Seminole County Public Schools

2014 Benefits and Enrollment Guide

January 1, 2014 to December 31, 2014
Employee Benefits Department

Health ■ Dental ■ Vision ■ Life ■ Disability ■ FSA
Wellness

Some Tips for You….

- Get your free annual physical.
- Are you due for a health screening? Listed below are some of the guidelines that are generally based on the recommendations of the US Preventative Task Force (check with your physician to ensure you are receiving the recommended screenings based on your health and family history):

  Cardiovascular Disease: Regular screenings should begin at age 45 for men & 55 for women.

  Cholesterol Screening: Every 5 years beginning at age 35 for men & 45 for women.

  Prostate Screening: Men 40 & older, consult with your physician.

  Colorectal Screening: Baseline colonoscopy at age 50 for both men & women. Higher risk individuals should be screened earlier. Consult with your physician.

  Mammograms: Beginning at age 40 every one to two years as directed by your physician for women of standard risk. Women that are identified as high risk should be screened earlier.

  Cervical Cancer Screenings (Pap Smears): Every two years beginning at age 21 & after 3 normal screenings, every three years or at a frequency recommended by your physician.

  Osteoporosis Screening (Bone Density Scan): Routine screenings for women 65 and older. Consult with your physician.

  Height, Weight, Blood Pressure, Vision & Obesity Screenings: Done at each annual preventative exam.

- Get your semi-annual teeth cleaning (at no cost to you in network if you have one of the dental PPO plans).
- Remember to file your wellness reimbursement claim if you have the Colonial Cancer or Hospital Indemnity plans.
- Call CIGNA's EAP (1-877-622-4327) to talk to a nurse if you are experiencing symptoms and are not sure what you should do.
- If you are enrolled in either the Medical or Dependent Care Flexible Spending Account, remember to keep ALL of your receipts with your tax documents.
- Keep your beneficiary for your life insurance up to date. You can change your beneficiary, in writing, at any time throughout the year with the Employee Benefits Department.

This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and polices will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. This booklet was coordinated by SCPS and Hylant for your convenience. It is paid for by Hylant and the carriers. This booklet is intended to give you a brief overview of your choices.

2014 Benefit Guide Overview

Seminole County Public Schools (SCPS) offers eligible employees a variety of benefits tailored to best fit their needs. Our benefits program is an important part of your overall compensation and the district regularly assesses the quality and cost of the benefits to ensure we offer the most competitive package possible. Changes and relevant new information are highlighted below, however, we encourage you to review this guide in its entirety. To help you understand your benefits and make informed decisions, we have designed this benefit booklet as a resource for you when you first join the School District, during the Annual Enrollment Period and throughout the year. It reflects highlights of our benefits program beginning January 1st and also includes important contact information. More detailed information about your benefits is available on the SCPS website: **www.scps.k12.fl.us**, click on departments, then the link to the Employee Benefits Department. The information provided in this booklet is accurate at the time of print. The benefits are subject to change due to further clarification of legislative changes. All plans are governed by your plan documents.

- **Annual Enrollment:** For returning employees and new employees hired by September 29, 2013, enrollment is available from October 1st through October 14th. This is the only opportunity you will have this year to make changes to your benefit elections. During this period you may add, drop, or modify coverage. You will be locked into the plan selections for one year unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status or loss or gain of coverage). All qualifying event changes must be made within 30 days of the event. Changes are not automatic.
- **Healthcare:** Our health insurance provider will be changing to CIGNA effective January 1, 2014. The District will continue to offer: the Wellness $400 deductible plan (annual physical requirement), the Standard Plan and the Family plan. See the booklet for more details.
- **Dental:** Assurant will remain our dental carrier. We will continue to offer three plans:, however the Heritage DHMO plan will be replaced with the Prepaid Plan 225. The Freedom Basic & the Freedom Preferred PPO plans will remain unchanged.
- **Other Benefits:** There are additional voluntary benefits that are available to you as well. Please review this guide for further details.
- **Employee Contributions:** Employees will be asked to share the cost of certain insurance benefits. Your contribution amounts are shown in the rate charts included with this guide. All amounts illustrated in this guide are based on 20 payroll deductions.

Eligibility

Seminole County Public Schools is pleased to offer its employees an excellent benefit program. These benefits are designed to protect you and your family while you are an active employee.

Eligibility: Health and benefit plans are available to all regularly appointed and elected employees of SCPS who are entitled to any or all of SCPS provided benefits. Casual employees such as OPS and substitute teachers are not entitled to benefits.

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

- Legal spouse, as defined by Federal Law; and
- Children under age 26; specifically
- MEDICAL - Your children up to age 26 regardless of marital status, financial dependency, residency with the eligible employee, student status, employment status, or eligibility for other coverage; coverage ends at the end of the calendar year in which they turn 26. In the state of Florida dependent coverage is available up to age 30 if the dependent is unmarried, a Florida resident , or a full-time student and uninsured. The dependent must maintain continuous service.
- DENTAL - Your children up to age 26 regardless of marital status, financial dependency, residency with the eligible employee, student status, employment status, or eligibility for other coverage.
- VISION - Your children up to age 26 regardless of marital status, financial dependency, residency with the eligible employee, student status, employment status, or eligibility for other coverage.
- It is your responsibility to provide the Employee Benefits Department with proof of your dependents' eligibility, in the form of: (a) your most recent Federal Income Tax Return, (b) Court Order specifying your responsibility to provide "group health care coverage" to your dependent children, (c) Copy of birth certificate or a marriage certificate.

New Hire Coverage: As a new hire, your plan eligibility date is the 89th calendar day including your date of hire with Seminole County Public Schools.

New employees have up to 30 days after their hire date to enroll. If you do not enroll by that deadline, you will not be eligible for coverage other than SCPS paid health and life benefits until the following annual open enrollment period. New employees are eligible for the Wellness plan due to their pre-employment physical and must submit your enrollment form to Employee Benefits.

Annual Elections: It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A family status change as defined by the IRS includes:

- Marriage
- Divorce
- Birth or adoption or change in custody of a child
- Death of a dependent
- Change in employment status or
- Loss of group or state coverage

If you have a family status change you must notify, in writing, the Employee Benefits Department within 30 days of the qualifying event to make your desired changes, or you will need to wait until the next annual enrollment period. The changes are not automatic.

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

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

Wellness Programs

Engage in a Wellness Committee

Each district location is unique. As a result, the wellness program at each location needs to be specific to that team's needs. Improve the health of the staff and the students at your site by engaging in your wellness committee. Doing so will help you identify your location's needs and may qualify your team for several wellness grants, free programs and resources. For questions or requests regarding the support of your wellness committee, email wellness@scps.k12.fl.us.

Tobacco Free

SCPS is a tobacco-free environment. There are programs available to employees who wish to quit the use of tobacco products. Some are free and offered through the state or other community organizations. Employees who are covered under the medical and prescription drug plans can receive smoking cessation drugs at the generic copayment with the appropriate prescription. Please see the Employee Benefits website for the list of drugs, tools & resources.

Get to know your health

Understanding your health can be the first step toward improvement, and a personal health review is a great way to get started. This easy-to-complete questionnaire is all about your health and well-being:

- Asks questions about habits, stress levels, family history and your overall health, and also records basic information such as weight, blood pressure and cholesterol level.
- Creates a personalized report with details about your most important health issues.
- Offers suggestions for health screenings, and information about wellness and health programs.
- Gives you information to share with your doctor at your next wellness visit.

Visit www.mycigna.com to get started.

Think Pink

Breast cancer is one of the leading diagnosis in the District. Early detection is the key to successfully fighting this disease. Out of the over 4,000 employees who should have had their annual mammograms in 2012, over 2,300 were actually screened-That's Over 55%!! We are improving. Let's keep the thermometer going up. The District's plan with CIGNA covers mammograms **at 100% (no money out of your pocket)** under the following circumstances:

- One baseline screening mammogram for women age 35-39
- One baseline screening mammogram every two years (or more frequently based on physician's recommendation) for women age 40-49
- An annual screening mammogram for women age 50 and older
- One or more mammograms based on your physician's recommendation for women who are more at risk for breast cancer due to personal or family history

If you fall into any of the categories above, you should get screened. You and your health are worth it!

Healthcare Benefits At-a-Glance (CIGNA)

Healthcare benefits are one of the most important and necessary parts of your benefit package. The following is a summary of your benefits offered through CIGNA. There is a more detailed explanation of benefits available on pgs 8 & 9 as well as in your certificate of coverage. You may access a list of participating providers at www.mycigna.com.

	WELLNESS Plan	STANDARD Plan	FAMILY Plan
	In-Network ***What you pay***	**In-Network** ***What you pay***	**In-Network** ***What you pay***
Doctors Office Visits *Primary Care Physcian*	$25 copay	$35 copay	$35 copay
Specialist	$50 copay	$45 copay	$45 copay
	20% after deductible for other services provided	30% after deductible for other services provided	30% after deductible for other services provided
Preventive Care Services	Covered in Full	Covered in Full	Covered in Full
Urgent Care	$50 co-pay	$50 copay	$50 co-pay
Emergency Room	$250 co-pay	$250 co-pay	$250 co-pay
Prescription Drugs Pharmacy Filled	Tier I: $7 Tier II: $30	Tier I: $7 Tier II: $30	Tier I: $7 Tier II: $30
Mail Order (90 day supply)	Tier I: $14 Tier II: $60	Tier I: $14 Tier II: $60	Tier I: $14 Tier II: $60
Diagnostic Labs & X-rays (LabCorp)	Covered in Full	Covered in Full	Covered in Full
Deductible/Basis	Calendar Year Deductible (CYD)	Calendar Year Deductible (CYD)	Calendar Year Deductible (CYD)
Individual	$400	$1,500	$5,000
Family	$800	$3,000	$10,000
Co-Insurance	20%	30%	30%
Out of Pocket Maximum	Includes Deductible & Coinsurance	Includes Deductible & Coinsurance	Includes Deductible & Coinsurance
Individual	$5,000	$6,350	$6,350
Family	$10,000	$12,700	$12,700
Complex Imaging & Diagnostics (MRI,CT Scan, PET Scan, etc.)	20% after CYD	30% after CYD	30% after CYD
Outpatient Surgery	20% after CYD	30% after CYD	30% after CYD
In Hospital Charges Facility Fees	20% after CYD	30% after CYD	30% after CYD
Professional Fees	20% after CYD	30% after CYD	30% after CYD
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited

NOTE: On all three plans, there is NO Out of Network coverage.

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Healthcare Benefits At-a-Glance (CIGNA)

The School Board pays an average of $6,638 annually towards the cost of your coverage. Employee 20 deduction contributions for dependent coverage are:

Log onto www.mycigna.com to find:

- ☑ A doctor near you
- ☑ Explanation of benefits (EOB)
- ☑ More information on a medical condition
- ☑ Take a Health Assessment

	Wellness Plan	*Standard Plan*	*Family Plan*
Employee Only	$0.00	$0.00	$0.00
Employee + Spouse	$413.00	$366.11	$347.83
Employee + Children	$351.65	$313.18	$298.20
Employee + Family	$750.27	$665.42	$632.36

Special Note Regarding the Wellness Plan

It is important for you to see your doctor for an annual physical exam. He or she can pick up on factors that you may not even know are happening in your body. Finding something early not only reduces the cost of your care, it can improve your life—even SAVE your life.

All Benefit eligible Employees will be eligible for the **$400 deductible Wellness Plan** if they have had an annual physical from September 16, 2012, through September 12, 2013.

Verification of your wellness exam completion will happen in one of three easy ways:

1) Your provider files a wellness exam claim with United Healthcare.

2) You are a new hire and you submitted a health certification form.

3) You had the provider who performed your exam complete the wellness physical examination certification and YOU turn that form into the Employee Benefits Department before the deadline.

The deadline for the Wellness Physical Exam Certification form is **no later than 4 pm on September 12, 2013** to the Employee Benefits Department located on the 1st floor of the Educational Support Center .

*Note: Physicals are not bound by Calendar Year per the District's United Healthcare plan.

Disability Coverage in Lieu of Medical Coverage

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

After you are disabled for 7 continuous days, you will receive a flat $300 weekly benefit for a maximum of 104 weeks. This benefit offsets with the CIGNA group disability plan, as well as any other income you receive such as retirement. Additionally since it is paid for by SCPS, your benefit will be taxed. To file a claim, call 1-800-877-5176.

More Health Plan Details

Benefit	Wellness Plan	Standard Plan	Family Plan
DEDUCTIBLE Individual/Family	$400/$800	$1,500/$3,000	$5,000/$10,000
OUT–OF-POCKET MAXIMUM Individual/Family	$5,000/$10,000 Non covered services do not apply	$6,350 /$12,700 Non covered services do not apply	$6,350 /$12,700 Non covered services do not apply
COINSURANCE	20% after deductible	30% after deductible	30% after deductible
Primary Care Office Visit	$25 copay	$35 copay	$35 copay
Preventive Care Office Visits	No charge	No charge	No charge
Specialist Office Visit	$50 copay	$45 copay	$45 copay
Maternity Care – Initial visit to confirm pregnancy	$25 (PCP) or $50 (Specialist) copay	$35 (PCP) or $45 (Specialist) copay	$35 (PCP) or $45 (Specialist) copay
Subsequent Prenatal visits, Postnatal visits, and Physician's Delivery charges	20% after deductible	30% after deductible	30% after deductible
Hospital Admission	20% after deductible	30% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	30% after deductible	30% after deductible
X-Rays and Lab	No charge	No charge	No charge
Complex Imaging & Diagnostics (MRI, CT Scan, PET Scan, etc)	20% after deductible	30% after deductible	30% after deductible
Therapeutic Treatments (Radiation, Chemo, Dialysis, etc)	20% after deductible	30% after deductible	30% after deductible
Mammography: Routine and Diagnostic	No charge	No charge	No charge
Urgent Care Facility (copay waived if admitted)	$50 copay	$50 copay	$50 copay
Emergency Room (copay waived if admitted)	$250 copay	$250 copay	$250 copay
Ambulance	20% after deductible	30% after deductible	30% after deductible
Home Healthcare	20% after deductible Limited to 60 visits per calendar year 16 hour maximum per day	30% after deductible Limited to 60 visits per calendar year 16 hour maximum per day	30% after deductible Limited to 60 visits per calendar year 16 hour maximum per day
Prosthetics	20% after deductible Unlimited maximum per calendar year	30% after deductible Unlimited maximum per calendar year	30% after deductible Unlimited maximum per calendar year

NOTE: There are no Out of Network benefits offered.

More Health Plan Details

Benefit	Wellness Plan	Standard Plan	Family Plan
Durable Medical Equipment Medical equipment, which can withstand repeated use and is not disposable, used for medical purpose, generally not useful in the absence of sickness or injury and is appropriate for use in the home	20% after deductible Unlimited maximum per calendar year	30% after deductible Unlimited maximum per calendar year	30% after deductible Unlimited maximum per calendar year
Hearing Aids	20% after deductible $5,000 maximum per calendar year	30% after deductible $5,000 maximum per calendar year	30% after deductible $5,000 maximum per calendar year
Short-Term Rehabilitation: **Chiropractic** **Physical Therapy** **Occupational Therapy** **Speech Therapy** **Pulmonary Rehab** **Cardiac Rehab**	$25 copay 60 days maximum per calendar year for all therapies combined 36 days maximum per calendar year	$35 copay 60 days maximum per calendar year for all therapies combined 36 days maximum per calendar year	$35 copay 60 days maximum per calendar year for all therapies combined 36 days maximum per calendar year
Mental Health Inpatient	20% after deductible	30% after deductible	30% after deductible
Mental Health Outpatient	$25 copay	$35 copay	$35 copay
Substance Abuse Inpatient	20% after deductible	30% after deductible	30% after deductible
Substance Abuse Outpatient	$25 copay	$35 copay	$35 copay
Skilled Nursing	20% after deductible 60 days maximum per calendar year	30% after deductible 60 days maximum per calendar year	30% after deductible 60 days maximum per calendar year
Vision - Annual Exam	$20 copay	$20 copay	$20 copay

This is for summary purposes only. In all instances your policy and certificate of coverage will govern.

How to Use Your Healthcare Benefits

Regardless of which CIGNA plan you choose, you have several resources and tools available to you at www.mycigna.com. *Here are just a few that might interest you:*

- Understand your coverage and costs
- See your coverage fully explained
- Check your eligibility, copays, deductibles and out of pocket expense information
- Keep track of immunizations and allergies on your Personal Health Record

Know more before you go:

- Get a personalized calculation based on your plan and current benefits status
- Helps you to know procedure, provider, & cost when shopping for healthcare.
- Uses estimates based on contracted rates

Make smart doctor and hospital choices:

- Locate in network physicians who meet your unique needs
- Search for a hospital and receive comparative quality and relative cost reporting at the procedure level.

Keep track of claims history:

- See personal and family claims history—all in one place
- Print a full explanation of benefits for any claim
- View account balances

Learn how to stay healthy:

- Find reliable, easy to understand medical and treatment information
- Improve your health awareness by taking an online Personal Health Review
- Chat with a registered nurse in real-time
- Investigate health improvement programs for weight loss, exercise, smoking cessation, stress reduction, aging, etc.

Explore health and wellness discounts through CIGNA Healthy Rewards program (up to 50%!):

- Weight and nutrition management
- Fitness
- Tobacco Cessation
- Vision and hearing care
- Vitamins, health and wellness products
- Alternative medicine
- Anticavity dental products
- Healthy lifestyle products

TAKE ADVANTAGE OF CIGNA'S EMPLOYEE ASSISTANCE PROGRAM

1-877-622-4327

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

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

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

Tips for a Successful Healthcare Experience

Use the following tips to ensure you have a successful healthcare experience:

- Set yourself up for a successful healthcare experience by taking the time to **find a family physician** in your network that you and your family trust. Do this before a health concern arises.
- Did you know that doctors base up to 80% of their diagnoses on what patients tell them about their symptoms, history, and lifestyle? Preparing for a trip to the doctor not only helps you to get your thoughts in order, but also helps you better understand what your doctor is talking about.
    - Bring a list of any and all medications, allergies, and other doctors you might see.
    - Be prepared to help the physician answer questions about your ailment, such as how, what, when, and where the symptoms are occurring in the body.
- **Register with www.mycigna.com for online claim tracking and review**.
- Periodically review your personal information to ensure your claims are being processed accurately and timely. Consider taking a Personal Health Review and creating a Personal Health Record.
- Ensure you have proper documentation before you see your physician. This includes your proper **medical insurance card** printed with your carrier name, policy number, claims address, and co-payment amounts. It's also helpful to bring your benefit plan summary with you just in case there is a question about co-pays, deductibles, or coinsurance. **Pay the correct co-payment every time you see your physician**. (Temporary cards are available online)
- When seeing your physicians, **confirm that they have your updated information on file**. This includes:
    - Group policy number
    - Individual identification number
- If receiving a routine physical examination, remind **your physician to file it as routine preventive care** instead of with a medical diagnosis.
- If you encounter a problem regarding eligibility, **make sure the provider is using your most up to date policy and individual identification numbers**; old information can cause unnecessary confusion. These problems are often easily resolved over the phone.
- **Contact the insurance company if you believe your claim has not been paid properly or in a timely manner**. Contact your health provider if you find the insurance carrier does not have the claim in question. For claim questions, please call the insurance carrier at the number on your card.
- **Keep a record of all communication** with your insurance carrier or healthcare provider. Include the date and time of any conversation and the name of the person with whom you spoke.

Choosing the Right Care Facility

With the rise of convenience care and urgent care clinics, it can sometimes be confusing untangling the web of care options available to you. The following should serve as a guide to help you successfully choose the right healthcare facility for your condition.

Primary Care Physician (PCP)

When you or a loved one is ill or needs medical care, but it is not an emergency situation, it is best to visit your primary care physician. Your PCP knows you and your health history and has access to your medical records. In addition, you most likely will pay the least amount of out of pocket when visiting your PCP versus a convenience care or emergency room facility.

Convenience Care Clinics

Located in retail stores such as CVS, Walgreens and Target, convenience care clinics are staffed by medical professionals and do not require an appointment. These clinics are best utilized when you have a non-emergency condition and you are not able to get an appointment with your primary care physician. Services are often provided at a lower out of pocket cost than an urgent care clinic or emergency room visit.

Typical conditions that may be treated at a Convenience Care Clinic include:

- Common infections (e.g.: bronchitis, bladder infections, ear infections, pink eye, strep throat)
- Minor skin conditions (e.g.: athlete's foot, cold sores; minor sunburn, poison ivy)
- Flu shots

This is a sample list and not all-inclusive. For a full listing of services please visit each clinic's website. To find an in-network Convenience Care Clinic near you visit www.mycigna.com.

Urgent Care Clinics

Urgent care clinics are a good option when you require urgent care outside your doctor's regular office hours or you are unable to be seen by your doctor immediately.

Typical conditions that may be treated at an urgent care clinic include:

- Sprains & Strains
- Small cuts
- Mild asthma attacks
- Minor infections

Services vary per clinic. If you choose to visit an urgent care clinic, visit www.mycigna.com or call the toll-free number on the back of your medical card to ensure the clinic is in-network.

Emergency Room

If you or your loved one is experiencing an emergent medical condition you should go to the nearest emergency room or call 911. In an emergency, all facilities are considered in-network.

An emergent medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in:

- Serious jeopardy to your or your loved one's health, including the health of a pregnant woman or her unborn child
- Serious impairment to your or your loved one's bodily functions
- Serious dysfunction of any of your or your loved one's bodily organ or part

Some examples of emergent conditions may include the following:

- Heavy bleeding or large open wounds
- Sudden change in vision
- Chest pain
- Sudden weakness or trouble walking
- Difficulty breathing

This list only provides examples and is not intended as an exclusive list. If you believe you or your loved one is experiencing an emergent medical condition, you should call 911 or go to the nearest emergency room , even if your symptoms are not described here.

Board Approved Leave of Absence

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

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

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

Coverage for Newborns

For most insurance, in order to be covered, newborns must be added to your plan within 60 days from the date of birth. Their coverage is effective as of their date of birth. You must notify the Employee Benefits Department in writing to add the newborn to your plan. The baby is **not automatically** added to your plan. Additionally, a copy of the birth certificate and the newborn's social security number is required to be submitted to the Employee Benefits Department within 30 days of the birth.

If you enroll the baby within the first 30 days of their birth, then your premium covers the baby for the first 30 days. If you enroll the newborn after the 30th day, but before the 60th day, then you will be responsible for all additional premiums from the date of birth.

Once the baby is enrolled in your plan, you CANNOT drop their coverage until the next annual enrollment. Due to IRS Section 125 rules and SCPS procedures, you need a qualifying event to make changes outside of annual enrollment.

If you want the baby to be covered under your spouse's group insurance plan, then you will need to add the baby to his or her plan at the time of birth. Please note that the purchase of an individual plan does not constitute a qualifying event.

Newborns will not be added if you fail to notify the Employee Benefits within 60 days from the date of birth.

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

CIGNA Healthy Pregnancy, Healthy Babies Program

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

Prescription Benefits At-a-Glance (Express Scripts)

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

Express Scripts has a national network of pharmacies that include major retail chains such as CVS, Costco, Sam's Club, Medicine Shoppe, Winn Dixie, K-Mart, Target & Wal-Mart to name a few. To locate a participating pharmacy, log onto www.express-scripts.com.

National Preferred Formulary

A formulary is the list of prescription drugs covered under your plan at lower copayments than prescriptions not included in the formulary. It is created, reviewed and updated by a team of doctors and pharmacists. Your plan's formulary contains generic drugs and a wide range of brand-named drugs that have been approved by the US Food and Drug Administration (FDA). Prescription drugs are chosen to be included on the formulary because they are safe, effective and save money. The list of drugs covered under the formulary is reviewed periodically. PLEASE NOTE: The drugs on the formulary can change during the plan year and as a result could change your copayment. **Beginning January 1, 2014 medications that are not either a generic (1st tier copay) or a preferred brand drug (2nd tier copay) will not be covered. Exceptions to this may be made if your doctor has documented medical necessity for a non-preferred medication and it is on file via prior authorization with Express Scripts. In this case, you will pay either $60 at retail or $120 at mail.**

Coverage Considerations

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

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

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

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

Your Copayments

	Retail Pharmacy 30 Day Supply	Home Delivery 90 Day Supply
Generic (1st tier)	$7	$14
Brand Name Preferred (2nd tier)	$30	$60
Brand Name Non-Preferred (3rd tier)	Not covered	Not covered

How to Use Your Prescription Benefits

Maintenance Drugs & Home Delivery

If you or a covered family member receive a prescription for a maintenance medication (any long-term medications taken for 90 days or more, such as cholesterol, blood pressure, diabetes, oral contraceptives, etc.), you can obtain the first 30-day fill and up to two 30-day refills for the retail copayments listed on the previous page. After the third fill, if you continue to get your medication at the retail pharmacy, you will be responsible for the FULL COST of the prescription.

Please remember:

- ☑ Order all maintenance medication through mail
- ☑ Ask for generic or lower cost alternatives to brand name drugs (www.express-scripts.com)
- ☑ Show your Express Scripts ID card at the pharmacy

Maintenance medication must be dispensed through the Express Scripts Mail Order Pharmacy. Convenient delivery of your covered maintenance medications is available to your home or other specified address. Please remember that prescriptions are dispensed for the exact quantity prescribed by your physician. The mail order copay is charged even if the prescription is for less than a 90-day supply.

Filling Prescriptions via the Home Delivery Pharmacy

Once you have obtained a prescription from your physician for a 90-day supply with refills for one year, send it along with a home delivery form and your payment to Express Scripts. Your medication should arrive to you within 10 to 14 days from the time Express Scripts receives your order.

Ordering refills can be done over the phone, by mail or fax or online at **www.express-scripts.com**.

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

IMPORTANT NOTE: Please remember that prescriptions are dispensed for the exact quantity prescribed by your physician. Here are some examples:

If Medication is Taken	Quantity to Prescribe	Refills
1 time a day	90	3
2 times a day	180	3
3 times a day	270	3

Prescription Savings

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

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

To find out more, call your local pharmacy or visit their website.

Dental (Assurant Employee Benefits)

How does the Prepaid 225 Plan work?

- ☑ Pay a copay for all covered services
- ☑ Multiple copays will apply for some visits
- ☑ A schedule of all covered copays is on the employee benefits website
- ☑ Go to Assurant's website, chose Florida Prepaid Dental Series and find a dentist.

Your dental coverage is provided by Assurant Employee Benefits. You have three plans to choose from to fit the needs of you and your family. The Prepaid 225 Plan is the lowest cost per payroll deduction. You have a limited network of providers to choose from and you must name a primary dentist. You pay a copayment each visit for covered services. This plan has NO annual maximum and covers orthodontia even for adults. Dental treatment codes not listed in the plan summary are not covered.

For a broader network of dentists there are two PPO plans from which you can choose. In network, your semi-annual cleanings are covered at 100% by the plan. These plans do have an annual maximum of $1,000. The PPO plans allow you to utilize both in and out of network providers. If you go out of network, you can be balance billed the difference of what Assurant pays and what the dentist charges. To see a list of participating providers go to: www.assurantemployeebenefits.com. Click on find a dentist under the resources header. The Assurant Dental network is for the PPO plans. For the Prepaid 225 Plan plan, select "Florida" under the DHMO or Prepaid Dental Care section and then select the Prepaid Dental Series (Florida only) to look for a provider.

	Prepaid 225 Plan (copay only plan)	Freedom Basic Plan		Freedom Preferred Plan	
	In Network Coverage Only	In Network	Out of Network	In Network	Out of Network
Preventive Services (Cleanings, Fluoride Treatment for Children, etc.)	See Copayment List located on Employee Benefits Website	Covered In Full (1 every 6 months)	You pay 10% (Balance Billing may occur)	Covered In Full (frequency limits apply)	You pay 10% (Balance Billing may occur)
Basic Services (Restorative, Endodontics, Fillings)	See Copayment List located on Employee Benefits Website	You pay 10% after deductible	You pay 30% after deductible (Balance Billing may occur)	10% after deductible	30% after deductible (Balance Billing may occur)
Major Services (Perio, Crowns, Bridges, Dentures)	See Copayment List located on Employee Benefits Website	You pay 70% after deductible	You pay 90% after deductible (balance billing may occur)	40% after deductible	60% after deductible (Balance Billing may occur)
Deductible (Waived for Preventive)	Not applicable	$50 per person	$50 per person	$50 per person	$50 per person
Maximum Annual Benefit (Amount is combined for in & out of network)	Not applicable	$1,000 per person	$1,000 per person	$1,000 per person	$1,000 per person
Orthodontics	See Copayment List for child & adult	Not Covered		Lifetime maximum: $1,000 (for children under the age of 19)	

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Employee Contributions (20 Payroll Deductions)

	Prepaid 225 Plan	***Freedom Basic Plan***	***Freedom Preferred Plan***
Employee Only	$ 8.47	$12.67	$18.87
Employee + 1 Dependent	$13.86	$23.72	$35.18
Employee + 2 or More Dependents	$22.95	$40.58	$59.58

Vision (United Healthcare Vision)

To print an ID card go to myuhcvision.com

The voluntary vision coverage is provided by United Healthcare Vision, formerly a company called Spectera. This plan is separate from the vision benefits available under your medical plan with CIGNA. The voluntary vision plan gives you coverage for the hardware that helps you see better like glasses and contacts in addition to the exams.

To see a list of participating providers for this plan go to: www.myuhcvision.com or call **1-800-638-3120**. The system will inform you of the providers located within 30 miles of your home.

ID cards are not provided therefore once you select a provider, simply call their office and make your appointment. Make sure you identify yourself as a United Healthcare vision participant in the Seminole County Public Schools program and give the provider your Social Security number and birth date. (If you wish to select a doctor for your dependents, you must provide their date of birth as well).

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

	In Network Benefits	Out-of-Network Reimbursement Plan
Office Visit Co-pay	$10 Eye Exam Copayment	$35 Optometrist or Ophthalmologist
Lenses (covered once every 24 months)	$10 Materials Copayment Progressive lenses available at a discount Polycarbonate lenses covered	$20 Single vision $40 Bifocal $60 Trifocal $60 Lenticular
Frames (covered once every 24 months)	$50 wholesale frame allowance at private practice providers, or a minimum of $120 retail frame allowance at our retail chain providers	$35
Contact Lenses (covered once every 24 months)	Contact Lenses-$150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses once every 24 months	$75 Elective $175 Medically Necessary

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Employee Contributions (20 Payroll Deductions)

Employee	*Employee + 1 Dependent*	*Employee + 2 or More Dependents*
$4.38	$7.00	$10.11

Board Paid Life and AD&D Insurance (ReliaStar)

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

Plan Features	Benefit Amount
Board Paid (Basic) Life Insurance	One times your annual salary up to $150,000 (minimum $25,000)
Accidental Death and Dismemberment	One times your annual salary up to $150,000 (minimum $25,000)
Benefit Reduction Schedule (occurs at the policy anniversary date of January 1st)	Age 65, insurance reduces to 65% of the original amount; Age 70, insurance reduces to 50% of the original amount; Age 75, insurance reduces to 35% of the original amount;

Additional Life & AD&D Insurance

Employees have the opportunity to elect additional voluntary Life and Accidental Death & Dismemberment Insurance. This will provide an additional Life Insurance benefit for yourself, your spouse and/or your dependent child(ren). Contributions for these premiums are 100% employee paid. *If you waive voluntary life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date.* Please allow 4 to 6 weeks for underwriting approval. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results which is determined by your health status. **This benefit ends upon retirement.**

Plan Features	Benefit Amount
Employee Life Insurance	Available in increments of $10,000 not to exceed four times (4X) your annual salary to a maximum benefit of $300,000 combined. New hires are eligible to purchase the lesser of two times (2X) your annual salary or $100,000 on a guaranteed issue basis if you are under the age of 65 at time of purchase. If you are over the age of 65, please consult the certificate of coverage or contact the Employee Benefits Department.
Spouse Life Insurance	You may also purchase Supplemental Term Life Insurance for your spouse in $10,000 increments up to a maximum of $150,000. The amount you can purchase for your spouse cannot exceed 50% of the Employee Basic & Supplemental Term Life Insurance amounts combined.
Dependent Child(ren) Life Insurance	This benefit provides coverage for all eligible dependent children, regardless of how many. You have three options to choose from: $2,000, ($.48) $5,000 ($1.20) and $10,000 ($2.40). Per deduction
Benefit Reduction Schedule (occurs at the policy anniversary date of January 1st)	Age 65, insurance reduces to 65% of the original amount; Age 70, insurance reduces to 50% of the original amount; Age 75, insurance reduces to 35% of the original amount;

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Voluntary Life Insurance Rates (ReliaStar)

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

	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	>70
$10,000	$0.24	$0.30	$0.50	$0.95	$1.67	$2.64	$4.58	$5.48	$10.62	$18.72
$20,000	$0.48	$0.60	$1.00	$1.90	$3.34	$5.28	$9.16	$10.96	$21.24	$37.44
$30,000	$0.72	$0.90	$1.50	$2.85	$5.01	$7.92	$13.74	$16.44	$31.86	$56.16
$40,000	$0.96	$1.20	$2.00	$3.80	$6.68	$10.56	$18.32	$21.92	$42.48	$74.88
$50,000	$1.20	$1.50	$2.50	$4.75	$8.35	$13.20	$22.90	$27.40	$53.10	$93.60
$60,000	$1.44	$1.80	$3.00	$5.70	$10.02	$15.84	$27.48	$32.88	$63.72	$112.32
$70,000	$1.68	$2.10	$3.50	$6.65	$11.69	$18.48	$32.06	$38.36	$74.34	$131.04
$80,000	$1.92	$2.40	$4.00	$7.60	$13.36	$21.12	$36.64	$43.84	$84.96	$149.76
$90,000	$2.16	$2.70	$4.50	$8.55	$15.03	$23.76	$41.22	$49.32	$95.58	$168.48
$100,000	$2.40	$3.00	$5.00	$9.50	$16.70	$26.40	$45.80	$54.80	$106.20	$187.20
$110,000	$2.64	$3.30	$5.50	$10.45	$18.37	$29.04	$50.38	$60.28	$116.82	$205.92
$120,000	$2.88	$3.60	$6.00	$11.40	$20.04	$31.68	$54.96	$65.76	$127.44	$224.64
$130,000	$3.12	$3.90	$6.50	$12.35	$21.71	$34.32	$59.54	$71.24	$138.06	$243.36
$140,000	$3.36	$4.20	$7.00	$13.30	$23.38	$36.96	$64.12	$76.72	$148.68	$262.08
$150,000	$3.60	$4.50	$7.50	$14.25	$25.05	$39.60	$68.70	$82.20	$159.30	$280.80
$160,000	$3.84	$4.80	$8.00	$15.20	$26.72	$42.24	$73.28	$87.68	$169.92	$299.52
$170,000	$4.08	$5.10	$8.50	$16.15	$28.39	$44.88	$77.86	$93.16	$180.54	$318.24
$180,000	$4.32	$5.40	$9.00	$17.10	$30.06	$47.52	$82.44	$98.64	$191.16	$336.96
$190,000	$4.56	$5.70	$9.50	$18.05	$31.73	$50.16	$87.02	$104.12	$201.78	$355.68
$200,000	$4.80	$6.00	$10.00	$19.00	$33.40	$52.80	$91.60	$109.60	$212.40	$374.40
$210,000	$5.04	$6.30	$10.50	$19.95	$35.07	$55.44	$96.18	$115.08	$223.02	$393.12
$220,000	$5.28	$6.60	$11.00	$20.90	$36.74	$58.08	$100.76	$120.56	$233.64	411.84
$230,000	$5.52	$6.90	$11.50	$21.85	$38.41	$60.72	$105.34	$126.04	$244.26	$430.56
$240,000	$5.76	$7.20	$12.00	$22.80	$40.08	$63.36	$109.92	$131.52	$254.88	$449.28
$250,000	$6.00	$7.50	$12.50	$23.75	$41.75	$66.00	$114.50	$137.00	$265.50	$468.00
$260,000	$6.24	$7.80	$13.00	$24.70	$43.42	$68.64	$119.08	$142.48	$276.12	$486.72
$270,000	$6.48	$8.10	$13.50	$25.65	$45.09	$71.28	$123.66	$147.96	$286.74	$505.44

Disability (CIGNA)

Both Short Term and Long Term Disability Insurance is provided by CIGNA. Think of disability coverage as insurance for your paycheck. A disability can put your life on hold while you recover. Unfortunately expenses such as your mortgage or rent, utility and grocery bills are not put on hold. Disability insurance provides you with a stable source of income that can help carry you and your family financially through this time. Short Term Disability covers you for up to 26 weeks. Should your disability take longer than this to recover from, then your claims would transition to Long Term Disability (if you are enrolled in it). These are two separate polices and you do not have to purchase both of them. It is recommended that the deductions for these plans come out of your check AFTER tax. If you choose to have your deductions on a pre-tax basis, your benefit will be considered taxable income. Please note this benefit does not pay if you are out on a worker's comp claim or receiving sick or vacation time.

Short Term Disability Benefit Highlights

Benefit Amount	You can select your benefit in increments of $100. Your maximum benefit amount is determined by your salary.
Benefit Maximum	$820
Benefit Duration	26 Weeks
Elimination Period	14 calendar days
Maximum Benefit Period	26 Weeks
Benefit Offsets	Including but not limited to sick pay, retirement (401(k) & pension), workers' compensation, social security & other group disability plans like the Mutual of Omaha policy

STD Employee Contributions (20 Payroll Deductions)

Annual Earnings	*Weekly Benefit Amount*	*Deduction*	*Annual Earnings*	*Weekly Benefit Amount*	*Deduction*
< $13,208	$120	$4.52	$39,260 to $51,948	$520	$22.69
$13,208 to $21,840	$220	$9.19	$52,000 to $60,632	$620	$27.22
$21,892 to $30,524	$320	$13.58	$60,684 to $69,316	$720	$31.76
$30,576 to $39,208	$420	$18.10	$69,368 & higher	$820	$36.29

Long Term Disability Benefit Highlights

Benefit Amount	60% of your monthly earnings
Benefit Maximum	$5,000 per month
Benefit Duration	3 1/2 years
Elimination Period	180 calendar days
Maximum Benefit Period	To age 65 for total disability
Benefit Offsets	Including but not limited to sick pay, retirement (401(k) & pension), workers' compensation, social security & other group disability plans like the Mutual of Omaha policy

LTD Employee Contribution (20 Payroll Deductions) $6.57

Long Term Care Insurance (UNUM)

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

Seminole County Public School's Long Term Care coverage can provide an important financial resource if you or a family member faces a debilitating accident or illness. Through SCPS, you have the opportunity to purchase Long Term Care coverage with UNUM through easy, after-tax, payroll deductions.

This group policy offers you and your family the ability to take advantage of group rates. If you did not sign up for this benefit when you were first eligible, then you will have to provide Evidence of Insurability. Family members are required to provide Evidence of Insurability when they sign up for this plan. You have the ability to pay for you and your spouse's coverage via payroll deductions. Your other family members will be billed directly by UNUM.

What does it cover?

Just as it sounds, Long Term Care is about needing care for lengthy periods of time, either in your home or in a facility that provides Long Term Care services. Long Term Care coverage can help cover the cost of care in a variety of places, a few of which are:

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

Why does it pay to enroll now?

You may need Long Term Care at any age whether you're 27 or 72. That's because accidents and sudden illness can happen at any age, to anyone, regardless of how well you take care of your health.

UNUM rates are based on your age at the time your coverage becomes effective. By enrolling now, your monthly rate is the lowest it will ever be. The younger you are when you enroll, the lower your rate will be for as long as you continue your coverage.

Remember, you can only buy this insurance before you need it. Waiting to enroll could mean you may risk losing the ability to qualify for coverage. **NOTE:** This plan does not have an accumulated cash value. If you terminate your coverage, there is not a cash surrender value.

This plan will require medical underwriting if you enroll after your initial eligibility period. If you are interested in enrolling, please contact the Hylant representative at 407-320-0364 in the Employee Benefits Department.

Long Term Care Benefit Highlights

Monthly Benefit Amount	Available in increments of $1,000 with $2,000 as the minimum and $6,000 as the maximum
Elimination Period	90 Days
Benefit Duration	Choose 3 year, 6 year or lifetime
Facility Benefit	Receive 100% of the benefit if receiving care at an approved facility such as a nursing home
Home Health Benefit	Receive 75% of the benefit if receiving approved home care
Who is eligible for coverage	You, your spouse, parents, grandparents, aunts, uncles, siblings, children over the age of 18 & in-laws
Additional Plan Features	Inflation protection available on some plans. ALL plans are indemnity reimbursement which means you do not need to submit receipts to receive reimbursement.

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Cancer, Hospital Indemnity & Accident Plans

Cancer Security

The Cancer Security Plan that is available to you and your eligible dependents through Colonial Life is designed to help offset some of the costs associated with the diagnosis and treatment of cancer.

Early detection is key to the fight against cancer, so your policy has a feature that reimburses you for annual cancer screenings.

This plan does require underwriting approval and an additional application **MUST** also be filled out. A policy will not be issued until the medical underwriting process is complete. Once approved payroll deductions will begin.

Please visit the SCPS webpage, www.scps.k12.fl.us, and click on the Employee Benefits link for more information and to obtain an application.

Cancer Security Highlights	
Annual Cancer Screening	$100
Skin Cancer Initial Diagnosis	$300 for skin cancer (once per lifetime) cancer
Chemotherapy & Radiation Benefit	$300 per day for approved treatments (maximums apply)
Hospital Confinement	$300 a day for the first 30 days

Employee Contributions
(20 Payroll Deductions)

Employee Only	*$17.34*
1 Parent Family	*$19.80*
2 Parent Family	*$29.40*

Accident Insurance

This benefit plan will reimburse covered members various amounts for emergency room treatments, hospital admissions and follow up doctor visits as a result of an accident.

The plan will not cover accidents due to certain activities such as parachuting, hang-gliding, parasailing, bungee jumping, etc.

This plan does NOT require underwriting approval but an additional application **MUST** be filled out. A policy will NOT be issued without the application.

Accident Plan Highlights	
Emergency Room Visit	$150
Hospital Admission due to an Accident	$750
Follow-up Doctor Visit	$50
Broken or Fractured Bones	Varies $75 to $7500 depending upon the severity

Employee Contributions
(20 Payroll Deductions)

Employee Only	*$10.80*
Employee + Spouse	*$14.40*
One Parent Family	*$18.00*
Two Parent Family	*$21.60*

Important Note:

All of the Colonial plans require an application for enrollment. This is in addition to going on-line to the ESS website and making your benefit election. Both the Cancer and the Hospital Indemnity Protection Plan require medical underwriting approval BEFORE a policy is issued. During Annual Enrollment, you will be able to apply on-line through Colonial. There will be a link in the ESS site that will take you to the Colonial site. Once you submit your on-line application, you and the Employee Benefits Department will be notified by Colonial if your policy is approved.

For **NEW** hires a paper application is required. This application and HIPAA form can be found on the Employee Benefits Department website. Please turn your application into the Hylant on-site representative who will forward it to Colonial. DO NOT send your application directly to Colonial. This will delay the process and you may run the risk of your policy not being issued at all.

Additional Voluntary Benefits (Colonial)

Hospital Indemnity Protection

This benefit supplements your major medical insurance if you or your dependents are hospitalized due to a covered accident or illness.

It pays you a lump sum if you are hospitalized or have an outpatient surgery. The surgery benefit is tiered depending upon they type of surgery you have. There is also an annual wellness benefit.

NOTE: This plan does require underwriting approval and an additional application **MUST** also be filled out. A policy will not be issued until the medical underwriting process is complete. Once approved payroll deductions will begin. Please visit the SCPS webpage, www.scps.k12.fl.us, and click on the Employee Benefits link for more information and to obtain an application. The Colonial application should be submitted to the on-site Hylant representative in the Employee Benefits Department.

Hospital Indemnity Highlights	
Hospital Confinement	$1,000
Outpatient Surgery	Tier 1 $500 Tier 2 $1,000 (benefit limited to $1,500 per year)
Annual Wellness Exam	$50

Employee Contributions (20 Payroll Deductions)

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

Important Note:

All of the Colonial plans require an application for enrollment. This is in addition to going on-line to the ESS website and making your benefit election. The Hospital Indemnity Protection Plan requires medical underwriting approval BEFORE a policy is issued. During **Annual Enrollment**, you will be able to apply on-line through Colonial. There will be a link in the ESS site that will take you to the Colonial site. Once you submit your on-line application, you and the Employee Benefits Department will be notified by Colonial if your policy is approved.

For **NEW** hires a paper application is required. This application and HIPAA form can be found on the Employee Benefits Department website. Please turn your application into the Hylant on-site representative who will forward it to Colonial. DO NOT send your application directly to Colonial. This will delay the process and you may run the risk of your policy not being issued at all.

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Flexible Spending Accounts (myCafeteriaPlan.com)

Currently Participating?

Your current card will be replenished if enrolled in the new plan year. New cards are provided for new enrollees, otherwise a $5 charge will be charged by MCP to the participant.

All eligible employees will have the opportunity to participate in a Flexible Spending Account (FSA) program administered through MyCafeteriaPlan. The plan covers your dependents even if they are not covered under the SCPS medical plan.

What is a Flexible Spending Account?

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

What are the types of Flexible Spending Accounts?

There is one for medical expenses. You can use this account to pay for medical expenses that you or your dependents incur even if they are not enrolled in the SCPS medical plan. You also have a dependent care flexible account. This account is for DAYCARE expenses ONLY & cannot be used for medical expenses.

How Does a Flexible Spending Account work?

First, you must estimate the amount of out-of-pocket expenses you feel you may incur in the upcoming year. This amount will be your election amount. Your election amount is divided by the frequency of pay periods. This amount is then deducted from your paycheck each pay period on a pre-tax basis. You will receive a debit card for the Medical FSA, which is the most convenient way to receive reimbursement. Simply swipe your debit card at your providers office, pharmacy, hospital, etc. at time of service and your claim will be paid instantly. It is important when you are utilizing the debit card to still ask for and keep an itemized receipt on file. You may still receive a letter from MyCafeteriaPlan requesting this receipt for IRS documentation purposes. Even if you use the debit card, YOU are ultimately responsible to the IRS for documentation (i.e. a receipt). YOU are required to keep it and submit it so the plan is compliant with government regulations.

The Use It or Lose It Rule

Section 125 Flexible Spending Plans are governed by the "use it or lose it" rule, whereby, any amounts remaining at the end of the year are forfeited due to IRS regulations. **All claims must be submitted no later than 90 days after the end of the plan year. For the plan year 2014, claims that happen (incurred) January 1, 2014 through December 31, 2014 you have until March 31, 2015 to file the claim.**

	Without Flex Plan	With Flex Plan
Salary	$700	$700
FSA Election	$0	$25
Taxable Income	$700	$675
Income Tax	$105	$101
State Tax	$56	$54
Social Security Tax	$53	$51
Income After Taxes	$486	$469
Medical Premium	$10	
Medical Expenses	$5	
Dependent Care	$10	$0
Take Home Pay	$461	$469
Net Increase		$8
Pay Periods		x 52
Annual Increase		$416

How Much Can I Contribute annually to the FSA Plan?

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

What if I don't substantiate my claims?

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

Medical FSA Overview (MyCafeteriaPlan)

There are at least two significant ways to benefit from a Flexible Spending Account.

The first is by taking advantage of the tax savings. By reducing your gross income, you pay less in taxes, take home more pay, and have the freedom to choose how your money is used.

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

Medical FSA Claims Reimbursement

Through MyCafeteriaPlan, you have a variety of ways to choose from to get reimbursed for your claims: debit card, on-line submission, fax or mail.

Debit Card

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

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

Filing a claim is easy. You have the convenience of several different methods: on-line, fax e-mail or mail.

On-Line

You can submit your claims on-line at www.mycafeteriaplan.com. To login to your account, go to www.mycafeteriaplan.com There you will be prompted to enter a Username (your 9-digit SSN) and Password (the last four digits of your SSN). Once you are logged in, you should change your Username and Password and verify your personal information. You can also check your account balance(s) and see the status of any claims you have submitted.

Fax, Email or Mail

You are also able to submit your claims via fax at 937-865-6502, by email at claims@mycafeteriaplan.com or by mail

MyCafeteriaPlan
ATTN: Claims Department
432 East Pearl Street
Miamisburg, OH 45342

Medical Eligible Expenses

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

- Acupuncture (if medically necessary)
- Ambulance service
- Chiropractic care
- Contact lenses (corrective)*
- Diagnostic tests
- Doctor's fees
- Drugs (prescription only**)
- Experimental medical treatment (only if referred by a physician)
- Eyeglasses
- Hearing aids & exams
- Injections and Vaccinations
- Optometrist fees
- Orthodontic treatment*
- Prescription drugs to alleviate nicotine withdrawal symptoms
- Smoking cessation programs/treatments
- Transportation for local medical care
- Wheelchairs
- X rays

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

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

Dependent FSA Expenses (myCafeteriaPlan.com)

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

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

Eligible expenses:

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

Ineligible expenses:

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

Ready, Set, Enroll...

This worksheet has been designed to help you manage your 2014 benefit elections. **Returning** employees and employees hired by September 3rd are able to enroll on-line. **New employees hired after September 3rd and employees** without access to the internet can turn an enrollment form into the Employee Benefits Department. Annual Enrollment begins October 1st and ends promptly at 4:30 pm on October 14th.

If are ready to make your elections, please log onto the ESS site (the site you view your paychecks) to enroll. Step-by-step instructions of this process begin on the next page. Please be sure to click the submit button so the system registers all of your elections.

If you are enrolling any of your eligible dependents, please have their names, dates of birth and social security numbers available when you are ready to enroll. Additionally, you will have to provide documentation that the dependents you enroll are eligible. Examples of such documentation are a marriage certificate, birth certificate, court order or a tax return. Please provide this documentation to the Employee Benefits Department.

BENEFIT	PLAN SELECTION	PAYROLL DEDUCTION
Medical (pg.6)		$
Board Disability (pg.7)		$
Dental (pg. 16)		$
Vision (pg. 17)		$
Additional Life Insurance (pg. 18)		$
Short Term Disability (pg. 20)		$
Long Term Disability (pg. 20)		$
Cancer Plan (pg. 22)		$
Accident Plan (pg. 22)		$
Hospital Income Protection (pg.23)		$
Medical Flexible Spending Account (pg.25)		$
Dependent Care Flexible Spending Account (pg. 26)		$
TOTAL DEDUCTIONS		$

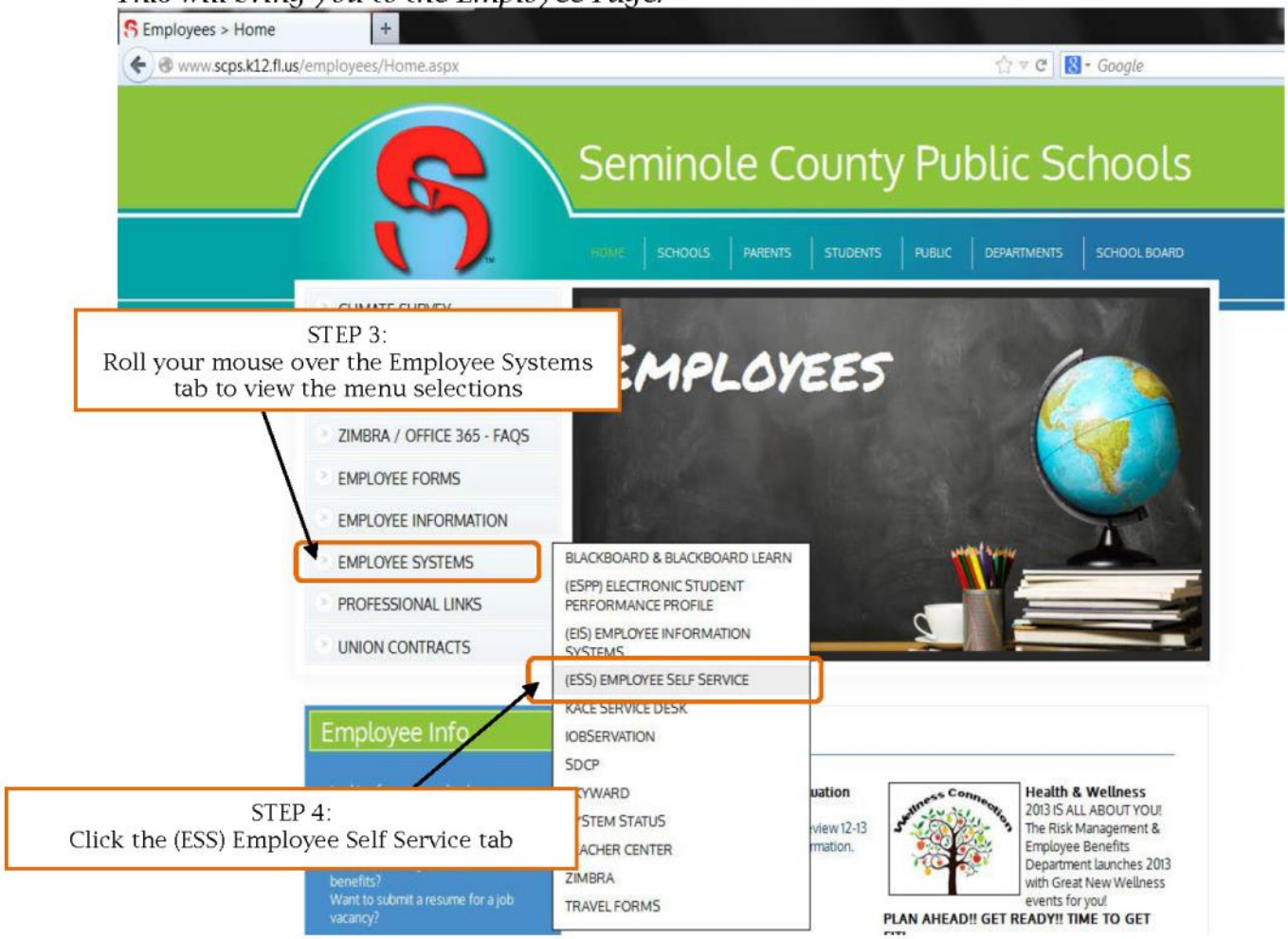
Ready, Set, Enroll…

You will sign into the ESS (Employee Self Service) system using your user ID and password. Click the self service tab, and then go to the Benefits panel. Click on the Benefits Enrollment link.

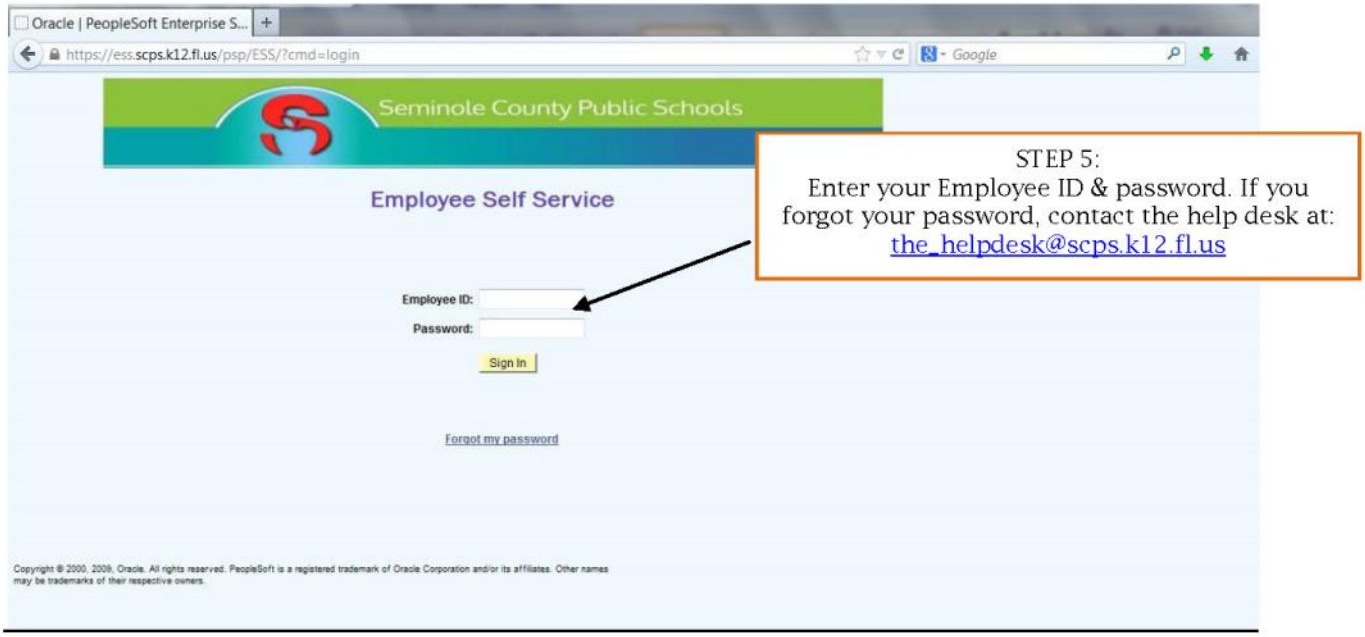
Annual Enrollment is from October 1 – October 14 until 4:30pm. Please be sure to complete any and all changes in advance. If you have NO CHANGES, please be sure to also review your benefits and submit. If you do not receive a confirmation page and number, you have NOT submitted completely.

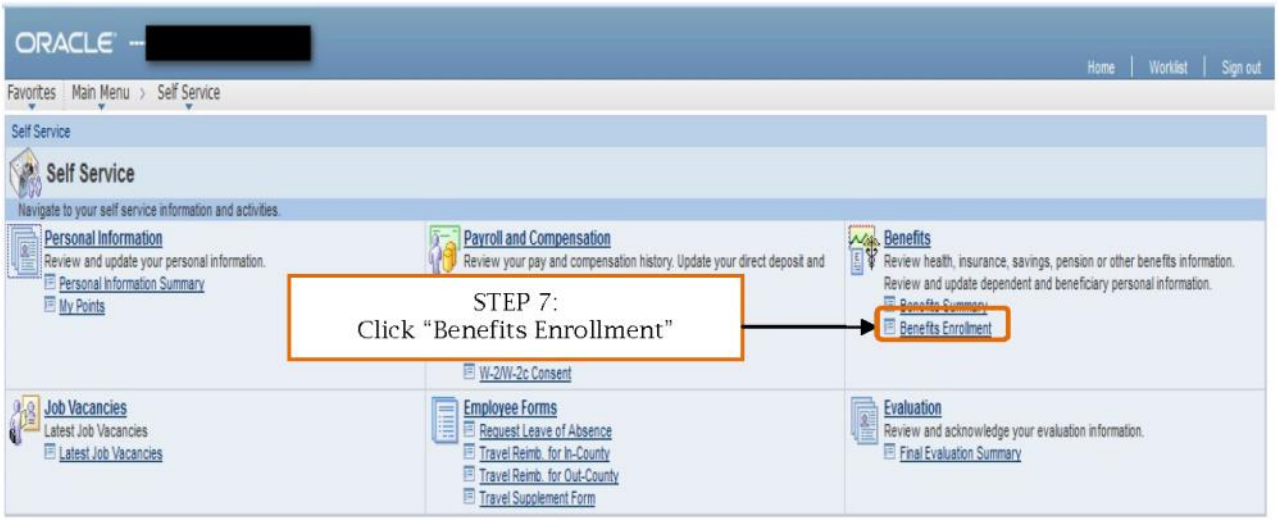
The step by step instructions will guide you through this process:

Step 1: Go to www.scps.k12.fl.us
Step 2: Scroll to the bottom of the page, and click "Employee Login" on the right side. *This will bring you to the Employee Page.*

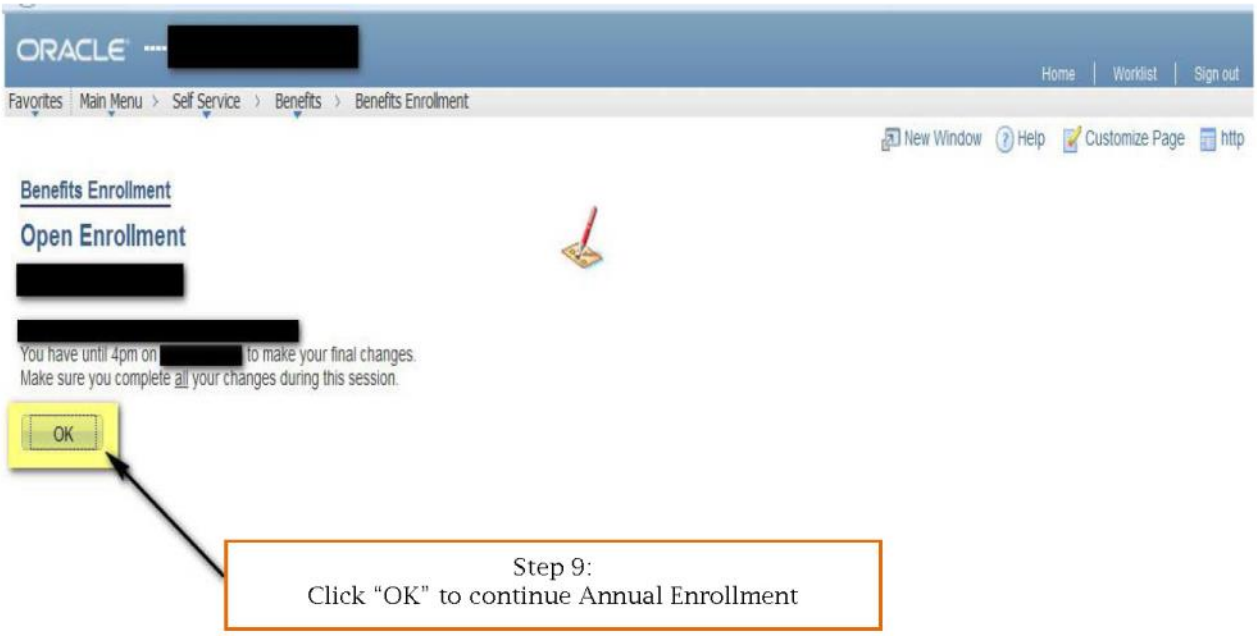


Ready, Set, Enroll…



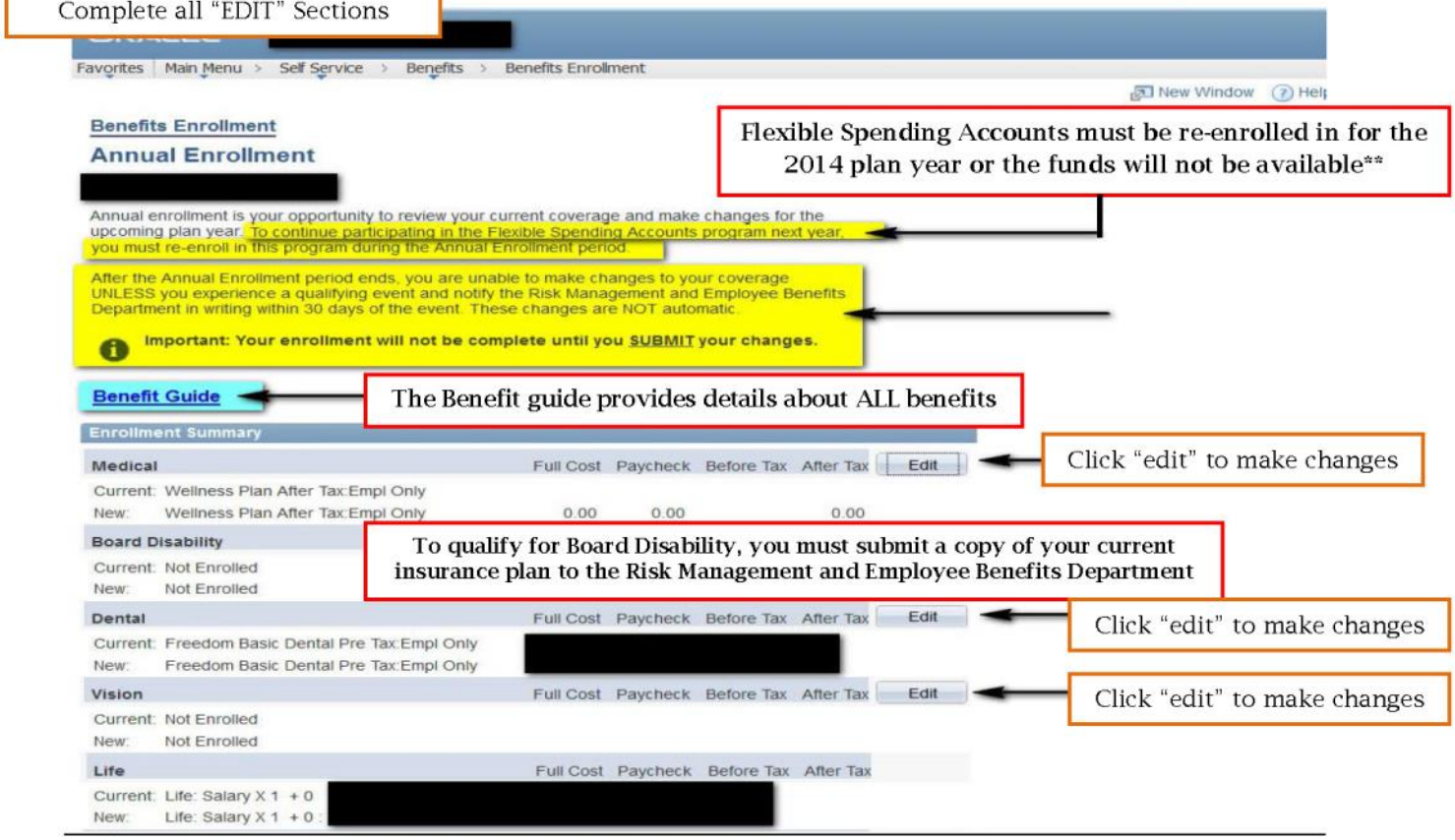


Ready, Set, Enroll...



Ready, Set, Enroll…

Step 10:
Complete all "EDIT" Sections



Flexible Spending Accounts must be re-enrolled in for the 2014 plan year or the funds will not be available**

The Benefit guide provides details about ALL benefits

Click "edit" to make changes

To qualify for Board Disability, you must submit a copy of your current insurance plan to the Risk Management and Employee Benefits Department

Click "edit" to make changes

Click "edit" to make changes

Click "edit" to make changes

Click "edit" to make changes

Click "edit" to make changes

Click "edit" to make changes

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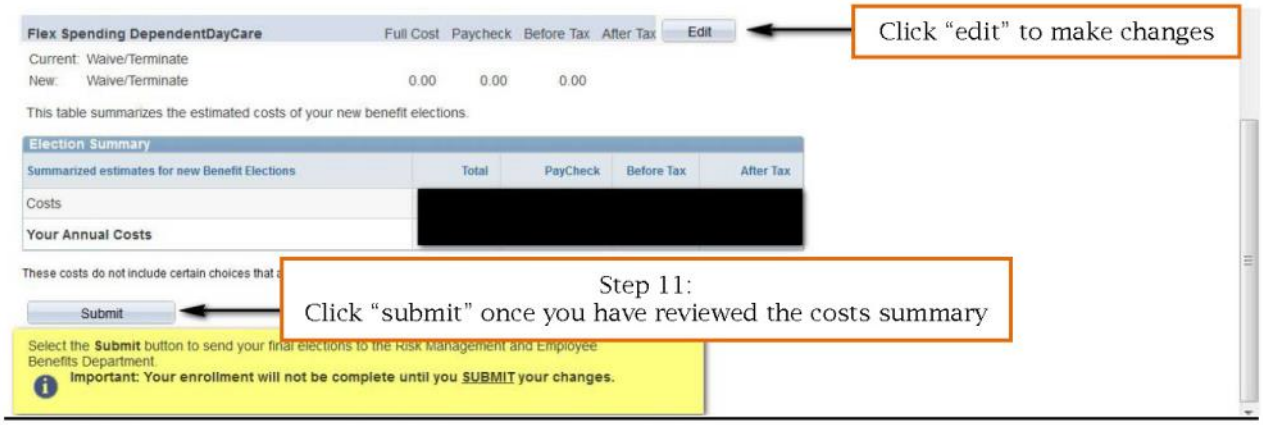
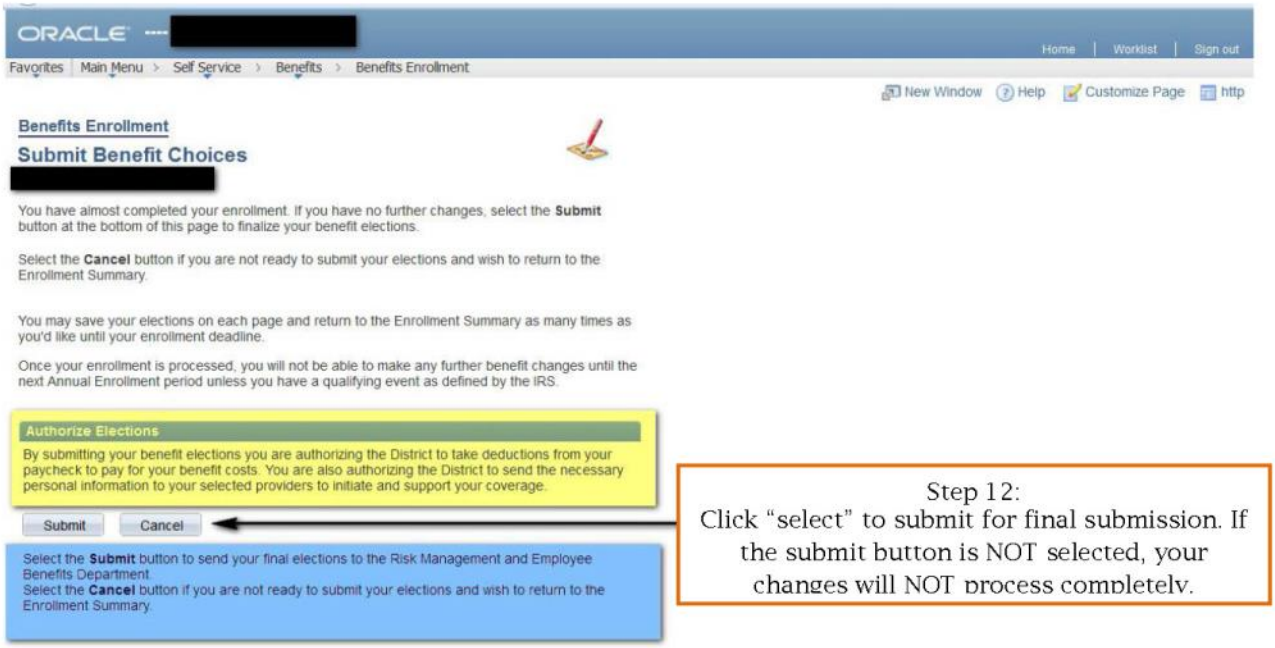
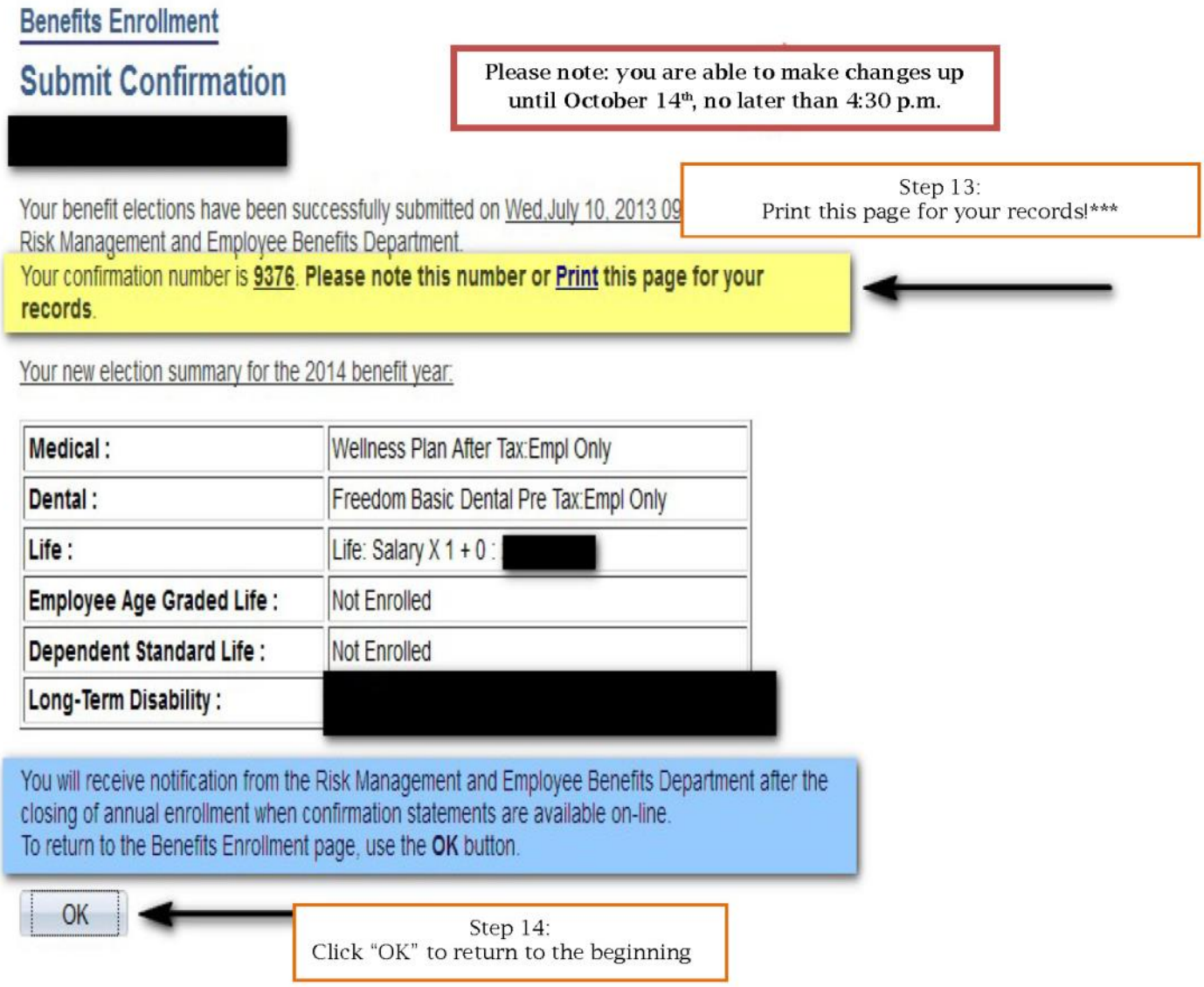
Click "edit" to make changes

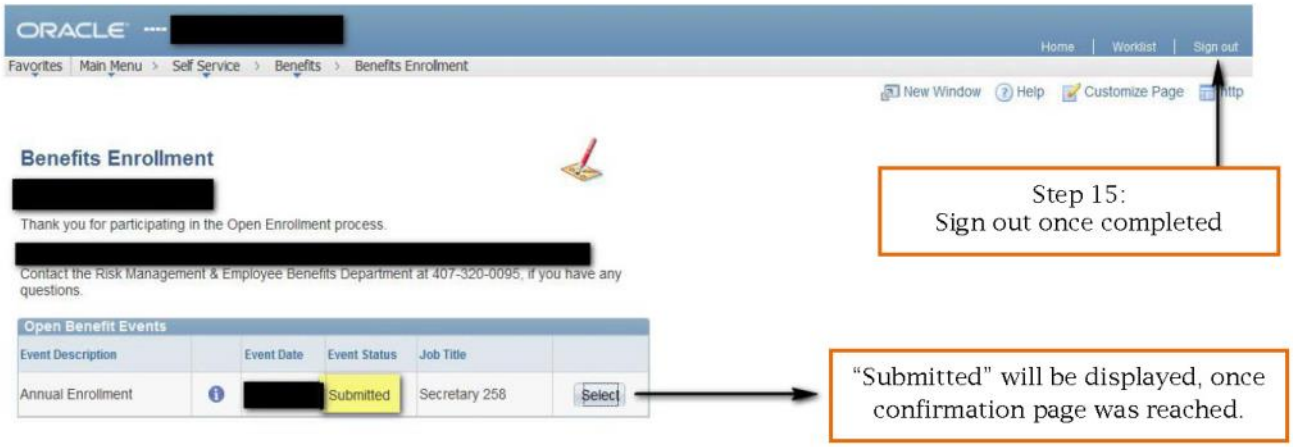
Ready, Set, Enroll...





Ready, Set, Enroll...





Retirement

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

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

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

Florida Retirement System (FRS)

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

Your employer contributes the majority of your FRS retirement plan savings. In addition, a mandatory 3% pre-tax contribution is directed from your paycheck into your retirement account regardless of the plan you choose.

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

Employees hired July 1, 2011, or after are vested under the FRS Pension Plan after you have COMPLETED eight (8) years of CREDITABLE service. Vesting refers to your earned right to receive a retirement benefit when you reach normal or early retirement age, even though you may have terminated employment before that age. Normal retirement is 65 years of age OR 33 years of service regardless of age. If you have at least eight years of creditable service but have not reached your normal retirement age, as described above, you can take early retirement. Your benefit will be reduced 5% for each year you are under normal retirement age. If you are a rehired employee who has Pension Plan service prior to July 1, 2011, you will vest in your benefit after six years of FRS service and your normal retirement age is 62.

Enrollment 403(b) & 457(b) Plans

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

Insurance Definitions

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

CARRIER: The insurance company.

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

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

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

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

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a medical claim processed on your behalf.

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

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

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

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

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

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

OUT OF NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

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

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

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

Important Disclosures

NOTE TO ALL EMPLOYEES:

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

Seminole County Public Schools
The Employee Benefits Department
400 East Lake Mary Blvd.
Sanford, FL 32773
407-320-0095

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY

This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS

Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED

Seminole County Public Schools reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

(a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within 30 days of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage. However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within 30 days of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within 60 days after either:

(1.) Your or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or

(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Annual Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Annual Enrollment Period.

(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Annual Enrollment Period).

Important Disclosures

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

Seminole County Public Schools
The Employee Benefits Department
400 East Lake Mary Blvd.
Sanford, FL 32773
407-320-0095

NOTICE REGARDING PRE-EXISTING CONDITIONS

The Seminole County Public Schools Group Health Plan (the "Plan") imposes a pre-existing condition limitation as detailed in the Benefit Guide issued by the insurance carrier. Please review the Benefits Guide carefully (you can obtain another copy of it by contacting the Plan Administrator). The following provides an overview of this limitation as well as protections provided under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordable Care Act of 2010 (PPACA).

The Plan complies with the changes set forth in the PPACA of 2010 and does not impose pre-existing condition exclusions with respect to eligible dependent children who are under 19 years of age. This change is effective as of the first day of the Plan Year beginning on or after September 23, 2010; and with respect to all other covered individuals on the first day of the Plan Year beginning on or after January 1, 2014.

Pre-existing condition exclusion means that if you have a medical condition before enrolling in the medical program, you might have to wait a certain period of time before the medical program will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month look-back period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a new hire waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the medical program or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of more than 63 days. **To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should promptly give the Plan Administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have**. If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or insurer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan Administrator if you need help demonstrating creditable coverage.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator (with the assistance of the prior plan administrator or insurer) to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment, and may result in a loss of coverage under this Plan and other employment disciplinary action.

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card.

If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address or phone number below.

Seminole County Public Schools
The Employee Benefits Department
400 East Lake Mary Blvd.
Sanford, FL 32773
407-320-0095

Important Disclosures

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

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

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

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

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

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

NOTICE REGARDING MICHELLE'S LAW

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

The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

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

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

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

NOTICE REGARDING PATIENT PROTECTION RIGHTS

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

One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010. You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. 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

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making referrals or notifying primary care provider or Plan of treatment decisions. If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

MEDICARE NOTICE

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

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

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

Seminole County Public Schools
The Employee Benefits Department
400 East Lake Mary Blvd.
Sanford, FL 32773
407-320-0095

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.
Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

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

If you are covered by Medicare this information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your company has determined that the prescription drug coverage offered by their carrier's Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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

You should also know that if you drop or lose your current

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coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 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 November to join.

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, visit Social Security at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

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

Seminole County Public Schools
The Employee Benefits Department
400 East Lake Mary Blvd.
Sanford, FL 32773
407-320-0095

NOTICE REGARDING THE EARLY RETIREE REINSURANCE PROGRAM

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

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

FAMILY MEDICAL LEAVE ACT

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

THE SECURITY OF YOUR INFORMATION (HIPAA)

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

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MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer -sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. **If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of April 16, 2010. You should contact your State for further information on**

ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants/default.aspx
Phone: 1-877-764-5437

ARKANSAS – CHIP

Website: http://www.arkidsfirst.com/
Phone: 1-888-474-8275

COLORADO – Medicaid and CHIP

Medicaid Website: http://www.colorado.gov/
Medicaid Phone: 1-800-866-3513
CHIP Website: http:// www.CHPplus.org
CHIP Phone: 303-866-3243

CALIFORNIA – Medicaid

Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

FLORIDA – Medicaid

Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml
Phone: 1-866-762-2237

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/oms/
Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP

Medicaid & CHIP Website: http://www.mass.gov/MassHealth
Medicaid & CHIP Phone: 1-800-462-1120

GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

INDIANA – Medicaid

Website: http://www.in.gov/fssa/2408.htm
Phone: 1-877-438-4479

KANSAS – Medicaid

Website: https://www.khpa.ks.gov
Phone: 800-766-9012

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.la.hipp.dhh.louisiana.gov
Phone: 1-888-342-6207

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Important Disclosures

STATES OFFERING PREMIUM PAYMENT ASSISTANCE PROGRAMS CONTINUED

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/index.htm
Phone: 573-751-6944

MONTANA – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092

NEVADA – Medicaid and CHIP

Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
CHIP Website: http://www.nevadacheckup.nv.org/
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm
Phone: 1-800-852-3345 x 5254

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP

Medicaid Website: http://www.hsd.state.nm.us/mad/index.html
Medicaid Phone: 1-888-997-2583
CHIP Website:
http://www.hsd.state.nm.us/mad/index.html
Click on Insure New Mexico
CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.nc.gov
Phone: 919-855-4100

OREGON – Medicaid and CHIP

Medicaid & CHIP Website:
http://www.oregonhealthykids.gov
Medicaid & CHIP Phone:
1-877-314-5678

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm
Phone: 1-800-644-7730

RHODE ISLAND – Medicaid

Website: www.dhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – Medicaid

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

VERMONT– Medicaid

Website: http://ovha.vermont.gov/
Telephone: 1-800-250-8427

WASHINGTON – Medicaid

Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-877-543-7669

WEST VIRGINIA – Medicaid

Website: http://www.wvrecovery.com/hipp.htm
Phone: 304-342-1604

WISCONSIN – Medicaid

Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: http://www.health.wyo.gov/healthcarefin/index.html
Telephone: 307-777-7531

To see if any more States have added a premium assistance program since April 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
OMB Control Number 1210-0137

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Notes

Contact Information

Carrier	Plan/Policy Number	Customer Service	Website & Network
Assurant	I-453		www.assurantemployeebenefits.com
Dental Insurance		1-800-442-7742 1-800-443-2995	PPO Network= Assurant Dental Network (DHA) Prepaid Network= Prepaid Dental Series
CIGNA		Member Services:	
Medical Plans		1-800-244-6224 Care24 & EAP: 1-877-622-4327	www.mycigna.com
CIGNA	LK8316 (STD)		
Short Term & Long Term Disability	LK8317 (LTD)	1-800-362-4462	www.cigna.com
Colonial Life			
Accident, Cancer & Hospital Indemnity		1-800-325-4368	www.coloniallife.com
Express Scripts	JRJA		
Prescriptions		1-877-279-6405	www.express-scripts.com
Mutual of Omaha	GUG-6K71		
Disability in Lieu of Medical		1-800-877-5176	
MyCafeteriaPlan			
Flexible Spending Accounts		1-800-865-6543 1-937-865-6502 (claims fax)	www.myCafeteriaPlan.com
ReliaStar Life Ins Co	65741-7		
Life Insurance		407-320-0095	benefits@scps.k12.fl.us
United Healthcare	SEME		
Vision Insurance		1-800-638-3120	www.myuhcvision.com
UNUM	067229		
Long Term Care Insurance		1-800-227-4165	www.unum.com
Questions	Pam Dixon — Onsite Cigna Representative	407-320-0106	pam_dixon@scps.k12.fl.us
	Prescription Questions	407-320-0095	
	Mark Zebott Voluntary Benefits	407-320-0364	mark_zebott@scps.k12.fl.us
	Employee Benefits	407-320-0095/407-320-0134	benefits@scps.k12.fl.us
	Fax	407-320-0389	

When contacting any of the companies above it is important to have the Insurance card or I.D. number (s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, i.e. Explanation of Benefits, denial letter, receipts, etc.