SEMINOLE COUNTY PUBLIC SCHOOLS

JANUARY 1, 2015 — DECEMBER 31, 2015

EMPLOYEE BENEFITS & ENROLLMENT GUIDE

CONTACT INFORMATION

Carrier	Plan/Policy Number	Customer Service	Website & Network
Medical Plans: Cigna	3337309	1-800-244-6224	www.mycigna.com
Employee Assistance Program: Cigna		1-877-622-4327	
Prescriptions: Cigna		1-800-244-6224	
Dental Insurance: Assurant	I-453	1-800-442-7742 1-800-443-2995	www.assurantemployeebenefits.com PPO Network= Assurant Dental Network (DHA) Prepaid Network= Prepaid Dental Series
Buy up Vision Insurance: United Healthcare	SEME	1-800-638-3120	www.myuhcvision.com
Flexible Spending Accounts: MyCafeteriaPlan		1-800-865-6543 1-937-865-6502 (claims fax)	www.myCafeteriaPlan.com
Short Term & Long Term Disability: Cigna	LK8316 (S.T.D) LK8317 (L.T.D)	1-800-362-4462	www.cigna.com
Disability in Lieu of Medical: Mutual of Omaha	GUG-6K71	1-800-877-5176	
Life Insurance: ReliaStar Life Ins Co:	65741-7		benefits@scps.k12.fl.us
Accident, Cancer & Hospital Indemnity: Colonial Life		1-800-325-4368	www.coloniallife.com
Long Term Care Insurance: UNUM	067229	1-800-227-4165	www.unum.com
FRS (Florida Retirement System)	Janice Hickson Retirement Specialist	407-320-0498	janice_hickson@scps.k12.fl.us enrollment@frs.state.fl.us
To reach the Employee Benefits Department		407-320-0095 For a Menu of Options Fax: 407-320-0389	benefits@scps.k12.fl.us pam_dixon@scps.k12.fl.us nicole_enright@scps.k12.fl.us mary_libersat@scps.k12.fl.us diane_mason@scps.k12.fl.us loyda_nieves@scps.k12.fl.us laura.ward@cigna.com mark_zebott@scps.k12.fl.us
Cigna Pre-enrollment Hotline	Medical & Pharmacy coverage	1-800-564-7642	

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OVERVIEW

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;
- 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, Social Security card or a marriage certificate.

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

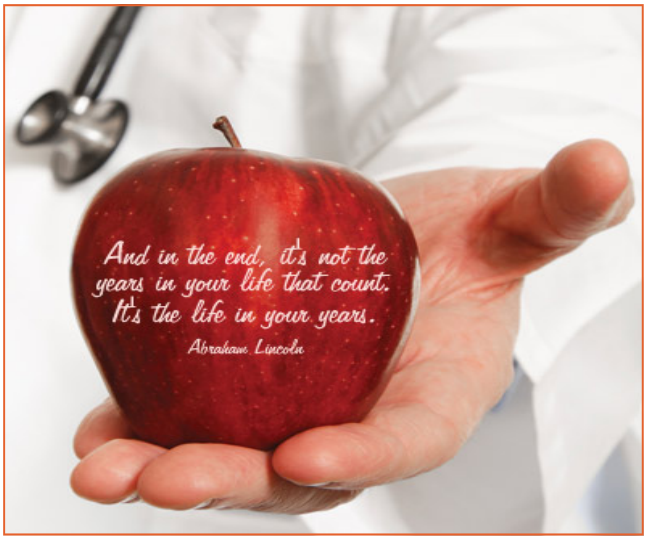
Qualifying Event: A family status change as defined by the IRS includes:

- 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.



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.

MEDICAL AT A GLANCE, CHANGES & TIPS

The School Board pays an average of $6,967 annually towards the cost of your coverage.

Employee 20 deduction contributions for dependent coverage are:

Type of Coverage	Wellness Plan	Standard Plan	Family Plan
Employee Only	$0.00	$0.00	$0.00
Employee + Spouse	$433.64	$384.41	$365.23
Employee + Children	$369.23	$328.84	$313.11
Employee + Family	$787.78	$698.70	$663.98

2015 Wellness Plan Requirements:

To have qualified for the Wellness Plan, all benefit eligible employees must have completed an annual physical and Lab work/biometrics. The dates for completion were from September 13, 2013 through August 31, 2014.

***Note: Physicals are not bound by calendar year per the District's medical plans.**

Verification of completion:

1) Your physician filed a wellness exam claim with United Healthcare (9/13/13—12/31/13) or Cigna (2014).
1) Your physician filed annual lab work/biometrics with United Healthcare or Cigna or you participated at any of the free SCPS biometric clinics between the months of March and April.
2) You are a new hire between 9/13/13 - 8/31/14 and submitted a health certification form to Human Resources.

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.

HEALTH & WELLNESS RESOURCES

More detailed information about your benefits is available on the SCPS website: www.scps.k12.fl.us/benefits.

Tips to better manage your Health:

- **Create an account on www.mycigna.com. By doing so, you will have access to:**
  - ☑ Search for doctors near you
  - ☑ Review the explanation of benefits (EOB)
  - ☑ Find more information on medical condition
  - ☑ Take a Health Assessment
- **When seeing your physician, confirm they have your updated information on file. This includes:**
  - ☑ Group policy number
  - ☑ Individual identification number
- **Complete any physician recommended exams and lab work based on age, sex, and family history.**
- **Keep a record of all communication with your insurance carrier or healthcare provider. Include the date and time of any conversation and the name of the person with whom you spoke.**

Engage in your health! Enroll in Cigna online or telephonic coaching programs today!

- Weight and nutrition management
- Stress management
- Tobacco Cessation
- Asthma
- Hypertension/Cardiac Concerns
- Anxiety/Depression
- Diabetes
- Low Back Pain…and more!

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

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.

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.

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

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

Register on mycigna.com:

- Find in-network doctors and medical facilities
- Manage and track your medical and pharmacy claims
- See cost estimates for medical procedures that are completely tailored to your medical plan's current deductible, coinsurance, and out-of-pocket maximum.
- Use the prescription drug price quote tool to compare prices between Cigna Home Delivery and our network of retail pharmacies to help ensure you're getting the best price possible. You can also use the tool to find lower-cost alternatives to your current prescriptions.
- Investigate health improvement programs for weight loss, exercise, smoking cessation, stress reduction, aging, etc.
- Compare quality of care ratings for doctors and hospitals
- Access a variety of health and wellness tools and resources

CHOOSING THE RIGHT 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 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.

BE A "SAVVY" HEALTHCARE CONSUMER AND LOWER YOUR OUT-OF-POCKET EXPENSES!

1. **Stay in network.** Save big when you use a doctor, hospital or facility that's part of the Cigna network. Chances are, there's a network doctor or facility in your neighborhood. Log onto mycigna.com and use the "Find a Provider" search. It's easy to find quality, cost-effective care right where you need it. In fact, one thing you won't find is higher costs.

2. **Ask before you go.** Your primary care doctor may be in your plan's network, but that doesn't mean everyone and everywhere they refer you to is, too. When your doctor gives you a referral, don't be afraid to ask if the facility, lab or specialist is in your plan's network. If you don't, you may unintentionally go out of network and be surprised by a higher bill than expected. You can always log onto **mycigna.com** to check if providers are in your network or call the number on the back of your ID card for help.

3. **Use Cost Transparency Tools on mycigna.** Compare out-of-pocket estimates – *specific to your coverage plan* – for actual treatment and procedure costs. *And*, out-of-pocket estimates calculate your deductible, the percentage you pay (coinsurance) and any account balances on that given day. Estimates show both doctor *and* facility fees in one place, allowing you to more accurately compare total costs of treatment *before* choosing your doctor and where to receive care.

4. **Use an urgent care center.** If you need medical attention but it's not serious or life threatening, you may not have to go to an emergency room (ER). An urgent care center provides quality care like an ER, but can save you hundreds of dollars. Visit an urgent care center for things like minor cuts, burns and sprains, fever and flu symptoms, joint or lower back and urinary tract infections.

   Urgent Care Copay = $50

   ER Copay: $250

5. **Go to a convenience care clinic.** Need to see your doctor but can't get an appointment? Try going to a convenience care clinic. You'll get quick access to quality and cost-effective medical care. A convenience care clinician can treat you for sinus infections, rashes, earaches, minor burns and other routine medical conditions. You can find convenience care clinics in grocery stores, pharmacies and other retail stores.

6. **Stick with lower-cost in-network labs.** If you go to a national lab such as Quest Diagnostics® or Laboratory Corporation of America® (LabCorp), you can get the same quality service and save up to 84%.** Even though other labs may be part of the Cigna network, you'll often get even bigger savings when you go to a national lab. And with hundreds of locations nationwide, they make it easy to get lab services at a lower cost.

7. **Consider Cigna Home Delivery Pharmacy.** Home Delivery is designed especially for individuals who take prescription medications on a regular basis, such as those used for diabetes, asthma, heart conditions, high blood pressure, birth control and more. Get a 90-day supply for a two-month copay. Reminder service to refill or take your medication available at Cigna.com/CoachRx. Cigna pharmacists are available 24/7, 365 days a year at 1.800.285.4812. Manage your medication on mycigna: compare medication prices, check order status, order refills and review number of refills remaining.

8. **Ask for Generics**. When prescribed a medication, ask your doctor if a generic version is available. Generics are always priced at a lower cost than brand name medications.

BECOME ENGAGED IN MANAGING YOUR HEALTH

1. **Be your own health advocate and work with a health coach!** Call the number on the back of your Cigna ID card to enroll in **telephonic health coaching**. Coaching is available for a variety of health conditions including: diabetes, COPD, hypertension, asthma, depression, anxiety, weight management, stress management, tobacco cessation, and more. You will receive one-on-one wellness coaching with the same health advocate who has convenient evening and weekend hours available for appointments. Each program is easy to use, free to you, and available where and when you need it.

2. **Improve Your Health Online!** Complete health coaching online via **My Health Assistant** on **mycigna.com**. You choose the goals and track your own progress! My Health Assistant gives you friendly reminders and encouragement. You can adjust your plan and change activities as you go. It's flexible and fit, just for you! Powered by WebMD, My Health Assistant delivers a robust and personalized coaching experience that can build habits and lay the groundwork towards achieving your goals.

3. **Complete your health assessment.** The **Cigna health assessment**, located on **mycigna.com** is an easy-to-use questionnaire about your health and well-being. It produces a personal report that includes suggestions for health screenings, provides a snapshot of overall health, identifies preventable and common conditions and recommends steps for improvement. This confidential, online questionnaire will give you a better understanding of your health today and teach you simple steps for improving your health in the future.

4. **Understand your medical and pharmacy plan.** Visit **mycigna.com** to enroll in health coaching programs, track your claims, stay updated on your deductible and out-of-pocket max amounts, print ID cards, find in-network providers/facilities, compare quality of care ratings for doctors and hospitals, access a variety of health and wellness resources, and use the cost-transparency tools to find the cost of medical procedures, surgeries, and prescriptions. Mycigna.com is your personal healthcare portal – the site is completely customized to YOU!

5. **Utilize your health dashboard.** Your **Health Dashboard on mycigna.com** shows your personalized health information on one page - such as goals, next steps, status and biometrics. The information is presented in simple ways making it easy for you to know your "numbers" and understand what to do next. The Dashboard links you to personally relevant information and tools - connecting you quickly and easily!

HEALTH PLAN DETAILS: CIGNA

BENEFIT	WELLNESS PAN	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 VISIT	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
EMERGENCY ROOM (copay waived if admitted)	$250 copay	$250 copay	$250 copay
AMBULANCE	20% after deductible	30% after deductible	30% after deductible
OUTPATIENT SURGERY	20% after deductible	30% after deductible	30% after deductible
X-RAYS AND LABS (LabCorp or Quest)	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	No charge	No charge	No charge
URGENT CARE FACILITY (copay waived if admitted)	$50 copay	$50 copay	$50 copay
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

NOTE: THERE ARE NO OUT OF NETWORK BENEFITS OFFERED.

HEALTH PLAN DETAILS: CIGNA

BENEFIT	WELLNESS PAN	STANDARD PLAN	FAMILY PLAN
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
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

NOTE: THERE ARE NO OUT OF NETWORK BENEFITS OFFERED.

PRESCRIPTIONS: CIGNA

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

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

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

PRESCRIPTION DRUG LIST

Your plan's drug list contains generic drugs and a wide range of preferred brand-name drugs that have been approved by the US Food and Drug Administration (FDA). Prescription drugs are chosen to be included on the prescription drug list because they are safe, effective and save money. The list of drugs covered under the plan is reviewed periodically. PLEASE NOTE: The drugs on the prescription drug list can change during the plan year and as a result could change your copayment. Non-preferred brand-name medications are not covered under your plan.

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

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

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

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

Tips to better managing your Prescriptions:

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

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

HOW TO USE CIGNA'S PHARMACY

MAINTENANCE DRUGS & 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.

Maintenance medication must be dispensed through the Cigna Home Delivery 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 for prescriptions that are dispensed for any quantity over a 31 day supply.

FILLING PRESCRIPTIONS VIA HOME DELIVERY

Once you have obtained a prescription from your physician for a 90-day supply with refills, send it along with a home delivery form and your payment to Cigna Home Delivery Pharmacy. Your medication should shipped to you within 7 to 10 days from the time Cigna Home Delivery Pharmacy receives your order. You may also call the Cigna Home Delivery Pharmacy at 800-285-4812 or request Cigna contact your physician for new prescriptions.

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

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

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

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

Please remember:

- ☑ Order all maintenance medication through Cigna Home Delivery Pharmacy
- ☑ Ask for generic or lower cost alternatives to brand name drugs
- ☑ Show your Cigna ID card at the pharmacy

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 Contributions (20 Payroll Deductions)

	Prepaid 225 Plan	Freedom Basic Plan	Freedom Preferred Plan
Employee Only	$8.47	$13.35	$20.00
Employee + 1 Dependent	$13.86	$25.06	$37.28
Employee + 2 or More Dependents	$22.95	$42.93	$63.14

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 better manage your dental benefits create an account on www.assurantemployeebenefits.com. By doing so, you will have access to see a list of participating providers go to: 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.

PLEASE NOTE: THIS BENEFIT BEGINS THE FIRST DAY OF THE MONTH FOLLOWING 90 DAYS FROM DATE OF HIRE. THE HIRE DATE COULD DIFFER FROM THE CONTRACT SIGN DATE.

	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 (Child and Adult)	See Copayment List located on the Employee Benefits website	Not Covered		Lifetime maximum: $1,000 (For children under the age of 19)	

VISION: UNITED HEALTHCARE

Employee Contributions (20 Payroll Deductions)		
Employee Only	**Employee + 1 Dependent**	**Employee + 2 or More Dependents**
$4.37	$7.01	$10.11

The voluntary vision coverage is provided by United Healthcare Vision. **This plan is separate from the vision benefits available under your medical plan with CIGNA.** The voluntary vision plan gives you coverage for the hardware that helps you see better like glasses 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 ($20 copay). If you have good eye sight and do not need glasses or contacts to see better, then your medical plan provides you coverage to have your eyes examined to ensure they stay healthy.

	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	$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	$75 Elective $175 Medically Necessary

Tips to better managing your vision benefits:

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

FLEXIBLE SPENDING: MYCAFETERIA

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

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 DAYCARE FSA OVERVIEW

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.

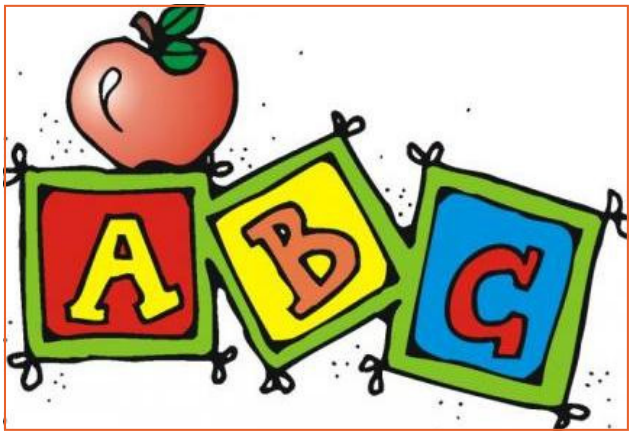
Funds in this account are only available for reimbursement as they are accumulated via payroll deductions, it does not have the same cash flow increase as the medical FSA. For example, if you have an annual election of $1,000 ($50 per paycheck), the full $1,000 is NOT available on January 1st. Only the 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



SHORT & LONG TERM DISABILITY: CIGNA

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

LTD Employee Contribution (20 Payroll Deductions) $6.57

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

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

LONG TERM CARE: UNUM

Long Term Care is care that isn't covered by any medical or disability income insurance, or by Medicare. Long Term Care is needed when you or a family member (spouse, parents, grandparents, in-laws, etc.) become unable to care for themselves on their own and 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

CANCER & ACCIDENT INSURANCE: COLONIAL

CANCER INSURANCE: Employee Contributions (20 Payroll Deductions)		
Employee Only	1 Parent Family	2 Parent Family
$17.34	$19.80	$29.40

ACCIDENT INSURANCE: Employee Contributions			
Employee Only	Employee + Spouse	1 Parent Family	2 Parent Family
$10.80	$14.40	$18.00	$21.60

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.

Accident Insurance

The Accident Insurance Plan is available to you and your eligible dependents through Colonial Life. 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.

Cancer Security Highlights	
Annual Cancer Screening	$100 (Paid only once)
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

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

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.

HOSPITAL INDEMNITY PROTECTION

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.

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 (Paid only once a year)

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.

LIFE INSURANCE: RELIASTAR

Board Paid Basic Life Insurance

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 does not continue when you retire.**

Plan Features	Benefit Amount
Employee Life Insurance	Available in increments of $10,000 not to exceed four times (4X) your annual salary to a maximum benefit of $300,000 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

ADDITIONAL LIFE INSURANCE RATES

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

	<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

APPROVED LOA & NEWBORN COVERAGE

Board Approved Leave of Absence

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

Billing 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

A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium.

Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

Your Dependents will be insured only if you are insured.

To permanently add your newborn to your policy, you must submit an enrollment form to the Employee Benefits Department no later than 60 days from the date of birth. Additionally, a copy of the birth certificate and the newborn's social security number is required to be submitted to the Employee Benefits Department within 30 days of the birth.

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

If you want the baby to be covered under your spouse's group insurance plan, then you will need to add the baby to his or her plan at the time of birth. 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.

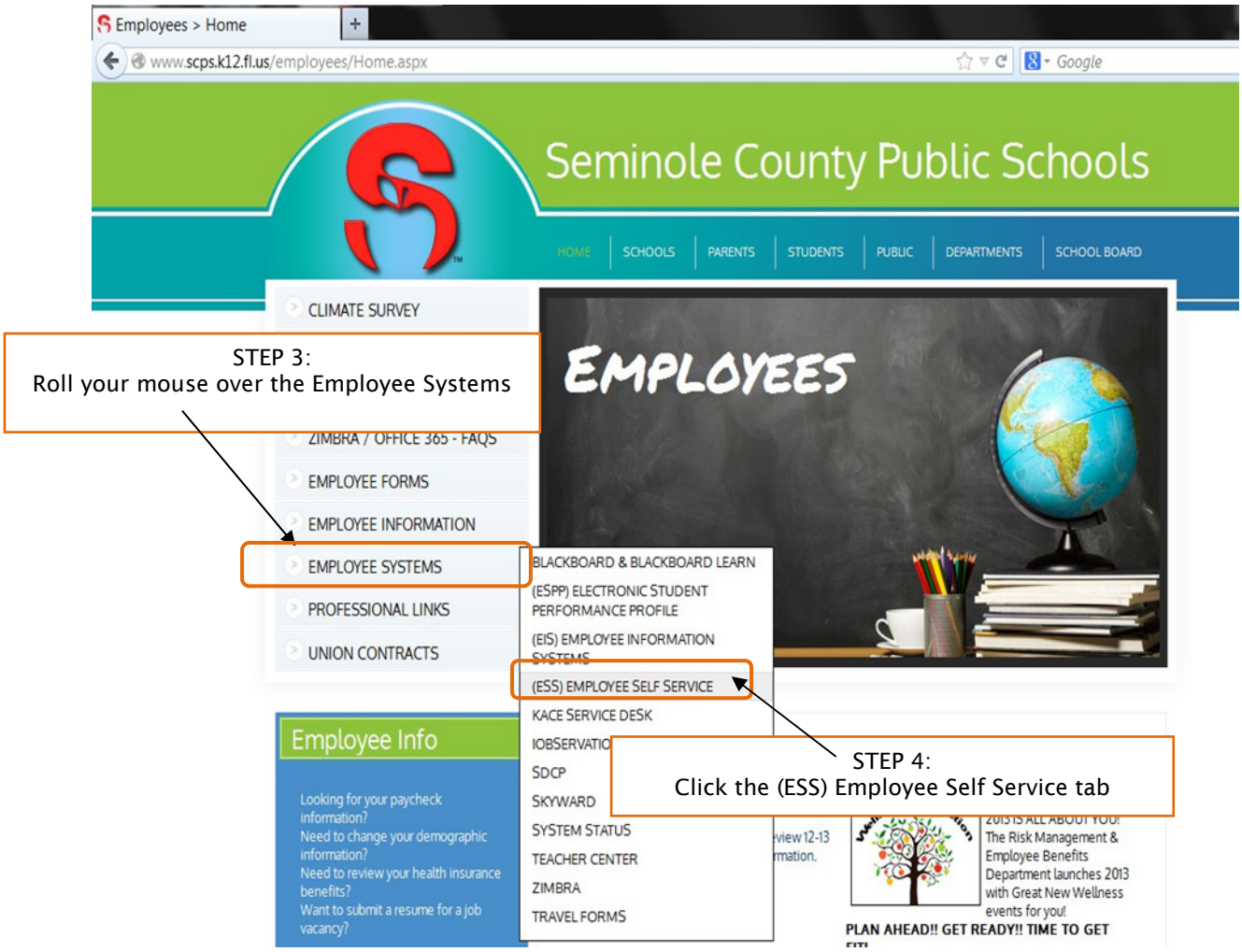
ANNUAL ENROLLMENT: HOW TO ENROLL

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.

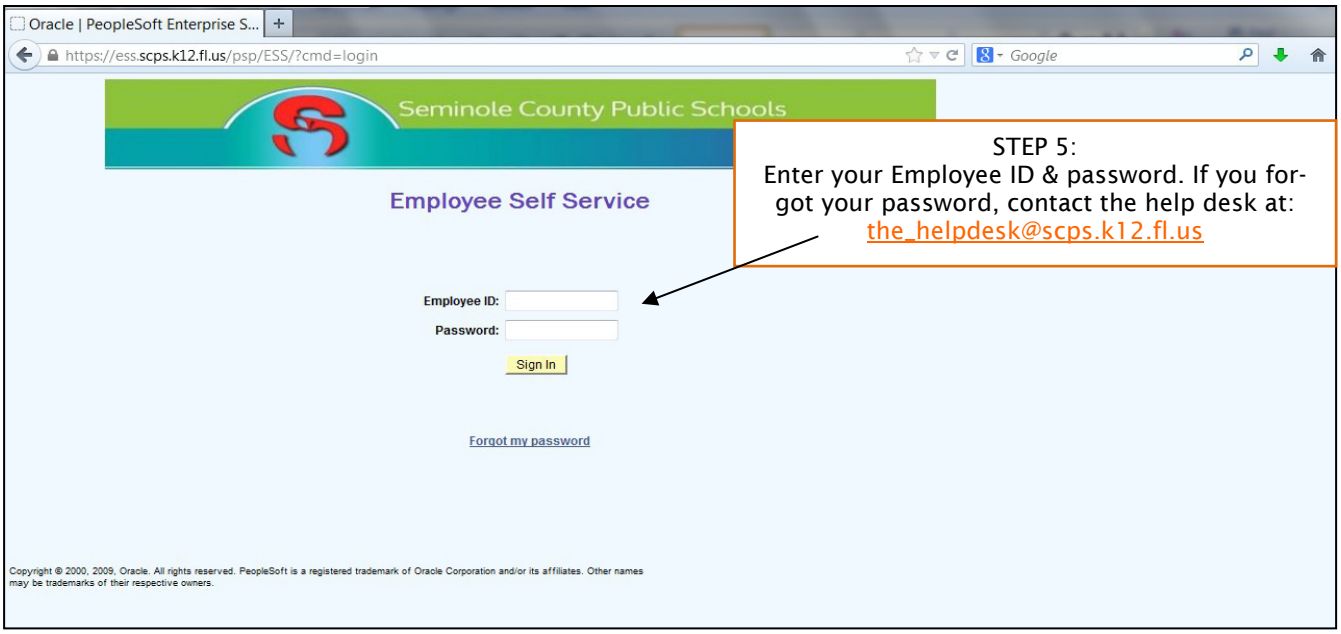
Annual Enrollment is from October 16 – October 31 until 4:30pm. Please be sure to complete any and all changes in advance. If you have NO CHANGES, please be sure to also review your benefits and submit. If you do not receive a confirmation page and number, you have NOT submitted completely.

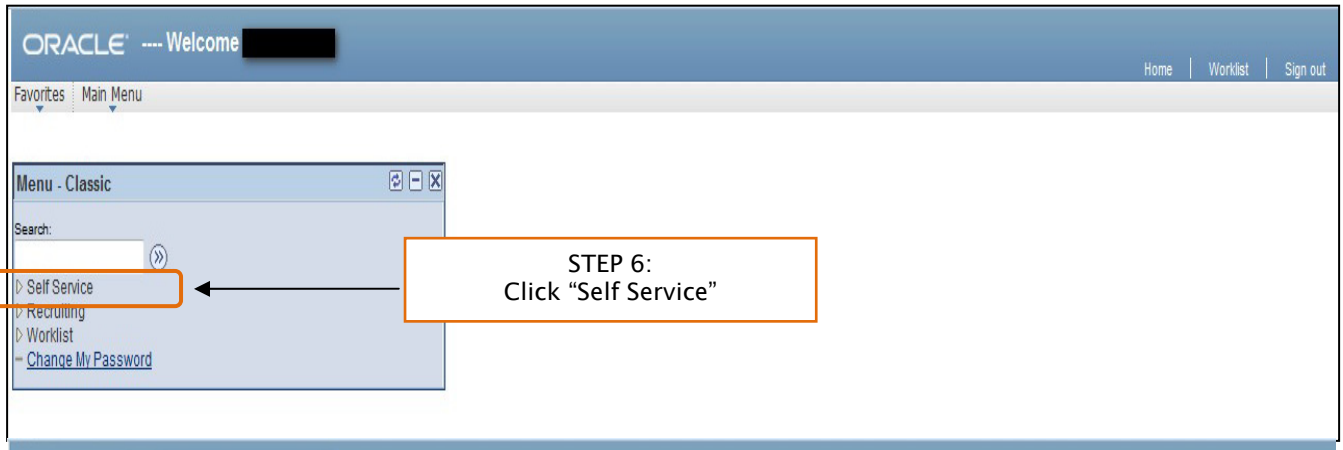
The step by step instructions will guide you through this process:

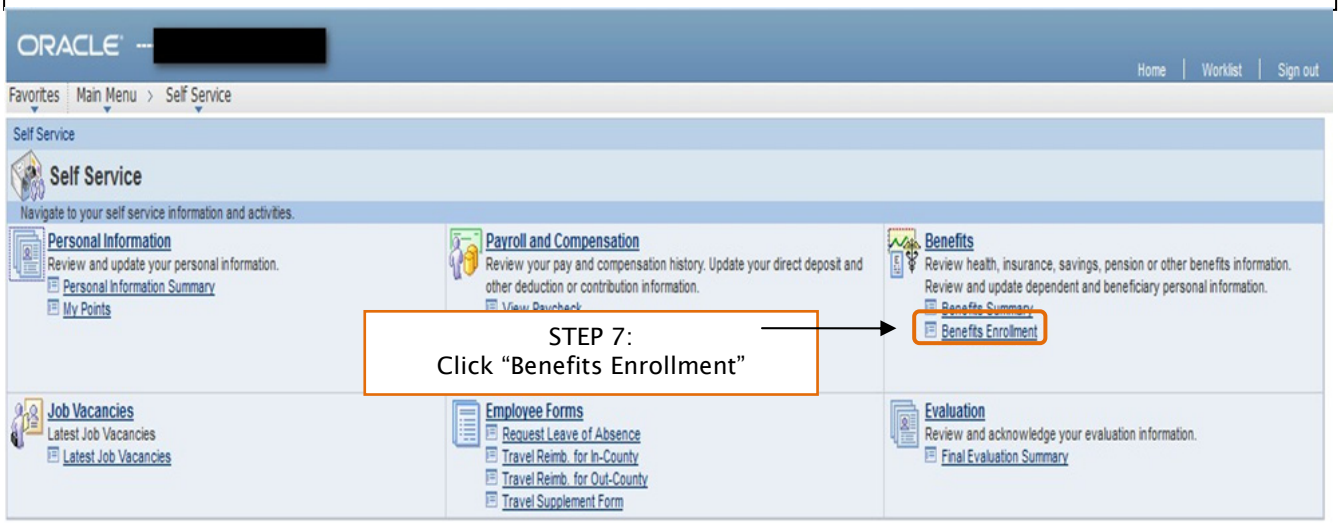
Step 1: Go to www.scps.k12.fl.us
Step 2: Scroll to the bottom of the page, and click "Employee Login" on the right side.
This will bring you to the Employee Page.



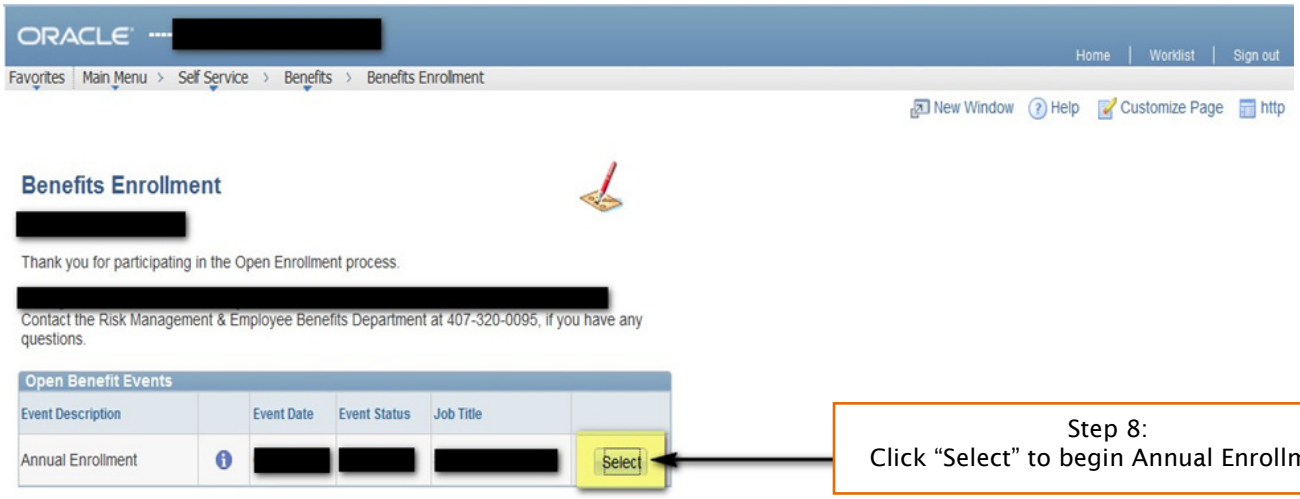
ANNUAL ENROLLMENT: HOW TO ENROLL



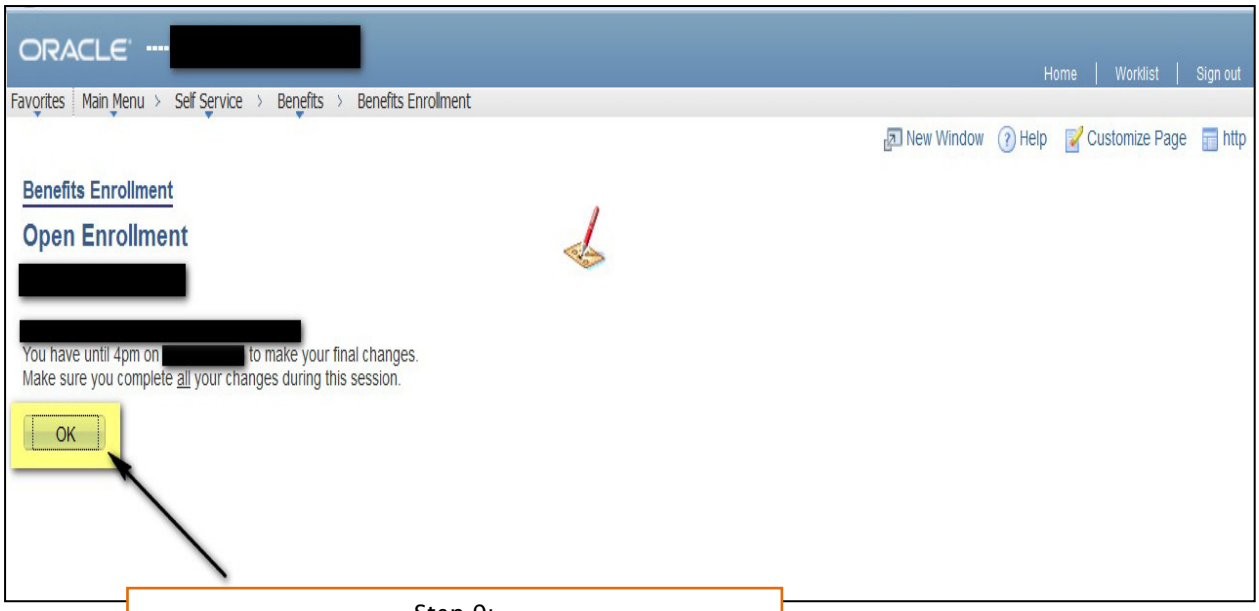




ANNUAL ENROLLMENT: HOW TO ENROLL



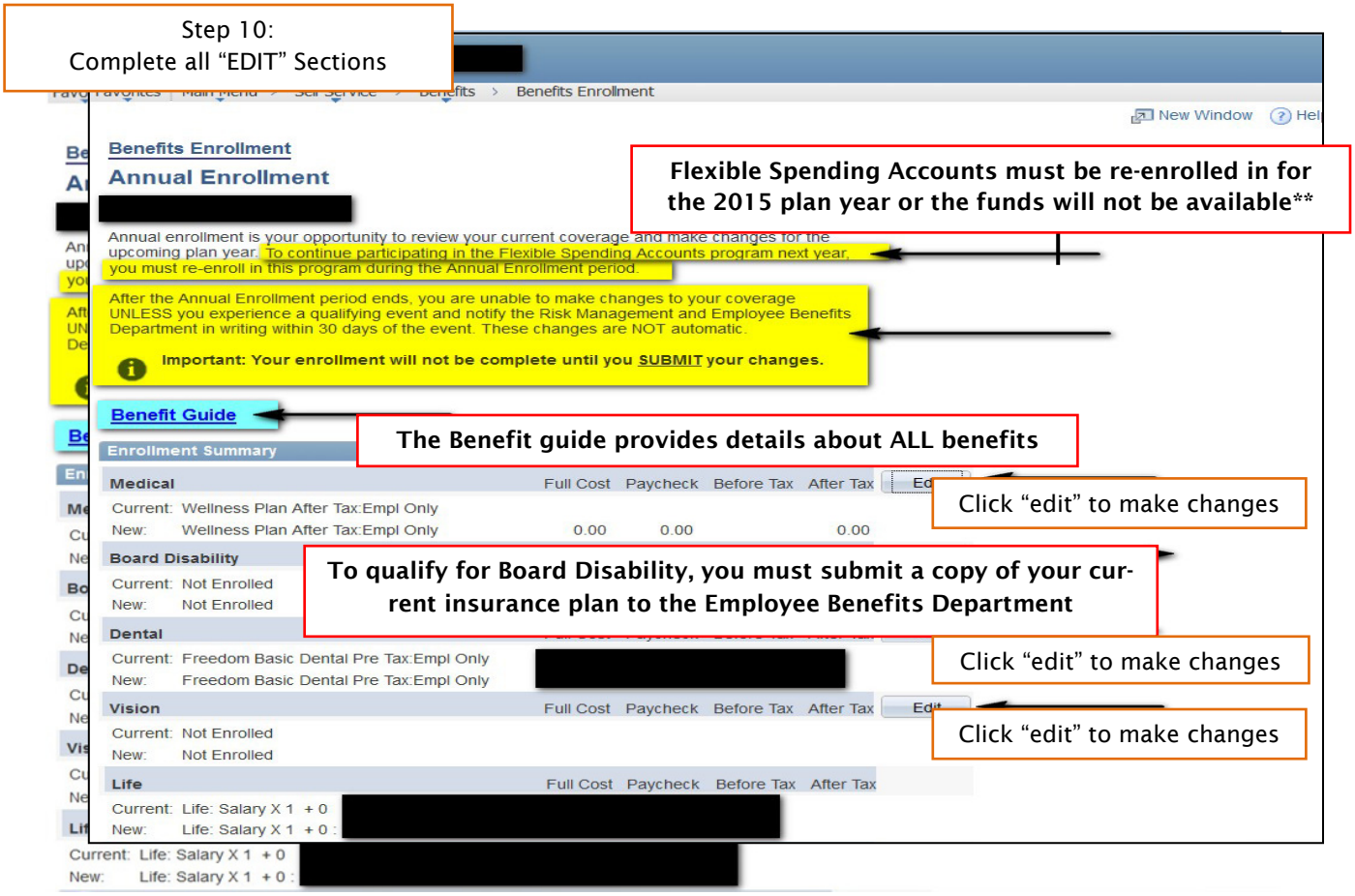
Step 8:
Click "Select" to begin Annual Enrollment

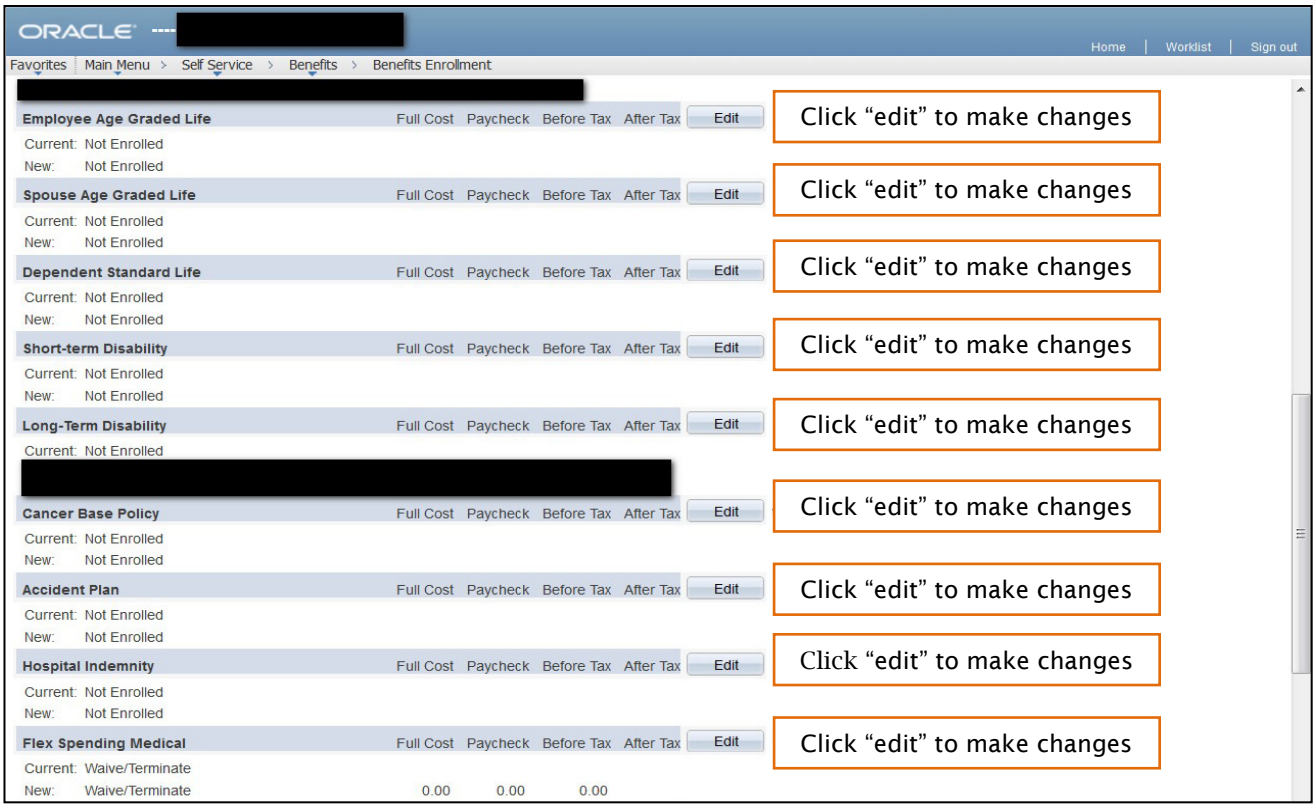


Step 9:
Click "OK" to continue Annual Enrollment

ANNUAL ENROLLMENT: HOW TO ENROLL

Step 10:
Complete all "EDIT" Sections





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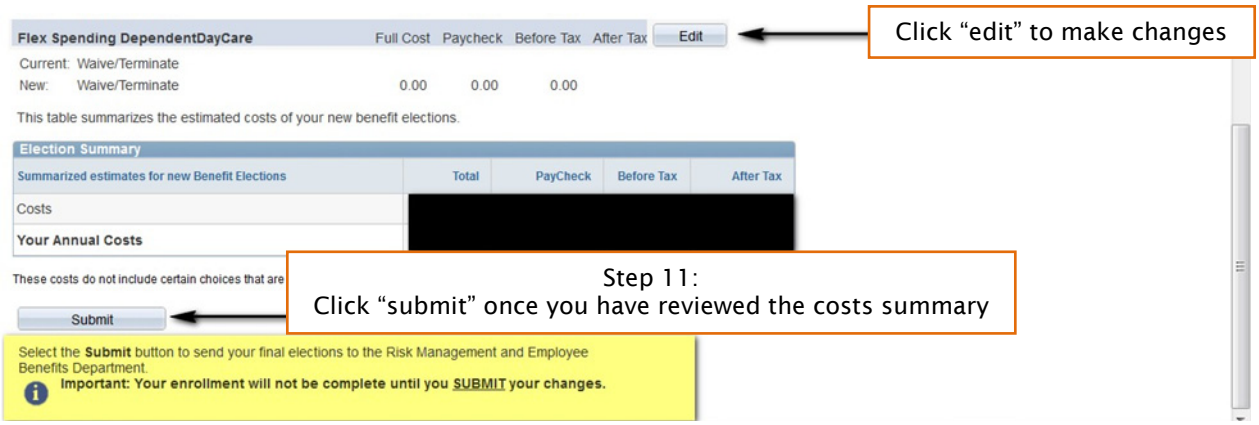
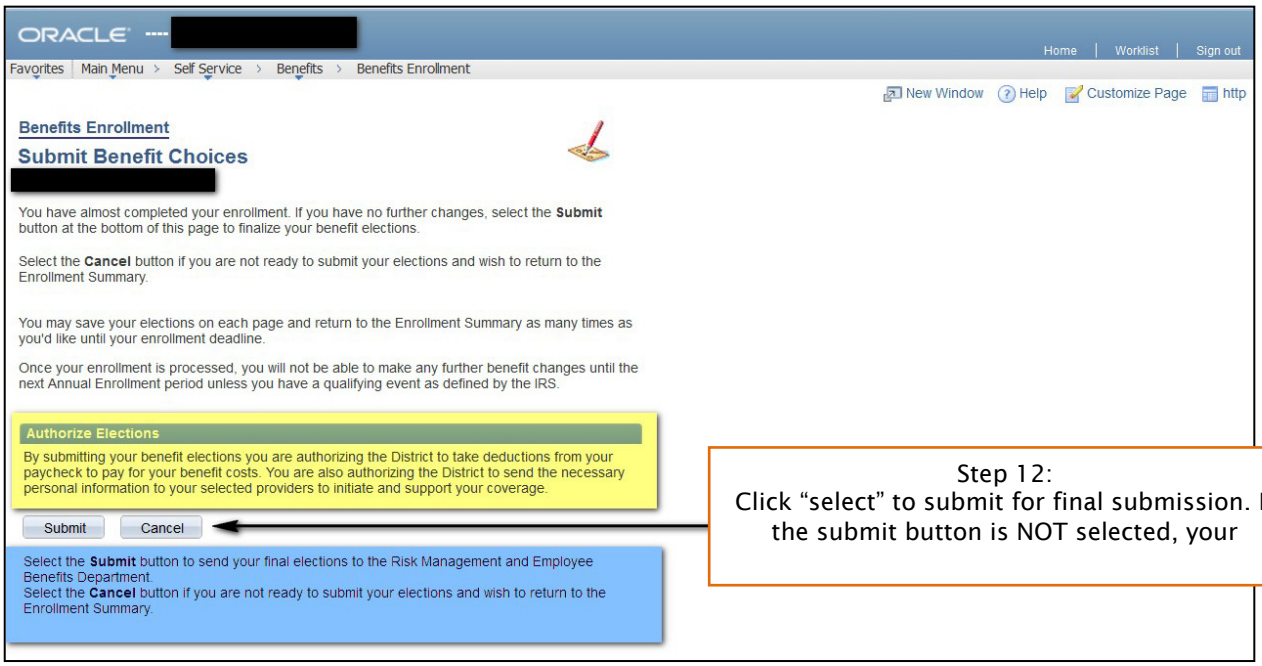


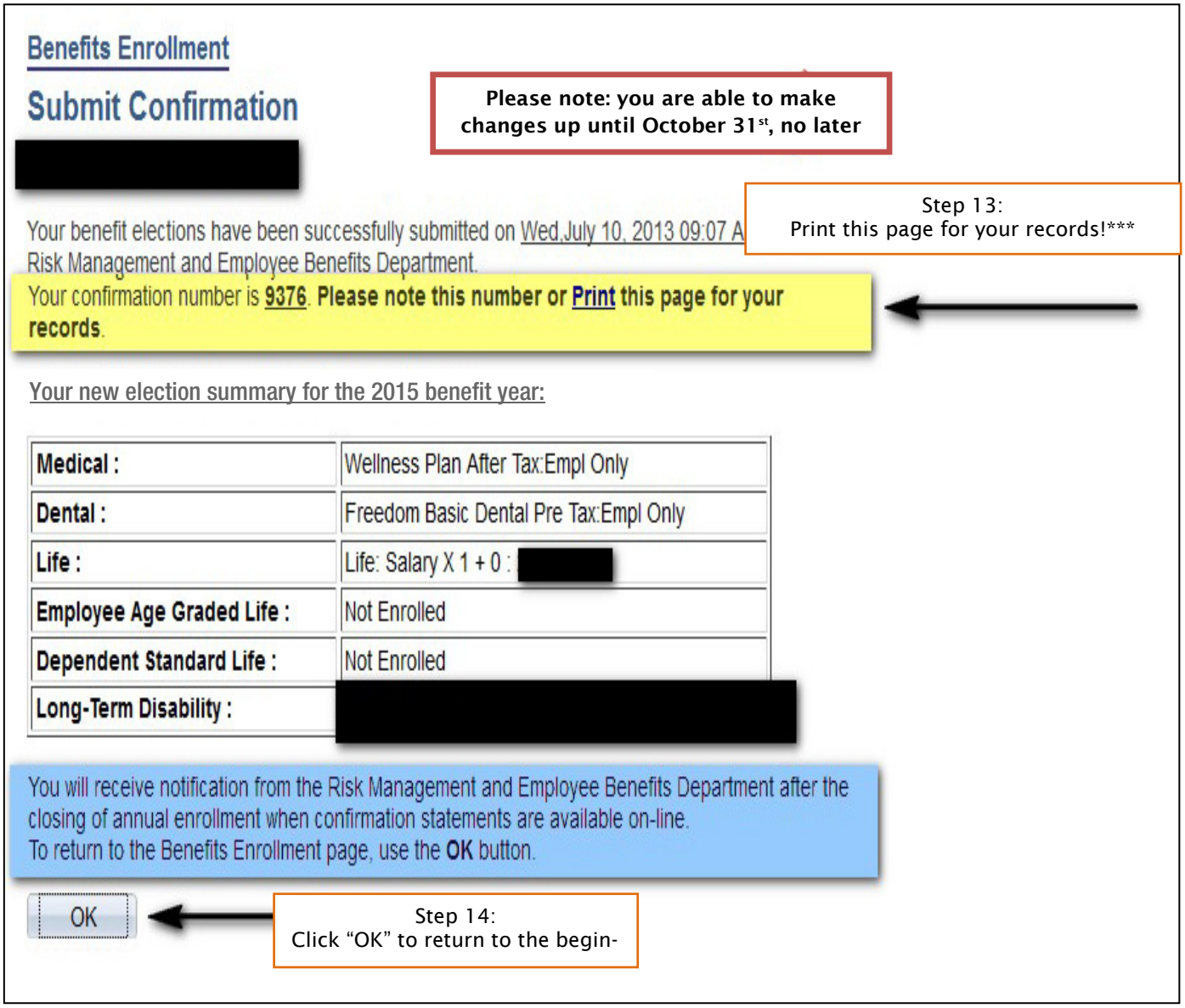
Click “edit” to make changes

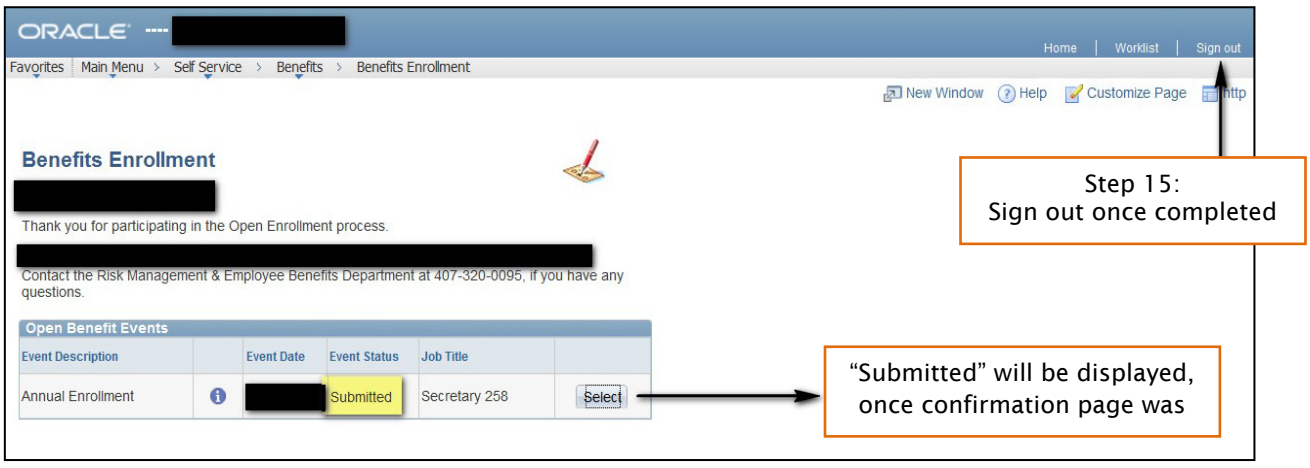
Step 11:
Click “submit” once you have reviewed the costs summary



Step 12:
Click “select” to submit for final submission. If the submit button is NOT selected, your

ANNUAL ENROLLMENT: HOW TO 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 your date of hire, you are automatically enrolled in the FRS Pension Plan. You have up to five months from your date of hire to choose whether to stay in the Pension Plan or change to the FRS Investment Plan. After that period, you will have one other opportunity to change plans (a second election) anytime during your FRS career.

The District contributes the majority of your FRS retirement plan savings. In addition, a mandatory 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. When you retire you are able to take your benefit in a single payment, in multiple payments over time, in guaranteed monthly payments for life, or any combination. DROP is not available.

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

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 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

IMPORTANT DISCLOSURES

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

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.

IMPORTANT DISCLOSURES

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

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

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.

IMPORTANT DISCLOSURES

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

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

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

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

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

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 January 31, 2014. Contact your State for more information on eligibility –

<table>
<tr><th>ALABAMA – Medicaid</th><th>COLORADO – Medicaid</th></tr>
<tr><td>Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><th>ALASKA – Medicaid</th></tr>
<tr><td>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><th>ARIZONA – CHIP</th><th>FLORIDA – Medicaid</th></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268</td></tr>
<tr><td></td><th>GEORGIA – Medicaid</th></tr>
<tr><td></td><td>Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150</td></tr>
<tr><th>IDAHO – Medicaid</th><th>MONTANA – Medicaid</th></tr>
<tr><td>Medicaid Website:
http://healthandwelfare.idaho.gov/Medical/Medicaid/Premiu</td><td>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</td></tr>
</table>

IMPORTANT DISCLOSURES

INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

IMPORTANT DISCLOSURES

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 10/31/2016)

NOTES

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.