152.00	$245.00	$195.00
Employee + Family	$502.00	$452.00	$580.00	$530.00
Half Family Primary	$50.00	$20.00	$220.00	$170.00
Half Family Secondary	$0.00	$0.00	$0.00	$0.00
Each Adult Dependent Child Ages 26-30	$375.00	$325.00	$435.00	$385.00

Medical [continued]:

	Open Access Plus	Open Access Plus Wellness
Employee Only	$100.00	$75.00
Employee + Spouse	$510.00	$460.00
Employee + Child(ren)	$300.00	$250.00
Employee + Family	$710.00	$660.00
Half Family Primary	$275.00	$225.00
Half Family Secondary	$0.00	$0.00
Each Adult Dependent Child Ages 26-30	$510.00	$460.00

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

Job Share – Employees classified as **"Job Share"** pay half the Board contribution ($170.65) plus the premium listed based on your choice.

DENTAL & VISION RATES **AT A GLANCE**

Dental:

	DHMO	PPO	
		Low Option	High Option
	Rate per pay	Rate per pay	Rate per pay
Employee	$7.50	$11.60	$19.00
Employee + One	$13.14	$23.79	$38.95
Employee + Family	$20.64	$41.62	$68.14

Vision:

Employee	$3.67
Employee + Family	$11.23

Other benefits:

The other benefits you can elect provide rates that are customized to your circumstances, which can be found by visiting the Benefits Enrollment System.

New Enhancements on your Humana Dental Plan!

DHMO:
- 3 routine cleanings
- No copay on periodontal maintenance (2x per year)
- No referrals needed to see a specialist within the network

PPO:
- 3 routine cleanings and 4 periodontal maintenance cleanings covered as preventative
- Preventative services do not reduce your annual maximum
- Extended annual maximum allows you to receive a 30% discount on all services (excluding orthodontics) after your annual maximum has been reached

Section 125

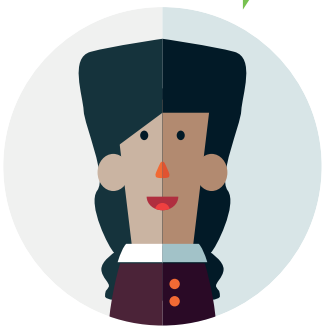
Under Section 125 of the Internal Revenue Service (IRS) code, you're allowed to pay for certain group insurance premiums using pre-tax dollars. This means your premium deductions are taken before federal income and Social Security taxes are calculated. Depending on your tax bracket, your savings could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

HOW TO **ENROLL**

Open Enrollment

If you don't elect your benefits by the deadline, you'll automatically be enrolled in the default plan: LocalPlus Plan with Employee Only coverage, and Basic Life and AD&D Insurance. You won't be able to enroll again until the next Open Enrollment, unless you experience an IRS qualifying event.

We take pride in the rich variety of benefits we offer, and work hard to ensure that your medical benefits continue to be provided at the best possible cost to you. Open Enrollment is YOUR opportunity to select your benefits for the coming year.



To make things convenient for you and your family, Open Enrollment can only be completed online using our Benefits Enrollment System. To help you through the process, here are the steps you need to take during this year's enrollment window.

1. Read this guide and make your benefit elections.
2. Use the handy form on page 3 to write down your elections.
3. Go to **https://osceolaschools.net/benefits**.
4. You'll need your **User ID**, which is your 9-digit Social Security number without dashes (e.g., 123456789) to log in. Your **password** is your date of birth in YYYYMMDD format. For example, if your date of birth is December 3, 1967, you would enter:19671203.
5. Once in the system, click on the "Begin Open Enrollment" button. You'll be directed to view each benefit option, one by one. Click on the "Save" and "Back" arrows to move from step to step. Caution! Don't use your browser's "Back" and "Forward" buttons, as it might cause your data to become corrupt.
6. **Don't forget to save!** Once you've made your elections, please click "Save My Enrollment" to complete the process. Please review your selections carefully; once confirmed, your choices are final and cannot be changed.
7. **Remember to print a copy for your records.** It's important to keep a copy of this as proof of your elections.

October 1, 2019
Your benefit elections are effective.

For the Trustmark products, see page 20 for information on how to enroll or change.

NEW TO THE DISTRICT?

New Hires

Your school or facility secretary will let you know that you're cleared for employment. You'll then be able to enroll in benefits using the Benefits Enrollment System.

! You'll have two weeks to select your benefits, otherwise you'll be enrolled in the default plans.

We'll also send emails to your District email address reminding you to enroll. It's vital that you check your email for updates from Risk & Benefits Management. If you don't receive your District email details within a week of being cleared for employment, contact your supervisor.

Your benefits are effective the first of the month after your date of hire. However, if this date has passed, you have not yet enrolled and are still within your enrollment period, insurance is effective the day of enrollment.

QUALIFYING **EVENTS**

Qualifying events include, but are not limited to:

- Marriage, divorce, or legal separation (although legal separation isn't recognized in Florida)
- The death of spouse or other dependent
- The birth or adoption of a child
- A spouse's employment beginning or ending (must have coverage from previous employer)
- A dependent's eligibility status changing due to age, student status, marital status, or employment
- You or your spouse experiencing a change in work hours that affect benefits eligibility
- Relocation into or outside of your plan's service area
- Voluntary or involuntary loss of other qualifying coverage or gaining other group coverage
- Your eligible child(ren) losing coverage under a federal or state sponsored health program

The changes you make during the qualifying event window must be consistent with the event. For example, if you get married, you can add your spouse to your current medical coverage, but you cannot switch medical plans.

Qualifying events give you an opportunity to review your benefit elections when your circumstances change throughout the year. You must notify Risk & Benefits Management within 30 days of your qualified status change.

Who's eligible to be a dependent?

Eligible dependents are defined as:

- Your legal spouse as defined under Federal law (Marriage Certificate required);
- Your domestic partner (refer to Benefit website for more information);
- Dependent children up to age 26, regardless of marital, financial, or student status (this doesn't include spouses of adult children), including:
  - Your biological children, legally adopted children or stepchildren
  - Any children for whom you have been appointed legal guardian
  - Any children for whom the court has issued a Qualified Medical Child Support Order requiring you or your spouse to provide coverage
  - Any dependents of a currently enrolled dependent (e.g., your grandchild), may be enrolled in a health plan for 18 months from birth
- Dependent children aged 26 to 30 who meet all of the following eligibility criteria:
  - Unmarried with no dependent children of their own
  - A resident of the state of Florida or a full-time or part-time student
  - Has no medical insurance as a named subscriber, insured enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan
  - Is not entitled to benefits under Title XVII of the Social Security Act
- If in 30 days of your enrollment or qualifying event, you have not submitted your dependent documentation, your dependents will be retroactively terminated from the plan.

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

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

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

YOUR MEDICAL PLANS **MADE SIMPLE**

Selecting your medical benefits could be the most important decision you make each year. To help you understand the different plans and select the right one for you and your family, we've provided a summary and a comparison of your medical plan options, all of which offer comprehensive medical coverage and are provided by Cigna. If you've met your wellness incentive for the year or are new to the District (hired after 04/01/19) then the wellness plans are available for you to enroll. If you have not qualified for the wellness incentive, you will be required to pay the higher premium and have the higher deductible.

We take your health seriously. The School Board contributes $6,826 per employee each year for benefits, including the Center for Employee Health, above and beyond your regular salary or hourly wage.

The Local Plus and Enhanced Local Plus Plans

Both these plans give you the flexibility to visit any provider (doctor or facility) within Cigna' Local Plus network, including specialists, without the need for a referral. Also, the pharmacy deductible is waived when you're purchasing generic medication. There is no out-of-network coverage under these plans except in the case of a true emergency, meaning you'll pay the full amount if you use out-of-network providers.

So what's the difference

Local Plus Plan/Local Plus Wellness Plan

With the Local Plus Plan, you must meet a deductible first, then pay 30% co-insurance of the discounted network charges for all doctors and procedures.

Enhanced Local Plus Plan/Enhanced Local Plus Wellness Plan

With the Enhanced Local Plus Plan, you have co-pays for visits to your primary care physician, specialists, and urgent care without having to meet the deductible first.

If you don't elect your benefits by the deadline, you'll automatically be enrolled in the Local Plus Plan with Employee Only coverage and Board-paid Term Life Insurance.

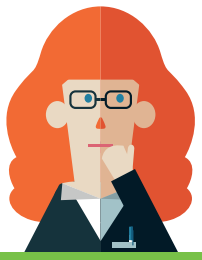
Open Access Plus Plan/Open Access Plus Plan Wellness

Open Access Plus Plan/Open Access Plus Plan Wellness offers a larger network of providers as well as out-of-network coverage. Since this plan has a larger network and offers out-of-network coverage, premiums are the highest for both the employee and their dependents.

This plan gives you the flexibility to visit any provider (doctor or facility) within Cigna's Open Access Plus network, including specialists, without the need for a referral. Although you can visit out-of-network providers, it's more expensive and can incur balance billing from your doctor.

Like the Enhanced LocalPlus Plan, you don't need to meet a deductible unless you're having a procedure or visit outside your doctor's office, and the pharmacy deductible is waived when you're purchasing generic medication.

We've included a summary of the main features of the plans on the next page. For more information on each of the plans, please visit the District Benefits website.



Concerned about medical costs? Find out more about how you can save tax free with a Flexible Spending Account to cover your medical expenses on page 18.

Prescription Benefits

Cigna Specialty Pharmacy Services help you manage your health and prescription needs in the privacy of your home if you have a condition that requires treatment with specialty medication. Medications are shipped, at no cost to you, in specially designed packaging to protect quality and privacy. They manage your refill schedule and help you find ways to make staying healthy more affordable.

Cigna 90 Now offers you the convenience of filling the medication you take every day in a 90-day supply and the choice of filling your prescriptions at local retail pharmacy or through Cigna Home Delivery Pharmacy. 90-day (or three month) prescriptions are available at certain retail pharmacies including CVS and Walmart, among others. To switch to 90-day home delivery, visit www.cigna.com/home-delivery-pharmacy.

Generic Medications are significantly less expensive than brand name alternatives. Under all three plans, if you choose to purchase a brand name drug over the generic drug when the generic drug is available and appropriate, you'll incur higher out-of-pocket costs.

Drug Quantity Limits means you may have coverage for a limited amount of a specific medication. Quantity limits are in place to ensure your medication is being used correctly and that you're getting the most appropriate treatment.

Drug Prior Authorization means that before a prescription is filled, your doctor, or your prescriber must first show that you have a medically necessary need for that particular drug and/or have met the prior authorization requirements for the drug.

Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug.

Value Prescription Drug List includes more generic and lower-cost brand medications compared to other Cigna drugs lists. It excludes drugs that have over-the-counter alternatives, specifically those that treat heartburn/acid-related conditions (Nexium, Prilosec, etc.) and allergies (Zyrtex, Xyzal, Claritin, etc.). Drugs that treat lifestyle conditions such as infertility, weight loss, erectile dysfunction, smoking cessation, etc. are also excluded. If you fill a prescription that isn't covered on the Value Prescription Drug List, you'll have to pay the full cost of the medication.

Plan details

	Local Plus	Local Plus Wellness	Enhanced Local Plus	Enhanced Local Plus Wellness	Open Access Plus		Open Access Plus Wellness	
Network	Local Plus					Out of Network		Out of Network
	Default Plan Coinsurance Plan	Coinsurance Plan	Copay and Coinsurance Plan					
Deductible *(Individual/Family)*	$1,500 / $3,000	$1,250 / $2,500	$1,200 / $2,400	$950 / $1,900	$1,500 / $3,000	$2,000 / $5,000	$1,250 / $2,500	$2,000 / $5,000
Coinsurance level	30%		25%		30%	50%	30%	50%
Out of Pocket Maximum *(Individual/Family)*	$6,300 / $12,600		$5,700 / $11,400		$6,000 / $12,000	$10,500 / $31,500	$6,000 / $12,000	$10,500 / $31,500
Preventive Care	$0					Deductible + 50%		Deductible + 50%
Primary Care Physician	Deductible + 30%		$30 copay		$35 copay	Deductible + 50%	$35 copay	Deductible + 50%
Specialist Physician	Deductible + 30%		$60 copay		$70 copay	Deductible + 50%	$70 copay	Deductible + 50%
Urgent Care	Deductible + 30%		$100			Deductible + 50%	$100	Deductible + 50%
Emergency Room	Deductible + 30%		Deductible + 25%		Deductible + 30%	Deductible + 50%	Deductible + 30%	Deductible + 50%
Lab and X-ray • PCP/Specialist • Independent Lab • All other facilities	Deductible + 30%		$30/$65 copay 25%, no deductible Deductible + 30%		$35/$70 copay 30%, no deductible Deductible + 30%	Deductible + 50%	$35/$50 copay 30%, no deductible Deductible + 30%	Deductible + 50%
Advanced Imaging	Deductible + 30%		Deductible + 25%		Deductible + 30%	Deductible + 50%	Deductible + 30%	Deductible + 50%

Prescription benefits	Local Plus		Enhanced Local Plus		Open Access Plus	
Deductible	$300 (waived for generics)		$75 (waived for generics)		$75 (waived for generics)	
Copays	30 day supply	90 day supply	30 day supply	90 day supply	30 day supply	90 day supply
Generic	$10	$25	$10	$25	$10	$25
Preferred	20% up to $75	20% up to $187.50	20% up to $50	20% up to $125	20% up to $50	20% up to $125
Non-preferred drugs	50% up to $200	50% up to $500	50% up to $150	50% up to $375	50% up to $150	50% up to $375
Specialty drugs	75% up to $250	Not applicable	55% up to $200	Not applicable	55% up to $200	55% up to $595*

*Home delivery only for 90 day supply of Specialty drugs.

CENTER FOR **EMPLOYEE HEALTH**

We care about you, and that's why we've partnered with RosenCare to provide an onsite Center for Employee Health which gives you access to high quality, affordable healthcare services and an excellent patient care experience. The Center will also provide you with access to a bilingual staff to support for your needs.

Effective October 1, 2019, we have contracted RosenCare Solutions to operate our onsite Center for Employee Health. The Center will still give you access to high quality, affordable healthcare services. However, you'll notice a change in the focus of the Center from an acute care clinic to an all-inclusive medical home.

The Center provides services you would normally receive at your primary care physician's office in addition to health services that focus on improving your health. Some examples of these services are:

- **Primary Care**
- **Physical Therapy**
- **Medical Nutrition Therapy**
- **Occupational Health**
- **On-Site Prescription Dispensing**
- **On-Site X-Ray and EKG**

Frequently Asked Questions

Are employees that opt-out of the District's medical coverage able to visit the Center?
Individuals who are not covered by the District's medical plan will not be eligible to utilize the Center. This includes those employees that opt-out of medical coverage or dependents not covered by the plan.

Has the eligibility for the Center for Employee Health changed?
Employees, retirees and their family members (24 months and older) enrolled in one of the District's medical plan options will be able to receive services at the Center at no cost.

Will my medical records automatically transfer?
Unfortunately, your medical records will not automatically transfer, but the good news is that it is a very simple process! Keep an eye out for an email with instructions on how to get your medical records transferred.

Who is Healics?
Healics is RosenCare's premier partner for healthcenter operations. You will see their name and logo on items such as employee name tags, the Patient Portal, new patient paperwork, online scheduling tools, health center communication pieces, etc.

Appointments:

407-483-5757 **SDOCEmployeeHealthCenter.net**

831 Simpson Road,
Kissimmee, FL 34744
(Next to OTEC).

Monday – Friday: 7am to 7pm
Saturday: 8am to noon
Sunday: Closed

New!

AdventHealth eCare for minor concerns available to you for a $25 copay

When: Anytime! Available 24/7/365.

How: Login to the eCare by AdventHealth app on your smartphone or tablet; choose a provider from the list and click "Join" to launch a video connection.

Employee Assistance Program (EAP)

Sometimes balancing work, home, family, finances, health, and wellbeing can seem challenging, and we want to make sure that you have access to the advice and support that you need. Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult, whenever and wherever you need them.

As a District employee, you, your immediate family members, and anyone living in your home, have access to a number of services, all at no cost, 24 hours a day, 365 days a year, including:

- **Confidential Emotional Support**
- **Work-Life Solutions**
- **Legal Guidance**
- **Financial Resources**
- **Free Online Will Preparation**
- **Online Support**

Contact information:

1-888-882-0797 **1-800-697-0353 (TTY)**

www.guidanceresources.com
using the web ID: **OCSOCS**

GuidanceResources® Now

MEDICAL INSURANCE
OPT OUT CREDIT

Opting out means you're choosing to decline medical coverage for yourself and your family. Only employees who are covered under another medical plan, either as a dependent or through individually acquired coverage, can select this option.

Because we fund the basic level of medical coverage and there's no employee premium, if you choose to opt out of medical coverage, you'll receive up to a $750 annual credit which you may apply toward voluntary benefits, such as:

- Dental Employee Only coverage
- Vision Employee Only coverage
- A Flexible Spending Account (FSA)
- Disability Insurance

Although you cannot use credit dollars to pay for dental and vision coverage for your dependents, you can elect dependent coverage and pay for it through your own pre-tax payroll deductions. We've included a summary of the costs for dental and vision coverage using the opt out credit below.

Dental premiums			
	DHMO	**PPO**	
		Low option	High option
	Opt out credit Rate per pay	Opt out credit Rate per pay	Opt out credit Rate per pay
Employee	$ 0.00	$ 0.00	$ 0.00
Employee + One	$ 5.64	$ 12.19	$ 19.95
Employee + Family	$13.14	$ 30.02	$ 49.14
Vision premiums			
	Rate per pay		
Employee	$ 0.00		
Employee + Family	$ 7.56		

If you chose to take the opt out credit in an FSA contribution only – due to Healthcare Reform Regulations – the District is limited to a $500 contribution. The full $750 contribution can be made by the District if you do not elect any of the above voluntary benefits and you contribute a minimum of $750.

If you contribute $500 or more to your Health Care FSA, the District will match your contribution dollar for dollar up to $750. Any voluntary benefit elections you select using this opt out credit will not be counted towards the $750 in the District's matching dollar amount.

Example 1: You elect no voluntary benefits and contribute $0 to your Health Care FSA. The District will contribute $500 to your Health Care FSA.

Example 2: You elect no voluntary benefits and contribute $450 to your Health Care FSA. The District will contribute $500 to your Health Care FSA.

Example 3: You elect no voluntary benefits and contribute $650 to your FSA. The District will also contribute $650 to your Health Care FSA.

Example 4: You elect Employee + Family Vision and contribute $750 to your Health Care FSA. The District will contribute $676.60 to your Health Care FSA.

$3.67 x 20 pay periods = $73.40
$750 - $73.40 = $676.60

Example 5: See page 18 for the FSA benefit available to all employees. For employees who opt out of all voluntary benefits, to receive the full $1,000 match ($750 opt out credit and $250 benefit), you must contribute $1,000 to your Health Care FSA.

! Please note, this isn't a cash pay-out and can only be used for eligible expenses.

KEEPING YOU **SMILING**

We care about your dental health, so you have a choice of three dental plans, depending on you and your family's needs. All plans cover most preventive and restorative procedures, as well as orthodontia, but coverage varies by plan.

We've provided a comparison of the plans below, but this is only a brief summary. Check out page 4 for more information about the premiums you could pay for these plans and find full details about the plans at www.humana.com or visit the District benefits website.

Humana Dental HS195S DHMO

Humana Dental's HS195S DHMO gives you and your covered family members access to the dental care you need through Humana's network of quality dentists.

Each covered family member can choose their own general dentist from the network. If you or your family members should need to seek services from a specialist, NO referrals are required. You simply search for a provider in the network and contact them for an appointment.

Humana Dental Traditional Preferred PPO

When you enroll in the Humana Traditional Preferred PPO, you and your covered family members can access the dental care you need through Humana Dental's network of quality dentists.

You can visit any dentist, both in- and out-of-network, however, in-network providers will almost always be less expensive. You also run the risk of balance billing from out-of-network providers. If you select the PPO option, you'll then have two options for coverage; either the High option or Low option.

Coverage comparison

	DHMO	PPO	
		Low option	**High option**
Network	In-network only	In- and out-of-network	In- and out-of-network
Annual deductible	None	$50 per subscriber, $150 per family Does not apply to Class 1 Care	
Annual maximum	None	$2,000 per covered person	
Class 1 - Diagnostic and Preventative			
Routine cleaning	No charge	20%	No charge
Fluoride application			
X-rays			
Sealants	No charge	No charge	No charge
Office visit fee			
Class 2 - Basic Restorative Care			
Periodontal maintenance cleanings	No charge for 2 cleanings per year (add'l $55)	20% (Four cleanings a year)	No charge (Four cleanings a year)
Amalgam fillings	No charge	40%	20%
Surgical extraction of impacted teeth	$50 - $100		
Class 3 - Major Restorative Care			
Crowns	$245*	50%	50%
Dentures	$325* + $425*		
Bridges	$245 (Per tooth/unit)		
Implants	Not covered		
Class 4 - Orthodontics			
Evaluation	$0	Dependent children – 50% Adults – Not covered	Dependent children – 50% Adults – Not covered
Orthodontic treatment	Dependent children & Adults – $1,850		
Lifetime orthodontic maximum	N/A	$1,000	$1,000

*** Plus lab cost not to exceed $200.** This is only a brief summary of the plans and is intended for comparison purposes only. Please go to **www.humana.com** for plan descriptions.

YOUR VISION
OUR FOCUS

Regular eye exams are an important part of health maintenance, no matter what your age. And if you or your family members wear glasses or contact lenses, you know that the cost of vision care can quickly add up.

EyeMed offers you a wide range of in-network providers, and there are additional benefits to using an in-network provider as you'll also be eligible to receive discounts on prescription eyeglasses and services. You can also visit out-of-network providers if you have a preferred optometrist. Need a second pair of glasses? EyeMed offers you a 40% discount on additional pairs.

For a complete list of in-network providers, visit www.eyemed.com or call 1-866-800-5457.

The District receives services on the Insight network.

Summary of benefits

Coverage Type		In-Network Benefit	Out-of-Network Reimbursement
Plan Basics	Eye Exam with Dilation as Necessary	$10 copay	Up to $35 reimbursement
	Frequency:		
	Exam	Once every 12 months	
	Lens	Once every 12 months	
	Frames	Once every 24 months	
Lenses & Frames	Frames	$0 copay; $130; 20% off balance over $130	Up to $45 reimbursement
	Lenses:		
	Single	$15 copay	Up to $25 reimbursement
	Bifocal	$15 copay	Up to $40 reimbursement
	Trifocal	$15 copay	Up to $60 reimbursement
Contacts	Conventional	$0 copay; $120 allowance; 15% off balance over $120	Up to $120 reimbursement
	Disposable	$0 copay; $120 allowance; plus balance over $120	Up to $120 reimbursement
	Medically Necessary	$0 copay, Paid-in-Full	Up to $120 reimbursement

This is only a brief summary of the plans and is intended for comparison purposes only. Please go to **www.eyemed.com** for plan descriptions including out-of-network reimbursements.

Interested in Lasik? With EyeMed you have access to discounts of 15% off the retail price or 5% off the promotional price in the U.S. Laser Network. Call 1-877-5LASER6 for more information.

PROTECTING YOUR WORLD

SDOC provides a number of benefits for you to choose from, designed to provide extra support and make life easier when you need it most.

Basic Life and AD&D Insurance

The District provides employees with basic group term Life and Accidental Death & Dismemberment (AD&D) Insurance in the amount of one times your annual salary, **at no cost to you**. If your pay is based on over 10 years of experience, you'll also receive an additional one times your annual salary in life insurance at no additional cost to you. You don't have to do anything to elect this coverage, however don't forget you need to elect a beneficiary.

Supplemental Life Insurance

In addition to the District funded benefit, you can elect an additional one or two times annual salary in term Life and AD&D Insurance. Please note that Professional Support employees earning less than $20,000 per year receive benefits based on the previously negotiated contract — see chart below.

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

Your duration of benefits for injury or sickness is:	
Annual Earnings (contract)	**Amount of Life Insurance**
$9,999 or less	$10,000
$10,000 - $14,999	$15,000
$15,000 - $19,999	$20,000
$20,000 or more	One times Annual Salary Rounded to the next $1,000

When you first become eligible for life insurance coverage, you must designate a beneficiary to receive these benefits in the event of your death. We'd recommend that you review and update your beneficiary elections during each year's Open Enrollment; however, changes can be made at any time, either through the Benefits Enrollment System or by contacting Risk and Benefits Management for a form.

For more information about these benefits:

1-800-638-6420 **www.metlife.com/mybenefits**

Premiums are based on your salary or salary schedule, so please review your elections carefully. Visit the Benefits Enrollment System for specific rates.

MetLife Advantages

MetLife offers several additional resources that can make a difference in your life, including will preparation, grief counseling, retirement education, and much more. You can find more details at **www.metlife.com/mybenefits**.

Disability Insurance

Have you ever thought about how your family would manage if an accident or major illness kept you from working for an extended period? Most people would have a hard time getting by without a regular paycheck, so Disability Insurance, offered by Lincoln Financial, replaces a portion of your income if you aren't able to work due to illness or injury.

You have three considerations when electing coverage:

1. How much coverage do you need?

You can purchase a monthly benefit in $100 units, starting at a minimum of $200, up to two-thirds of your monthly earnings, with a maximum monthly benefit of $7,500.

2. When would you want coverage to start?

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

3. How long will coverage last?

Your duration of benefits is determined by your age at the time you're disabled, as outlined in the table below.

1st Day Hospital Benefit: If you elect the 14 day or 30 day elimination period, you automatically receive a 1st Day Hospital Benefit. With 1st Day Hospital, benefits will begin on the 1st day if you're admitted to the hospital for 8+ hours.

Age at disability	Your duration of benefits for injury or sickness is:
Less than age 60	To age 65, but not less than five years
Age 60-64	Five years
Age 65-69	To age 70, but not less than one year
Age 70 and over	One year

Maternity leave is one of the most common claims for short-term disability, and you'll be glad to hear that pregnancy and maternity are covered under the plan.*

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

It's worth noting that the Plan won't cover any disability that begins in the first 12 months after your effective date of coverage that is caused by, contributed by, or resulting from a pre-existing condition. A pre-existing condition is any condition you have already received medical advice or treatment in the three months prior to enrollment.

Family Care Benefit

The Family Care Benefit helps pay for dependent care when an employee is out on claim. The benefit pays up to $350 for each dependent, per month, for up to 12 months.

Survivor Benefit

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

- Your disability had continued for 180 or more consecutive days
- And -you were receiving or were entitled to receive payments under the plan

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

Minimum Indemnity for Accidental Dismemberment

A monthly Accidental Dismemberment benefit will be paid according to the Covered Losses and Benefit Amounts listed below if:

1. The insured employee sustains an Injury
2. Such injury directly causes one of the following losses within 100 days of such Injury

Covered Loss	Benefit Amount
One Hand or One Foot	23 monthly payments
Sight of One Eye	15 monthly payments

For more information about these benefits:

1-800-423-2765, prompt 1 **www.lincolnfinancial.com**

*Subject to pre-existing condition limitation.

Manage your expenses with FSA

A Flexible Spending Account (FSA) is a great way to handle any medical expenses not covered by your medical insurance, or your dependent day care expenses. You make regular, pre-tax contributions to your account through payroll. This means you'll pay less in taxes and overall, have more money to spend and save.

You can enroll in both a Healthcare and a Dependent Care FSA in the same way:

1. When you enroll in an FSA, you specify the dollar amount you'd like to direct into your account from each paycheck, up to the annual maximum;
2. You make deposits to your account through tax-free payroll deductions;
3. You use the money in the account to pay for your eligible health or dependent day care expenses

Estimate your account

Be sure to carefully estimate your FSA contribution amount, as you can't transfer money between accounts and can only carry up to $500 into the next year's Healthcare FSA (you must enroll in an FSA for the subsequent year to be able to carry over).

Healthcare FSA

- ✔ Reimburses eligible medical, dental, or vision expenses for you, your spouse, or your eligible dependents.
- ✔ Can be used to pay for certain medical expenses not covered by another insurance plan, such as deductibles and coinsurance payments, for anyone you claim as a dependent on your tax return.
- ✔ You'll receive a Cigna HealthCare Visa Flexible Spending Account debit card, for easy access to your savings. Use it to pay for eligible health care goods and services at the point of purchase.
- ✔ Funds will automatically be deducted from your Healthcare FSA, reducing your account balance and getting rid of the process of submitting reimbursement requests.

For more information and a list of most eligible and ineligible expenses, go to **www.mycigna.com** or review the IRS Publications available at **www.irs.gov**:

- Publication 502, "Medical and Dental Expenses"
- Publication 503, "Child and Dependent Care Expenses"

Dependent Care FSA

- ✔ Set aside money to pay for eligible non-medical dependent day care expenses such as child care or adult care center, a nursery school, summer day camp, or a caregiver for an elderly or incapacitated dependent.
- ✔ Your Dependent Care FSA is not prefunded. You're only reimbursed up to the balance in your account at the time you submit your claim.
- ✔ If your claim is more than your account balance, Cigna will automatically reimburse you as additional deductions are deposited into your account.

To make a claim, you'll need to complete a claim form (available at **www.mycigna.com**) and attach itemized receipts that include:

- The dependent's name(s)
- The period during which the services were rendered
- The name, address, and Taxpayer ID or Social Security number of the individual or organization providing services

Alternatively, if the above information is documented on the reimbursement form, you can have the provider sign the reimbursement form in place of a receipt.

If you elect to contribute $750 to your Healthcare FSA, the District will contribute an additional $250 to your Healthcare FSA.

Annual FSA contribution limits

Type of FSA Account	Limits
Healthcare FSA	$240 minimum up to $2,500 maximum
Dependent Care FSA	Up to $5,000 if single or married filing a joint tax return, and up to $2,500 if married filing an individual tax return*

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

If you think an FSA would benefit you, all you need to do is elect this as part of Open Enrollment.

You must elect the amount you want deferred every year during Open Enrollment.

How much could I save with setting aside an FSA?

We've included some examples here, to show the difference saving into an FSA can make to your paycheck. These examples are fictional and you should consider your own circumstances before deciding to elect to save into an FSA.

Example 1: **Amy**

Amy is single and wants to plan ahead and save on known medical expenses. She works out that she'll probably need $1,000 to cover her expenses for the year.

Amy saves in an FSA

Amount Amy spends on medical expenses each year	$1,000
Her tax bracket	22%
Federal Income Tax applied	$0
Money available to spend on medical expenses	$1,000

Instead of the FSA, Amy puts the money into a checking account after each payroll

Amount Amy spends on medical expenses each year	$1,000
Her tax bracket	22%
Federal Income Tax applied	$282
Total spent	$1,282

Amy can save $333 more by saving with an FSA – that's one of her car payments!

Example 2: **Michael**

Michael and his wife both work, and want to plan ahead and save on child care, as well as setting aside a small amount for unforeseen healthcare costs. In total, Michael decides to contribute $272.50 over 20 pay periods to his FSA accounts.

He'll have the maximum of $5,000 in his Dependent Care FSA and $450 in his Healthcare FSA. Based on his tax bracket of 32%, he saves $1,798.50 – enough to make one mortgage payment!

Healthcare FSA	$450
Dependent Care FSA	$5,000
Total contributions	$5,450
His tax bracket	32%
Savings	$1,744

Example 3: **Angie**

Angie doesn't have an FSA, so her savings for expected medical expenses are taken from her paycheck, after tax. This means Angie does not benefit from possible tax savings, and her contributions cost her more.

Personal savings account	$1,300
Dependent Care FSA	$0
Total contributions	$1,300
Her tax bracket	22%
Savings	-$366.67

Universal LifeEvents® Insurance

Universal LifeEvents Insurance, provided by Trustmark, provides a range of benefits to give you peace of mind if the worst should happen.

If elected, you'll receive coverage for:

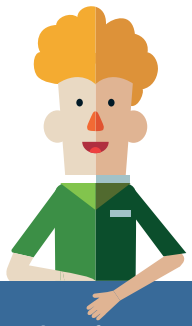
- Death benefit to your beneficiaries if you pass away
- Living benefits for long-term care
- You'll build up a cash value

You're able to cover your spouse even if you choose not to participate. Dependent children and grandchildren can also be covered. You'll also benefit from guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all policies in your class changes.

Primary Care

LifeEvents pays a higher death benefit during your working years, when expenses are high and you need maximum protection.

Then, at age 70 (or on the 15th policy anniversary) when your financial needs are lower, your death benefit reduces to one-third.



If you're dropping yourself or removing any dependents from current coverage, call Trustmark on 1-800-918-8877.

To add coverage including a dependent, see the instructions below.

Living benefits

In the event that you become ill and need long-term home healthcare, assisted living, nursing home care and adult day care, your coverage is accelerated to help cover these costs. You'll receive 4% of your death benefit for up to 25 months.

If you're diagnosed with a terminal illness with a life expectancy of 24 months or less, you'll be eligible for up to 75 percent of your death benefit.

Visit http://www.trustmarksolutions.com/ for a schedule of benefits and more information about the Trustmark plans.

Accident Insurance

You do everything you can to keep your family safe, but accidents do happen. When they do, it's good to know you have help to manage the medical costs associated with accidental injuries. Trustmark's Accident Insurance helps take care of medical bills, so you can take care of your family.

Benefits are paid directly to you without any restrictions on how you can use them. 24-hour coverage includes benefits for:

- Hospital Admission
- Hospital Confinement
- Hospital Intensive Care Unit
- Emergency Room Treatment

You can also apply for coverage for your spouse, children and dependent grandchildren. There is no medical eligibility criteria, but you must be actively at work and your spouse or domestic partner must answer a disability question.

The policy is renewable as long as premiums are paid, and premiums and benefits won't change because of age. Even better, you can take your coverage with you and pay the same premium. It's yours to keep even if you change jobs or retire.

	Rate per pay
Employee	$11.65
Employee + Spouse	$20.08
Employee + Children	$28.75
Employee + Family	$37.18

HOW TO ENROLL

There are two easy ways you can apply for a new Accident or Universal LifeEvents policy.

1. **Call 1-888-249-9291**
2. **Email osceolaschools@simplenroll.net**

This is also how you add a dependent to an existing plan or increase your existing coverage.

Hours: Monday – Friday: 8am to 4:30pm EST

Tax Sheltered Annuities

SDOC offers employees the opportunity to contribute to a 403(b) Tax Sheltered Annuity. Tax Sheltered Annuities are a type of retirement plan that's available to public education employees, which lets them save money for retirement.

This plan is optional and is offered in addition to your Florida Retirement System retirement benefits.

If you're already contributing towards a Tax Sheltered Annuity, you can change your deduction (either increase or decrease) at any time during the year.

There are many benefits to investing in a Tax Sheltered Annuity:

- Immediate income tax savings
- You're taxed only on the amount distributed to you in that tax year; the funds remaining in your account continue to be tax-deferred
- High annual contribution limits
- Flexible loan provisions
- Account portability
- Beneficiary provisions
- Lifetime income options

You can contribute to the following investment vehicles:

Fixed interest and variable annuities

Fixed interest annuities usually provide protection of principal and a current interest crediting rate. Variable annuities usually offer a fixed interest account along with separate accounts that are invested in bond and/or equity markets.

Service-based mutual funds and custodial accounts

Investment portfolios can include funds from a single fund family or a custodial platform that spans several fund families on a single statement.

No-load/low-fee mutual funds

No-load funds are described as investments with no sales fees on the market-based mutual funds offered. Ongoing investment management fees are charged to the funds selected. The no-load/low-fee offerings are good for those individuals who don't want to work with an investment advisor.

For an up-to date listing of agents and board approved tax sheltered annuity companies to help you reach your financial goals, visit: https://www.osceolaschools.net/departments/risk_and_benefits_management/tax_sheltered_annuities/. This website also has information if you wish to suspend a current deduction and the Salary Reduction Form.

SDOC Board Approved Tax Sheltered Annuity Companies

403(b)/403(b)(7) Accounts	
Ameriprise Financial	1-800-862-7919
*MetLife	1-800-560-5001
Pacific Life	1-800-722-2333
403(b)/403(b)(7) Accounts and 457(b) Deferred Compensation Plans	
*AIG/VALIC	1-800-369-0314
American Century	1-800-345-3533
*AXA Equitable	1-800-628-6673
Fidelity Investments	1-800-343-0860
Great American (GALIC)	1-800-854-3649
*Horace Mann Company	1-800-999-1030
VOYA Retirement Plans (formerly ING)	1-800-584-6001
The Legend Group	1-800-749-4221
*LSW - National Life Group	1-800-732-8939
Lincoln Investment Planning	1-800-242-1421
*Oppenheimer Funds	1-800-525-7040
*Plan Member Services	1-800-874-6910
Security Benefit Group/NEW	1-800-222-3003

*Also offer ROTH 403(b)

OTHER **INFORMATION**

Leaves of Absence

If you're going on a Leave of Absence (LOA), you can keep your District benefits while on District-approved leave.

Employees who are granted a LOA may elect to continue coverage through their District benefits. Employees will be responsible for paying the full cost of premiums. This includes Board-Paid Medical and Life Insurance, Medical dependent coverage, supplemental Life Insurance, Dental, Vision, Disability Insurance, Flexible Spending Account contributions, Accident Insurance and LifeEvents.

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

For leave at the end of the year, see below.

Go to http://osceolaschools.net/departments/risk_and_benefits_management for more information.

The Family and Medical Leave Act (FMLA)

The FMLA permits employees to take up to 12 weeks unpaid, job-protected leave, or on an intermittent basis (work a reduced schedule) for certain family and medical reasons, such as:

- The birth of a child
- Adopting a child or becoming a foster parent
- Caring for a seriously ill spouse, child or parent
- A serious health condition
- Caring for a covered service member who is recovering from a serious illness or injury sustained in the line of active duty (26 weeks)
- Any "qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation (26 weeks)

Employees are eligible if they've worked for the District for at least one year, and have worked for 1,250 hours over the previous 12 months.

Go to http://osceolaschools.net/departments/risk_and_benefits_management for more information.

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

Requesting FMLA Leave

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

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

COBRA Continuation of Coverage

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

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

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

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

Go to http://osceolaschools.net/departments/risk_and_benefits_management for more information.

COBRA Participants With FSAs

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

Life Insurance Portability

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

What happens to your coverage if you leave your job or retire?

You can continue your coverage at group rates when the coverage would otherwise end.

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

How do you port?

At the time of separation you'll automatically receive information in the mail from MetLife with your options.

Maximum COBRA Continuation

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

End of school year insurance end dates

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

You won't lose your benefits at the end of the current contract if:

- **You resign at the end of the current contract** – If you would have been reappointed for the coming year, but you know you won't be returning for the new contract year, you can resign your position now and have insurance benefits available to you until the day before you're due to return to work for the following school year.
- **You would have been reappointed; however, a position is not available due to a reduction in force (RIF)** – Benefits will terminate the day before you're due to return to work for the following school year.
- **You're granted an LOA for the coming year** – Your benefits will continue until August 1, 2020. Employees on LOAs will then have the option of keeping their benefits during the leave. A letter detailing insurance options will be sent to the LOA employee automatically.
- **You retire at the end of your current contract** – Your benefits will remain in effect until August 1, 2020. Retirees will then have the option of keeping their benefits. A letter detailing insurance options will be sent to the retiree automatically.

Your benefits will terminate immediately if:

- **You resign your position before the end of your current contract** – Your insurance benefits will terminate on your last day.
- **Your employment is terminated by the District (except for RIF employees as noted above) at the end of your current contract** – Your insurance benefits will terminate the day your contract ends as follows:
    - 188 Day Employees — May 28, 2020
    - 190 Day Employees — May 28, 2020
    - 196 Day Employees — May 29, 2020
    - 197 Day Employees — June 1, 2020
    - 200 Day Employees — June 4, 2020
    - 217 Day Employees — June 12, 2020
    - 230 Day Employees — June 22, 2020
    - 11 Month "A" Employees — June 15, 2020
    - 11 Month "B" Employees — June 22, 2020
    - 12 Month Employees — June 30, 2020

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

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

ANNUAL NOTICES

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

HIPAA Special Enrollment Rights

If you're declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, you must request enrollment within 30 days of the end of your or your dependents' other coverage (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

Florida Medicaid

Website: **www.flmedicaidtplrecovery.com**

Phone: **1-877-357-3268**

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

U.S. Department of Labor
Employee Benefits Security Administration

Website: **www.flmedicaidtplrecovery.com**

Phone: **1-866-444-EBSA (3272)**

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

Website: **www.cms.hhs.gov**

Phone: **1-877-267-2323, Menu Option 4, Ext. 61565**

Section 111

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

Women's Health and Cancer Rights Act of 1998

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

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

Newborns' and Mothers' Health Act

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

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

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

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

The exemption from these Federal requirements will be in effect for the 2019-20 plan year beginning 10/1/19 and ending 9/30/20. The election may be renewed for subsequent plan years.

HIPAA Privacy Act Legislation

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

Patient Protection

If your group health plan requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the group health plan will make one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

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

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

KEY CONTACTS

Here are some frequently used telephone numbers and websites if you need more information about any of the benefits we offer.

Medical Group ID 3198508	CIGNA Member Services (includes FSA)	1-800-244-6224 www.mycigna.com
	CIGNA Online Provider Directory	www.cigna.com
	CIGNA Technical Support	1-800-284-8346
	CIGNA Home Delivery Pharmacy (Mail Order)	1-800-835-3784
	CIGNA Behavioral	1-800-274-4573 www.cignabehavioral.com
Center for Employee Health	RosenCare	407-483-5757 SDOCEmployeeHealthCenter.net
Dental Group ID 830049	Humana	1-800-233-4013 www.humana.com
Vision Group ID 1012310	EyeMed	1-866-800-5457 www.eyemed.com
Life and AD&D Group ID 145776	MetLife	1-800-638-6420 www.metlife.com/mybenefits
Universal LifeEvents Accident Insurance	Trustmark	1-800-918-8877 www.trustmarkins.com
Disability Group ID OSCEOLACTY	Lincoln	1-800-423-2765, prompt 1 www.lincolnfinancial.com
Retirement benefits	Florida Retirement System	1-866-446-9377 myFRS.com
Employee Assistance Program (EAP)	ComPsych	1-888-882-0797 1-800-697-0353 (TDD) guidanceresources.com (web ID: OCSOCS)
Worker's Compensation Linda Scheuer		407-870-4903; Internal Extension 67557 workcomp@osceolaschools.net
Johns Eastern Company, Inc.		1-800-749-3044
TSA Consulting Group		1-888-796-3786 Fax: 866-741-0645

Visit the Benefits Enrollment System at
http://osceolaschools.net/benefits

Risk and Benefits Management	t: 407-870-4899 f: 407-943-7749 http://osceolaschools.net/departments/risk_and_benefits_management insurance@osceolaschools.net
Onsite CIGNA Representative	t: 407-870-4900; Internal Extension 67559 insurance@osceolaschools.net
Cigna Health and Wellbeing Representative	t: 407-870-4840 cignarep@osceolaschools.net
COBRA Administrator Discovery Benefits	t: 1-866-451-3399 (then, option 1 and option 2)

831 Simpson Road, STE 100
Kissimmee, Florida, 34744-5328