SEMINOLE COUNTY PUBLIC SCHOOLS

SCPS Benefits and Insurance Services

HEALTHIER TOGETHER

2018 BENEFITS GUIDE

Superintendent's Message

Dear District Employees,

We are fortunate to work in a district where the safety and health of students and employees is of prime importance. You perform your best when you feel your best. We want all of our employees to have the opportunity to reach their full potential, professionally and in their personal lives. Investing in your health now can provide priceless, long-term benefits in the future.

The Seminole County School Board and I are advocates of doing your homework when it comes to finding the right benefit plan to meet the needs of you and your family. To help you choose the plan that best fits your health care needs, we encourage you to take time to assess your own wellness, as well as your family's health needs. An easy way to do so is by scheduling a physical so you will know your numbers and establish a baseline for the year. Knowledge is your greatest ally in the fight against illness, and is a great preventative measure as well. We're committed to making sure you feel fully informed and prepared when choosing your 2018 benefit plan.

Our district offers a wide range of detailed benefit plans that were crafted to ensure you and your family members receive the coverage you need if illness or an injury occurs. The School Board has put forth substantial funding and time to provide the best programs possible for the employees of Seminole County. With the well-being of our students and staff in mind, we know our investment in offering you great health care options will reap invaluable benefits for our district as a whole. Please take the time to carefully review the options available to you. Having peace of mind is the greatest gift you can give yourself and your family.

Sincerely,

Dr. Walt Griffin

Karen Almond
School Board Member

Jeffrey Bauer
School Board Member

Tina Calderone
School Board Vice Chair

Amy Lockhart
School Board Chairman

Abby Sanchez
School Board Member

Table of Contents

This guide is a summary of the benefit programs offered through Seminole County Public Schools for the plan year January 1, 2018 through December 31, 2018. The contents summarize the key features of each plan. Complete details are provided in plan documents, policy guidelines, and insurance contracts that legally govern the operation of each plan. If there is a discrepancy between this guide and the official plan documents, the plan documents will prevail.

Key Things to Know

MANDATORY ENROLLMENT

Dates to Remember

Your Annual Enrollment dates are:
October 9, 2017, through October 31, 2017

Your Period of Coverage dates are:
January 1, 2018, through December 31, 2018

The School Board of Seminole County pays an average of $8,300.00 annually toward the cost of your medical plan.

Benefits Update

Attention! This year's annual enrollment is mandatory. Whether or not you plan to enroll in medical insurance, if you are benefit eligible you will need to make an election accepting or declining benefits.

KEY THINGS TO REMEMBER:

- Enrollment is mandatory
- Voluntary Benefits will not roll over without making an election
- You must attest your tobacco status or receive a $500 annual surcharge

The School Board of Seminole County offers two medical plans, the High Deductible Health Plan (HDHP) and the Open Access Buy-Up Plan. You may waive medical coverage with proof of coverage under another medical plan. When you opt out, you will receive a Board Paid Disability benefit. For more details see page 11.

- The employer-paid plan will continue to be the High Deductible Health Plan (HDHP).
- Tobacco users will again be charged a $500 annual surcharge for medical premium rates unless you complete an approved program. For more details visit tinyurl.com/benefits2018.
- Medical plans will default to the High Deductible Health Plan (HDHP) with the Smoker Premium surcharge if you don't make an election and voluntary benefits will not enroll.
- The wellness program helps make you more aware of your health by encouraging you to achieve five wellness incentive points to earn your 2019 wellness incentive. See page 39 for program details.

Disability Insurance

- Short-Term Disability - Benefit levels have increased an additional $30 for each weekly benefit level. See the new $950 benefit level on page 31.
- Long-Term Disability - continued lower rates with the $5.92, 20-pay deduction rate.

Term Life Insurance

Standard Life Insurance will continue to be your life insurance provider for the 2018 plan year. All rates and plan features remain the same. If you elect this coverage, you will be eligible for a $10,000 guarantee issue.

Who Do I Talk to If I Have Questions?

Should you have any questions or need assistance during your enrollment, see the Benefits Guide directory located on the inside back cover for contact information.

Key Things to Know

How to Waive the $500 Tobacco Surcharge:

During annual enrollment, you are required to attest whether you are a tobacco user or not. If you fail to attest, your payroll deduction will increase by $25 per pay period for 20 pay periods. To avoid this $500 surcharge, you must attest in the ESS Benefit Enrollment Portal and follow the prompts to confirm your tobacco user status. Employees who use tobacco products as defined below in the Board Policy will have an annual surcharge of $500 added to their premium.

For the purpose of this policy, "tobacco" is defined to include any lighted or unlighted cigarette, cigar, pipe, bidi, clove cigarette, cigarillo, hookah or any other smoking product, and any smokeless tobacco also known as dip, chew, snuff, snus, orbs, strips, sticks or any other products developed in the future that contains tobacco/nicotine or a combination of the two, and any/all products commonly referred to as electronic cigarettes or e-cigs including but not limited to like products with name brands such as v2cigs, Vaporzone, Premium Vapes, Bull Smoke, halo cigs, Whitecloud, Green Smoke, South Beach Smoke, Firebrand, Vapor 4 Life, Smoke Stik, Eversmoke, Blu Cigs, etc.

If you are a tobacco user, you can avoid the surcharge by participating in an approved smoker cessation program and submitting your course completion to the Benefits and Insurance Services Department. Cessation courses can be found on the Benefits and Insurance Services Department intranet page. You may also complete a new affidavit attesting you no longer use tobacco products.

If you're a tobacco user and want to avoid the $500 tobacco surcharge for Plan Year 2018, you must complete one of the following programs:

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

Online Enrollment

Enroll in your benefits by visiting tinyurl.com/benefits2018. Select "Click to Enroll", login with your ePassport/ PeopleSoft Username and Password, then you will be directed to "Benefits Enrollment".

You may also enroll through the ePassport Employee Self Service system. Log in to the ESS website at www.scps.k12.fl.us. Click ePassport at the top right corner of the page, login, then click Employee Self Service > Main Menu > Self Service > Benefits > Benefits Enrollment.

Be sure to submit your elections and print a "Submit Confirmation" for your records. You must present the confirmation statement when appealing your elections. Please note: you are able to make changes up until October 31st, no later than 6 p.m.

New to Seminole County Public Schools?

If you are electing Benefits as a New Hire or Re-Hire, the Benefits and Insurance Services Department will email you to begin your benefit elections through Employee Self Service (ESS) 'Benefits Onboarding'. This is the same process as you completed with Human Resources when you were hired.

Once the Benefits and Insurance Services Department sends your email to begin enrollment, you will have 30 days to complete your benefit elections. If you are adding coverage for your spouse, you will need to upload your marriage license and a copy of their Social Security card. If you are adding dependents to your plan, you will need to upload a copy of their birth certificate(s) and Social Security card(s). You should have these scanned and saved for access to upload during the election process. Should you have questions, contact your assigned Benefit Specialist for assistance through the ESS Benefit Onboarding system, or call 407-320-0095.

Keep in mind that you will not be able to elect benefits until your hiring process is completed by the Human Resources Department.

Medical Plan: Cigna

The School Board of Seminole County contributes certain dollars annually toward benefit costs for each employee. That's above and beyond your regular salary or hourly wage. With those dollars we are able to continue to offer medical plans that focus on our employees' and dependents' health with integration with the wellness incentive.

You can choose between two medical plan options: the High Deductible Health Plan and the Open Access Buy-up Plan. Both plans offer comprehensive medical coverage, however, each plan provides coverage in a different way. Be sure to review the Medical Benefits Plan Comparison Chart on page 8 to help you decide which plan is right for you.

1. High Deductible Health Plan (HDHP)
No Premiums for Employee Only Coverage (tobacco surcharge applies).

The High Deductible Health Plan is the employer-paid plan for employee-only coverage. This is also the plan that you will default into (employee-only coverage) if you do not actively enroll, so it is recommended that you review the plans carefully and make an informed decision.

The High Deductible Health Plan gives you the flexibility to visit any provider (doctor or facility) within Cigna's LocalPlus network, including specialist, without a referral.

With this plan, you must meet a deductible first then pay 20% co-insurance of the discounted network charges for all doctors and procedures. When filling a prescription, you also have to meet a deductible.

Keep in mind that there is no out-of-network coverage under this plan except in the case of a true emergency; you will pay the full amount if you use out-of-network providers.

Board Contribution: $8,864.16 annually

See page 9 for details about prescription coverage under this plan.

2. Open Access Buy-up Plan
Buy-up plan - $64.37 per pay period for employee-only coverage, unless you meet your wellness incentives; then you will receive a reduced premium of $26.88 per pay period (tobacco surcharge applies).

If you elect employee-only coverage, you will have 20 payroll deductions per year. You're paying an employee premium because of the choice of a larger network, and a combination of copays and co-insurance.

With this plan, you do not need to meet a deductible unless you are having a procedure/visit listed on the Medical Plan Benefit Summary on page 8.

Board Contribution: $8,532.45 or $7,782.45 annually if Wellness Incentive is not met

See page 9 for details about prescription coverage under this plan.

Medical Plan: Cigna

Important Notes:

- Tobacco users will be charged a $500 annual surcharge if they do not complete a smoking cessation program.
- All employees can earn up to a $750 incentive award by completing the five (5) wellness activities.
- Per contract language, those employees who are employed in a contracted position for less than 30 hours per week, or at least fifty percent (50%) of a full-time position, the Board will offer to contribute fifty percent (50%) of an individual single premium of a health insurance plan.

EMPLOYEE 20 DEDUCTION	HIGH DEDUCTIBLE HEALTH PLAN (WITHOUT TOBACCO SURCHARGE)	HIGH DEDUCTIBLE HEALTH PLAN ($500 TOBACCO SURCHARGE APPLIED)	OPEN ACCESS BUY-UP WITH (WELLNESS INCENTIVES MET)	OPEN ACCESS BUY-UP (WELLNESS INCENTIVES NOT MET)	OPEN ACCESS BUY-UP ($500 TOBACCO SURCHARGE APPLIED) (WELLNESS INCENTIVES MET)	OPEN ACCESS BUY-UP ($500 TOBACCO SURCHARGE APPLIED) (WELLNESS INCENTIVES NOT MET)
SINGLE	$0	$25.00	$26.88	$64.37	$51.88	$89.37
EMPLOYEE + SPOUSE	$487.53	$512.53	$525.72	$563.22	$550.72	$588.22
EMPLOYEE + CHILD(REN)	$398.89	$423.89	$435.03	$472.52	$460.03	$497.52
FAMILY	$886.41	$911.41	$933.87	$971.37	$958.87	$996.37

Tobacco Surcharge = $500 Annually

Part-Time Employee Rates

EMPLOYEE 20 DEDUCTION	HIGH DEDUCTIBLE HEALTH PLAN (WITHOUT TOBACCO SURCHARGE)	HIGH DEDUCTIBLE HEALTH PLAN ($500 TOBACCO SURCHARGE APPLIED)	OPEN ACCESS BUY-UP WITH (WELLNESS INCENTIVES MET)	OPEN ACCESS BUY-UP (WELLNESS INCENTIVES NOT MET)	OPEN ACCESS BUY-UP ($500 TOBACCO SURCHARGE APPLIED) (WELLNESS INCENTIVES MET)	OPEN ACCESS BUY-UP ($500 TOBACCO SURCHARGE APPLIED) (WELLNESS INCENTIVES NOT MET)
SINGLE	$221.61	$246.61	$240.19	$258.94	$265.19	$283.94
EMPLOYEE + SPOUSE	$709.13	$734.13	$739.03	$757.78	$764.03	$782.78
EMPLOYEE + CHILD(REN)	$620.49	$645.49	$648.34	$667.09	$673.34	$692.09
FAMILY	$1,108.01	$1,133.01	$1,147.18	$1,165.93	$1,172.18	$1,190.93

Tobacco Surcharge = $500 Annually

Medical Plan Benefit Summary: Cigna

	HDHP	OAP Buy Up
NETWORK (LIST OF DOCTORS)	LocalPlus* Default Plan, Coinsurance Plan	Open Access Plus Copay and Coinsurance Plan
INDIVIDUAL DEDUCTIBLE	$1,500	$500
FAMILY DEDUCTIBLE	$3,000	$1,500
COINSURANCE LEVEL	20%	20%
INDIVIDUAL MAXIMUM OUT OF POCKET	$5,500	$6,400
FAMILY MAXIMUM OUT OF POCKET	$11,000	$12,800
PRIMARY CARE PHYSICIAN VISITS	20% after deductible	$25 copay
SPECIALIST OFFICE VISITS	20% after deductible	$50 copay, waived if admitted
CONVENIENT CARE CENTER	20% after deductible	$25 copay, no deductible
URGENT CARE CENTER	20% after deductible	$50 copay, waived if admitted
EMERGENCY ROOM	20% after deductible	$250 copay, waived if admitted
HOSPITAL SERVICES	20% after deductible	20% after deductible
SURGICAL PROCEDURES	20% after deductible	20% after deductible
OUTPATIENT SERVICES	20% after deductible	20% after deductible
LAB AND X-RAY • **PHYSICIAN'S OFFICE** • **INDEPENDENT LAB** • **ALL OTHER FACILITIES**	 20% after deductible 20% after deductible 20% after deductible	 $25 PCP or $50 Specialist copay 100% covered 100% covered
MATERNITY • **INITIAL VISIT TO CONFIRM PREGNANCY** • **GLOBAL MATERNITY FEE**[1] • **PHYSICIAN'S OFFICE VISIT (IN ADDITION TO GLOBAL MATERNITY FEE AT OB/GYN OR SPECIALIST)** • **DELIVERY -- FACILITY (INPATIENT HOSPITAL OR BIRTHING CENTER)**	 20% after deductible 20% after deductible 20% after deductible 20% after deductible	 $25 PCP or $50 specialist copay 20% after deductible $25 PCP or $50 specialist copay 20% after deductible
PREVENTIVE CARE • **WELL-BABY, WELL-CHILD,** • **WELL-WOMAN AND ADULT** • **PREVENTIVE CARE** • **IMMUNIZATIONS - ALL AGES** • **PAP, PSA TESTS**	100% covered	100% covered
MAMMOGRAMS: • **SCREENING MAMMOGRAM** • **DIAGNOSTIC MAMMOGRAM**	 100% covered 20% after deductible	 100% covered 20% after deductible
ADVANCE IMAGING (CT, MRI, PET)[2]	20% after deductible	20% after deductible
OUT OF POCKET MAXIMUM	Includes Deductibles and Copays	Includes Deductibles and Copays
LIFETIME MAXIMUM	Unlimited	Unlimited
PRE-CERTIFICATION REQUIREMENTS[3]	Coordinated by your physician	Coordinated by your physician
HEARING AIDS	20% after deductible $5,000 maximum per calendar year	20% after deductible $5,000 maximum per calendar year
VISION EYE EXAM	$20 Copay	$20 Copay

1 Includes all routine prenatal visits, routine postpartum visits, physician's delivery charges, management of hospital observation for up to 48 hours for the evaluation of latent phase of labor or uterine contractions w/o cervical dilatation, admission to the hospital, all medical services required for prep and delivery.

2 Advanced radiological imaging (MRI, CAT Scan, PET Scan, etc.); outpatient facility charges, independent lab and X-ray facility.

3 Required for all inpatient admissions and selected outpatient procedures and diagnostic testing. Contact Cigna at 1-800-244-6224 to confirm if authorization is required for individual services.

Prescriptions: Cigna

	RETAIL PHARMACY 30-DAY SUPPLY	HOME DELIVERY + RETAIL 90 90-DAY SUPPLY
GENERIC (1ST TIER)	$7.00*	$14.00*
BRAND NAME PREFERRED (2ND TIER)	$30.00**	$60.00**
BRAND NAME NON-PREFERRED* (3RD TIER) *Prior Authorization and/or Step Therapy may apply.	$60.00**	$120.00**
SPECIALTY (RETAIL)	$75.00**	$75.00**

* Limited to 30 day supply with prior authorization only

** For High Deductible Health Plan (HDHP), deductible must be met before the plan shares costs of services.

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 and Wal-Mart - to name a few (Walgreens is not part of the network). To locate a participating pharmacy, you may use www.cigna.com or call 1-800-Cigna24.

Prescription Drug List

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

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

You can call Cigna Customer Service 24/7 at 1-800-Cigna24 or use the Prescription Drug Cost Transparency Tool on www.myCigna.com to find out the cost of a specific prescription 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: In Step Therapy, you need to try the most appropriate and cost-effective medication before brand name medications are approved for coverage. Typically, these are generics or certain preferred-brand drugs. It is important to note that generic medications have the same strength and active ingredients as brand name medications – but often cost much less – in some cases, up to 80–85% less.*

HOW STEP THERAPY WORKS: When you fill a prescription for a Step Therapy medication, Cigna will send you and your doctor a letter that lets you know the steps you need to take before you refill your medication. This may include trying a generic or lower-cost alternative, or asking Cigna to approve coverage of your medication. At any time, if your doctor believes an alternative medication isn't right for you due to medical reasons, he or she can request prior authorization for continued coverage of a Step Therapy medication.

ARE YOU TAKING A STEP THERAPY MEDICATION?
You can go to Cigna.com/druglist to look up your medication. If there's a (ST) listed next to your medication, then it's part of the Step Therapy program. Once you're enrolled with Cigna, you can log into myCigna.com to view a list of prescription medications covered under your specific plan.

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

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

How to Use Cigna's Pharmacy

Maintenance Drugs and Home Delivery

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

Two ways to fill maintenance medications for a 90-day supply:

- Cigna Home Delivery
- Retail: Publix, Walmart

Maintenance medication may be dispensed through the Cigna Home Delivery Pharmacy or use the retail 90-day option at Publix and Wal-Mart. Convenient delivery of your covered maintenance medications is available to your home or other specified address with Cigna Home Delivery. The mail order copay is charged for prescriptions that are dispensed for any quantity over a 31-day supply.

Filling Prescriptions via Home Delivery

Once you have obtained a prescription from your physician for a 90-day supply with refills, send it, along with a home delivery form and your payment, to Cigna Home Delivery Pharmacy. Your medication should ship to you within seven to 10 days from the time Cigna Home Delivery Pharmacy receives your order. You may also call the Cigna Home Delivery Pharmacy at 1-800-285-4812 or request Cigna contact your physician for new prescriptions.

Refills can be ordered 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.

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

Prescription Savings

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

- Publix: a variety of oral antibiotics for FREE

IMPORTANT NOTE:

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

- CVS: 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

Generic Medications

When it comes to prescription medications, you and your doctor usually have a choice between a brand name drug and its generic equal. Generic medications provide you with the same quality, strength, purity and stability as the brand name – but often cost much less. If you decide to buy a brand name medication when the generic is available and appropriate, you will pay a higher amount – even if your doctor recommends the brand name medication.

When you choose generic medications, you're choosing to save money.

In most cases when you take your prescription for a brand name medication to a pharmacy, your prescription will be filled with the generic equivalent unless your doctor indicates that brand medication is medically necessary. If this is the case, you will need to get prior approval from Cigna for your medication to be covered.

You should talk with your doctor to see if a generic medication will work for you. Also, you can use the **Prescription Medication Price Quote** tool on myCigna.com to view medication costs based on your pharmacy plan, see if there are lower cost alternatives and compare prices between retail pharmacies and Cigna Home Delivery Pharmacy.

You have questions? We have answers. CoachRx is here to help. We're a team of pharmacists here to talk with you about your medication choices, costs, side-effects, and many other questions you might have. We can also help you sign up to have refill reminders sent by text or email. We're here for you 24 hours a day, seven days a week. Call us anytime at 1-800-325-1404 or visit myCigna.com.

Opting Out of Medical Coverage

Mutual of Omaha Disability Coverage in Lieu of Medical Coverage

"Opting out" means you may choose to decline medical coverage for yourself and your family. Only employees who are covered under another medical plan, either as a dependent or through individually acquired coverage, can select this option. For example, you might consider opting out of medical insurance if your spouse has elected family medical coverage through his or her employer, or if you are covered under another medical plan.

You may opt out only when: enrolling for the first time as a new employee, as a current employee during Open Enrollment for the next plan year, or when you have an approved qualifying change in status. Your opt-out election will remain in effect through December 31, 2018 unless you or a qualified dependent experience an approved qualifying change in status event.

When you opt out, you will 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. Proof must be submitted to the Benefits and Insurance Services Department.

After you are disabled for seven continuous days, you will receive a flat $300 weekly benefit for a maximum of 104 weeks. This benefit offsets with the Cigna group disability plan, as well as any other income you receive, such as retirement. Additionally, since it is paid for by SCPS, your benefit will be taxed. To file a claim, call Mutual of Omaha at 1-800-877-5176, and reference Plan/Policy #GUG-6K71.

Health Savings Accounts and Health Reimbursement Accounts

What is a Health Savings Account or Health Reimbursement Account?

A Health Savings Account (HSA) is a savings account, owned by you and established by your employer, in conjunction with the High Deductible Health Plan if you do not have any other medical coverage; it allows you to use pretax dollars to establish the HSA. You may also elect to add additional pretax dollars to the HSA. This means you will not have to pay taxes on the money you set aside, which simultaneously lowers your taxable income. The HSA money can be used for eligible medical, dental and vision expenses.

An HSA allows contributions to roll over each year, so even if you don't regularly incur medical expenses, an HSA can be used to build savings for future medical expenses, while reducing your taxable income today.

Health Savings Account

How your HSA is funded: Rewarded for healthy actions if you meet the Seminole County Public Schools (SCPS) Wellness Incentive Goals. Once your HSA is established, a new debit card will arrive from HSA Bank. You can use your card to pay for your health care expenses or pay out-of-pocket and reimburse yourself by transferring funds from your HSA to your checking or savings account.

CIGNA makes it easy for you to manage and access your HSA plan whenever you need. Simply log in online to www.myCigna.com or download the myCigna mobile app.

Health Savings Account Fee and Interest Schedule

HSA Bank wants you to understand the fees associated with your Health Savings Account. For details regarding the general terms and conditions that apply to your HSA, see the Deposit Account Agreement and Disclosures for Health Savings Accounts included in your Welcome Kit, or contact Cigna Customer Service at 1-800-244-6224.

STANDARD FEE[1]

DESCRIPTION	AMOUNT
Monthly Account Maintenance Fee	No charge to your account. Your employer covers this fee as long as you are employed with SCPS and remain in the High Deductible Health Plan.

SERVICE FEES[1]

DESCRIPTION	AMOUNT	HOW TO AVOID FEE
Debit Card	$6.00	n/a
HSA Fee[2]	$10.00	Check your available account balance online before you withdraw funds.
HSA Checkbook Order Fee (50 Checks)	$10.65	Use your Health Benefits Debit Card or online transfers to access your funds.
Printed HSA Account Summary Fee	$1.25	Elect to receive free e-statements through Internet Banking.

1 You may incur a lesser fee than that disclosed to you when your account has insufficient funds to cover the entire amount of the fee.

2 Distributions from your Health Savings Account presented in the form of checks, ACH withdrawals or other electronic means will be returned unpaid if there are insufficient funds in your account to cover the amount of the withdrawal, and you will be charged a returned item fee.

Health Savings Accounts and Health Reimbursement Accounts

HSA Investment Account

You have the option to invest in mutual funds. Your investment application can be completed through the online portal. Visit www.myCigna.com.

Eligibility criteria: When you apply for an investment account, you must have a minimum balance of $2,000 in your HSA Bank Account.

Health Reimbursement Account

For those employees covered under another medical plan, such as Medicare, Tricare or a spouse's employer group health plan, a Health Reimbursement Account (HRA) will be set up. The HRA is available to employees enrolled in a High Deductible Health Plan and have other medical coverage. An HRA is an employer-only contribution account and is only available if you met the five wellness incentive activities. The funds in the account will roll over from plan year to plan year. However, if you have a separation of service, if you retire or if you switch to the Buy Up Plan, the remaining funds stay with the Insurance Trust.

How your HRA is funded: Rewarded for healthy actions if you meet the Seminole County Public Schools (SCPS) Wellness Incentive Goals and have other insurance that would make you unable to qualify for an HSA.

Money from your HRA will be used to pay for eligible medical, dental and vision expenses until funds are exhausted.

CIGNA makes it easy for you to manage and access your HRA plan whenever you need. Simply log in online to www.myCigna.com or download the myCigna mobile app.

Deductible, Out-of-Pocket Maximun and Out-of-Network Care

The health care costs that are paid from your HSA and HRA typically count toward your deductible – an annual amount you'll pay before the health plan begins to pay for covered health care costs. You will need to check your plan to verify expenses that will count toward your deductible.

Once you meet your deductible, you pay a percentage of the cost (coinsurance) for your covered in-network health care expenses, and the health plan pays the rest.

Your plan includes an out-of-pocket maximum. This means that if you spend up to the maximum amount during the plan year, your health plan will pay for your covered health care costs at 100% for the remainder of the plan year.

If you go out-of-network for care, your expenses may exceed the out-of-pocket amount because the doctor may bill you for charges not covered under your plan.

Flexible Spending Accounts: myCafeteriaPlan

What is a Flexible Spending Account?

A Flexible Spending Account allows participants to set aside pretax dollars to be used to pay for various out-of-pocket medical expenses, and dependent care expenses.

When you enroll in a flexible spending account, you specify the dollar amount you'd like to direct into your account from each paycheck, up to the annual maximum. You make deposits to your account through tax-free payroll deductions. You then use the money in the account to pay for your eligible health or dependent care expenses. Be sure to carefully estimate your FSA contribution amount. Any unused dollars in your account(s) at the end of the plan year will be forfeited (see page 15 for use-it-or-lose -it information).

What are the types of Flexible Spending Accounts?

A Medical FSA is used to pay for medical expenses that you or your dependents incur, even if they are not enrolled in the SCPS medical plan. Health Care FSA reimburses you for eligible medical, dental, or vision expenses for you, your spouse, or your eligible dependents. You can use it to pay for certain medical expenses not covered by another insurance plan for anyone you claim as a dependent on your tax return.

When you enroll in a Health Care FSA, your account is prefunded up to the amount you elect to contribute for the entire year. So even if you incur eligible expenses before the account is fully-funded, you can charge up to your total plan-year election before the funds are actually deducted from your paycheck and deposited into your account.

When you enroll in a Dependent Care FSA, you can set aside money to pay for eligible non-medical dependent day care expenses for your children and/or elderly parents so you and your spouse can go to work. These funds are available for reimbursement after they accumulate through your payroll deductions. Examples of eligible expenses include a child care or adult care center, a nursery school, summer day camp, or a caregiver for an elderly or incapacitated dependent.

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 pretax basis. You will receive a debit card for the FSA, which is the most convenient way to receive reimbursement.

FSA Savings Example

	(With FSA)	(Without FSA)
Annual Gross Income	$31,000.00	$31,000.00
FSA Deposit for Eligible Expenses	- 2,500.00	- 0.00
Taxable Gross Income	$28,500.00	$31,000.00
Federal, Social Security Taxes	- 6,455.25	- 7,021.50
Annual Net Income	$22,044.75	$23,978.50
Cost of Eligible Expenses	- 0.00	- 2,500.00
Spendable Income	$22,044.75	$21,478.50

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of **$566.25!**

To continue participating in the Flexible Spending Accounts Program next year, you must re-enroll in this program during the Annual Enrollment period. If the annual contribution is not submitted, you will waive this benefit.

Flexible Spending Accounts: myCafeteriaPlan

How Much Can I Contribute Annually to the FSA Plan?

- Medical Flexible Spending:
  $250 Minimum/$2,500 Maximum
- Dependent Care Flexible Spending: $5,000 Single Head of Household or Married Filing Jointly; or $2,500 for Married Filing Separately

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 2018, claims that happen (incurred) January 1, 2018 through December 31, 2018, you have until March 31, 2019 to file the claim.**

Retirees

If you retire or terminate employment during the plan year, please remember you have 31 days from your retirement or termination date to submit claims that were incurred prior to your last day worked.

Keep Your Receipts

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

Important Notice

Please remember if you are enrolling in the High Deductible Health Plan, you are not eligible to have a Medical Flexible Spending Account. You are still eligible to enroll in the Dependent Daycare Flexible Spending Account.

Medical FSA Overview

Current Participants

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

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

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

Medical FSA Claims Reimbursement

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

Medical FSA Eligible Expenses:

This list is NOT comprehensive and is intended only as a guide to reimbursable expenses. To find out about specific items visit www.myCafeteriaPlan.com for more information.

- Acupuncture
- Ambulance
- Chiropractors' Fees
- Coinsurance
- Contacts/Lens Solution*
- Copayments
- Crutches
- Dentists' Fees
- Dentures
- Diabetic Supplies
- Eye Exams/Glasses
- Fees Associated with Organ Donations
- Guide Animals (Purchase, training & care)
- Hearing Aids/Batteries
- Immunizations/Vaccinations
- Insulin
- Laboratory Fees
- Language Training for Disabled Person
- Laser/Lasik Eye Surgery
- Obstetrical Fees
- Physical therapists' Fees
- Prescription Drugs
- Radial Keratotomy
- Routine Physicals
- Skilled Nurses' Fees
- Smoking Cessation Treatments & Prescriptions
- Treatment for Substance Addiction
- Transportation Expenses (for Medical Reasons)
- Wheelchair
- X Ray

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

Medical FSA Overview

Debit Card

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

Please be advised that if you do not respond to myCafeteriaPlan's request for an itemized receipt, your card and your account will be suspended. In addition, you will be payroll deducted for the unsubstantiated amount on an after-tax basis or reclassify the unsubstantiated claim(s) total as taxable income. Check your balances, file claims and send pictures of receipts using an iPhone, iPod Touch, iPad or Android-powered device.

Online

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

About Your Initial Login

You will need to log in for the first time with the following information:

Username: First Initial, Last Name, Last 4 digits of Social Security Number

Example: Tsmith1234

Password: Last 4 digits of your Social Security Number.

Example: 1234

Your password will need to be changed after your first login.

Information about Weight-Loss and Smoking Cessation Programs

The IRS now allows prescribed smoking cessation programs to be reimbursable under a Health Care FSA, even if there is no specific illness.

Expenses incurred for weight-loss programs and special foods may only be reimbursable if the treatment is prescribed by a physician as medically necessary to prevent, treat, mitigate, or alleviate a specific, objectively diagnosable medical defect or illness (i.e., hypertension, arteriosclerosis, or diabetes). If the special food is a substitute for the patient's normal diet, it is reimbursable only to the extent that the cost exceeds the cost of a normal diet.

Fax or Mail

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

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

Mobile App

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

Dependent Day Care FSA Overview

Outlined on this page is a list of expenses that qualify for reimbursement from the Dependent Day Care Account. Generally, eligible expenses include the cost of child care 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. You will only be able to "swipe" the debit card for the amount that has been payroll deducted. Be sure to keep your receipts with your tax records and provide them if requested.

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

Eligible Expenses:

Under IRS rules, dependent care must be provided by a person with a Social Security number or by a dependent care facility with a Taxpayer Identification number. Dependent care provided by any sitter who you or your spouse claim as a dependent on your tax return cannot be reimbursed through your Dependent Care FSA. This includes dependent care services provided by your children or stepchildren under age 19.

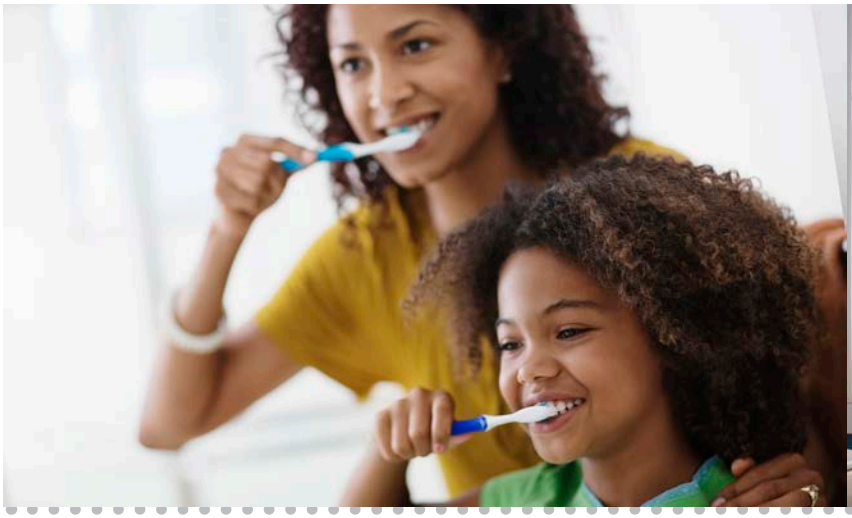
Eligible Dependent Day Care Expenses:

- After school care
- 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 babysitter in or outside your home
- Fees paid to a relative who provides dependent care services, other than your spouse, your child under age 19 or a dependent you claim for federal income tax purposes
- Fees paid to a housekeeper or cook who also is responsible for providing care for an eligible dependent
- Fees paid to a nurse or home healthcare agency for care for your spouse or legal dependent who is physically or mentally incapable of self-care
- Legally mandated amounts paid on behalf of the provider – Social Security (FICA), federal (FUTA) and state (SUTA) unemployment taxes

Ineligible Dependent Day Care Expenses:

- Food, clothing and education
- Transportation to and from the place where dependent care services are provided
- Fees paid for a 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 Healthcare Account Search fees for a dependent care provider

Dental Plans: Sun Life Financial



Your dental coverage is provided by Sun Life Financial. Sun Life Financial acquired Assurant Employee Benefits in 2016. Your dental plan options have not changed. You have three plans to choose from to fit the needs of you and your family, the Prepaid 225 Plan, Freedom Preferred Plan Low Option and Freedom Preferred Plan High Option.

The Prepaid 225 Plan

The Prepaid 225 Plan offers benefits through a network of participating dentists. You must receive all your dental care from participating dentists. You and each covered dependent must select a participating general dentist as your primary dentist. This plan has no annual maximum, no deductible and covers orthodontia – even for adults. Treatments you receive from your selected dentist will be provided at reduced fees, called copayments. The Prepaid 225 Plan is the lowest cost per payroll deduction.

Freedom Preferred Plan (PPO)

There are two PPO plans from which you can choose. These plans pay specific percentages of allowable charges for covered services. Benefits are paid after any applicable deductible has been met, up to the annual maximum benefit which is $1,250 per person per calendar year. Both of the PPO plans include the Preventive Max Waiver℠ (PMW) feature, which means that benefits paid for Type I Preventive Services will not be applied to the calendar year maximum.

The PPO plans allow you to have access to the Assurant® Dental Network[2] providers and take advantage of their fee discounts. Treatment is available from dentists who do not participate in the network, but their fees are subject to a Maximum Allowable Charge (MAC). The allowable amount for non-participating dentists is based on 20 percent off the 80th percentile of usual and customary. You will be responsible for fees in excess of the MAC. There can be significant out-of-pocket expenses if a non-participating dentist is chosen. Plan frequencies, limitations, and waiting periods apply to the PPO plans.

The PPO plans also include Lifetime of Smiles® dental health program. Lifetime of Smiles includes:

- Four cleanings per year to help prevent gum disease (coverage for up to 4 periodontal cleanings in a 12-month period)[1]
- Posterior tooth-colored fillings (white fillings on back teeth)
- Brush biopsies for early detection of cancer
- Periochips to control bacteria and reduce the size of periodontal pockets
- Genetic testing to help identify individuals who are at genetic risk for gum disease
- Access to the Online Dental Health Center for the most up-to-date information available on preventive dental care

1 Dental prophylaxis cleaning is limited to 1 time in any 6 month period and periodontal maintenance procedure is limited to 1 in any 3 month period. Total number of combined dental prophylaxis cleanings and periodontal maintenance procedures cannot exceed 4 in a 12 month period.

2 The PPO network remains as the Assurant Dental Network. The Assurant name and related logos are trademarks of Assurant, Inc. and are used under license.

Dental Plans: Sun Life Financial

DENTAL INSURANCE: Employee Contribution Rates (20 Payroll Deductions)

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

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

** Allowable amount for non-participating dentists is based on the Maximum Allowable Charge (MAC) of 20% off the 80th percentile of usual and customary charges. Patients are responsible for fees in excess of the MAC. There can be significant out-of-pocket expenses if a non-participating dentist is chosen.

Dental Plans: Comparison Chart

	PREPAID 225 PLAN (COPAY ONLY PLAN)*	FREEDOM PREFERRED PLAN † W/ PMW (LOW OPTION)**		FREEDOM PREFERRED PLAN † W/ PMW (HIGH OPTION)**	
	IN-NETWORK COVERAGE ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE	Not Applicable	$50 per person per year; waived for Type I services			
ANNUAL MAXIMUM	Not Applicable	$1,250 per person per year; amount is combined for in and out-of-network; benefits paid for Type I services do not apply to the annual maximum			
TYPE I - PREVENTIVE DENTAL SERVICES, INCLUDING:	You Pay (Fixed Copay)	You Pay (Subject to Frequency Limitations[1])			
ORAL EVALUATION* - ONCE IN ANY 6-MONTH PERIOD**	No Charge	0%	10%	0%	10%
ROUTINE DENTAL CLEANING - ONCE IN AN 6-MONTH PERIOD[2]	No Charge	0%	10%	0%	10%
SEALANTS[3]	No Charge	0%	10%	0%	10%
BITEWING X-RAYS[4]	No Charge	0%	10%	0%	10%
FLUORIDE TREATMENT[5]	No Charge	0%	10%	0%	10%
OFFICE VISIT - DURING REGULARLY SCHEDULED HOURS	$10	Not Applicable	Not Applicable	Not Applicable	Not Applicable
TYPE II - BASIC DENTAL SERVICES, INCLUDING:					
X-RAYS - PANORAMIC OR COMPLETE SERIES[6]	No Charge	10%	30%	10%	30%
NEW AND REPLACEMENT FILLINGS, INCLUDING POSTERIOR COMPOSITES[7]	$10-$95	10%	30%	10%	30%
SIMPLE EXTRACTIONS[8]	$18-$95 (depending on complexity)	10%	30%	10%	30%
TYPE III - MAJOR DENTAL SERVICES, INCLUDING:					
ENDODONTICS (INCLUDES ROOT CANAL THERAPY)[8]	$110-$485 (depending on complexity)	70%	90%	40%	60%
COMPLEX ORAL SURGERY[8]	$65-$165 (depending on complexity)	70%	90%	40%	60%
PERIODONTAL SCALING AND ROOT PLANING[8]	$35-$75 per quadrant	70%	90%	40%	60%
PERIODONTAL MAINTENANCE[2]	$45	70%	90%	40%	60%
GINGIVECTOMY, OSSEOUS SURGERY, OTHER MAJOR PERIODONTIC PROCEDURES[8]	$65-$320 (depending on complexity)	70%	90%	40%	60%

Dental Plans: Comparison Chart

	PREPAID 225 PLAN (COPAY ONLY PLAN)*	FREEDOM PREFERRED PLAN † W/ PMW (LOW OPTION)**		FREEDOM PREFERRED PLAN † W/ PMW (HIGH OPTION)**	
	IN-NETWORK COVERAGE ONLY	IN-NET-WORK	OUT-OF-NETWORK	IN-NET-WORK	OUT-OF-NETWORK
INITIAL PLACEMENT, REPLACEMENT AND MAINTENANCE OF INLAYS, ONLAYS, CROWNS[8]	$75-$225 (plus lab fees)	70%	90%	40%	60%
FIXED PARTIAL DENTURES (BRIDGES) AND PARTIAL AND COMPLETE DENTURES[8]	$225-$700 (plus lab fees)	70%	90%	40%	60%
TYPE IV - ORTHODONTIC DENTAL SERVICES					
ORTHODONTIC TREATMENT (24 MONTH ROUTINE) - CHILD UNDER 19[8]	$2,000	Not Covered		50%; $1,000 Lifetime Orthodontia Maximum	
ORTHODONTIC TREATMENT (24 MONTH ROUTINE) - ADULT[8]	$2,200	Not Covered		Not Covered	
IMPLANT COVERAGE	A $285 reduction in the charges to the Member applies for the placement of an endosteal implant (ADACode D6010) in conjunction with one of the following crowns ADA Code D6065, D6066, or D6067. This reduction in charges applies only when the implant is used instead of replacing a single missing tooth meeting the criteria of being replaced with a traditional 3 unit, cast bridge with single pontic. The space that was occupied by the single missing tooth must currently have a tooth mesial and distal to it. The tooth loss must have occurred within the 24 month period prior to the initiation of treatment. This reduction in charges is limited to the replacement of one tooth per each arch during the lifetime of the Member. Member is responsible for paying the entire charge less the $285 reduction either at the time the service is received or in accordance with the Plan Dentist's or Plan Specialist's billing procedures.	Not Covered		Not Covered	

* You must use a participating General Dentist or Specialist.

** Allowable amount for non-participating dentists is based on the Maximum Allowable Charge (MAC) of 20% off the 80th percentile of usual and customary charges. Patients are responsible for fees in excess of the MAC. There can be significant out-of-pocket expenses if a non-participating dentist is chosen.

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

† The Freedom Preferred plans are subject to the Alternative Treatment provision. If the cost of a proposed Dental Treatment Plan exceeds $300, it should be submitted for an estimate of benefits payable.

1 All services may be subject to frequency limitations, allowable charges, limitations and exclusions.

2 For Freedom Preferred plans, Periodontal Maintenance covered once in any 3 consecutive months (frequencies combined with routine cleanings).

3 For Freedom Preferred Plans, no more than once per tooth per person, only for permanent molar teeth, only for children under age 16.

4 For Prepaid Dental plan, once every 6 months; for Freedom Preferred plans, once in any 12-month period.

5 For Freedom Preferred plans, once in any 12-month period; only for children under age 14.

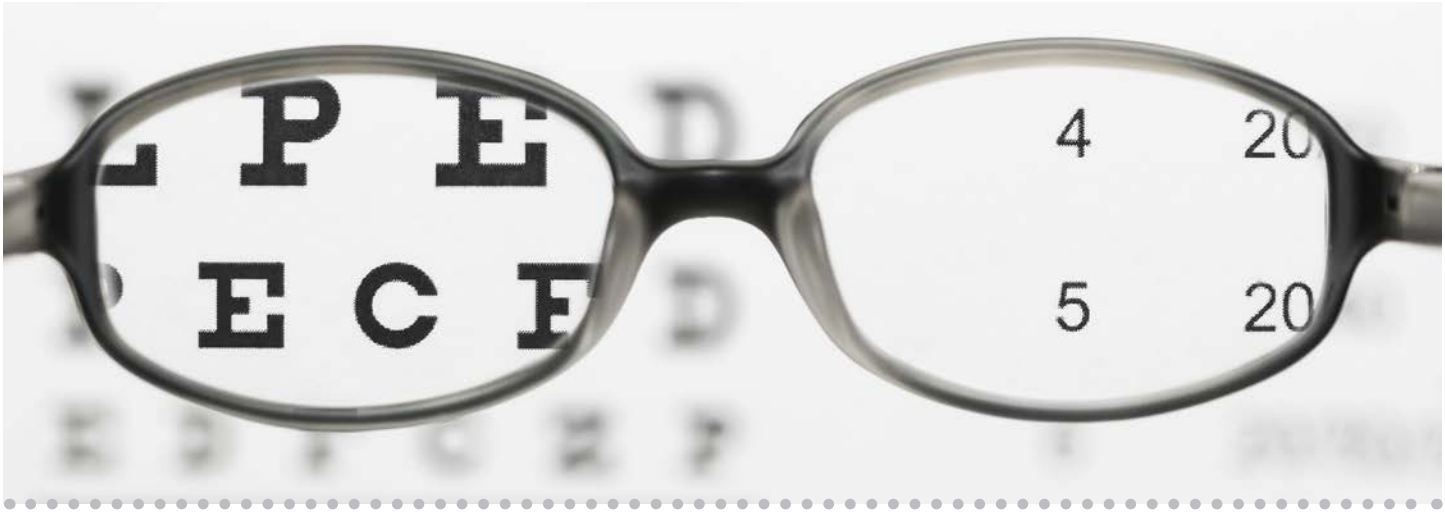
6 For Prepaid Dental plan, once in any 3 calendar years; for Freedom Preferred plans, once in any 60-month period.

7 For Freedom Preferred plans, replacement fillings once in any 24-month period.

8 For Prepaid Dental plan refer to full copayment schedule for a complete list of all copayments.

This provides only a brief summary of the dental plans for your ease of comparison. For complete details, please refer to the dental plan documents that are available on the Seminole County Public Schools website. For additional information, Contact Sun Life Financial. Plans contain limitations, exclusions, and restrictions.

Vision Plan: UnitedHealthcare



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

To see a list of participating providers for this plan, go to www.myuhcvision.com or call 1-800-638-3120. The system will inform you of the providers located within 30 miles of your home. Once you select a provider, simply call their office and make your appointment. Make sure you identify yourself as a UnitedHealthcare vision participant in the Seminole County Public Schools program and give the provider your Social Security number and birth date (If you wish to select a doctor for your dependents, you must provide their dates of birth as well).

Tips to Better Manage 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, but UnitedHealthcare Vision will mail you a Vision card
  - » Review benefit details

As a reminder, your medical plan has a vision benefit, so you can get your eyes examined every year ($20 copay). If you have good eyesight 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.

Important to Remember:

Always identify yourself as a UnitedHealthcare Vision member when making your appointment.

Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.

Your contact lens allowance may be applied towards the evaluation/fitting fee, a supply of contacts and up to 2 follow-up visits depending on the contacts that are prescribed for you. Please see an example of select contacts vs. non-select contacts below. Patient options such as UV, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

UNITED HEALTHCARE VISION - EXAMPLE

SERVICE	TOTAL RETAIL COST	MEMBER COST
Selection Contact Lenses		
Comprehensive Eye Exam	$65.00	$10.00
Contact lens fitting & follow-up	$35.00	$0.00
Alcon Air Optix Aqua (Monthly Replacement (up to 6 boxes, depending on contact frequency)	$200.00	$0.00
Materials Copay	--	$20.00
Total Cost	**$300.00**	**$30.00**
Non-Selection Contact Lenses		
Comprehensive Eye Exam	$65.00	$10.00
Contact lens fitting & follow-up	$35.00	$35.00
Non-Selection Contact Lenses	$200.00	$50.00
Materials Copay	--	--
Total Cost	**$300.00**	**$95.00**

Vision Plan: UnitedHealthcare

VISION INSURANCE: Employee Contribution Rates (20 Payroll Deductions)

EMPLOYEE	EMPLOYEE + 1 DEPENDENT	EMPLOYEE + 2 OR MORE DEPENDENTS
$4.22	$6.76	$9.75

UnitedHealthcare has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eyeglasses.

Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$10.00
Materials	$20.00
Frame Benefit (for frames that exceed the allowance, and additional 30% discount may be applied to the coverage)[2]	
Private Practice Provider	$150.00 retail frame allowance
Retail Chain Provider	$150.00 retail frame allowance
Lens Options	
Standard Scratch Resistant Coating, Standard progressive lenses, Polycarbonate lenses - covered in full. Other optional lens upgrades may be offered at a discount (discount varies by provider).	
Contact Lens Benefit[3]	
Selection contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay (if applicable).	If you choose disposable contacts, up to 6 boxes are included when obtained from a network provider.
Non-selection contact lenses An allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection. Materials copay (if applicable) is waived.	$150.00
Necessary contact lenses[4]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eye Glasses[3]	Up to $150.00
Necessary Contacts in Lieu of Eye Glasses[4]	Up to $210.00
Discounts	
Laser Vision - UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at LasikPlus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.	
Additional Material - At a participating network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.	
Hearing Aids – As a UnitedHealthcare plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.	

Vision Plan: UnitedHealthcare

Discounts	
	Laser vision UnitedHealthcare has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off standard or 5% off promotional pricing at more than 550 network provider locations and even greater discounts through set pricing at LasikPlus® locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on high-quality hearing aids when you buy them from hi HealthInnovations™. To find out more go to hiHealthInnovations.com. When placing your order use promo code myVision to get the special price discount.

[1]On all orders processed through a company owned and contracted lab network.
[2]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[3]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames. Coverage for Selection contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for Non-selection contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.
4 Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, facial deformity; or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare selection.
- Your $150.00 contact lens allowance applies to materials. No portion will be exclusively applied to the fitting and evaluation. Your material copay is waived when purchasing non-selection contacts.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. All receipts must be submitted at the same time to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX or VPOL.13TX and associated COC form number VCOC.INT.06.TX or VCOC.CER.13.TX. Plans sold in Virginia use policy form number VPOL.06.VA or VPOL.13.VA and associated COC form number VCOC.INT.06.VA or VCOC.CER.13.VA.

UnitedHealthcare®

Vision Plan: UnitedHealthcare

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service, visit our website at www.myuhcvision.com or call 800-638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com (see example of card).

Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.

Network Provider - copays and non-covered patient options are paid to provider by program participant at the time of service.

Non-Network Provider - participant pays full fee to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to non-network benefits. All receipts must be submitted at the same time to the following address:

UnitedHealthcare
Attn. Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

FAX: 248.733.6060

Written proof of loss should be given to the Company within 90 days after the date of loss. If it was not reasonably possible to give written proof in the time required, the company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, no later than 1 year after the date of service unless the covered person was legally incapacitated.

Life Insurance/AD&D: Standard

Group Term Life Insurance

SCPS provides board-paid Group Term Life and matching Accidental Death and Dismemberment (AD&D) insurance for benefit-eligible employees regularly working at least 17.5 hours each week underwritten by The Standard Insurance Company. The board pays an amount equal to your annual earnings, up to $250,000 maximum, $25,000 minimum.

Additional Life/ AD&D Insurance

All SCPS employees are able to elect in multiples of $1,000, up to four times their annual salary, in life and matching AD&D insurance coverage, not to exceed $300,000.

New hires are eligible to purchase the lesser of two times your annual salary or $100,000 on a guaranteed issue basis (no medical questions asked). Anything over this amount requires Evidence of Insurability (EOI).

Existing employees can increase their Additional Life/ AD&D by $10,000, up to the Guarantee Issue amount without EOI during annual enrollment or within the first 31 days following a family status change. Anything over this amount requires EOI.

Spouse Life/AD&D Insurance

You may also purchase Term Life/AD&D Insurance for your spouse in $1,000 increments up to a maximum of $150,000. The amount you can purchase for your spouse cannot exceed 100 percent of the Employee Board Paid & Additional Term Life/AD&D Insurance amounts combined.

New hires are eligible to purchase spouse coverage up to $10,000 on a guarantee issue basis (no medical questions asked). Anything over this amount requires Evidence of Insurability (EOI).

Existing employees can add Spouse Life/AD&D during annual enrollment with EOI approval.

Dependent Child(ren) Life/AD&D Insurance

This benefit provides coverage for all eligible dependent children, regardless of how many. You have three options to choose from: $2,000, $5,000 and $10,000, per child. No EOI required for children.

Premium Waiver

If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Basic and Additional Life and your child/ spouse's life insurance may continue without premium payment, subject to the terms of the group policy. If you have any questions, you may contact the Benefits & Insurance Services Department at 407-320-0095.

Terminating Employment

If you terminate your employment from SCPS, you may elect to continue coverage one of two ways:

- Port* a minimum of $10,000 (combined) Term Life and Accidental Death and Dismemberment (AD&D) coverage up to the same amount of coverage you had as an active employee (not to exceed $750,000 Group Life & AD&D plans combined). Employee must be under age 80 to be eligible to port. Group portability rates in force at time of port will apply; or

- Convert your Group Term Life coverage to an individual Whole Life contract up to the same amount of coverage you had as an active employee at the individually underwritten rates effective at such time.

All current employees who retire with SCPS may retain their Basic Life amount under the Retiree group insurance plan. A retiree may also elect to convert any portion of optional coverage to an individual Whole Life contract. Regardless of the elected option upon retirement, you will pay the premium.

If you would like to obtain the Portability/Conversion packet or have any questions, contact the Benefits & Insurance Services Department at 407-320-0095 or email: Benefits@scps.k12.fl.us.

*You are not eligible to apply for portable coverage if you are unable to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience.

Life Insurance/AD&D: Standard

Plan Provider

The Standard Insurance Company insures this plan. The Standard Insurance Company has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Founded in 1906, The Standard Insurance Company has developed a national presence in the employee benefits industry, providing customers with group and individual disability insurance and retirement plans, and group life and dental insurance.

Beneficiary

It is important that you review your policy every couple of years and update your beneficiary designations (insurance policies, retirement accounts, pensions, payable-on-death accounts, etc.) whenever there's a big life event: you get married, you divorce, or a child or grandchild joins the family.

Don't Try to Use Your Will to Change a Beneficiary

If you want to name or change a life insurance beneficiary, fill out the required documents with the District. You can't change a beneficiary in your will - the terms of your will have no effect on your agreement with the life insurance company.

Designating a Minor as Beneficiary

While you may name your minor children as your designated beneficiary, the life insurance carrier will be unable to pay the life insurance proceeds to your children until the earlier of:

- The date that your children reach the age of majority (usually age 18 or 21, depending on applicable state law).
- The date that a legal guardian of the minors' estate has been appointed by a court. This appointment process can be costly, and state laws may limit who may be named a guardian of an estate. Generally, a guardian of the minors' estate will hold the money for their benefit until they reach the age of majority, usually age 18 or 21, depending on state law.

If you want your minor children to receive your life insurance proceeds, you should consult your legal advisor to determine the best way to accomplish this under the laws of your State.

Designating an Ex-Spouse as Beneficiary:

Effective July 1, 2012, the Florida Legislature passed Section #732.703, Florida Statute, which will invalidate the designation of an ex-spouse as a beneficiary on life insurance policies and other elements within an employee benefits plan if those designations were made prior to the divorce.

After July 1, 2012, if an employee wants their ex-spouse to be a beneficiary on a life insurance policy or another employee benefit plan product, they will have to make that designation after the dissolution of the marriage. Any employees who currently have an ex-spouse as a beneficiary and want to keep this designation will have to re-submit a beneficiary form designating the ex-spouse dated after July 1, 2012.

If coverage becomes effective, and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. Neither the information presented in this summary nor the certificate modifies the group policy or the insurance coverage in any way.

Life Insurance/AD&D: Standard

Board Paid Basic Life and AD&D Insurance

PLAN FEATURES	BENEFIT AMOUNT
BOARD PAID (BASIC) LIFE AND AD&D INSURANCE	One times your annual earnings up to $250,000 (minimum $25,000)

Additional Life & AD&D Insurance

PLAN FEATURES	BENEFIT AMOUNT
EMPLOYEE LIFE AND AD&D INSURANCE	Available in increments of $1,000 not to exceed four times (4x) your annual salary to a maximum benefit of $300,000. During annual enrollment and the first 31 days following a family status change, employees who are not already insured are guaranteed issue up to $10,000, and employees who are already insured may increase coverage by $10,000 not to exceed lesser of two times annual salary or $100,000. New hires are eligible to purchase the lesser of two times (2x) your annual salary or $100,000 on a guaranteed issue basis. Employees age 65 or older will be subject to age reductions. Please consult the certificate of coverage or contact the Benefits & Insurance Services Department for more information.
SPOUSE LIFE INSURANCE	You may also purchase Supplemental Term Life Insurance for your spouse in $1,000 increments up to a maximum of $150,000. The amount you can purchase for your spouse cannot exceed 100% of the Employee Basic & Additional Term Life Insurance amounts combined. Spouse coverage is guaranteed issue up to $10,000. Amounts in excess require Evidence of Insurability (EOI).
DEPENDENT CHILD(REN) LIFE INSURANCE	This benefit provides coverage for all eligible dependent children, regardless of how many. You have three options to choose from: $2,000, $5,000 and $10,000, per child. No EOI required for children.
BENEFIT REDUCTION SCHEDULE (OCCURS AT THE POLICY ANNIVERSARY DATE OF JANUARY 1ST)	At employee 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. Age reduction applies to both Employee and Spouse Life amounts.

Life Insurance/AD&D: Standard

Additional Life/AD&D 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.

Employee Life/AD&D and Spouse Life/AD&D Insurance rates (based on 20 payroll deductions):

Ages	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	>70
$10,000	$0.24	$0.30	$0.50	$0.95	$1.67	$2.64	$4.58	$5.48	$10.62	$18.72
$20,000	$0.48	$0.60	$1.00	$1.90	$3.34	$5.28	$9.16	$10.96	$21.24	$37.44
$30,000	$0.72	$0.90	$1.50	$2.85	$5.01	$7.92	$13.74	$16.44	$31.86	$56.16
$40,000	$0.96	$1.20	$2.00	$3.80	$6.68	$10.56	$18.32	$21.92	$42.48	$74.88
$50,000	$1.20	$1.50	$2.50	$4.75	$8.35	$13.20	$22.90	$27.40	$53.10	$93.60
$60,000	$1.44	$1.80	$3.00	$5.70	$10.02	$15.84	$27.48	$32.88	$63.72	$112.32
$70,000	$1.68	$2.10	$3.50	$6.65	$11.69	$18.48	$32.06	$38.36	$74.34	$131.04
$80,000	$1.92	$2.40	$4.00	$7.60	$13.36	$21.12	$36.64	$43.84	$84.96	$149.76
$90,000	$2.16	$2.70	$4.50	$8.55	$15.03	$23.76	$41.22	$49.32	$95.58	$168.48
$100,000	$2.40	$3.00	$5.00	$9.50	$16.70	$26.40	$45.80	$54.80	$106.20	$187.20
$110,000	$2.64	$3.30	$5.50	$10.45	$18.37	$29.04	$50.38	$60.28	$116.82	$205.92
$120,000	$2.88	$3.60	$6.00	$11.40	$20.04	$31.68	$54.96	$65.76	$127.44	$224.64
$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
$280,000	$6.72	$8.40	$14.00	$26.60	$46.76	$73.92	$128.24	$153.44	$297.36	$524.16
$290,000	$6.96	$8.70	$14.50	$27.55	$48.43	$76.56	$132.82	$158.92	$307.98	$542.88
$300,000	$7.20	$9.00	$15.00	$28.50	$50.10	$79.20	$137.40	$164.40	$318.60	$561.60

Dependent Child(ren) Life/AD&D Rates - based on 20 payroll deductions:

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

Short-Term and Long-Term Disability: Cigna

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

Disability insurance provides you with a stable source of income that can help carry you and your family financially through this time. Short-Term Disability covers you for up to 26 weeks. Should your disability take longer than this to recover from, then your claims would transition to Long-Term Disability (if you are enrolled in it). These are two separate 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 pretax 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 pay. Employees can use earned vacation time while on disability.

Benefit levels have increased an additional $30 for each weekly benefit level.
See the NEW $950 Weekly Benefit!

Short-Term Disability Employee Contribution Rates (20 Payroll Deductions)

BI-WEEKLY EARNINGS	WEEKLY BENEFIT	DEDUCTION
Less than $508	**$150**	$4.52
$508 - $841	**$250**	$9.19
$842 - $1,175	**$350**	$13.58
$1,176 - $1,569	**$450**	$18.10
$1,570 - $1,999	**$550**	$22.69

BI-WEEKLY EARNINGS	WEEKLY BENEFIT	DEDUCTION
$2,000 - $2,333	**$650**	$27.22
$2,334 - $2,687	**$750**	$31.76
$2,688 - $3,035	**$850**	$36.29
$3,036 or higher	**$950**	$40.68

Short-Term Disability Highlights

BENEFIT AMOUNT	You can select your benefit in increments of $100. Your maximum benefit amount is determined by your salary.
BENEFIT MAXIMUM	$950
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.

NOTE: Employees waiving medical coverage and providing proof of coverage elsewhere, will receive the Mutual of Omaha Disability. If adding Cigna Short-Term Disability, the premium will be reduced since coordination of benefits apply.

Short-Term and Long-Term Disability: Cigna

Long-Term Disability Employee Rate (20 Payroll Deductions) New Lower Rate of $5.92!

Long-Term Disability Highlights

BENEFIT AMOUNT	60% of your monthly earnings
BENEFIT MAXIMUM	$5,000 per month
ELIMINATION PERIOD	180 calendar days
MAXIMUM BENEFIT PERIOD	To age 65/Graded ADEA as stated below. Benefits are paid on a graded scale if the employee becomes disabled after age 62. Age When Disability Begins — Maximum Benefit Period Age 62 or under — Your 65th birthday or the date the 42nd Monthly Benefit is payable, if later Age 63 — The date the 36th Monthly Benefits is payable. Age 64 — The date the 30th Monthly Benefits is payable. Age 65 — The date the 24th Monthly Benefits is payable. Age 66 — The date the 21st Monthly Benefits is payable. Age 67 — The date the 18th Monthly Benefits is payable. Age 68 — The date the 15th Monthly Benefits is payable. Age 69 or older — The date the 12th Monthly Benefits is payable.
BENEFIT OFFSETS	Including but not limited to sick pay, retirement (401(k) & pension), workers' compensation, Social Security & other group disability plans like the Mutual of Omaha policy

Long-Term Care: Unum

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

Long-Term Care Benefit Highlights

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

Long-Term Care: Unum

Why does it pay to enroll now?

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

NOTE: This plan does not have an accumulated cash value. If you terminate your coverage, there is not a cash surrender value. This plan will require medical underwriting if you enroll after your initial eligibility period. Evidence of Insurability and a Benefit Election Form are required with signatures and dates to enroll. If you are interested in enrolling, please contact the FBMC representative at 1-407-320-0364 in the Benefits and Insurance Services Department.

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

If you add Unum Long-Term Care:

Then print the Enrolling in Unum info:

- Visit http://unuminfo.com/scps/index.aspx and click on the "Enrollment" tab to access the Enrollment Form. After agreeing to the consent to use electronic signatures, you will be directed to "Review Your Plan Details" and the "Outline of Coverage."
- Select either Employee Enrollment, Spouse Enrollment or Family Enrollment.
- Click on the Employee Enrollment Form AND the Long Term Care Insurance Application with HIPAA Authorization to provide the Evidence of Insurability. Please note that if enrolling a spouse or dependent, a separate enrollment form AND Evidence of Insurability MUST be completed.
- If you did not sign up for this benefit when you were first eligible, then you will have to provide Evidence of Insurability. Family members are required to provide Evidence of Insurability when they sign up for this plan.
- Click on the "Long-Term Care Insurance Application" to provide Evidence of Insurability.
- Please retain a copy of the completed form for your records.
- Please make sure your name and Social Security number are on the top of each page to ensure proper processing, if the pages get separated.
- Complete the form in its entirety. Missing information will delay processing time and could prevent you or your dependents from being approved for this benefit.
- Mail your Employee Enrollment Form and Evidence of Insurability in a confidential envelope to the FBMC On-site Representative located in the Benefits and Insurance Services Department.

Accident Insurance: Colonial Life

Accident Insurance

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

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

Plan Features Include Benefits for:

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

Accident Plan Highlights

EMERGENCY ROOM VISIT	$200
HOSPITAL ADMISSION DUE TO AN ACCIDENT	$2,000
FOLLOW-UP DOCTOR VISIT	$120 (up to three visits)
BROKEN OR FRACTURED BONES	$75 - $7,500

Rates For Accident Insurance Based On 20 Payroll Deductions:

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

To Enroll in Colonial Life and Accident Insurance products:

- A Colonial Life and Accident Insurance application is required and may require an EOI to be completed.
- All forms must be signed and dated (Required for new or replacement coverage).
- The Colonial Life Cancer insurance requires medical underwriting and carrier approval before a policy is issued.
- Access the Colonial Life enrollment site and complete the required enrollment documentation.

All policy premiums are 100% employee paid. For more complete details please refer to the product brochure found on the Seminole County Public Schools website.

This policy has exclusions and limitations. Coverage may vary by state and may not be available in all states. Applicable to policy form ACCPOL-FL. This is not an insurance contract only actual policy provisions will control.

Cancer Insurance: Colonial Life

Cancer Insurance

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

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

Colonial Life & Accident Insurance Company's Cancer insurance helps guard against financial difficulties if you or a family member (covered under plan) is diagnosed with cancer.

1. Annual cancer screening benefit of $100 (per person, per year). Cancer will provide a wellness benefit for specific wellness tests outlined in your brochure.
2. Pays benefits to help with the cost of cancer treatment
3. Hospital confinement benefit and chemotherapy and radiation benefits.
4. Pays regardless of any other insurance you have with other companies.
5. Benefits paid directly to you unless you specify otherwise.
6. Guaranteed renewable as long as premiums are paid when due.
7. You can take your coverage with you even if you change jobs or leave your employer. Also included is an initial diagnosis rider; this rider pays a lump sum of $2,000 for the initial (first) diagnosis of internal (not skin) cancer per adult and $3,500 per child.

Cancer Insurance Highlights

ANNUAL CANCER SCREENING	$100 (Paid Per Year Per Covered Person)
SKIN CANCER INITIAL DIAGNOSIS	$2,000 Initial Diagnosis of Internal Cancer $300 in addition to the Skin Cancer initial diagnosis
CHEMOTHERAPY & RADIATION BENEFIT	$300 per day for approved treatments (maximums apply), $600 per day 31+
HOSPITAL CONFINEMENT	$300 a day for the first 30 days

Obtain a claim form:

Visit ColonialLife.com and click on the "Learn More" button under Claim and Service Forms.

How to File a Claim:

- Include your Social Security number on each page of the claim form.
- Be sure the claim form is completed in full and that supporting documentation, such as an itemized bill, is attached before you send in the claim form to Colonial Life.
- Sign and date the HIPAA form in case we need to obtain any information from your doctor.
- Be sure to initial any specific services that you want to authorize, such as sending payments by overnight delivery.

Fax or mail the completed claim form:

1. Fax to 1-800-880-9325
2. Mail to: Colonial Life
   P.O. Box 100195
   Columbia, SC 29202

You will receive a telephone call within two to three days after your claim is received.

If you select the electronic messaging option, you will also receive a telephone call when the claim is paid.

Looking for a claim's status?

Visit ColonialLife.com or call 1-800-325-4368. An automated service is available 24 hours per day, 7 days per week. Customer Service representatives are available from 8 a.m. until 8 p.m., ET.

Rates for Cancer Insurance and the Initial Diagnosis Rider Based on 20 Payroll Deductions:

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

All policy premiums are 100% employee paid. For more complete details please refer to the product brochure found on the Seminole County Public Schools website.

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

This policy and the rider have exclusions and limitations. Coverage may vary by state and may not be available in all states. Applicable to policy form C1000 (including state abbreviations where used) and applicable to ride form R-C1000-Indx (including state abbreviation where used).

Hospital Indemnity Protection: Colonial Life

Hospital Confinement Indemnity Insurance

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

Plan Features:

- Lump-sum hospital confinement benefit of $1,000; payable per confinement.
- Includes outpatient surgical procedure benefit; calendar year maximum is $1,500.
- Annual wellness test benefit is included; maximum of one test per calendar year for named insured only coverage or maximum of two tests per calendar year for all covered persons combined. The amount of $50 is paid only once a year for specific wellness exams outlined in your brochure.
- Rehabilitation unit confinement benefit of $100 per day; maximum of 15 days per confinement with a 30-day maximum per covered person per calendar year.
- A waiver of premium benefit is available after 30 continuous days of the named insured's hospital confinement.
- Coverage options for you, your spouse and eligible dependent children.

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

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

All policy premiums are 100% employee paid. For more complete details please refer to the product brochure found on the Seminole County Public Schools website.

This policy has exclusions and limitations.

Coverage may vary by state and may not be available in all states. Applicable to policy number MB3000-FL.

Earning Your Wellness Incentive Points

The 2018 Wellness Incentive

You should have successfully completed the Strive for Five Wellness Incentives between, July 1, 2016 and July 31, 2017. If you earned five wellness incentive points, you will receive an incentive that either:

1. Contributes $750 into a Health Savings Account or a Health Reimbursement Account, if you are enrolled in the High Deductible Health Plan. If your spouse also completed the Strive For Five wellness incentive points, an additional $500 will be deposited into your HSA or HRA on January 1, 2018. OR

2. Reduces the premiums for employees enrolled in the Open Access Buy-Up Plan by $750 a year.

Your good health is important to you, your family and to us, therefore, each school location has a Wellness Champ who is focused on wellness. Engage with your SCPS wellness programs online at mycigna.com or contact your Wellness Champ for district wellness events. They are there for you.

Need to Know – New This Year for the 2019 Wellness Incentive

Now is the time to work on achieving your wellness incentives for next plan year (2019). The window to complete your 2019 Wellness Incentives is August 1, 2017 through July 31, 2018. The incentives are built to encourage you to engage in a healthy lifestyle throughout the year. Take time to read the new incentives that have been posted throughout the district and in your 2018 Benefits Guide. Start your wellness activities now!

In order to encourage you to visit your primary care physician and get your labwork done, **on-site biometrics at district locations WILL NOT be offered this year.** Please make it a priority to schedule your annual physical with your primary care physician and complete your labwork. Points toward your incentive goal WILL NOT accumulate until you complete this step AND you complete your health assessment on mycigna.com. It is good for your health AND you'll earn points toward your incentive goal.

Know Your Numbers

Knowing your numbers for key biometric measurements will be even more important because the wellness incentive is a combination of preventive care and an outcome-based points system.

Outcome-based programs have pre-established health values for important health tests that prevent health risks, like: heart disease, stroke, diabetes, cancer and other health conditions. This is just another step in making us all accountable for our health and health care decisions. It is intended to identify past, current and potential medical problems. Understanding your health values from the past few years of participating in the wellness incentive will make you aware of your health in order to take advantage of the resources to improve your numbers.

Wellness Incentive

SCPS BENEFITS AND INSURANCE SERVICES

STRIVE FOR 5

GOAL	REWARD ($$ per year for 5+ points)	COMPLETION TIMEFRAME
Preventive Care Goals		
Get annual lab results at your PCP and complete the Cigna Health Assessment (Gatekeeper Goal)	Must complete both goals to earn any incentive points	8/1/17 - 7/31/18*
Get preventive annual exam	2	8/1/17 - 7/31/18
Get well-woman exam	1	8/1/17 - 7/31/18
Get a mammogram	1	8/1/17 - 7/31/18
Get a colonoscopy	1	8/1/17 - 7/31/18
Get a cervical cancer screening	1	8/1/17 - 7/31/18
Get a PSA screening	1	8/1/17 - 7/31/18
Get skin cancer screening	1	8/1/17 - 7/31/18
Biometric Outcome Goals*		
Achieve a Waist Circumference <40 Men or <35 Women	1	8/1/17 - 7/31/18
Achieve a healthy LDL level of less than or equal to 129 mg/dl	1	8/1/17 - 7/31/18
Achieve a healthy blood pressure level of less than or equal to 139/89 or improve blood pressure to a healthy level*	1	8/1/17 - 7/31/18
Achieve a Fasting Blood Sugar level less than 100 OR Non-Fasting Blood Sugar level less than 140	1	8/1/17 - 7/31/18
Health Coaching Goals		
Achieve a Personal Health Goal by working with a Health Coach	2 (can complete 2 times)	8/1/17 - 7/31/18
Get Help Improving Lifestyle Habits (Stress, Weight and Tobacco – telephonic)	1	8/1/17 - 7/31/18
Complete an online coaching program via My Health Assistant (Exercise, Nutrition, Positive Mood, Weight, Stress, Tobacco, Asthma, Diabetes, Heart Failure, COPD, Heart Disease)	1 (can complete 2 times)	8/1/17 - 7/31/18
Steerage Goals		
Get your Orthopedic Back Surgery done at a Center of Excellence facility	1	8/1/17 - 7/31/18
Get your Orthopedic Joint Surgery done at a Center of Excellence facility	1	8/1/17 - 7/31/18
Get your Cardiac Surgery done at a Center of Excellence facility	1	8/1/17 - 7/31/18
Get the best care during childbirth at a Center of Excellence hospital	1	8/1/17 - 7/31/18
Social Health Goals		
Get Connected! Have fun and earn rewards on Apps and Activities	1	1/1/18 - 7/31/18

*Biometric screening must include: Total cholesterol, LDL, Glucose, Blood Pressure, BMI *If an individual does not qualify for a Biometric Outcome reward, a reasonable alternative standard or waiver is available.

tinyurl.com/benefits2018

WELLNESS

Dependent Eligibility

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Proof of dependent status (legal guardianship or adoption, for example) is required to enroll eligible dependent children. If proof is not provided, your dependent will not be covered by carrier. You and your dependents must be enrolled in the same plan.

Eligible dependent children include:

- your own children
- legally adopted children
- stepchildren
- a child for whom you have been appointed legal guardian
- a child for whom the court has issued a Qualified Medical Child Support Order requiring you or your spouse to provide coverage
- a dependent of a currently enrolled dependent (e.g., your grandchild) may be enrolled in a health plan for a period of 18 months from birth

Covering Dependent Children

The following criteria do not apply to adult dependent children who are mentally or physically incapable of supporting themselves. These children may qualify for coverage at any age by virtue of their incapacitation, as long as they became incapacitated prior to age 26 or 30 and maintain continuous coverage with the District.

Medical Plan Coverage

Through Age 26

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.

Age 26 Through 30

Florida law allows employees enrolled in a District-sponsored medical plan to cover their adult dependent children, age 26 through age 30 (benefits terminate on their birthday). To qualify for this extended coverage, your adult dependent child must meet all of the following eligibility criteria. Your adult dependent child must:

- Be unmarried and have no dependent children of his or her own,
- Be a resident of the state of Florida or a full-time or part-time student, and
- Have no medical insurance as a named subscriber, insured enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan; or not be entitled to benefits under Title XVII of the Social Security Act.

Dental, Vision, Life

Your children, through the end of the calendar year in which the unmarried dependent child, attains the age of 26.

Cancer, Accident, Hospital

Your children, up to their birth date in the year the unmarried dependent child attains the age of 26.

Dependent Eligibility

Proof of Dependent Eligibility

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

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

It is important that you make your choices carefully, since changes can only be made during the annual enrollment period. Mid-year benefit changes are permitted for qualified events as defined by IRS 125 Rules.

Special Enrollment Rights

If you decline coverage for yourself and any eligible dependents, including your spouse, because you and/or your dependents are covered under another major medical plan, you may be able to enroll yourself and/or your dependents in a District medical plan if you lose eligibility under the other plan. An individual policy is not considered a major medical plan. For more information, contact the Benefits Specialist assigned to your facility.

Dependent Verification Process

In addition to a Social Security card, the following documents are required to meet the criteria for verification of dependent eligibility:

- **Spouse** - Original or copy of government-issued marriage certificate
- **Birth Child** - Original or copy of government-issued birth certificate that shows proof of relationship
- **Stepchild** - Original or copy of government-issued birth certificate that shows proof of relationship AND marriage certificate to child's parent
- **Adopted Child** - Legal adoption records naming employee as parent. If the spouse (not employee) is the adoptive parent, a marriage certificate is required.
- **Child born outside of the USA** - Naturalization papers that show proof of relationship
- **Legal Guardianship** - Original or copy of government-issued birth certificate AND court order naming employee as legal guardian. If the spouse (not employee) is the guardian, a marriage certificate is required. Educational guardianship is not sufficient documentation.
- **Grandchild (newborn to 18 months of age)** - Original or copy of government-issued birth certificate that shows proof of relationship AND original or copy of government-issued birth certificate of covered dependent birth parent who is also enrolled in the plan. If a grandchild is older than 18 months, legal guardianship must be obtained and provided in order to remain on the plan.
- **Disabled Adult Child** - Original or copy of government-issued birth certificate that shows proof of relationship AND physician's statement or Social Security disability papers.

Qualifying Changes to Your Coverage

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

However, you must make your benefit elections carefully, including the choice to waive coverage, because IRS regulations state that your pretax elections will remain in effect until the next annual open enrollment period, unless you experience an IRS-approved qualifying change in status. Qualifying change-in-status events include, but are not limited to:

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

* Does not apply to a Medical Expense FSA plan.
† Does not apply to a Dependent Care FSA plan.
** after deductible met on HDHP

Qualifying Changes to Your Coverage

Changing your Coverage during the Plan Year

Within **30 days** of a qualifying event, you must submit supporting documentation to the Benefits & Insurance Services Department. Upon the approval of your election change request, your existing coverage will be stopped or modified (as appropriate). However, if your election change request is denied, you will have **30 days**, from the date you receive the denial, to file an appeal. Visit www.irs.gov for information on rules governing periods of coverage and IRS Special Consistency Rules.

Please note that your qualified status change must be consistent with the event. For example, if you get married, you can add your spouse to your current medical coverage, but you cannot switch medical plans. You must notify the Benefits & Insurance Services Department within 30 days of your qualified status change.

Effective Date Following a Qualifying Event

Your benefits effective date following a qualified status change is the first month after paperwork is received and online enrollment is completed. Birth or adoption of a child will be effective the date of birth or date of placement for adoption.

Adding Newborn(s) or Adopted Child(ren)

In accordance with Florida Statute 627.6575 Coverage for newborn children, children added after birth or adoption will have 30 days coverage without an additional premium. However, the plan co-insurance and deductibles still apply.

If a child is not enrolled within thirty-one (31) days from the date of birth, but is enrolled within 60 days from the date of birth by written notification, coverage for the newborn child will become effective from the date of birth. Any premiums due must be paid retroactive to the date of birth for coverage to be effective.

Board-Approved Leave of Absence

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 the Personnel Specialist, Olga Buitrago at 407-320-0082 information concerning your leave options prior to any inquiries to the Benefits and Insurance Services Department.

Billing

Billing statements will be sent monthly and will be based on the number of missed checks/deductions during this period. You may choose to voluntarily terminate your insurance while on leave by submitting termination notification to the Benefits and Insurance Services Department **in writing.** 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. Upon returning from leave to active duty, you may only re-enroll in the same coverages you had prior to the leave. Online enrollment must be completed within 30 days of the date you return to work. The effective date of all plans will be the first of the month following 30 days of continuous service.

Payroll deductions are based on the number of months of coverage divided by number of remaining pay periods in the current plan year. You may contact your Benefit Specialist for specific cost.

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

Contact Human Resources at 407-320-0082 for additional information.

Newborn Coverage

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.

How to Enroll Newborns

To permanently add your newborn to your policy, you must submit an enrollment form to the Benefits and Insurance Services 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 are required to be submitted to the Benefits and Insurance Services Department within 30 days of the birth. Once the baby is enrolled in your plan, you CANNOT drop their coverage until the next annual enrollment. Due to IRS Section 125 rules and SCPS procedures, you need a qualifying event to make changes outside of annual enrollment. If you want the baby to be covered under your spouse's group insurance plan, then you will need to add the baby to his or her plan at the time of birth. Newborns will not be added if you fail to notify the Benefits and Insurance Services Department within 60 days from the date of birth.

State Mandated Coverage for Newborns

When an employee adds a baby on a high deductible health plan (HDHP) or OAPIN (Buy Up plan) for the free 31-day, state-mandated coverage, their deductible during those 31 days becomes the collective family deductible of $3,000, if they are enrolled in the HDHP plan. If they are enrolled in the OAPIN (Buy Up Plan), each eligible family member meets his or her individual deductible ($500), covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible ($1500) has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

If the employee does not have family coverage at the time of the birth, their coverage will switch back to individual coverage at the end of the 31 days. Though the deductible will go back to the individual deductible ($1,500 on the HDHP and $500 on the OAPIN Buy Up), any claims with dates of services during the 31 days the baby was on the policy will be processed with the family deductible ($3,000 on the HDHP and $1,500 on the OAPIN Buy Up). When the deductible returns to the individual coverage deductible on either plan, the additional money paid towards the family deductible is applied to the non-collective out-of-pocket maximum (OOP max) for 2018.

Some new moms are choosing instead to add the baby to the father's policy rather than their SCPS plan to avoid paying the $3,000 family deductible on the HDHP or $1,500 family deductible on the OAPIN Buy Up plan. In order to do this, there is a waiver of coverage form that needs to be completed and returned to your SCPS Benefit Specialist, if you would rather waive coverage for your newborn. If that form is not returned, the baby will be automatically added when the birth claim is received and your claims will be processed with the $3,000 deductible if you are enrolled in the HDHP or processed with the $1,500 deductible if you are enrolled in the OAPIN Buy Up plan.

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

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

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

Insurance Definitions

- **ADMINISTRATIVE SERVICES ONLY (ASO) - SELF-FUNDED:** Your employer is exclusively liable for all of the financial (claims and related expenses) and legal aspects of you group benefits plan.
- **ANNUAL ENROLLMENT:** Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.
- **BENEFIT YEAR:** The 12-month cycle during which the benefits expenses that you incur, and that are covered by the insurance plan, count toward your annual or calendar-year deductible.
- **CAFETERIA PLAN:** A written benefit plan maintained by an employer which allows employees to select qualified benefits on a pretax basis.
- **CARRIER:** The insurance company.
- **CLAIM:** The request for payment for benefits received in accordance with an insurance policy.
- **COPAY:** A capped contribution defined in the policy and paid by an insured person each time a medical service is received. It must be paid before any policy benefit is payable by an insurance company.
- **COBRA:** The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances.
- **COINSURANCE:** A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80 percent of the allowable charge, with the covered person responsible for the remaining 20 percent. The 20 percent amount is then referred to as the coinsurance amount.
- **DEDUCTIBLE:** A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.
- **EVIDENCE OF INSURABILITY (EOI):** Medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.
- **EXPLANATION OF BENEFITS (EOB):** A document produced by your insurance carrier that explains their response and action (whether it be payment, denial, or pending) to a claim processed on your behalf.
- **FLEXIBLE SPENDING ACCOUNT (FSA):** A tax-favored account that can be set up through a cafeteria plan by an employee to pay for eligible medical or dependent day care expenses on a pretax basis.
- **HEALTH ASSESSMENT:** A physician collects, validates, and analyzes your biometric information in order to make a judgement about your health status and life processes.
- **HEALTH REIMBURSEMENT ACCOUNT (HRA):** an IRS approved, employer-funded, tax-advantaged employer health benefit plan that reimburses employees for out-of-pocket medical expenses and individual health insurance premiums.
- **HEALTH SAVINGS ACCOUNT (HSA):** A savings account used in conjunction with a high-deductible health insurance policy that allows users to save money tax-free against medical expenses.
- **HIGH-DEDUCTIBLE HEALTH PLAN (HDHP):** A health insurance plan with lower premiums and higher deductibles than a traditional health plan.
- **IN-NETWORK:** Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.
- **MAIL ORDER PRESCRIPTIONS:** Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.
- **MAINTENANCE DRUGS:** A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.
- **OUT-OF-NETWORK:** The use of health care providers who have not contracted with the health plan to provide services.
- **OUT-OF-POCKET MAXIMUM:** The total amount a covered person must pay before his or her benefits are paid at 100 percent for the remainder of the plan year. Deductible, copayments, and coinsurance apply towards the maximum out-of-pocket.
- **PARTICIPATING PROVIDER:** Individual physicians, hospitals and professional 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.
- **PRIMARY CARE PHYSICIAN (PCP):** A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.
- **PROTECTED HEALTH INFORMATION (PHI):** Any information about health status, provision of health care, or payment for healthcare that can be linked to a specific individual. This is interpreted rather broadly and includes any part of a patient's medical record or payment history.

COBRA Continuation of Coverage

Terminations

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

COBRA

An employee's insurance coverage ceases on the last day worked at Seminole County Public Schools (SCPS). The District's COBRA administrator will mail a written notice to each terminated employee describing the employee's rights and obligations under COBRA.

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

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

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

Who Can Continue Coverage?

COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." Depending on the type of qualifying event, a qualified beneficiary can be a covered employee, a covered employee's spouse and/or a covered employee's dependents who were covered by one of the SCPS Health Plans the day before a qualifying event.

Definition of Qualified Beneficiaries

The following individuals can become qualified beneficiaries under COBRA:

- An employee
- A former employee
- The spouse of any of the above
- The dependent child(ren) of any of the above

COBRA Participants With FSAs

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

Keep Your Address Current

It's important to keep the plan administrator and SCPS informed of yours and your qualified beneficiary's address, since all notices are mailed to a home address.

Beyond Your Benefits

TAXABLE BENEFITS AND THE IRS

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

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

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

LIFE INSURANCE PREMIUMS AND THE IRS

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

NOTICE OF ADMINISTRATOR'S CAPACITY

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

1. Contract Administrator. FBMC Benefits Management (FBMC) has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.

2. Policyholder. This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Insurer. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

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

NOTICE REGARDING MICHELLE'S LAW

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

Dependent Child Change in College
The dependent child's change in college enrollment must meet the following requirements:

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

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

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

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

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

NOTICE REGARDING PATIENT PROTECTION RIGHTS

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

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

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.

WELLNESS PROGRAM NOTICE

Seminole County Public Schools is committed to helping you achieve your health and wellness goals. If it is unreasonably difficult or medically inadvisable for you to attempt to achieve the wellness target under this program, contact your SCPS Wellness Program Team at benefits@scps.k12.fl.us or call 407-320-0095 and they will work with you to develop an alternative way to reach the tobacco-free wellness target.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your SCPS Wellness Program Team at benefits@scps.k12.fl.us or call 407-320-0095 and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

Beyond Your Benefits

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

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

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.
Group Health Plans may not:

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

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

NOTICE OF SOCIAL SECURITY NUMBER DISCLOSURE

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

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

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

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www. askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

FLORIDA MEDICAID

Website: https://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

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

- **U.S. DEPARTMENT OF LABOR**
  Employee Benefits Security Administration
  Website: www.dol.gov/ebsa
  Phone: 1-866-444-EBSA (3272)
- **U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**
  CENTERS FOR MEDICARE & MEDICAID SERVICES
  Website: www.cms.hhs.gov
  Phone: 1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

Beyond Your Benefits

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits and Insurance Services Department at 407-320-0095 or email Benefits@scps.k12.fl.us.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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 Benefits and Insurance Services 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. School District of Seminole County Public Schools has determined that the prescription drug coverage offered by Cigna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

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

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

MEDICARE PRESCRIPTION DRUG COVERAGE OPTIONS

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

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

Important Phone Numbers and Dates

Physician: _____

Dentist: _____

Pediatrician: _____

Eye Doctor: _____

Other Doctor #: _____

Last physical exam: _____ Last mammogram exam: _____

Last eye exam: _____ Last Well Woman visit: _____

Last colonoscopy: _____

Notes

Notes

Directory

Medical and Prescription Plans
Cigna
Plan/Policy #3337309
1-800-244-6224
www.mycigna.com
Cigna Help Desk: 1-800-284-8346
Cigna Pre-enrollment Hotline
Medical & Pharmacy coverage
1-800-401-4041

Cigna Pre-enrollment Online Plan Comparison Guide -
www.myCignaplans.com
Open enrollment ID: SCPS2018
Password: cigna

Cigna Vision:1-877-478-7557

Employee Assistance Program Cigna: 1-877-622-4327
pam_dixon@scps.k12.fl.us, Cigna On-site Representative
laicadz@scps.k12.fl.us, Cigna On-site Representative

Dental Plan Insurance
Sun Life Financial
Plan/Policy #I453
PPO Network = Assurant Dental Network
1-800-442-7742
DHMO or Prepaid Network = Prepaid Dental Series
1-800-443-2995
www.sunlife.com/onlineadvantage

Vision Plan Insurance
UnitedHealthcare
1-800-638-3120
www.myuhcvision.com

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

Short-Term & Long-Term Disability
Cigna Disability Group
Plan/Policy #LK8316 (STD)
Plan/Policy #LK8317 (LTD)
1-800-362-4462
www.cigna.com

Disability in Lieu of Medical
Mutual of Omaha
Plan/Policy # GUG-6K71
1-800-877-5176

Life Insurance
Standard Insurance Company
1-800-628-8600
Policy# 161865

Accident, Cancer Insurance & Hospital Indemnity
Colonial Life & Accident Insurance
1-800-325-4368
www.coloniallife.com

Long-Term Care Insurance
Unum
Plan/Policy #067229
1-800-227-4165
www.unum.com

FBMC Benefits Management
For questions concerning the voluntary benefit products, including: Dental, Vision, STD/LTD Disability, Cancer, Accident, Hospital, FSA, Life and Long-Term Care, contact FBMC On-site Representatives:
karen_milligan@scps.k12.fl.us
or laverskz@scps.k12.fl.us

Retiree Pension Plan
FRS (Florida Retirement System)
Janice Hickson, Retirement Specialist
1-407-320-0498
janice_hickson@scps.k12.fl.us
enrollment@frs.state.fl.us
1-850-488-4742 or 1-844-377-1888

SCPS Benefits & Insurance Services
Phone: 1-407-320-0095
Fax: 1-407-320-0389
Benefits: benefits@scps.k12.fl.us
Wellness: wellness@scps.k12.fl.us

Leave of Absence Information
Olga_buitrago@scps.k12.fl.us
407-320-0082

Additional Resources
TSA Consulting Group: 1-888-777-5827
SCPS Help Desk: 1-407-320-0350

Contract Administrator : FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
To reach the SCPS Benefits & Insurance Services, call 1-407-320-0095.

FBMC BENEFITS MANAGEMENT™

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

Insurance & Wellness Committee

Front row: Kim Dansereau, Tina Calderone, Ed.D. , Tina McClory, Dawn Bontz.
Back row: Stephen Browne, Jordan Rodriguez, Todd Seis, Richard Miles, & Thomas Bugos II.

Benefits & Wellness Team

Front row: Donna Laica, Dawn Lobkovich, Mary Libersat, Klaryssa LaVersa, Loyda Nieves, & Karen Milligan.
Back row: Edna Tello, Pam Dixon, Mayra Diaz, Dawn Bontz, Cindy Johnston, & Holly Acord.

Questions?

benefits@scps.k12.fl.us

SCPS BENEFITS AND INSURANCE SERVICES

400 E. Lake Mary Blvd. | Sanford, FL 32773

(407) 320-0095 | tinyurl.com/benefits2018