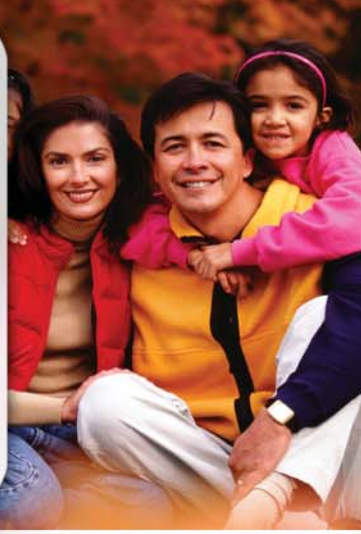
4 YOUR Benefit

2008-2009

SCHOOL DISTRICT OF OSCEOLA COUNTY

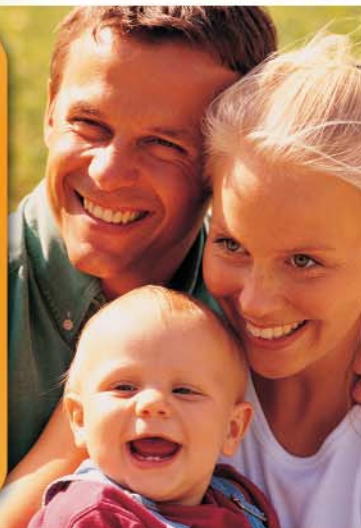
1. Learn

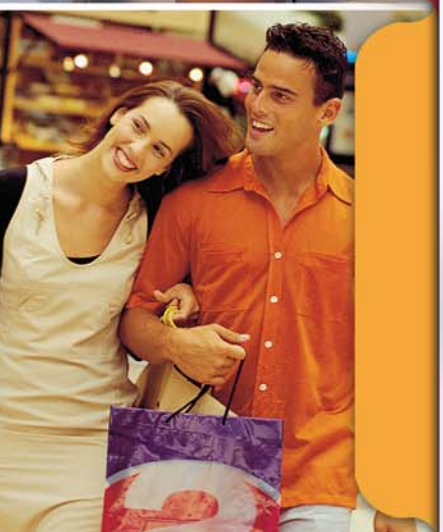


2. Plan

3. Enroll

4. Use Wisely





Superintendent's Message

Dear District Employees,

Welcome to the 2008-2009 school year. It is my pleasure to be the new Superintendent for the School District of Osceola County. I am impressed with the District, our employees, and their dedication to the children of our community.

I am also impressed by the comprehensive benefits program we offer. As I was reviewing my own benefits package, I was pleased to see the progressive plans and tools offered through the District.

We all know that health care costs are continuing to rise, and the District is doing its part to contain costs. You can help too, by controlling your personal health care expenses. The best way to reduce health care spending is to stay well. And the District has implemented the *4 the Health of It! Wellness Program* to help you do just that (see pages 46-47).

In conjunction with our Wellness Program, you can earn a $100 wellness incentive by completing a Health Risk Assessment, attending a wellness fair, and getting your annual physical examination. I can't stress enough the importance of these simple steps that can help you prevent and treat illnesses, as well as saving money in the long run.

The 4 Your Benefit Guide you are reading provides the information you need in order to learn, plan, enroll, use your benefits wisely, and save money. Please read the Guide and all your benefits materials for details.

Meanwhile, the District will do everything we can do to continue offering comprehensive benefits at affordable prices. But with health care costs at an all-time high, I ask that you do your part as well. When we work together toward the same goal, we will get the results we seek.

I wish you a safe and healthy school year.

Michael A. Grego, Ed.D.
Superintendent

What's Inside

Welcome to *4 Your Benefit*

Open Enrollment

September 3 to September 19, 2008

Benefits Effective:
October 1, 2008

Plan Year:
October 1, 2008 to September 30, 2009

See page 3 for new hire eligibility.

¡Se habla Español! and more than 140 other languages

CIGNA provides bilingual Spanish-speaking representatives; for any other non-English speaking members, CIGNA also offers a Language Line service that can translate virtually any language.

This Guide is available in Spanish on Benefits Corner of your First Class email.

Welcome to 4 Your Benefit 2008 - 2009

The School District of Osceola County (the District or SDOC) is pleased to offer you a comprehensive employee benefits program that allows you to tailor your benefits to suit your needs.

This Benefits Guide highlights your choices and provides instructions for enrolling beginning on page 35. Be sure to read this Guide and any individual plan materials you receive before you make your elections. Take the time to consider your choices carefully, just as you would for any other major household purchase. If there's something you don't understand, please ask questions. **The Risk & Benefits Management (R&BM) staff is here to help you (407-870-4899).**

What is "4 Your Benefit"?

1. Learn	Find out everything you need to know about the benefits SDOC offers.
2. Plan	Before enrolling, determine which benefits are the right ones for you and your family.
3. Enroll	Read simple step-by-step instructions for making your benefit elections.
4. Use Wisely	Get tips for staying healthy and saving health care dollars.

What's New?

Two Medical Plans

For the 2008-2009 plan year you can choose between two CIGNA medical plans: the new **Choice Fund Health Reimbursement Arrangement (HRA) Open Access Plus Plan** (referred to as the **Choice Fund HRA** throughout this Guide) and the **Open Access Plus In-Network Plan** (referred to in this Guide as the **Plus In-Network Plan**).

Attention Point of Service and Open Access HMO Plan Participants:

The Point of Service Plan and the Open Access HMO Plan will no longer be available as of October 1, 2008. If you are currently enrolled in either of these plans and do not make an active election during Open Enrollment, **you will automatically be enrolled in (default into) the new Choice Fund HRA Plan.**

The Choice Fund HRA Plan may or may not be the right plan for you and your family. It is in your best interest to read this Guide and carefully consider your plan options to make an informed decision. **Don't let someone else make this important decision for you.**

Open Access Plus In-Network Plan Changes

The deductible and out-of-pocket maximums will increase on October 1, 2008. See pages 7-10 for details.

Learn About the New Choice Fund Health Reimbursement Arrangement (HRA) Open Access Plus Plan

The new **Choice Fund HRA Plan** provides more than just comprehensive medical insurance. It comes with a health reimbursement arrangement that helps you pay a portion of your covered medical expenses. Taking time to understand how the new plan works can make managing your health care dollars simpler. And if you use the plan wisely, the Choice Fund HRA Plan could turn out to be more economical in the long run. See pages 8-10 for a full explanation of the plan.

Payroll Deductions

Plus In-Network Plan premiums for dependent coverage and Dental PPO High Option Plan premiums will increase.

Board Contributions

The Board will contribute $305.40 per pay period toward the cost of employee-only medical coverage, as well as toward the two Alternative to Medical Plans (the Hospital Indemnity Plan and the Disability Protection Plan).

$mart Tip!

Open Enrollment Resources

For medical and dental plans
Available now through September 30

CIGNA HealthCare Pre-enrollment Information Line: 1-800-401-4041
Monday – Friday • 8:00 a.m. – 6:00 p.m.

mycignaplans.com
Open Enrollment ID: Osceola2008
Password: cigna

Eligibility and Effective Dates

As an SDOC benefits-eligible employee, you are eligible for the plans described in this Guide.

- Medical Insurance
- Alternative to Medical Insurance
- Dental
- Vision
- Wellness Incentive
- Flexible Spending Accounts
- Employee Assistance Program
- Life Insurance
- Disability Insurance
- Tax-Sheltered Annuities

Effective Dates for New Employees

Instructional, administrative staff, and non-instructional support staff *(e.g., teachers, principals, secretaries, etc.)* — Your benefits are effective the first of the month after your date of hire.

Non-Instructional Teamster Members *(e.g., food service workers, maintenance workers, warehouse and transportation workers, excluding managers)* — Your benefits are effective the first of the month after you complete your 90-day probationary period.

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Got Questions?

Visit Benefits Corner on your First Class email for information and answers to most of your benefits questions.

Be sure to watch the Benefits Highlight Video. A link is available on *Benefit Corner*.

Take Action to Avoid Default Coverage

If you do not enroll in benefits by the appropriate deadline, you will automatically be enrolled in the Choice Fund HRA plan (employee-only) and Board-paid Term Life Insurance. You will not be able to re-enroll until the next open enrollment or if you experience a qualified change-in-status event (see page 6).

New Employee Enrollment Process

1. **Get Started:** Attend your orientation class.
2. **Learn and Plan:** Read this Guide and use the resources and tools available to you.
3. **Enroll:** As soon as you are cleared for employment,* log onto the online enrollment system and enroll in your benefits. Refer to the Enroll section of this Guide for detailed instructions.
4. **Use Wisely:** Once your benefits are effective, get the most out of your benefits. Read the Use Wisely section of this Guide for more information.

You have two weeks to enroll in benefits from the date you are cleared.*

* *Your facility secretary will notify you as soon as you are cleared for employment.*

Open Enrollment Effective Date

All changes made during Open Enrollment are effective from October 1, 2008 through September 30, 2009.




Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Your dependents are defined as:

- your legal spouse.
- your unmarried children who are under the age of 25, including a stepchild or:
  - a child you legally adopt, is placed for adoption, or for whom you serve as guardian. Proof of legal guardianship is required to enroll eligible dependents.
  - a child who is supported primarily by you and incapable of self-sustaining employment by reason of mental or physical handicap (proof of their condition and dependence must be submitted).
  - 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 current dependent may be enrolled in a health plan for a period of 18 months (e.g., your son's or daughter's child [your grandchild] may be enrolled in your health insurance for a maximum of 18 months).

Do Not Enroll Ineligible Dependents

Enrolling a dependent who is not eligible for coverage or failing to remove a dependent who has become ineligible for any District benefit plan in a timely manner is a violation of District policy and will lead to disciplinary action, including possible termination.

If you violate District policy, the District may bar your participation in the benefit plans and seek reimbursement from you (even if you no longer work for the District) for any and all benefits paid under the plan on behalf of the ineligible dependent, plus any costs and attorney fees associated with obtaining reimbursement.

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. For more information, please see page 6 for Section 125 and Benefit Changes or contact the Benefits Specialist assigned to your facility at 407-870-4899.

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Who is My Benefit Specialist?

Each employee has a Benefits Specialist who is assigned to your facility. Your Benefits Specialist can answer many of your benefits questions and direct you to the appropriate resource or tool. To find out who your facility's Benefits Specialist is, visit Benefits Corner and click on the PDF called "Benefits Specialist Facility Assignment."

Paying for Your Benefits

Your medical (or alternative to medical), dental, vision, optional life, and disability premiums are paid through payroll deductions **over 20 pays** (regardless of the number of paychecks you actually receive), with the exception of Flexible Spending Accounts (FSA) and Tax-Sheltered Annuity (TSA) contributions. FSA and TSA deductions are taken out of **every paycheck** you receive.

You pay for certain benefits using pretax dollars and other benefits using after-tax dollars. See Section 125 and Benefit Changes on next page for more information about pretax benefits.

Benefit Plan	Who Pays		Pretax or After-Tax
Medical Insurance (includes Prescription Drug Benefits)	SDOC and you*	You must enroll in a medical plan or an alternative to medical plan	Pretax or After-Tax, your choice
Alternative to Medical Insurance	SDOC		N/A
Dental and Vision	You		Pretax
Flexible Spending Account	You		Pretax
Employee Assistance Program	SDOC		N/A
Term Life Insurance	SDOC		N/A
Optional Supplemental Life	You		After-tax
Universal Life	You		After-tax
Disability	You		After-tax**
Tax-Sheltered Annuities	You		Pretax

N/A = not applicable, 100% paid by Board contribution

* *Depending on the plan (Open Access Plus In-Network has a $25 premium) or coverage level you select (employee only, employee plus one, etc.).*

** *You have the option of paying your Disability Insurance premiums on either a pretax or after-tax basis. By choosing to pay premiums after-tax, any disability benefits you collect will not be taxed. If you pay the premiums pretax, any disability benefits you collect will be taxed, reducing the amount of your benefit at a time when you may need income most.*

SDOC Board Contributions

The Board contributes $305.40 per pay period toward each employee's medical insurance (or alternative to medical insurance) for the 2008 - 2009 plan year.

Medical Plan Election: Depending on the medical plan you choose, the Board Contribution may cover your entire employee-only premium (payroll deductions for medical insurance) for the year. For example, if you choose to enroll in the Choice Fund HRA Plan with employee-only coverage, the Board Contribution is equal to your premium and you will not have a payroll deduction for medical insurance. If you enroll in the Plus In-Network Plan, you will pay a small premium (see page 7).

Alternative to Medical Plan Election: The Board Contribution covers 100% of alternative coverage.

Both Spouses Work for SDOC – Half-Family Status

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




Section 125 and Benefit Election Changes

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:

- Marriage, divorce, or legal separation*
- Death of spouse or other dependent
- Birth or adoption of a child
- A spouse's employment begins or ends
- A dependent's eligibility status changes due to age, student status, marital status, or employment
- You or your spouse experience a change in work hours that affect benefits eligibility
- You relocate into or outside of your plan's service area

* *Legal separation is not recognized in Florida.*

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 Risk and Benefits Management within 30 days of your qualified status change.

InfoBit

The Value of Your SDOC Benefits

To maximize the value of your benefits package, you need to make good choices. The District contributes a significant portion toward the cost of employee-only medical coverage and provides basic life insurance. The board contribution alone equals $6,108 a year in addition to your salary!

Medical Benefits

SDOC offers a choice of two medical plans: the Choice Fund Health Reimbursement Arrangement Open Access Plus Plan **(Choice Fund HRA)** and the Open Access Plus In-Network Plan **(Plus In-Network Plan)**. Both plans offer comprehensive medical coverage through the same CIGNA provider network. However, each plan provides coverage in a different way.

Please read this section carefully and use the resources and tools at *www.mycigna.com* to help you decide which plan is right for you and your family. Be sure to review the Medical Benefits Plan Comparison Chart on page 10 as well as the Enroll section of this Guide (pages 33-43) to decide which plan is right for you and your family.

CIGNA Medical Plan Premiums - 20 Pays

Coverage Level	Plus In-Network Plan	Choice Fund HRA
Employee	$25	$0
Employee + Spouse	$167	$122
Employee + Child(ren)	$150	$107
Employee + Family	$210	$150
Half-Family Primary*	$80	$30
Half-Family Secondary*	$0	$0

CIGNA Open Access Plus In-Network Plan

The Open Access Plus In-Network Plan (Plus In-Network Plan) gives you the flexibility to visit any provider (doctor or facility) within CIGNA's network, including specialists, without the need for a referral.

$mart Tip!

A Note About Prescription Drug Coverage

Prescription drug coverage is included with your medical plan premium. See page 13 for details.

How the Plus In-Network Plan Works*

1. When you enroll in this plan, you must choose a Primary Care Physician (PCP) from the provider directory, available at *www.cigna.com*.
2. Once you meet the deductible ($300 employee-only; $600 family), you pay coinsurance equal to 10% of the discounted network charges.
3. You continue to pay coinsurance until you reach the out-of-pocket maximum ($3,000 employee-only; $6,000 family). Then the plan pays 100% of charges for the remainder of the plan year.
4. 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.

* *Please read page 13 to understand your prescription drug coverage under the Plus In-Network Plan.*

CIGNA Choice Fund Health Reimbursement Arrangement (HRA) Open Access Plus Plan

The District offers a consumer-directed plan called the CIGNA Choice Fund Health Reimbursement Arrangement Open Access Plus (Choice Fund HRA) Plan. This plan can give you more control in managing your health care dollars by combining health insurance coverage with a health reimbursement arrangement that helps you pay a portion of your covered medical expenses.

The Choice Fund HRA Plan uses the same network as the Plus In-Network Plan. However, you can use any provider, in- or out-of-network, without a referral. (You will pay less when you use in-network providers.)

$mart Tip! • Should I Enroll in the Choice Fund HRA Fund?

Only you can decide. Statistics show that the average medical plan member spends less than $700 a year for medical care. Depending on your personal situation, you may end up having no out-of-pocket expenses with this plan because:

- SDOC pays the employee portion of your premium through the Board Contribution.
- SDOC puts $750 for single coverage and $1,500 for family (amounting to half your deductible) into your Health Reimbursement Arrangement at the start of the plan year.
- Preventive care is covered at 100%.

$mart Tip!

Use In-Network Providers and Save

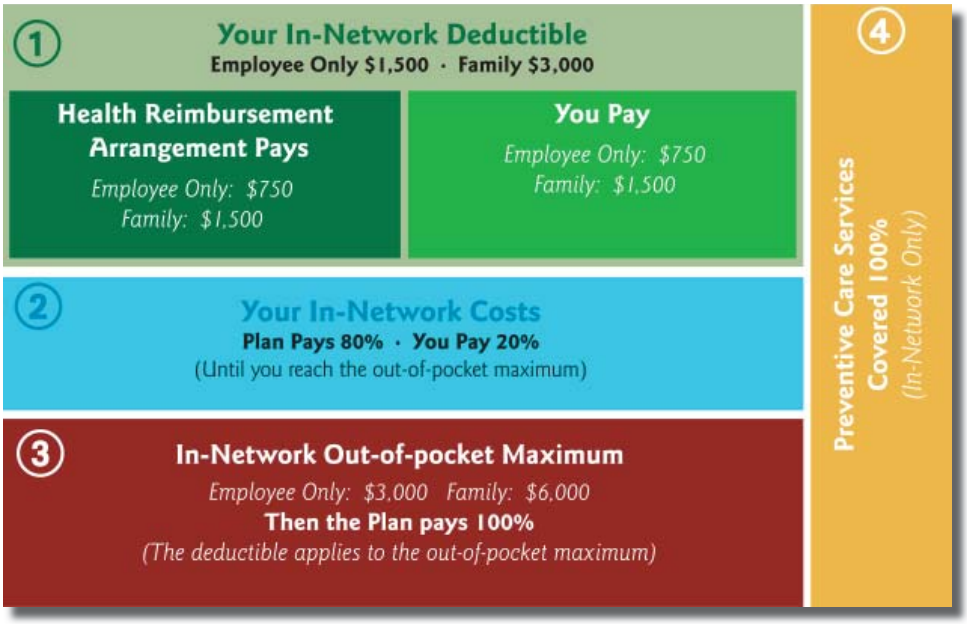
Using in-network providers whenever possible can save you time and money.

In-Network	Out-of-Network
Plan pays a higher percentage of coinsurance coverage, based on the discounted rates CIGNA negotiates with in-network providers.	Plan pays a lower percentage of coinsurance coverage based on reasonable and customary charges. You will have higher out-of-pocket costs when you use out-of-network providers.
You pay prescription copays or coinsurance based on the drug tier.	No coverage for prescription drugs.
Lower deductible and out-of-pocket maximum. Your Health Reimbursement Arrangement will go farther when you stay in-network.	You pay significantly higher deductibles and out-of-pocket maximums. You'll use up your Health Reimbursement Arrangement faster if you use out-of-network providers.
No claim forms.	You may have to pay 100% of the cost up-front and file claims for reimbursement.

Understanding Reasonable and Customary (R&C) Charges

Reasonable and customary charges are the amounts CIGNA considers appropriate for a health care expense. It is based on the typical rate charged for a specific service within a provider's ZIP code. (R&C charges are sometimes referred to as usual and customary charges or allowed amounts.)

How the Choice Fund HRA Plan Works In-Network



1. Your In-Network Deductible

The first half of your deductible is paid using the money in your health reimbursement arrangement established by the District on your behalf.

- Although this plan has a higher deductible than the Plus In-Network Plan, the District deposits a set amount of dollars into a Health Reimbursement Arrangement to help you pay your deductible amount.
- When your network provider bills CIGNA for the services they provide, the full amount is deducted from your health reimbursement arrangement and applied to your deductible.

Once your Health Reimbursement Arrangement is depleted, you are responsible for paying 100% of the charges until you satisfy the remainder of your deductible. You pay coinsurance only after your full deductible is reached.

If you don't spend all the money in your health reimbursement arrangement by the end of the plan year, the remainder will roll over to the next plan year for as long as you remain enrolled in this plan. Note: Your Health Reimbursement Arrangement balance cannot exceed $2,250 for employee-only coverage or $4,500 for family coverage.

2. Your In-Network Costs

You begin paying coinsurance after you meet your deductible. You continue paying coinsurance until you reach your out-of-pocket maximum. Your in-network coinsurance is 20%. If you go out of network, you will pay 40% of reasonable and customary charges. You will always pay less for in-network care. See the $mart Tip on page 8.

3. In-Network Out-of-Pocket Maximum

Your out-of-pocket maximum protects you in case of a catastrophic illness. After your share of coinsurance reaches $3,000 for employee-only coverage or $6,000 for family, the play pays 100% of your costs for the remainder of the plan year. Please note, your deductible counts towards the out-of-pocket maximum.

4. Preventive Care Services

In-network preventive care (e.g., annual physicals, well-child care, mammograms) is not subject to the deductible. The plan pays 100% of your covered preventive care.




Medical Plan Benefits At a Glance

Benefit	Plus In-Network Plan	Choice Fund HRA	
	In-Network	In-Network	Out-of-Network
Health Reimbursement Arrangement (HRA) amount deposited in an account for you to use	None	$750 Individual* $1,500 Family*	
Plan year deductible	$300 Individual $600 Family	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Plan year out-of-pocket maximum	$3,000 Individual (excludes deductible) $6,000 Family (excludes deductible)	$3,000 Individual (includes deductible) $6,000 Individual (includes deductible)	$6,000 Family (includes deductible) $12,000 Family (includes deductible)
Lifetime maximum	$2 million	$2 million	
Physician services			
• Office visits	10% after deductible	20% after deductible	40% after deductible
• Specialist	10% after deductible	20% after deductible	40% after deductible
• Preventive Care: Mammograms, PSA, PAP Test	No charge for covered services	No charge for covered services	Not covered
• Other Preventive Care	10%, no deductible	No charge for covered services	Not covered
Emergency Services, including urgent care facilities[1]	10% after deductible	20% after deductible	40% after deductible
Hospital services[2]	10% after deductible	20% after deductible	40% after deductible
Laboratory and Radiology	10% after deductible	20% after deductible	40% after deductible
Short-term Rehab and Chiropractic[4]	10% after deductible	20% after deductible	40% after deductible
Maternity[5]	10% after deductible	20% after deductible	40% after deductible
Pre-certification Requirements[6]	Coordinated by your physician	Coordinated by your physician	Member's responsibility[7]

1 *Includes: Physician's Office, PCP, or specialist; hospital emergency room; outpatient professional services; urgent care facility or outpatient facility; ambulance.*

2 *Inpatient: doctor's visits and consultations, hospital professional services, diagnostic and therapeutic lab and X-ray. Outpatient: physician and outpatient professional services.*

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

4 *Includes cardiac rehab; physical, speech, occupational, chiropractic, pulmonary rehab, and cognitive therapy.*

5 *Initial and subsequent prenatal and postnatal office visits; office visits not included in total maternity fee charged by obstetrician or specialist; inpatient hospital or birthing center.*

6 *Required for all inpatient admissions and selected outpatient procedures and diagnostic testing.*

7 *Subject to penalty, reduction of benefit, or denial of claim for noncompliance.*

* *If you are hired after October 1, the amount deposited in your Health Reimbursement Arrangement will be prorated based on your benefits effective date (see page 3). For example, if your benefits effective date is January 1, your HRA will be prorated over nine months (January 1 – September 30).*

After You Enroll in a CIGNA Medical Plan

CIGNA Health Care ID Card

Once you enroll in a medical plan, you will automatically receive an ID card from CIGNA. Carry it with you at all times and present it whenever you visit a medical provider or pharmacy. This will help ensure that your claim is handled properly. To order a new ID card, contact CIGNA Member Services at 1-800-244-6224 (1-800-CIGNA24).

If you enroll in the Hospital Indemnity Plan, you will also receive a CIGNA ID card for prescription drugs. Present this card only when you use the CIGNA Pharmacy Network Prescription Plan.

CIGNA Member Services 1-800-244-6224

For answers to plan questions, members and their physicians should contact CIGNA Member Services at 1-800-244-6224 (1-800-CIGNA24). Please have your CIGNA Health Care ID Card handy when you call.

CIGNA Medical Plans Programs, Features, and Resources

CIGNA offers many programs, features and resources to help you with everything from making an enrollment decision through managing your personal health and wellness. See pages 48-49 in the *Use Wisely* section for more information.

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What is Self-Insurance?

The District is self-insured and uses CIGNA as its third-party administrator. The Board's contribution for employee medical plans, alternative to medical plans, and optional benefit premiums for dependents are deposited into a Trust Fund and used to pay for medical expenses incurred by members.




Alternatives to Medical Insurance

The following options are designed for employees who are covered under a medical insurance policy other than a District plan, and choose to decline SDOC medical insurance (i.e., the employee is covered under a plan that is sponsored by their spouse's employer). This SDOC-paid benefit is available at no cost to the employee. Dependent coverage is **not** available under these plans.

The Hospital Indemnity Plan (HIP)

The HIP provides coverage that you can use to pay for hospitalization costs and is available for employee-only coverage. This plan includes:

- A $225 per-day cash benefit for eligible employee hospital stays. Benefits begin on the first day of your hospital stay, but will not exceed 365 days. This plan is provided through CIGNA.
- An additional $10,000 of Term Life Insurance with Accidental Death and Dismemberment (AD&D).
- A prescription drug benefit for the employee only through the CIGNA Pharmacy Network Prescription Drug Plan (see Prescription Benefits section on page 13).
- CIGNA Dental PPO, High Option, employee-only coverage.
- Humana/CompBenefits Vision Care Plan, employee-only coverage.

If you enroll in the HIP and you need to file a hospital-stay claim with CIGNA, log onto your District email and download the form from Benefits Corner (hipform.pdf: "**Group Medical Direct Claim Form"**). Attach a statement, bill or claim form (sometimes called a UB-92 form) from the hospital. Look for the words "**Room and Board**" on the bill or statement to determine proper documentation. Circle the dates of your hospital stay on the bill or statement. Mail the form to the address listed on the form for processing. CIGNA will then process your claim and send your benefit directly to you.

Disability Protection Plan (DPP)

The DPP is an option designed for employees seeking disability insurance instead of the standard HIP plan. This plan includes:

- Disability Insurance through Unum Educator Disability Gold 14/14 Plan with a maximum monthly benefit of $1,200 (not to exceed $66^{2}/_{3}$ of your monthly earnings).
- An additional $10,000 of Term Life Insurance with Accidental Death and Dismemberment (AD&D).
- Humana/CompBenefits Vision Care Plan, employee-only coverage.

$mart Tip!

A Note About Prescription Drug Coverage

Prescription drug coverage is included with your medical or Hospital Indemnity Plan premium.

Prescription Benefits

When you enroll in either CIGNA medical plan or the HIP Alternative to Medical Plan you receive prescription benefits through the **CIGNA Pharmacy Network Prescription Drug Plan.** There are no out-of-network prescription benefits, so be sure to use one of the pharmacy providers listed on this page, or use CIGNA's home-delivery pharmacy for maintenance (ongoing) prescriptions.

How the Prescription Drug Plan Works

- You are automatically enrolled in the prescription drug plan when you enroll in either of the CIGNA medical plans or the HIP Alternative to Medical Plan.
- The prescription drug plan does not have a deductible.
- When you have prescriptions filled at a network pharmacy, you pay a preset copay for generic and preferred drugs.
- If you use non-preferred or specialty drugs, you will pay a percentage of the negotiated rate (see chart below), up to the per-prescription cap.

  Because you always pay less for the generic version of a drug, ask your doctor to write your prescription for the generic (if available).
- If you are enrolled in either CIGNA medical plan:
  - You do not have to meet your plan's deductible before you are eligible for benefits under the prescription drug plan.
  - Any coinsurance you pay for non-preferred and specialty drugs is applied toward your plan's out-of-pocket maximum.
  - Copays do not apply toward your plan's out-of-pocket maximum; you will always pay a copay for generic and preferred drugs.
- If you are enrolled in the CIGNA Choice Fund HRA, prescription drug copays and/or coinsurance cannot be paid out of the health reimbursement arrangement.

CIGNA Pharmacy Network

The following chain pharmacies are included in the CIGNA pharmacy network:

- Publix
- Albertsons
- K-Mart
- Target
- Medicine Shoppe
- Walgreens
- CVS Pharmacy
- Sam's Club
- Wal-Mart
- Winn Dixie

Visit *www.cigna.com* for a more in-depth pharmacy provider directory.

Home-Delivery Prescriptions

CIGNA Tel-Drug is the home-delivery pharmacy program that's part of your prescription benefits. Tel-Drug provides a cost-effective way for you to obtain maintenance drugs (prescription medication you and/or your covered dependents take on an ongoing basis).

Benefits of Home Delivery

- FDA-approved medications
- Verification of every order by a licensed pharmacist
- Standard delivery to your home or other preferred address at no additional cost
- 90-day supply reduces out-of-pocket expenses and trips to a retail pharmacy
- Refill reminders so you don't forget to reorder

To learn more about CIGNA's home delivery program, call 1-800-835-3784 toll free or visit *www.teldrug.com*. To switch your current prescription, call CIGNA Tel-Drug toll-free at 1-800-285-4812, Option 1.

Prescription Drug Coverages (in-network only)

Drug Tier (Level)	30 day supply	90 day supply (Tel-Drug)
Generic	$7 copay	$16 copay
Preferred drug	$25 copay	$70 copay
Non-preferred drugs	40% with $75 cap*	40% with $220 cap*
Specialty drugs	50% with $150 cap*	50% with $445 cap*

* *Cap per prescription.*




Dental Benefits

The SDOC offers District employees a choice of the three CIGNA dental plans described in this Guide.

CIGNA Dental Care covers most preventive and restorative procedures. Orthodontia is also covered, but varies by plan. See the Dental Plan Comparison Chart on the next page to determine which plan best fits your and your family's needs.

CIGNA Dental Care DHMO

When you enroll in the CIGNA Dental Care HMO (DHMO), you and your covered family members can access the dental care you need through CIGNA's network of quality dentists. Each covered family member can choose their own general dentist from the network. You will need a referral from your general dentist to see an endodontist, periodontist, or oral surgeon. You do not need a referral to see an in-network specialist, pedodontist (pediatric dentist), or orthodontist.

DHMO Features and Benefits

- No deductible. No dollar maximums. No claim forms to file. No waiting periods for coverage.
- Reduced rates on all covered services.
- Coverage for most preventive services at no charge.
- Discounts on complex procedures.
- Specialty care provided at the same fee as general care with an approved referral.
- Orthodontic benefits for adults and children.

CIGNA Dental Care PPO

When you enroll in the CIGNA Dental Care PPO, you and your covered family members can access the dental care you need through CIGNA's network of quality dentists. You can visit any dentist, both in- and out-of-network, but you will pay less when you use an in-network provider. You do not need a referral to see a specialist.

CIGNA Dental Care PPO High Option and Low Option

You can choose either the High Option or Low Option PPO. Your premiums are higher in the High Option plan, but services are generally covered at a higher percentage.

PPO Features and Benefits

- Visit any dentist, in or out of CIGNA's preferred provider network.
- No referral required to see a specialist.
- Visit a network dentist for maximum savings.
- In network or not, you'll be reimbursed for all or part of your costs for covered procedures, up to your annual $1,500 maximum, after meeting your deductible or satisfying any waiting periods.
- Orthodontic benefits for children ages 18 or younger.

Coverage Level	DHMO	DPPO		
		Low Option	High Option	High Option DHIP*
Employee	$8.83	$10.33	$16.91	$0.00
Employee + One	$14.58	$21.18	$34.67	$17.76
Employee + Family	$21.56	$37.04	$60.66	$43.75

* *The High Option DHIP is for employees covered under the Alternative to Medical HIP plan.*

Dental Plan Comparison Chart

	DHMO*	Dental PPO			
		PPO High Option		PPO Low Option	
Annual Deductible	None	$50 per subscriber; $150 per family; does not apply to Class I care		$50 per subscriber; $150 per family; does not apply to Class I care	
Annual Maximum	None	$1,500 per covered person		$1,500 per covered person	
Class I • Diagnostic & Preventative	In-Network	In-Network	Out-of-Network**	In-Network	Out-of-Network***
Semi-Annual Cleaning (2 cleanings a year, 1 every 6 months)	No charge	No charge	No charge	20%	20%
Sealants	$10 per tooth	No charge	No charge	20%	20%
X-Rays (Bitewings and Full Mouth)	No charge	No charge	No charge	20%	20%
Fluoride Application	No charge	No charge	No charge	20%	20%
Office Visit Fee	$5	N/A	N/A	N/A	N/A
Class II • Basic Restorative Care					
Amalgam Fillings	No charge	20%	20%	40%	40%
Surgical Extraction of Impacted Teeth	$30-$85 (depending on complexity)	20%	20%	40%	40%
Class III • Major Restorative Care					
Crowns	$325 - $445	50%	50%	50%	50%
Dentures	$260 - $485	50%	50%	50%	50%
Bridges	$385 - $445	50%	50%	50%	50%
Class IV • Orthodontics					
Dependent Children					
Evaluation	$50	50%	50%	50%	50%
Records/Treatment Plan	$150	50%	50%	50%	50%
Orthodontic Treatment (24 month routine)	$1,500				
Adults		Not covered	Not covered	Not covered	Not covered
Evaluation	$50				
Records/Treatment Plan	$150				
Orthodontic Treatment (24 month routine)	$2,000				
Lifetime Orthodontic Maximum	N/A	$1,000		$1,000	

* *You must use a participating general dentist or specialist*

** *Coverage based on Usual, Customary and Reasonable Fees*

*** *Coverage based on contracted fees for the PPO Network*

Note: This is only a brief summary of the plans and is intended for comparison purposes only. Please see your brochure for a complete schedule of benefits. The benefits for each plan will be determined by the contract. For a complete listing of benefits plus limitations and exclusions, please reference your certificate of coverage.

1-800-CIGNA24 (1-800-244-6224)

Continues on next page




Estimate Your Dental Costs Easily

If your dentist recommends a procedure or treatment, or you are interested in a particular service, you can get a good idea of the cost beforehand. Just log onto *www.mycigna.com* using your unique user ID and password, then select the "myPlans" tab at the top of the home page and follow the EXACT instructions below.

- Select the "view Dental main page" link under the "myplans" section the home page.
- Click on the Dental Treatment Cost Estimator link; after reading and agreeing to the CIGNA licensing agreement, click "AGREE."
- After your home ZIP code displays and you must hit "submit."
- Follow the directions on screen to choose the appropriate treatment you would like to estimate the cost for. The tool will pull up the estimated costs based on the dental plan you are enrolled in.

CIGNA Dental's Oral Health Integration Program℠

CIGNA Dental's Oral Health Integration Program offers enhanced benefits for members enrolled in both CIGNA medical and dental plans. This program is not offered to employees enrolled in either of the Alternative to Medical Insurance plans (HIP and DPP).

These enhanced benefits are subject to your plan's limitations, except for periodontal maintenance (D4910) where the frequency limitation has been increased to four times per year. Annual maximums and out-of-network maximum reimbursable charges may apply for non-DHMO plans. You can request a reimbursement form from CIGNA Member Services at 1-800-CIGNA24 or by visiting *www.mycigna.com*.

CIGNA Dental Oral Health Maternity Program®

Research shows that women with periodontal (gum) disease may be at increased risk for preterm babies and that treatment for gum disease may reduce the likelihood of premature birth for women at risk. Eligible members may receive 100% reimbursement of copays or coinsurance for covered services performed during pregnancy.

Oral Health Diabetes Program

Research has linked periodontal (gum) disease, a bacterial infection, to complications from diabetes. This program provides enhanced dental benefits for members with both CIGNA medical and dental coverage who also participate in the CIGNA Well Aware Program for Better Health® diabetes program. Eligible members may receive 100% reimbursement of their out-of-pocket payment to the dentist for these services:

- Periodontal root scaling and planing, sometimes referred to as "deep cleaning" (procedure codes D4341, D4342) and
- Periodontal maintenance (procedure code D4910).

Cardiovascular Program

Research has linked periodontal (gum) disease, a bacterial infection, to complications from heart disease and stroke. This program provides enhanced dental benefits for members with both CIGNA medical and dental coverage who also participate in the CIGNA Well Aware Program for Better Health® heart disease program. Eligible members may receive 100% reimbursement of their out-of-pocket payment to the dentist for these services:

- Periodontal root scaling and planing, sometimes referred to as "deep cleaning" (procedure codes D4341, D4342) and
- Periodontal maintenance (procedure code D4910).

Dental Oral Health Integration Program

Covered Service	Procedure Code
Oral evaluation	D0120, D0140, D0150, D0180 (all programs)
Periodontal scaling and root planing	D4341, D4342 (all programs)
Periodontal maintenance, up to four times per year*	D4910 (all programs)
Treatment of inflamed gums around wisdom teeth	D9110 (Maternity program only)
Frequency limitation for cleanings waived to include an additional cleaning	D1110 (Maternity program only)

** No frequency limit in the Maternity Program*

Vision Benefits

The SDOC offers you the option of purchasing vision insurance through Humana/CompBenefits' VisionCare Plan. When you enroll, you will choose a provider from the Humana/CompBenefits network at *www.compbenefits.com*, and download a Vision Pass from the website. Present the Vision Pass to your provider at the time of service to receive the negotiated rates.

VisionCare Premiums - 20 Pays

Coverage Level	Employee Cost	HIP/DPP Plan Members*
Employee	$3.85	$0
Employee + Family	$11.77	$7.92

* *Only employees enrolled in either Alternative to Medical Plan (Hospital Indemnity Plan or Disability Protection Plan) pay this amount.*

VisionCare Features and Benefits

- Eye health examinations, frames, glasses or contacts based on the service frequency shown in the chart.
- LASIK surgery discount.
- Preferred member pricing for other frame and lens options.
- If you purchase eyeglasses or contact lenses from a Humana/CompBenefits network eye doctor during the same year you had an eye exam, you will receive:
  - a 20% discount on a second pair of eyeglasses.
  - a 15% discount on your contact lens fitting fee.

If you have questions, call the Humana/CompBenefits Customer Care Department at 1-800-865-3676 or visit *www.compbenefits.com*.

	VisionCare Services	
Benefit	**Service Frequency**	**Coverage**
Vision Exam	Once every 12 months	You pay $10 copay
Lenses	Once every 12 months	You pay $15 copay for materials
Frames	Once every 24 months	
Contact Lenses (fitting, follow-up, and lenses)	Once every 12 months	
Elective**		Plan pays $120 allowance
Preferred brand contacts***		Plan pays 100%
Medically necessary		Plan pays 100%
LASIK – Humana/CompBenefits has contracted with many of the finest LASIK facilities and eye doctors (including TLC Laser Centers) to offer this procedure at discounted rates.		

* *You receive a $45 wholesale allowance toward the cost of frames. If you select frames that cost more than the allowance, you are responsible for paying the balance.*

** *If you elect lenses other than the four brands offered through preferred member pricing, the plan will pay up to a $120 allowance toward the purchase.*

*** *One pair of soft daily wear lenses (Visitint, CibaSoft, Optima 38, Wesly Jensen – D2T4).*




Life Insurance

Term Life Insurance

The District provides employees with basic group term life insurance in the amount of one times your annual salary at no cost to you. An additional one times your annual salary in Board-paid life insurance is provided to employees whose pay is based on 10+ years experience. Employees enrolled in an Alternative to Medical Insurance plan receive an additional Board-paid $10,000 in life insurance.

Note that Professional Support employees earning less than $20,000 per year receive benefits based on the previously negotiated contract — see chart.

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

Annual Earnings (contract)	Amount of Life Insurance
$9,999 or less	$10,000
$10,000 - $14,999	$15,000
$15,000 - $19,999	$20,000
$20,000 or more	Rounded to the next $1,000

Designating a Beneficiary

You must designate a beneficiary when you first become eligible for life insurance coverage. You should review and update your beneficiary elections during each year's Open Enrollment. Your beneficiary designation for basic and optional life insurance may be changed at any time, either through the Online Enrollment System or by contacting R&BM for a form.

Note: If you designate a trust or a trustee, you must have a written trust agreement. If you designate a minor (a person who is not of legal age), it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid. This means there will be a legal expense for the beneficiary and a delay in payment. Please take this into consideration when naming your beneficiary.

Optional (Supplemental) Life Insurance

You can elect an additional one or two times annual salary in term life insurance as a new employee without having to provide evidence of insurability (EOI). If you decide to increase your Optional Life Insurance during Open Enrollment, you must complete an EOI form which must be approved by the life insurance company. Premium payroll deductions will not start until R&BM is notified of the EOI approval.

Special Computation for Bus Drivers: There is a special computation for bus drivers based on actual time worked during the previous two pay periods, plus credit for extended routes. For example, your salary for a five-hour guarantee route bid is $15,000. If you win a bid for an extended route/field trip that pays an additional $15,000, your life insurance will be based on a $30,000 annual salary.

Universal Life Insurance

SDOC offers employees the ability to purchase Universal Life Insurance through Colonial Supplemental Insurance. You can purchase Universal Life for yourself, your spouse, and/or your child(ren). Features include:

- The policy is portable, meaning it's yours to keep, even if you change jobs or retire. Only your payment method will change.
- Premiums will not increase as you get older.
- Premiums build cash value.
- Family coverage is available, even if you do not buy a policy for yourself.
- Universal Life policy for each child provides:
  - protection at low rates because of issue age
  - continuing coverage even if health problems develop
  - a cash value fund that will grow throughout the years
  - the opportunity to increase coverage at ages 18, 21, and 24 without Evidence of Insurability.

For information or individual rates, contact your Colonial representative:

Nancy Bennett at 321-228-7024 or *nben2000@gmail.com*

Disability Insurance

Have you ever thought about how your family would manage if an accident or major illness kept you from working for an extended period? Most people would have a hard time getting by without a regular paycheck. Disability insurance replaces a portion of your income if you are unable to work due to illness or injury. SDOC offers optional disability insurance through Unum Educator Disability Plans. You can choose from two options: Platinum or Gold. Your premiums will be based on the level of protection you select.

Eligibility

All benefited employees are eligible for this plan. If you are absent from work due to injury, illness, temporary layoff or leave of absence on your effective date of coverage, coverage will begin on the date you return to active employment.

Underwriting Guidelines

New Hires. New employees have up to 14 days from when they have been cleared for employment to sign up for coverage without having to provide evidence of insurability (answers to health questions). However, the full amount of coverage you select is subject to the 3/12 pre-existing condition limitation.

Currently Insured Employees. You can increase your level of coverage during Open Enrollment. Evidence of Insurability (answers to health questions) is not required. However, the additional coverage you select is subject to the 3/12 pre-existing condition limitation.

Late Entrants. Employees who do not sign up for coverage during their new hire period or the most recent Open Enrollment period must wait until the next Open Enrollment to elect coverage. Evidence of Insurability (answers to health questions) is not required at the time you elect coverage. However, the full amount of coverage you select is subject to the 3/12 pre-existing condition limitation.

3/12 Pre-existing Condition Limitation

The plan will not cover any disability that begins in the first 12 months after your effective date of coverage that is caused by, contributed to by, or resulting from a pre-existing condition.

A pre-existing condition is a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three (3) months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the three (3) months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

Benefit Amount

You can purchase a monthly benefit in $100 units, starting at a minimum of $200, up to $66^{2}/_{3}$ percent of your monthly earnings, with a maximum monthly benefit of $7,500.

Elimination Period

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

If you select an elimination period of 30 days or less and are admitted to a hospital as a result of your disability, benefits will begin immediately and the remainder of the elimination period will be waived.

Waiver of Premium

Once you have received disability payments for 90 consecutive days, you do not have to continue paying disability premiums for as long as you are receiving disability payments under the plan.

Continues on next page

Duration of Benefits

The duration of benefits depends on the plan you choose, as shown in the chart below.

Disability Plan Highlights

Platinum Plan		Gold Plan	
Your duration of benefits is based on your age when the disability occurs as shown below:		Your duration of benefits is based on your age when the disability occurs and whether the disability is due to a covered injury or sickness, as shown below:	
Age at Disability	Platinum Duration of Benefits	Age at Disability	Gold Duration of Benefits
Your duration of benefits for a sickness or injury is:		**Your duration of benefits for injury only is:**	
Less than age 60	To age 65, but not less than 5 years	Less than age 60	To age 65, but not less than 5 years
Age 60-64	5 years	Age 60-64	5 years
Age 65-69	To age 70, but not less than 1 year	Age 65-69	To age 70, but not less than 1 year
Age 70 and over	1 year	Age 70 and over	1 year
		Your duration of benefits for a sickness only is:	
		Less than age 65	5 years
		Ages 65-69	To age 70, but not less than 1 year
		Age 70 and over	Not applicable

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Designate a Beneficiary for the AD&D Portion of Your Disability Coverage

When you enroll in Disability Insurance, you automatically receive Accidental Death & Dismemberment (AD&D) coverage. AD&D requires you to choose a beneficiary(ies) who will receive a benefit in the event of your accidental death.

Note: This policy is completely separate from your Life Insurance coverage, so even if you designated a life insurance beneficiary, you still need to designate a beneficiary for your AD&D benefit

Flexible Spending Accounts

Keep more of what you earn. The **Health Care FSA** and **Dependent Care FSA,** allow you to pay for certain eligible health and/or dependent care expenses using pretax dollars. This means that you will pay less in taxes and have more money to spend and save.

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. Use the worksheet on page 31 to help you calculate your contribution amount.

When you enroll in a flexible spending account during Open Enrollment, 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 day care expenses. CIGNA administers SDOC's flexible spending accounts.

Annual FSA Contribution Amounts

Health Care FSA	• $240 minimum up to $3,000 maximum
Dependent Care FSA*	• Up to $5,000 if single or married filing a joint tax return • Up to $2,500 if married filing an individual tax return

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

Please Note: You cannot transfer money between accounts.

InfoBit

If You Have Both a Health Care FSA and a Health Reimbursement Arrangement...

Your eligible expenses will be deducted from your Health Reimbursement Arrangement first. After the money in your Health Reimbursement Arrangement is depleted, your eligible expenses will be deducted from your health care flexible spending account.

$mart Tip!

Flexible Spending Accounts

Eligible Expenses

Eligible health care expenses include deductibles, copays, coinsurance, and other out-of-pocket expenses for medical, dental, and vision care. Many over-the-counter expenses are also eligible for reimbursement including (but not limited to):

- antihistamines, allergy, and asthma medication
- antacids and acid reducers
- cough medicine
- contact lens solution
- first aid supplies

You can view a partial list of eligible and ineligible expenses on Benefit Corner, or use the resources listed below. Eligible Dependent Care expenses are explained on page 23 and more details can be found in the following resources.

Resources

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

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

Health Care Flexible Spending Account

This account 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 "spend" up to your total plan-year election before the funds are actually deducted from your paycheck and deposited into your account. Your Health Care FSA contributions will continue to be deducted from your paycheck throughout the year.

Accessing the Money In Your FSA

If You Are Enrolled in the Plus In-Network Plan or an Alternative to Medical Plan:

If you are enrolled in one of these plans and a Health Care FSA, you will receive a CIGNA HealthCare Visa Flexible Spending Account debit card. You can use your debit card to pay for eligible health care goods and services at the point of purchase. Funds will automatically be deducted from your Health Care, reducing your account balance. The debit card eliminates your need to submit reimbursement requests.

Use your FSA debit card at all providers who accept Visa, including physicians, dentists, vision providers, hospitals, and pharmacies. Note that there is no Personal Identification Number (PIN) associated with the debit card. Always select "credit" when doing a transaction.

CIGNA medical plan participants do not have to submit receipts for certain in-network expenses (see the Save Your Receipts Smart Tip). CIGNA will mail a notice to your home address requesting documentation for expenses that cannot be substantiated electronically. If you do not provide necessary documentation after three notices, your debit card will be suspended until you provide the requested documentation.

If You Are Enrolled in the Choice Fund HRA Plan:

If you are enrolled in this plan, **you will not receive a debit card when you enroll in a Health Care FSA.** Your medical plan expenses will automatically be deducted from your CIGNA Choice Fund HRA. Once your HRA is depleted, in-network expenses will automatically be deducted from your FSA. You will have to submit reimbursement requests and receipts for all other eligible health care expenses including prescription drug copays and coinsurance.

$mart Tip!

Save Your Receipts!

CIGNA medical plan participants do not need to submit receipts for:

- Medical copays at doctor's offices
- Medical coinsurance at a hospital or outpatient facility
- Pharmacy copays and coinsurance (if purchasing multiple prescriptions, have each prescription run as a separate transaction)

FSA Debit Card Users

To meet IRS regulations, you must submit receipts for all debit card transactions, with the exception of expenses that can be substantiated electronically. In cases where an expense cannot be substantiated electronically, you will be required to submit additional documentation. Items that require documentation will be considered as post-tax expenses until the receipts are received and validated by the plan administrator.

Reimbursements

If you have an FSA debit card and use it, you do not need to submit reimbursement requests. If you don't have an FSA debit card or if you have one and do not use it, you must submit a reimbursement claim form (available on *www.mycigna.com*) and attach all itemized receipts from the service provider. Receipts must include:

- Name of employee or dependent.
- Dates of service.
- Charges incurred.
- Explanation of Benefits (EOB).
- Note that canceled checks, bank card receipts, credit card receipts, and credit card statements are not acceptable forms of documentation.

Submit your claim form and all supporting documentation via mail or a dedicated claims fax line (which ensures confidentiality) to the address or fax number on your claim form.

Direct Deposit of Reimbursement Checks

You can choose to have your reimbursement checks direct deposited into your personal checking account. Please see the **Use Wisely** section of this Guide for details.

$mart Tip!

Estimate Carefully to Avoid "Use It or Lose It"

You'll need to carefully calculate the amount you plan to contribute to your FSA(s). Typically, any unused dollars in your account(s) at the end of the plan year will be forfeited.

Grace Period for Health Care FSA Claims

The IRS allows a grace period for health care FSAs that gives you an additional 2½ months after the end of the plan year to spend any unused money in your account. You must submit claims by December 31, 2009 to be reimbursed for expenses incurred between October 1, 2008 and December 15, 2009.

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.

Dependent Care Flexible Spending 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. 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.

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.

When estimating your dependent care expenses, do not include vacation time or sick time during which you or your spouse will not be at work or at school – even if you must pay your day care provider to hold your dependent's space. This is not an eligible expense under IRS regulations.

Continues on next page




How it Works

When you enroll in the Dependent Care FSA, you will need to submit reimbursement claims to CIGNA. Unlike a Health Care FSA, your Dependent Care FSA is not prefunded. This means that you will be reimbursed only up to the balance in your account at the time you submit your claim. If your claim amounts to more than your account balance, the unreimbursed portion of your claim will be tracked by CIGNA. You will automatically be reimbursed as additional deductions are deposited into your account, until your entire claim is paid out.

Note: Because of the way the District payroll deductions are taken and the fact that you must pay the day care provider before receiving reimbursement, you will experience a negative cash flow during the first month of the plan year. In subsequent months, the reimbursement from the previous month's deduction can be used to pay the day care provider for the current month.

Reimbursements

To obtain reimbursement from your dependent care FSA, complete a claim form (available at *www.mycigna.com*) and attach itemized receipts that include:

- The dependent's name(s).
- The period during which the services were rendered.
- The name, address, and Taxpayer ID or Social Security number of the individual or organization providing services.
- Alternatively, if the above information is documented on the reimbursement form, you can have the provider sign the reimbursement form in place of a receipt.
- Note that canceled checks, bank card receipts, credit card receipts, and credit card statements are not acceptable forms of documentation.

Submit your claim form and all supporting documentation via mail or the dedicated claims fax line (which ensures confidentiality) to the address or fax number on your claim form.

Direct Deposit of Reimbursement Checks

You can choose to have your reimbursement checks direct deposited into your personal checking account. Please see the Use Wisely section of this Guide for details.

$mart Tip!

How Much Can I Save?

The actual amount you save will vary by the amount you contribute, how much you earn, and your tax-filing status and exemptions. In the following examples, Carmen, Yolanda, and Alex are all in the same tax bracket, but each contributes different amounts to their FSA(s).

Carmen Saved $1,526

She contributed:	
Health Care FSA	$450
Dependent Care FSA	$5,000
Total Contributions	$5,450
Her Tax Bracket*	x 28%
Savings	$1,526

Carmen's savings equaled one of her mortgage payments.

Yolanda Saved $280

She contributed:	
Health Care FSA	$1,000
Dependent Care FSA	$0
Total Contributions	$1,000
Her Tax Bracket*	x 28%
Savings	$280

Yolanda can make a car payment with her savings.

Alex Saved $980

He contributed:	
Health Care FSA	$2,600
Dependent Care FSA	$0
Total Contributions	$2,600
His Tax Bracket*	x 28%
Savings	$728

Alex saved enough to pay for a new personal computer.

* *Federal income tax + Social Security*

Tax-Sheltered Annuities

SDOC offers employees the opportunity to contribute to a 403(b) Tax Sheltered Annuity. Tax Sheltered Annuities are a type of retirement plan that is available to public education employees. These tax-free plans enable you to save money for retirement. This plan is optional and is offered in addition to your Florida Retirement System retirement benefits.

Following are examples of the types of investment vehicles to which you can contribute:

- **Fixed-Interest and Variable Annuities.** Annuities are sold only by life insurance companies. Fixed interest annuities usually provide protection of principal and a current interest crediting rate. Variable annuities usually offer a fixed interest account along with separate accounts that are invested in bond and/or equity markets.
- **Service-Based Mutual Funds and Custodial Accounts.** These products are offered by investment management companies and brokerage firms. Investment portfolios can include funds from a single fund family or a custodial platform that spans several fund families on a single statement.
- **No-Load/Low-Fee Mutual Funds.** No-load funds are described as investments with no sales fees on the market-based mutual funds offered. Ongoing investment management fees are charged to the funds selected. The no-sales fee/low-asset management fee offerings are good for those individuals who do not want to work with an investment advisor.

Select a Board-Approved Company and Agent

Visit Benefits Corner in your email for an up-to-date listing of agents who can assist you in selecting the product that helps you reach your financial goals.

$mart Tip!

Advantages of Participating in a TSA

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

You must contact an approved company and agent to enroll in or change your Tax-Sheltered Annuity.

Once you have reviewed all your options with an agent and you are ready to enroll, the agent will send your Salary Reduction Form to Risk and Benefits Management. There are a few investment companies that do not require you to work with agents, so the Salary Reduction Form is also available on Benefits Corner.

Canceling Your Tax-Sheltered Annuity Contribution

To cancel a Tax Sheltered Annuity contribution, ***you must complete a Salary Reduction Form and submit it to Risk and Benefits Management prior to the payroll in which you want your contributions to end***. Your agent can help you complete this form or you can download and print one from Benefits Corner.

SDOC Board Approved Tax Sheltered Annuity Companies

Fixed/Variable Annuities

AIG VALIC (formerly VALIC)	1-800-448-2542
AXA/Equitable Life	1-800-628-6673
Horace Mann	1-800-999-1030
ING Retirement Plans (formerly Northern Life)	1-877-884-5050
Life Insurance Company of the Southwest	1-800-579-2878

Mutual Funds (Load Based)

Plan Member Financial Corporation	1-800-874-6910
Waddell and Reed	1-888-923-3355

Mutual Funds (No Load)

American Century Investments	1-800-345-3533
Fidelity Funds	1-800-343-0860




Plan Carefully

Employee health care has become one of the largest operating expenses for most employers, in both the private and public sector. As for employees, many of you are struggling to manage your household's health care expenses. That is why the District offers health care plans designed to help control costs without sacrificing quality of care.

It is important to consider all of your options, regardless of whether you are enrolling for the first time, or re-evaluating your benefits before open enrollment. Your benefits provide you with security in times of illness, emergencies, and routine annual health care.

Taking time today to understand your options may save you a lot of time and money down the road.

Choosing a Medical Plan

Your health history and that of your family are important things to think about when deciding which medical plan to choose.

Consider your costs and:

1. Estimate how often you and your covered dependents are likely to use your benefits (i.e., doctor visits, prescriptions, hospitalizations). Take into consideration whether you need to use out-of-network providers.
2. Using the medical expense planner on the next page,* calculate your premiums and estimate your expenses for each plan you are considering. Use the comparison chart on page 10 to estimate your expenses. Make sure to include copays, deductibles, coinsurance, etc. The planner takes into consideration how the Choice Fund Health Reimbursement Arrangement would offset your costs, if you choose that plan.
3. If your spouse has coverage through his or her employer, calculate your costs under that plan.
4. Add your premiums and expenses to come up with your estimated total cost for medical care.

* *During Open Enrollment, you can access mycignaplans.com and use CIGNA'S online tool to compare the District's plans.*

InfoBit

Need Help Choosing a Plan During Open Enrollment?

Go to the source: CIGNA

1. **Call the CIGNA HealthCare Pre-enrollment Information Line**
   1-800-401-4041
   Monday - Friday 8 a.m. - 6 p.m.
   Available through September 30, 2008

2. **Compare Plans Online**
   www.mycignaplans.com

   Open Enrollment ID: **Osceola2008**
   Password: **cigna**

   Available through September 30, 2008

   This online comparison tool allows you to compare your benefit plan costs.

Medical Expense Planner

	Your Estimated IN-NETWORK Medical Expenses*		
Refer to the medical plan comparison chart on page 10.	Open Access Plus In-Network Plan	Choice Fund Health Reimbursement Arrangement Open Access Plus Plan	Your Spouse's Plan
Annual Payroll Deductions See page 7 and multiply by 20 pays	$	$	$
Annual Deductible (circle one)	$300 Individual $600 Family	$1,500 Individual $3,000 Family	$
Health Reimbursement Arrangement (circle one)	None	-$750 Individual -$1,500 Family	$
Coinsurance or copay after you pay the deductible			
• Office visits	$	$	$
• Specialist visits	$	$	$
• Covered preventive care	$	$0 (Plan pays 100%)	$
• Diagnostic and lab	$	$	$
• Inpatient hospital	$	$	$
• Outpatient hospital	$	$	$
• Emergency room visits	$	$	$
• Therapy *(physical and/or mental health)*	$	$	$
• Prescription drug copays	$	$	$
• Other	$	$	$
Totals	**$**	**$**	**$**

* *The Plus In-Network Plan does not cover out-of-network care except for emergencies. The Choice Fund HRA Plan covers out-of-network care, but at significantly higher out-of-pocket costs than for in-network care.*

InfoBit

CIGNA Choice Fund Benefits Calculator

During Open Enrollment you can access *mycignaplans.com* to use an interactive calculator that can help you choose a plan based on cost. If you are more comfortable using paper, or open enrollment has ended, you can print out the Choice Fund Calculator from **Benefits Corner** in your First Class email to help you understand how much the Choice Fund Health Reimbursement Arrangement will cover and how much you will have to pay out-of-pocket.




Choosing an Alternative to Medical Plan

If you do not need a major medical plan because you are covered under a spouse's plan or other medical insurance, you have the option of choosing one of the two alternative plans offered by SDOC: the **Hospital Indemnity Plan** or the **Disability Protection Plan**. The premium for both plans is covered by the Board Contribution. See page 12 for details about these plans.

Consider Enrolling in the Hospital Indemnity Plan (HIP) if You Want:

- A cash benefit in case you have a hospital stay.
- Life insurance in addition to the amount provided by the School District.
- Accidental Death and Dismemberment coverage.
- Prescription drug benefits (employee-only coverage).
- Dental Insurance (employee-only coverage).
- Vision Insurance (employee-only coverage).

Consider Enrolling in the Disability Protection Plan (DPP) if You Want:

- Disability insurance.
- Life insurance in addition to the amount provided by the School District.
- Accidental Death and Dismemberment coverage.
- Vision Insurance (employee-only coverage).

Comparing the Plans

I need...	Hospital Indemnity Plan	Disability Protection Plan
Cash Hospitalization Benefit *(does not include health insurance coverage)*	Yes	No
Disability Benefits	No	Yes
Life Insurance	Yes	Yes
Accidental Death and Dismemberment coverage	Yes	Yes
Prescription benefits	Yes	No
Dental Insurance	Yes	No
Vision Insurance	Yes	Yes

Choosing a Dental Plan

You can choose from two dental plans, the **CIGNA Dental HMO** or the **Dental PPO**. If your spouse is employed, you may want to consider any dental plans offered through their employer.

Consider your costs and:

- Estimate how often you and your covered dependents are likely to use your dental benefits (i.e., semiannual cleanings, crowns, fillings, etc.).
- Calculate your premiums for each plan. Then estimate the in-network expenses for each plan you are considering, making sure to include deductibles, copays, coinsurance, fees for services, etc. (Keep in mind, the DHMO does not cover out-of-network expenses; the DPPO covers in- and out-of-network expenses up to the annual coverage maximum of $1,500. Adult orthodontia for members age 19 and older is covered only in the Dental HMO.)
- Use the comparison chart on page 15 to estimate your expenses.
- Add your premiums and expenses to come up with an estimated total cost for dental care.

Dental Expense Estimator

Refer to the dental plan comparison chart on page xx. You may have to call your dental provider to get cost estimates for services if you are not currently enrolled in a CIGNA dental plan..	Your Estimated IN-NETWORK Dental Expenses*		
	Dental HMO	**Dental PPO****	
		High Option	Low Option
Payroll Deductions See page 14 and multiply by 20 pays	$	$	$
Annual Deductible (circle one) Does not apply to DPPO Class 1***	$0	$50 Individual $150 Family	$50 Individual $150 Family
Coinsurance, copay, or fee			
• Class I - Diagnostic and Preventive: includes cleaning once every six months, sealants, X-rays (bitewing and full mouth), fluoride application, office visit fee	$	$	$
• Class II - Basic Restorative Care			
• Class III - Major Restorative Care	$	$	$
• Class IV - Orthodontics	$	$	$
Totals	**$**	**$**	**$**

* *The Dental HMO does not cover out-of-network care. The Dental PPO covers out-of-network care, but at significantly higher costs than for in-network care.*

** *The Dental PPO has an annual maximum of $1,500 for in- and out-of-network expenses. This means you will pay any expenses over $1,500 during the calendar year. See pages 14-16 for details.*

*** *The Dental PPO deductible does **not** apply to Class 1 services. If you expect to have expenses for **only** Class 1 services, do not include a deductible in your total.*

InfoBit

CIGNA Dental Treatment Cost Estimator

If you are currently enrolled in a CIGNA dental plan and registered on mycigna.com, you can use the Treatment Cost Estimator. This user-friendly online tool allows you to estimate and plan for your dental care costs. See page 50 for more information about this tool.




Should I Enroll in the Vision Plan?

If you and any of your eligible dependents wear glasses and/or contacts, the vision plan may save you money on exams and materials. Just like you estimated your medical and dental expenses, add up your current vision expenses and then determine how they would be paid under the vision plan.

If your spouse has coverage through their employer, consider your costs under that plan. The **Humana/ CompBenefits Vision Plan** reimburses you a set amount for materials like lenses and frames. You pay a low copay. See the chart on page 17 for details.

Supplemental Life Insurance

Most people buy life insurance to make sure their family can continue to support their current lifestyle, even if a breadwinner passes away. To calculate your life insurance needs, add up your family's expenses, subtract sources of income that will be available if you die, and buy enough life insurance to make up the difference.

Keep in mind that your maximum life insurance benefit is equal to four times your annual salary (the Board Contribution amounts to two times your salary for employees with 10 years experience, plus you can purchase an amount equal to two times your salary).

Disability Insurance

If becoming disabled may seem unlikely, consider this. Of Americans under the age of 65:

- 1 in 3 will be disabled for three months
- 1 in 5 will be disabled for 1 year or more
- 1 in 7 will be disabled for 5 years or more

So how much disability insurance should you have? Add up your monthly living expenses. Then consider any income you can count on from personal savings, other disability coverage, etc. If the income from all your sources isn't enough to cover your expenses, then you should consider purchasing enough disability insurance to cover the difference.

Source: Health Insurance Association of America

$mart Tip!

Are Babies in Your Future?

Maternity leave falls under the category of disability leave. So, if you are planning to have a child in future, you may want to consider purchasing disability insurance during Open Enrollment.

CAUTION! The disability plans have a pre-existing condition limitation. You must be covered by the plan for a specified period of time before you become pregnant in order to qualify for a benefit. See page 19 for details.

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Free Online Calculators

Life Insurance

Kiplingers.com
http://partners.leadfusion.com/tools/kiplinger/lifeins01/tool.fcs

CNNMoney.com
http://money.cnn.com/galleries/2007moneymag/0709/gallery.35minutes.moneymag/15.html

LifeLine.org
http://www.life-line.org/life-insurance/life-calculator

Disability Insurance

SmartMoney.com
http://www.smartmoney.com/insurance/disability/index.cfm?story=worksheet

Life-Line.org
http://www.life-line.org/disability-insurance/disability-calculator

How Much Should I Contribute to an FSA?

There are two types of Flexible Spending Accounts: the **Health Care FSA** and the **Dependent Care FSA** (see pages 21-24 for details). The worksheets on this page will help you determine whether you should enroll in an FSA.

Consider enrolling in a Flexible Spending Account if you:

- Pay medical, dental, and/or vision deductibles, copays, and/or coinsurance.
- Purchase eligible over-the-counter medication.
- Have upcoming dental and/or orthodontia expenses.
- Buy prescription eyeglasses, contact lenses, or saline solution.
- Pay a day care center or nanny to take care of your children or elderly parents so that you and your spouse can go to work.

Estimate Your Expenses

Use this worksheet to help you estimate the amount of money to contribute to a Health Care FSA and/or Dependent Care FSA.

Health Care FSA Expense Budget Worksheet

Estimate your eligible out-of-pocket medical expenses for the plan year, which is October 1, 2008 through September 30, 2009. Remember, the "use it or lose it" rule applies.

		Estimated 2008/2009 Expenses
1.	Your eligible health care expenses: medical, dental and vision	
	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____
	_____	$ _____
2.	Subtotal your estimated eligible expenses for the plan year. Amount must be at least $240, but not more than $3,000.	$ _____
3.	Divide by the number of your pay periods: 20, 22, or 24.* This is your total per-pay period deduction amount.	$ _____

Dependent Care FSA Expense Budget Worksheet

Estimate your eligible dependent care expenses for the plan year, which is October 1, 2008 through September 30, 2009. Remember, the "use it or lose it" rule applies.

1.	Number of weeks you will have eligible dependent care expenses during the plan year. **Remember to subtract holidays, vacations, and other times you may not be paying for eligible child, adult, or elder care.**		_____
2.	Multiply by the amount you expect to spend each week.	X	$ _____
3.	Subtotal (cannot exceed IRS limits for the calendar year). Amount must be at least $240, but not more than $5,000.		$ _____
4.	Divide by the number of pay periods: 20,22, or 24.* This is your total per pay period deduction amount. Enter this amount on your enrollment form.		$ _____

* *If you were hired after October 1, 2008, the number of pay periods remaining in the year will be less than 20, 22, or 24.*




Tax-Sheltered Annuities

Saving money for retirement is often a low priority in our busy lives. We usually have more immediate financial concerns, such as paying the rent or mortgage, feeding our family, or saving for a child's college education.

However, putting money aside for your retirement years should be an important part of your personal financial plan. That is why the District gives you the opportunity to contribute to a **Tax-Sheltered Annuity** through pretax payroll deductions. Read page 25 for more information about this benefit. There, you'll also find a list of District-approved vendors.

Deciding how much to save and how to invest your savings is a very personal matter. As a District employee, you are also a member of the **Florida Retirement System**. The District contributes a set percentage to your FRS Investment Plan or Pension Plan. But will that benefit provide enough money so you can realize your retirement dreams?

$mart Tip!

Get Free Financial Planning Help

Not sure which investment funds to choose? As a member of the Florida Retirement System, you can get free financial guidance from unbiased Ernst & Young financial planners through the MyFRS Financial Guidance Program. See page 25 for more information about the Tax-Sheltered Annuities.

Call 1-866-446-9377
Option 2
(TDD 1-888-429-2160)
OR
Visit MyFRS.com

In addition to the free financial counseling available through the MyFRS Financial Guidance Program, the following websites offer additional information:

- **Social Security Administration:** *www.ssa.gov*
  Find answers to your questions concerning Social Security.
- **Administration on Aging:** *www.aoa.gov*
  Information on retirement, Medicare, and other issues for retirees.
- **Internal Revenue Service:** *www.irs.gov*
  Source for tax information including changes to the tax code.
- **U.S. Department of Labor:** *www.dol.gov*
  Information for the workforce.
- **TSA Consulting Group, Inc:** *www.tsacg.com*
  Obtain employer-specific forms, the most up-to-date list of authorized vendors, benefit information, and more.
- **Morningstar:** *www.morningstar.com*
  Information on stocks, funds, and factors affecting the stock market.
- **A.M. Best Company:** *www.ambest.com*
  Information on company ratings, products, and news.
- **Standard and Poors:** *www.standardandpoors.com*
  Information on company ratings, fund information, indices, and more.
- **American Savings Education Council:** *www.choosetosave.org/asec*
  Information about saving for retirement.
- **Employee Benefit Research Institute:** *www.ebri.org*
  Information on employee benefit programs.

Newly Hired Employees

You must use the Online Enrollment System to enroll in your benefits. To help you navigate the system, online enrollment instructions begin on page 35.

New Employee Enrollment

After attending your Benefits Orientation, you will receive a call from your school or facility secretary clearing you for employment and letting you know you can now enroll in benefits using the Online Enrollment System. Emails will also be sent to your District email address reminding you to enroll. It is vital that you check your email for updates from Risk & Benefits Management. Contact your supervisor if you do not receive your First Class log-in and password within a week after you are cleared for employment.

If you do not log on and enroll in benefits by your deadline, you will automatically be enrolled in the following plans.

Medical Insurance: Choice Fund Health Reimbursement Arrangement Open Access Plus Plan (Choice Fund HRA Plan).

Life Insurance: Board-Paid Term Life Insurance.

All elections (active and default) are final and cannot be changed until the next Open Enrollment period unless you experience an IRS qualifying event (see page 6).

Enrollment Deadline and Effective Dates

Enrollment Deadline

Your enrollment deadline is two weeks from the date you are cleared for employment. Your school or facility secretary will notify you when you are cleared.

Effective Dates

Employment Classification	Your Effective Date
Instructional, administrative, and non-instructional support staff (e.g., teachers, principals, secretaries, etc.)	The first of the month after your date of hire.
Non-instructional Teamster Members (e.g., food service workers, maintenance workers, warehouse and transportation workers, excluding managers)	The first of the month after you complete your 90-day probationary period.

InfoBit

1. Learn
   - Take the time to review this guide. You will learn about all the benefits offered by the District by reading this guide and using the resources listed in each section.
2. Plan
   - Once you've reviewed your benefit options, use the Plan section to make your decisions before you visit the Online Enrollment System. This guide is yours to keep, so feel free to make notes on the pages.
   - Visit the insurance carrier's websites (see Contacts on the back cover).
3. Enroll
   - Before logging on, collect your dependent's Social Security number(s) and date(s) of birth. This information is required when you when you elect coverage for dependents and designate a beneficiary.
   - Go to: *http://benefits.osceola.k12.fl.us*
   - Follow the instructions in this guide and on screen.
4. Use Wisely
   - Once you are enrolled, refer back to the Use Wisely section to make sure you get the most out of your benefits.




Open Enrollment for Current Employees

September 3 to 19, 2008
For the plan year October 1, 2008 – September 30, 2009

You must make your benefit elections for the new plan year during Open Enrollment. Your elections will be effective from October 1, 2008 to September 30, 2009. You cannot change your benefits during the year unless you experience an IRS qualifying event (see page 6).

You must use the Online Enrollment System to enroll by 4:30 p.m. on September 19, 2008. After that time, you will be locked out of the system.

If you were hired after June 30, 2008 the elections you made as a new hire will remain in effect through September 30, 2009. You will not be able to log onto the enrollment system during Open Enrollment or change your elections unless you experience a qualifying event (see page 6).

$mart Tip

Flexible Spending Accounts Do Not Roll Over From Year To Year

If you want a flexible spending account for the new plan year, you must re-enroll in FSAs every Open Enrollment.

InfoBit • Open Enrollment Resources

CIGNA Pre-Enrollment Line
1-800-401-4041

Through September 30, 2008

Monday – Friday, 8:00 a.m. – 6:00 p.m. You can speak with a CIGNA benefit specialist and get answers to your questions about our medical plans.

***mycignaplans*.com**

Through September 30, 2008

This online tool can help you decide which medical plan best suits your needs.

Logon ID: Osceola2008 • Password: cigna

Benefits Help Line
407-870-4944

Wednesday, September 10, 2008, 10:00 a.m. to 4:30 p.m.
Thursday, September 18, 2008, 11:00 a.m. to 5:00 p.m.

Customer service representatives from each insurance carrier will be available to answer all your insurance questions and help you navigate the Online Enrollment System. The Help Line is available for only two days, so don't miss your opportunity to ask the experts your questions.

Welcome Back

Osceola Heritage Park, Exhibition Hall • September 3, 2008 • 2:00 p.m. to 6:00 p.m.

Employees are encouraged to attend Welcome Back at Osceola Heritage Park. Representatives from all our insurance and benefit carriers (including some Tax-Sheltered Annuities agents) will be on hand to answer questions.

Online Enrollment System Step-by-Step Instructions

On the following pages are step-by-step enrollment instructions, along with screen shots to help you become familiar with the system.

New Employee Enrollment

Go to http://*benefits.osceola.k12.fl.us*.

1. Your User ID is your 9-digit Social Security number without dashes (e.g., 123456789).
2. Your password will be your date of birth in CCYYMMDD format (for example, if your date of birth is December 3, 1967, you would enter: 19671203).
3. Be sure to make your benefits decisions before you log into the system. Once you confirm your elections, you will be locked out from making further changes.
4. Make sure you complete your enrollment by the deadline noted in your initial email, or you will default into the Choice Fund HRA medical insurance plan and Board-Paid Term Life Insurance, which may or may not be the best plans for you. Go to *http://benefits.osceola.k12.fl.us*.

Open Enrollment

Go to http://*benefits.osceola.k12.fl.us*.

1. Your User ID is your 9-digit Social Security number without dashes (e.g., 123456789).
2. Your password will be your date of birth in CCYYMMDD format (for example, if your date of birth is December 3, 1967, you would enter: 19671203).
3. The Point of Service Plan and the Open Access HMO Plan will no longer be available as of October 1, 2008. If you are currently enrolled in either of these plans and do not make an active election during Open Enrollment, you will automatically be enrolled in (default into) the new CIGNA Choice Fund Health Reimbursement Arrangement (HRA) Open Access Plus Plan.

Enrollment Instructions

1. Visit *http://benefits.osceola.k12.fl.us* from any computer that has Internet access.
2. Once in the system, click on the *Begin Open Enrollment* button. You will be directed to view each benefit option, one-by-one. Click on the *Save* and *Back* arrows to move from step to step. **(Caution! Do not use your browser's Back and Forward buttons. This will cause your data to become corrupt.)**
3. Make your selections.
4. Review your selections and make sure they are correct before you confirm your choices. Once you reach the last step and confirm your choices, your choices are final and you will be locked out from making any changes.
5. Confirm your elections and print a copy for your records. It is important to keep a copy of this verification as proof of your elections. (Set your printer settings to "landscape" to ensure all data gets printed.)

$mart Tip

Employee Portal — New! Register Today!

New this school year: the Employee Portal Website

The Employee Portal is a new website that gives you access to your personal information, including pay stubs and leave of absence history. See page 44 for more information.

To access the site, visit *https://employees.osceola.k12.fl.us* from any computer that has Internet access. Once on the site, register as a new user and create your portal account. You will need to provide your email ID, your date of birth and your Social Security number when you register.

Visit often — new features will be added as ideas are suggested.

Questions? Contact the Help Desk at 407-870-4037.

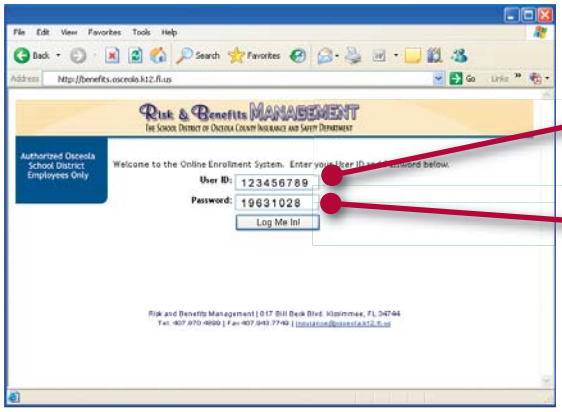
All elections are final and cannot be changed until the next Open Enrollment for the next plan year unless you experience an IRS qualifying event (see page 6).

ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

SAVE FOR LATER

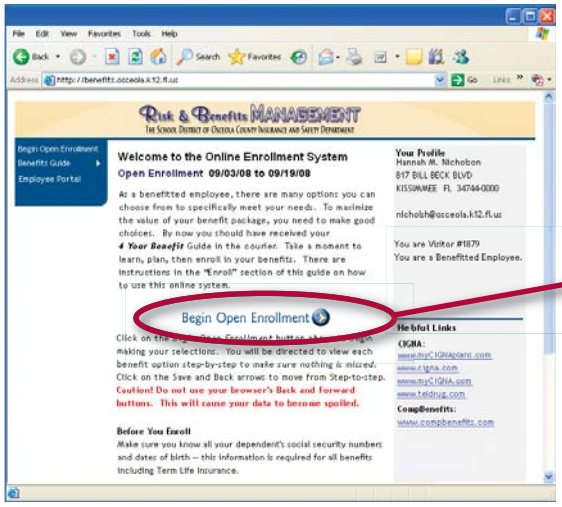
Screen Shots

Online Enrollment Instructions



Log-In

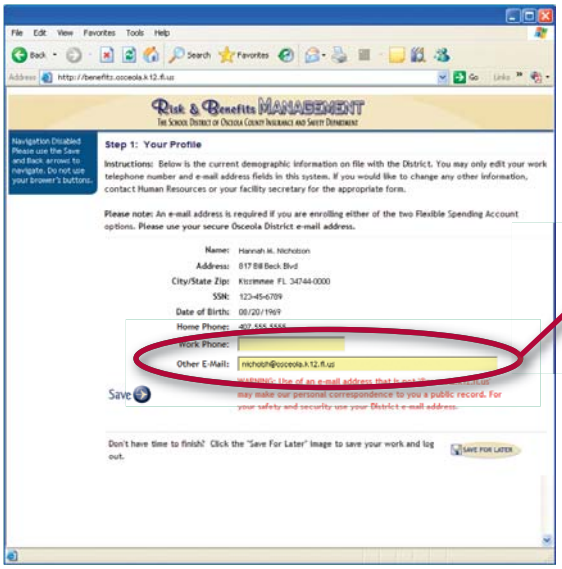
- Visit *http://benefits.osceola.k12.fl.us*
- Your Social Security number is your User ID (no dashes). Example: An employee with a Social Security number of 123-45-6789 would enter the number as 123456789.
- Your date of birth is your password (CCYYMMDD). Example: An employee with a birth date of October 28, 1963 would enter 19631028.



Welcome Screen

- When you first enter the system, you will see a welcome screen. During Open Enrollment, you'll see a ***Begin Open Enrollment*** arrow in the middle of the screen. Click this to begin making your changes.

- Review each screen and make your elections. If you need to log out and come back at a later time, you can save your changes by using the *Save for Later* button at the bottom of the screen.



Profile

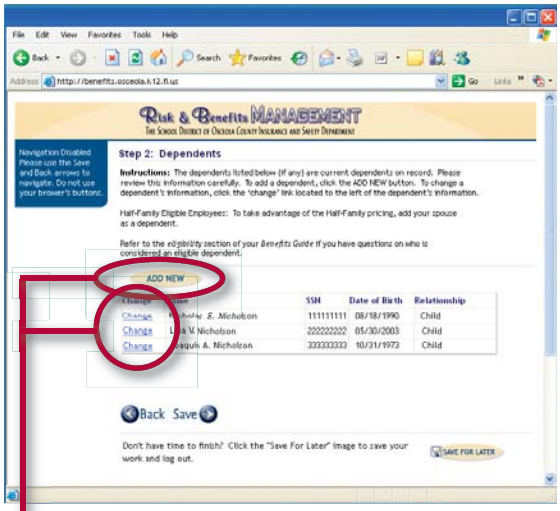
- The **Profile** screen allows you to view your current address, telephone number and email address. To change your home address, contact your facility secretary or Human Resources for the appropriate form.
- Update your email address in the space provided.

  TIP: Your District email address is secure. Enter this email address instead of one outside the network.
- Click the *Save* arrow to continue to the next step.

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots

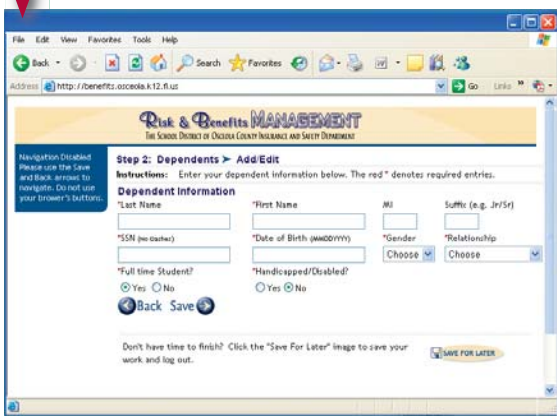
Online Enrollment Instructions



Dependents

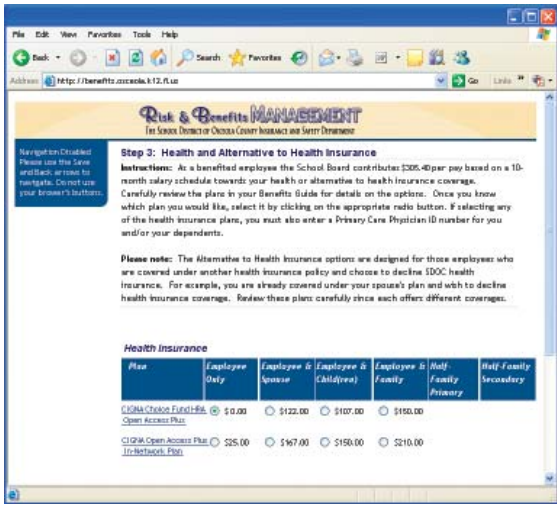
- You can add, but not delete, those eligible dependents you want to cover under the plans that offer dependent coverage. Click the *Add New* button to add a new eligible dependent. Click the "Change" link located to the left of a dependent's name to change his/her information. You only need to enter dependent information one time, unless you need to make changes.

  TIP: You are not allowed to delete dependents from this screen. To drop a dependent, see the instructions for the specific coverages. If you entered information by mistake, contact Risk & Benefits Management to correct the mistake.



- Enter or edit your dependents' demographic information
- Use the *Save* arrow to advance to the next step.

  TIP: You are required to enter your dependents' Social Security numbers and dates of birth for the plans under which they are being covered. Collect this information before you begin the process.



Health and Alternative to Health Insurance

- Choose your Health or Alternative to Health Insurance plan here. You will only see the plans and premiums you qualify for. For example, if you did not add your spouse on the *Dependents* screen, you will not have the option of choosing coverage for your spouse. To make the dependent coverage option available, return to the *Dependents* screen and add your spouse (or other eligible dependents) to your list. Return to the *Health* screen and scroll down to see that this person has been added to your options.

  TIP: Half-Family option is available only when the spouse's information you entered on the Dependent step matches another SDOC benefits-eligible employee.

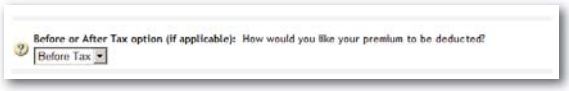
Continues

ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

SAVE FOR LATER

Screen Shots

Online Enrollment Instructions

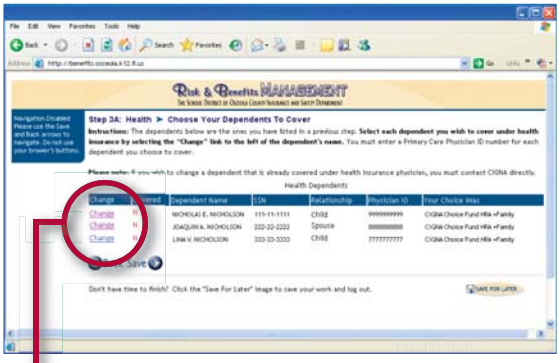


Health and Alternative to Health Insurance, *continued*

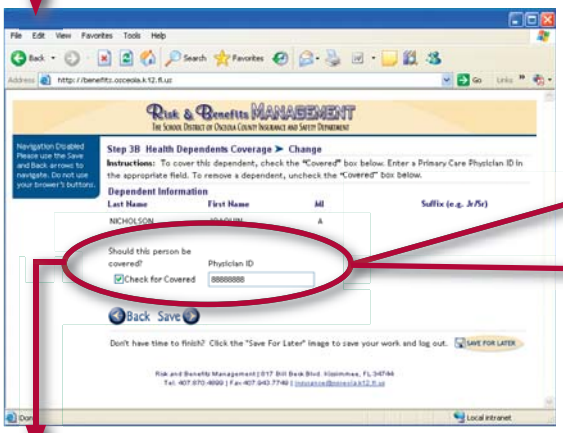
- Before you hit Save, select whether you want your deductions taken *Before Tax* or *After Tax*. Before Tax means you would like your deductions taken out before your income and Social Security taxes are calculated and deducted, reducing the amount of income taxes you pay. *After Tax* means you want your deductions taken out after your income and Social Security taxes have been deducted. For more information, speak with your personal accountant or tax attorney.

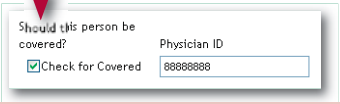
  TIP: Be sure to scroll down to see all your options.

- If you enroll in either Alternative Plan – the Hospital Indemnity or Disability Protection Plan – you will be directed to an added step in which you must provide information about your primary insurance coverage (coverage you have through a spouse's employer or other source not connected with the District). If you enter a District group number, the page will display an error until you adjust your information.



- If you select dependent coverage for a plan, you will need to specify which dependent(s) from your list you want to cover. Otherwise, you will click *Save* to move on to the *Dental* step.
- The Covered column shows the dependents you are covering. "Y" for Yes displays in black text; "N" for No displays in red text.





- To cover or drop a dependent under health insurance, click the "Change" link to the left of the dependent's name.
- The system will ask you to confirm any dependents who you did not cover.
- To cover a dependent, click the "Check for Covered" box and enter a Primary Physician ID number from the Provider Directory at www.cigna.com.
- To drop a dependent, uncheck the "Check for Covered" box.
- Click the *Save* arrow to continue to the next step.

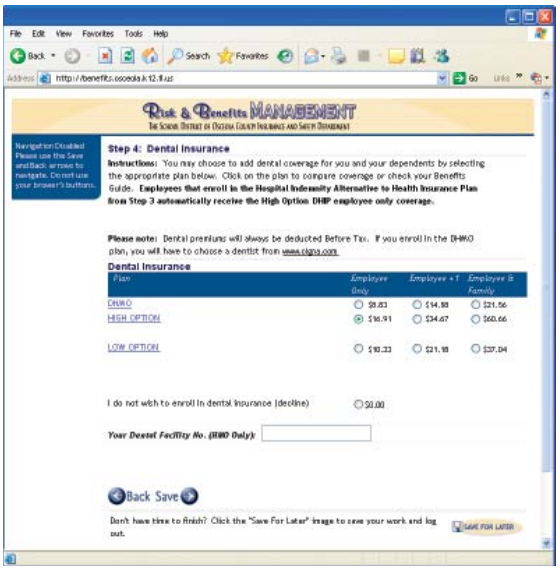
  TIP: The effective date and termination date fields shown are populated by Risk and Benefits Management.

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots

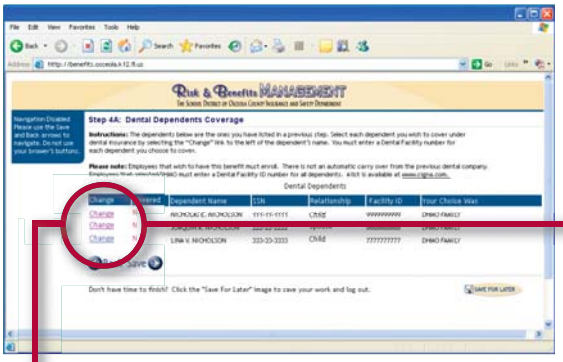
Online Enrollment Instructions

Dental Insurance

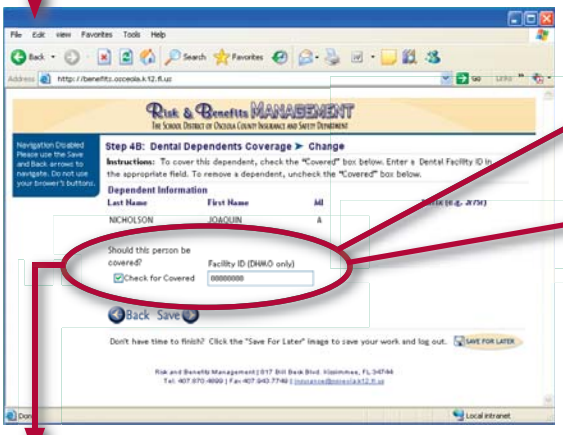


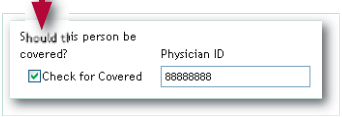
- The **Dental Insurance** screen lets you choose which dental insurance, if any, you would like to select or drop.
- You will only see plans and premiums you qualify for. So, if you did not add a spouse under your *Dependents* step, for example, you will not have the option of choosing this coverage for a spouse. (To make the options available, return to the *Dependents* step and add that dependent to your list.)

  TIP: Before or After-Tax option. Dental premiums are always deducted before taxes. That is why there is no Before or After-Tax option.



- If you select dependent coverage for a plan, you will need to specify which dependent(s) from your list you want to cover. Otherwise, you will click *Save* to move on to the *Vision* step.
- The Covered column shows the dependents you are covering. "Y" for Yes displays in black text; "N" for No displays in red text.
- To cover or drop a dependent under dental insurance, click the "Change" link to the left of the dependent's name.





- The system will ask you to confirm any dependents who you did not cover.
- To cover a dependent for the DHMO, click the "Check for Covered" box and enter a Dental Facility ID number from the Provider Directory at *www.cigna.com*.
- To drop a dependent, uncheck the "Check for Covered" box.
- Click the *Save* arrow to continue to the next step.

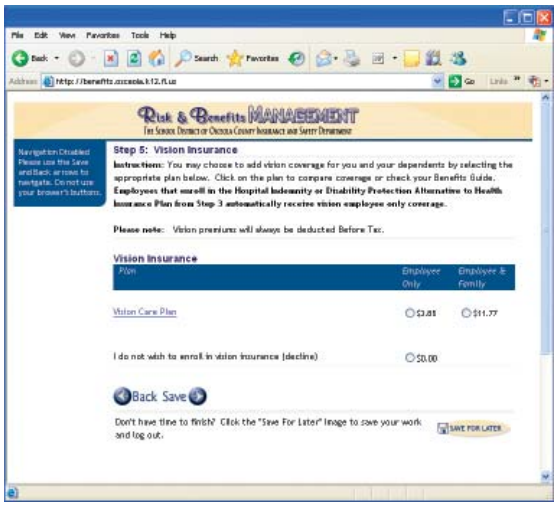



ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

SAVE FOR LATER

Screen Shots

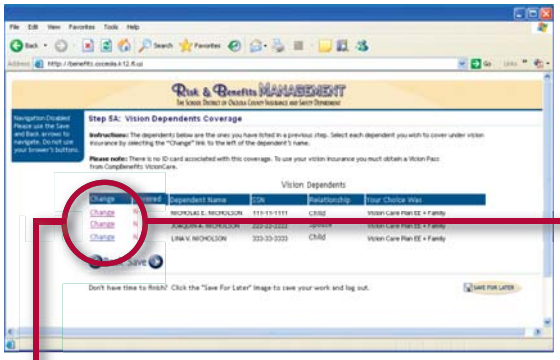
Online Enrollment Instructions



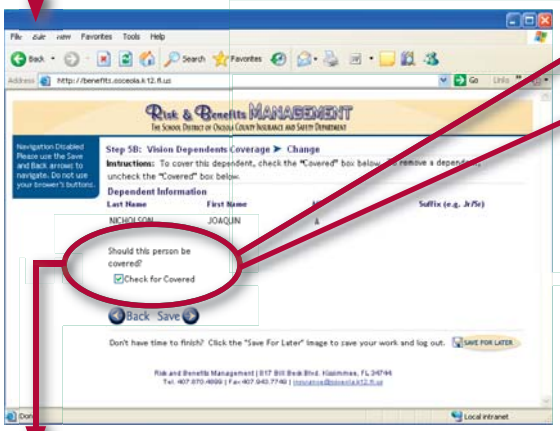
Vision Insurance

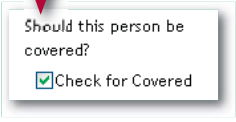
- The **Vision Insurance** screen lets you choose which vision insurance, if any, you would like to select or drop.
- You will only see plans and premiums you qualify for. So, if you did not add a spouse under your *Dependents* step, for example, you will not have the option of choosing this coverage for a spouse. To make the options available, return to the *Dependents* step and add that dependent to your list.

  TIP: Before or After-Tax option. Vision premiums are always deducted before taxes. That is why there is no Before or After-Tax option.



- If you select dependent coverage for a plan, you will need to specify which dependent(s) from your list you want to cover. Otherwise, you will click Save to move on to the Life step.
- The Covered column shows the dependents you are covering. "Y" for Yes displays in black text; "N" for No displays in red text.
- To cover or drop a dependent under vision insurance, click the "Change" link to the left of the dependent's name.
- The system will ask you to confirm any dependents who you did not cover.



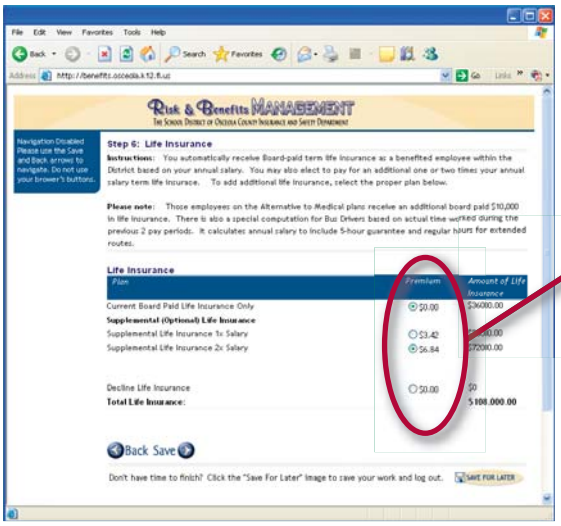


- To cover a dependent, click the "Check for Covered" box.
- To drop a dependent, uncheck the "Check for Covered" box.
- Click the *Save* arrow to continue to the next step.

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

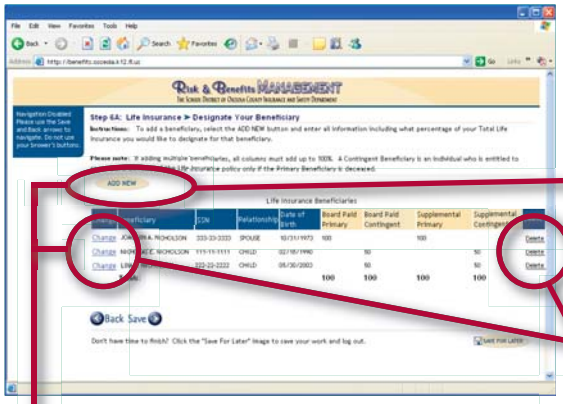
Screen Shots

Online Enrollment Instructions

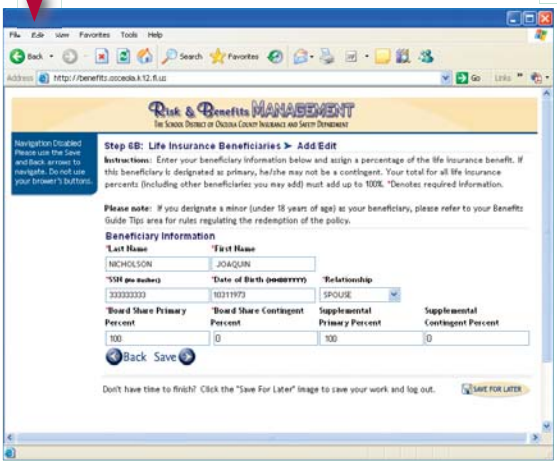


Life Insurance

- The **Life Insurance** screen lets you choose how much *Term Life Insurance* you want to purchase, if any, and designate your beneficiary for both Board-Paid and any *Supplemental (Optional) Life Insurance* you purchase.
- Use the radio buttons to make your selection.
- Once you make your selections, the total Life Insurance benefit will be displayed. If you are increasing coverage during Open Enrollment, you must print and complete an **Evidence of Insurability Form and send it to the insurance carrier.** Your change will not become effective until R&BM receives approval from the insurance carrier.



- After clicking the *Save* arrow, you will be directed to the Designate Your Beneficiary step. All District employees must designate a Board-Paid beneficiary. You will also need to designate a beneficiary for Supplemental (Optional) Life Insurance if you elect this coverage.
- To add a beneficiary, click the *Add New* button, then enter the information in the fields provided, as well as the percentage of life insurance you would like to direct to that beneficiary. You can designate as many beneficiaries as you'd like for each category; make sure each column adds up to 100%.
- To change a beneficiary, click the "Change" text to the left of the beneficiary's name, then edit necessary fields and assign a percentage of the life insurance benefit to that beneficiary.
- To remove a beneficiary, click *Delete* to the far right of the beneficiary's name.



- Click the *Save* arrow to continue to the next step.

TIP: A Contingent Beneficiary is a person(s) you name to receive the life insurance benefit in the event that your primary beneficiary(ies) is (are) no longer alive. Example: You name your spouse as your primary beneficiary and your children as the contingents. If you and your spouse both die, the children would receive the life insurance benefit. If your spouse is still alive, he/she will be the one receiving the benefit. Naming a contingent beneficiary is not required, but is recommended.

TIP: Dependent Life - If you would like to purchase a dependent life policy or change your current policy, you must contact Colonial Life Insurance directly.



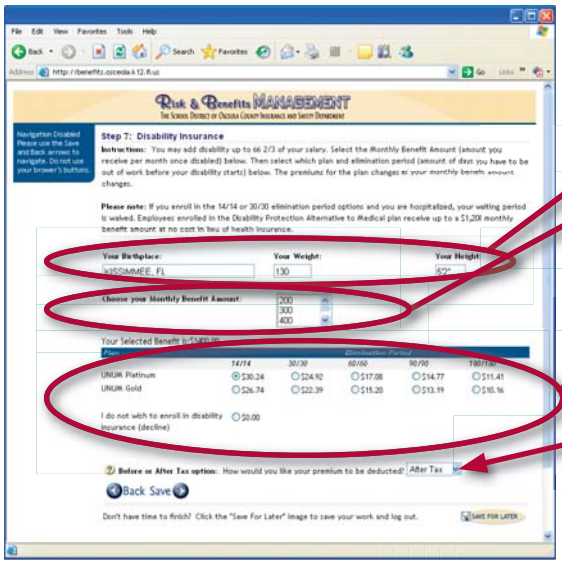

ENROLL TIP: Review each step carefully and make all necessary changes. If you need to stop at any time, you can use the SAVE FOR LATER button located at the bottom of each screen and continue later.

SAVE FOR LATER

Screen Shots

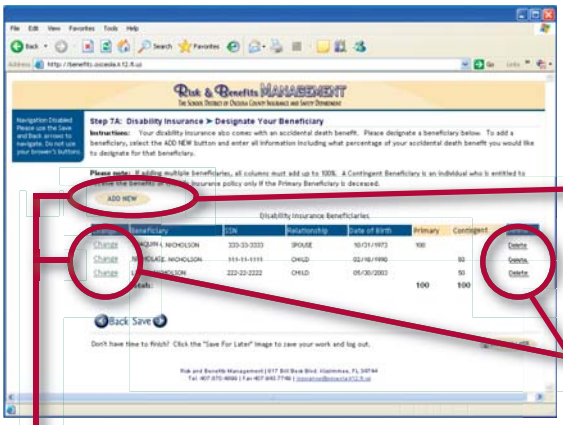
Online Enrollment Instructions

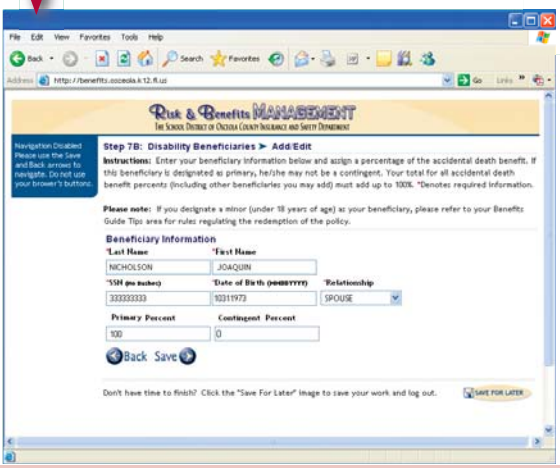
Disability Insurance



- The **Disability Insurance** screen lets you choose how much disability insurance you want to purchase.
- You must enter your birth place and height and weight.
- Then select the monthly benefit you want to purchase (the amount of money you would receive each month if you were disabled). The menu only shows the maximums you are eligible for.
- Then select the elimination period (the number of days you have to wait for benefits to begin once disabled) for the plan you want (Platinum or Gold — you cannot enroll in both).
- Finally, you must select whether you want your disability premiums deducted from your paycheck before or after taxes are calculated and deducted from your paycheck.

  TIP: Remember, if you select before tax and you are disabled, your disability benefit will be taxed. Most likely, the tax savings on your premium will be significantly less than the taxes you would pay on a disability benefit.

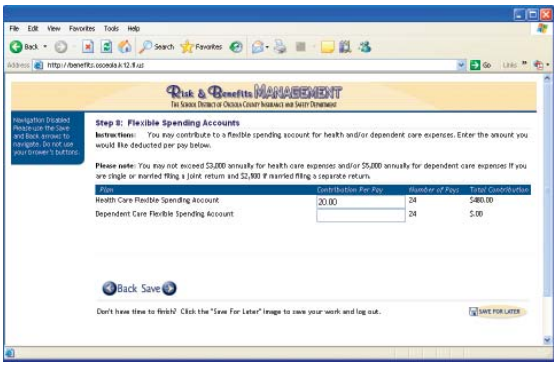




- When you elect disability coverage, you automatically receive Accidental Death and Disability coverage. This coverage requires you to designate a beneficiary (for the accidental death benefit), so you will be navigated to the *Designate Your Beneficiary* step.
- To add a beneficiary, click the *Add New* button, then enter all information in the fields provided, along with the percentage of your benefit you would like to direct to that beneficiary. You can designate as many beneficiaries as you'd like for each category; make sure each column adds up to 100%.
- To change a beneficiary, click the "Change" text to the left of the beneficiary's name. Then edit the necessary fields and assign the percentage of your benefit you would like to direct to that beneficiary.
- To remove a beneficiary, click the "Delete" text to the far right of the beneficiary's name.

CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots

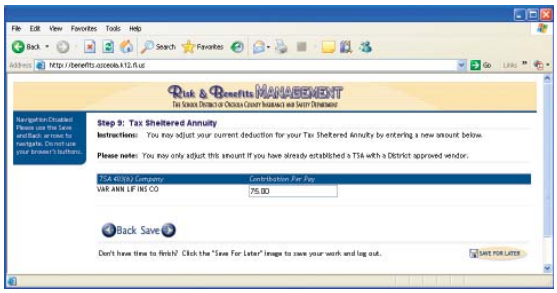


Online Enrollment Instructions

Flexible Spending Accounts

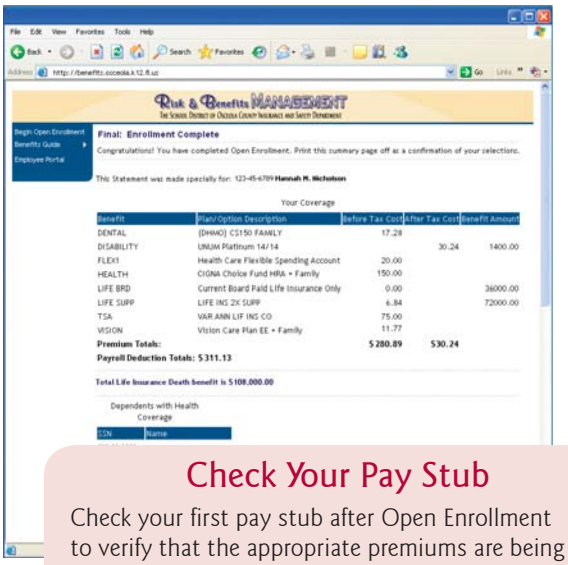
- The **Flexible Spending Accounts** screen lets you enter the amount you would like to contribute from each paycheck to your Health Care FSA and/or your Dependent Care FSA.
- Enter the per-pay amount you would like directed into either of the two plans.
- Your annual amount will be calculated based on the number of pays you have already elected.
- If you do not want an FSA, click *Save* to skip this step.
- Click the *Save* arrow to continue to the next step.

TIP: Be sure you enroll in the right FSA. If you want only the Health Care FSA, do not enter an amount under the Dependent Care FSA as this premium cannot be reimbursed.



Tax Sheltered Annuity

- Employees who currently have a TSA can increase, decrease or suspend their current deduction. Employees who do not have a TSA must contact an approved agent or company to open a TSA.
- Enter your contribution amount in the appropriate field.
- Click the *Save* arrow to continue to the next step.



Enrollment Complete

- The **Enrollment Complete** step shows the deductions you chose, the amount of life insurance you elected, your covered dependents (if any), and your beneficiaries.
- Use the *Back* arrow if you need to make any changes.
- Confirm your elections and print a copy for your records. It is important to keep a copy of this verification as proof of your elections. Set your printer settings to "Landscape" to ensure all data gets printed.
- You can enter the Enrollment System multiple times during Open Enrollment. Your elections become final when the System closes on September 19, 2008 at 4:30 p.m.
- Click the *Save* arrow to complete the process.

At the close of Open Enrollment, your elections are final and cannot be changed until the next Open Enrollment period unless you experience an IRS qualifying event (see page 6).

Check Your Pay Stub

Check your first pay stub after Open Enrollment to verify that the appropriate premiums are being deducted. If you find a discrepancy, contact Risk & Benefits Management immediately. Remember that the IRS does not allow changes during a plan year, except in the case of a qualifying event (page 6).




Use Your Health Care Dollars Wisely

You can't turn on the radio, TV, or open a newspaper these days without reading about the rising cost of health care. One of the ways we can all help to hold down health care costs is to use our benefit programs wisely and take good care of ourselves and our families. Everything we do to improve or maintain our health will help the District continue to offer quality and affordable health care plans to our employees and their families.

The District provides a number of tools to help you use your health care dollars wisely. Plans like the new ***Choice Fund HRA plan*** and the ***Flexible Spending Accounts*** can help you plan and keep track of your expenses and become a wiser health care consumer.

Employee Portal – New! Register Today!

https://employees.osceola.k12.fl.us

To access the site, go to *https://employees.osceola.k12.fl.us* from any computer that has Internet access. Once on the site, register as a new user and create your portal account. You will need to provide your email ID, your date of birth and your Social Security number when you register.

The Employee Portal is a new website that gives you access to your personal information, including:

- **Pay stubs** — most pay information is available two days prior to the scheduled pay date.
- **Leave history** — view the amount of sick and/or vacation time you have available as well as a history of time you have taken off.
- **Personal information** — view your address and telephone number on file with Human Resources as well as other demographic information.
- **Payroll forms** — download Direct Deposit forms, W-4 and W-5 forms.
- **Employee wellness information** — view the wellness calendar, health tips, District wellness activities, contests, and programs including the new walking path locations at designated facilities.
- **Links** — links to department websites including the Benefits Enrollment website.

Visit often — features will be added as new ideas are suggested.

Questions? Contact the Help Desk at 407-870-4037




$mart Tips for Health Care Consumers

Ways to Control Your Health Care Costs

The cost of health care continues to rise for most Americans. Therefore, taking action to improve your health will also help to lower your health care costs. Here are some suggestions.

Consider This	Take Action
1. **Eat a healthy diet and get active.** Eat a healthy diet and exercise. Unhealthy diets plus lack of exercise can lead to illnesses and, consequently, increased health care costs. Eating well and staying in good physical shape will benefit you and your health care costs. Always check with your doctor before beginning a new diet or exercise regimen.	If you are enrolled in a CIGNA medical plan you have access to value added programs (see pages 48-49). The dental plan also offers several value added programs if you are enrolled in both a CIGNA medical and a dental plan (see page 16). See the Wellness Calendar on page 46 for District-wide events.
2. **Check ups and screenings.** Schedule examinations with your regular doctor, dentist, eye doctor, and so on. Being diligent about your health care now can help prevent serious health problems later.	The CIGNA Choice Fund Health Reimbursement Arrangement Plus Plan pays for 100% of eligible preventive care. The Open Access Plus In-Network plan waives the deductible and pays for 90% of eligible preventive care costs.
3. **Know your health plans and stay in-network.** Learn what is covered and what is not covered under your plans. Network doctors and facilities have contracts that ensure you pay no more than the discounted prices for services.	Read the information in this guide and use each plan's online resources to make sure you get the most out of your coverage. Review your medical bills carefully. Billing errors can cost you hundreds or even thousands of dollars.
4. **Save money on prescription drugs.** Ask your doctor to write your prescription for the generic version of the drug you need, if one is available. Costs tend to differ from one pharmacy retailer to the next, so shop around and compare prices.	Both medical plans and the Hospital Indemnity Plan Alternative provide prescription drug benefits. Generic drugs are the lowest in cost. Use CIGNA Tel-Drug home delivery service to save even more. You can also use the generic discount programs offered at many retailers (like $4 generics) and free antibiotics at other retailers.
5. **Open a Flexible Spending Account (FSA).** You can save money by enrolling in one of the two accounts. Your contributions are deducted from your paycheck before taxes, so you reduce your eligible expenses by the amount of taxes you save.	Read pages 21-24 in this guide to see how a little planning up front can save you money in the long run when you contribute to a Flexible Spending Account.




4 the Health of It! Wellness Program

4 the Health of it!

The School District of Osceola County, FL

1. Eat smart
   - watch your portion size
2. Move more, sit less
   - 30 minutes most days of the week
3. Relax, don't stress
   - take deep breaths and time for yourself
4. Get regular check-ups
   - practice preventive care, see your doctor

Your health and wellness is very important to the School District of Osceola County. The School District's worksite wellness program, called ***4 the Health of It!***, is designed to help you make small, but meaningful, lifestyle changes that add up to big health rewards.

The program's activities are intended to help you enhance your health and wellness, reduce your risk for certain chronic diseases, and have fun in the process. By applying these 4 simple steps, you can lead a healthier lifestyle and help to prevent chronic diseases.

Health and Wellness Program Activities for 2008-2009

- Five Wellness Fairs throughout the year (see calendar)
- Health Information Centers at all school locations and worksites. Be sure to check the Health Information Center at your school/facility and Benefits Corner for more information on these programs. The information is updated monthly.
- 10 fitness and wellness trails at designated locations
- Healthy cooking classes
- Fitness boot camps
- Lunch and Learn Seminars hosted by Florida Hospital and Osceola Regional Medical Center
- Online and Bilingual Health Assessments through CIGNA (see page 48 for details)
- Disease and Lifestyle Management classes, topics include diabetes, heart disease, healthy babies campaign, stress management and weight loss
- And much more!

2008-2009 Wellness Fair Calendar

Date/Time	Location
October 24 11:30 a.m. to 3:30 p.m.	Kissimmee Middle School
January 16 1:00 p.m. to 5:00 p.m.	St. Cloud Elementary
February 20 - Rodeo Day 10:00 a.m. to 2:00 p.m.	District Administration Center
March 27 Noon to 4:00 p.m.	Liberty High School
May 14 9:00 a.m. to 1:00 p.m.	Transportation




The Wellness Incentive

SDOC is so committed to your wellness that the District will reward you with a $100 Wellness Incentive each school year to help you pay for medical expenses.

- **Eligibility:** Only active benefits-eligible employees qualify. When both husband and wife work for the District, each employee must individually satisfy the qualification requirements.
- **Program Duration:** July 1, 2008 – June 8, 2009 (for the 2009 – 2010 school year).
- **Deadline:** June 8, 2009.
- **Reward:** When you qualify, your $100 reward will be deposited in a Health Care Flexible Spending Account in your name on October 1, 2009. You will also be entered to win a $100 gasoline card. You can use the money in your FSA to pay of covered medical, dental, and vision expenses. See pages 21-24 for FSA details.

Win a $100 Gasoline Card

When you meet the Employee Wellness Incentive qualifications you will automatically be entered into a drawing for one of four $100 gasoline gift card on June 30, 2009 (Elementary School, Middle School, High School, and Departments). The winners will be contacted using the phone numbers on file.

$mart Tip! • Incentive Documentation

Submit all three documents at the same time. Write your name and employee ID number on each piece and staple them together.

- Health Assessment score
- Health Fair Proof of Attendance Card
- Proof of annual physical

3 Steps to Qualify

You have from July 1, 2008 through June 8, 2009 to complete and submit documentation for all three activities. You must complete or update all three steps each year to continue to qualify for the incentive.

1. **Complete a Health Assessment by June 8, 2009.**
   - **CIGNA Medical Plan and Hospital Indemnity Plan (HIP) Participants:** Complete CIGNA's online, confidential Health Assessment. See page 48 for details about the Health Assessment.
     - Log onto *mycigna.com* and complete or update your Health Assessment.
     - Print out "Physician Profile" and submit it to Risk & Benefits Management.
   - If you are enrolled in the **Disability Protection Plan or as a Secondary Half-Family Spouse,** you can take the Diet and Fitness Evaluation at *http://www.hopeflorida.org/*. Be sure to enter **Promotional Code HPC59.**
2. **Attend a Health Fair** between July 1, 2008 and June 8, 2009. Submit the original Proof of Attendance Card you get at the Health Fair. Replacement cards are not available and photocopies cannot be accepted.
3. **Get Your Annual Physical.** Visit your doctor for your annual physical (PCP or GYN depending on your age and medical history) between July 1, 2008 and June 8, 2009. Submit a copy of your Explanation of Benefits. You can print one from *www.mycigna.com* or have your doctor certify (on letterhead or a prescription pad) that you received your physical.

Submit Your Documentation by June 8, 2009

You must submit all three pieces of documentation to Risk & Benefits Management by the deadline along with your full name and employee ID number.




CIGNA Programs, Features and Resources

As a CIGNA medical plan participant, you have access to these programs, features, and resources.

Making the Most of Your Preventive Care Benefits

Preventive care services include your periodic wellness visits, routine immunizations, and routine screenings. The following items are considered preventive care, as appropriate by age.

- Periodic health exams for men, women and children, including immunizations
- Mammogram (one per plan year for women age 40+)
- Osteoporosis screening for women ages 65+, or at 60 for women at high risk
- Pap test (one per plan year for women ages 19-64)
- Prostate screening (PSA; once per plan year for men 50+ or any age with high risk factors)
- Colorectal cancer screenings starting at age 50:
  - Sigmoidoscopy (once every five years)
  - Colonoscopy (outpatient; one every ten years)
  - Fecal Occult Blood Test (one per plan year)
  - Barium Enema (once every five years)
- Including the associated lab charges and fees for reading reports or films

This list is not all-inclusive and may vary by medical plan. For more information about what is covered under preventive care, please call CIGNA Customer Service.

mycigna.com

mycigna.com is your personalized website that provides tools to help you better understand your benefits and manage your overall health and well-being. With *MyCIGNA.com* you have the ability to:

- View your claims and benefits.
- Complete a brief questionnaire with the Health Assessment tool.
- Get information on health conditions, health and wellness, first aid, and medical exams through Healthwise, an interactive library.
- Use the pharmacy tools to:
  - Check prescription drug costs.
  - Use DrugCompare to look at condition-specific drug treatments.
  - Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.
- Through Select Quality Care, learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.
  - Use the Online Provider Directory to find hospitals that rank highest for certain procedures and conditions.

CIGNA Customer Service

Questions About Your Medical Plan?
Call CIGNA's customer service
1-800-244-6224 (CIGNA24)

The Health Assessment and the Wellness Initiative

Health Assessment Tool at *mycigna.com*

CIGNA HealthCare offers an online, confidential health management tool. Completing the health assessment starts you on a path to better health *and meets one of your Wellness Incentive requirements*. Your results will help you understand your current state of health, whether you are at risk for certain conditions like diabetes and high blood pressure, and provide recommended steps for improvement. You may also receive an invitation to join a CIGNA Online Coaching Program.

CIGNA Health Advisor℠

For Choice Fund HRA Members Only

Once you complete a health assessment, you can call the toll-free number on your CIGNA ID card to speak with a CIGNA Health Advisor. Available Monday to Friday, 9:00 a.m. to 9:00 p.m. and Saturdays, 9:00 a.m. to 12:00 p.m., Health Advisors can give you personalized health and wellness coaching and resources to achieve and maintain your goals.

Personal Health Record (PHR)

You can store and monitor your health information in a secure location by having your lab results and other medical and pharmacy claims data automatically entered in your PHR. You can manually enter other related information that is not provided on your claims data (e.g., allergies, over-the-counter medications, etc.).




Be a Wiser Consumer with Healthwise®

Imagine the decisions you could make if you had access to a tool with information on more than 5,000 health topics. For CIGNA HealthCare members, that tool is real. It's Healthwise and it's on *myCIGNA.com*. Health conditions, everyday health and wellness, first aid and medical exams are just four of the 5,000 health topics you can access through this interactive tool. It's an informative source, and because it's on *myCIGNA.com*, it's available whenever you need it.

CIGNA HealthCare 24-Hour Health Information Line℠

1-800-244-6224 (1-800-CIGNA24)

No matter where you are in the U.S., you can call the CIGNA HealthCare 24-Hour Information Line toll free. You can speak to a registered nurse for answers to your health questions, talk to a Member Services Representative for assistance with emergency care, locating nearby medical facilities, and self-care tips. You can also listen to recorded audio tapes covering hundreds of health topics.

CIGNA Healthy Rewards Program

1-800-870-3470 or *www.cigna.com/healthyrewards*

Healthy Rewards offers discounts for acupuncture, laser vision correction, hearing aids, cosmetic dentistry, smoking cessation, fitness club memberships, herbal supplements and a variety of other services and programs. Members use their CIGNA medical plan ID card for identification. You must use a Healthy Rewards participating provider to obtain the discount (a list of providers and services is available by calling 1-800-870-3470 or visiting *www.cigna.com/healthyrewards*).

CIGNA Behavioral Health

1-800-274-4573

Your mental well-being is just as important as your physical well-being. If you have personal issues and concerns, you can reach out to CIGNA Behavioral Health for help.

CIGNA HealthCare Healthy Babies®

1-800-244-6224

The CIGNA Healthcare Healthy Babies program provides education and support for covered mothers-to-be along with special attention for high-risk pregnancies. The program includes:

- Access to a toll-free information line staffed by experienced registered nurses.
- Educational materials on pregnancy and babies.
- Post-delivery support and services.

Call CIGNA Member Services at 1-800-CIGNA24 to enroll in this program.

CIGNA HealthCare Well Aware® Program

1-866-797-5833 or *www.mycigna.com/betterhealth*

The CIGNA HealthCare Well Aware Program offers confidential support for you and your covered family members who have specific chronic conditions. You have access to registered nurses who specialize in your condition, educational materials that help you learn more about your health condition, regular reminders of important checkups and tests, and helpful information that keeps your doctor.

Lifestyle Management Programs

1-866-417-7848 or *www.mycigna.com*

These programs can help you make lasting behavioral and lifestyle changes that lead to improved health. They can also help you reduce your risk factors for conditions such as diabetes, heart disease and high blood pressure, and improve your level of energy.

Weight Management — Adopt healthy eating and exercise habits to help you lose weight.

Continues on next page




CIGNA Programs, Features and Resources, *continued*

Tobacco Cessation — Develop a personalized plan to stop using tobacco. This program includes one regimen of nicotine replacement therapy.*

Stress Management — Learn what your stress triggers are and how to cope with them.

* *Over-the-counter nicotine replacement therapy is provided by CIGNA Tel-Drug Home Delivery Pharmacy, but must be ordered through the CIGNA Quit Today℠ program. Only one course of over-the-counter nicotine replacement therapy is available per participant per calendar year.*

CIGNA Dental Treatment Cost Estimator Tool

Log onto *www.mycigna.com* using your unique user ID and password, then select the "myPlans" tab at the top of the home page and follow the EXACT instructions below.

- Select the "view Dental main page" link under the "myplans" section the home page.
- Click on the Dental Treatment Cost Estimator link; after reading and agreeing to the CIGNA licensing agreement, click "AGREE."
- After your home ZIP code displays, you must hit "submit."
- Follow the directions on screen to choose the appropriate treatment you would like to estimate the cost for. The tool will pull up the estimated costs based on the dental plan you are enrolled in.

Benefits and Features

You can:

- Estimate what your out-of-pocket costs may be prior to receiving treatment
- Plan for treatments and procedures according to your budget
- Compare the financial impact of using in-network providers versus out-of-network providers
- Locate a CIGNA dental network provider
- Search for additional information by key words, procedure codes, etc. and access a dental glossary
- Link to WebMD

Flexible Spending Account Direct Deposit

If you enroll in one or both of the FSAs, you can have your reimbursement checks direct deposited into your bank account. Log into your *mycigna.com* account, click on "Settings and Preferences" in the page header, then click on "Direct Deposit" and enter the requested information. Please allow 21 days for the direct deposit of your reimbursements to begin.

Employee Assistance Program

The SDOC offers you an Employee Assistance Program (EAP) through Horizon Health. The EAP is a free, confidential service that helps you and your eligible household members balance your personal and professional life. Experienced professionals are ready to provide confidential counseling for a variety of life's problems, including:

- stress management
- marital and relationship issues
- alcohol and drug abuse
- grief
- eldercare
- financial and legal issues

Your EAP is an important part of your health benefits. Telephone and face-to-face counseling are accessible 24 hours a day by calling 1-800-272-7252. You can also visit Horizon Health at *www.horizoncarelink.com*.

Login: OCS • Password: OCS




Fine Print

Medical Plan Exclusions

Medical Plan — Expenses for the following are excluded and/or limited:

1. For Cosmetic Surgery or Therapy. Cosmetic Surgery or Therapy is defined as surgery or therapy performed to improve appearance or self esteem
2. For or in connection with procedures to reverse sterilization.
3. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation and transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
4. For infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
5. Care or services of any kind performed for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by an Ambulatory Surgical Facility or the outpatient department of a Hospital in connection with surgery.
6. For orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, Medically Necessary treatment for TMJ disorder is covered.
7. Diagnosis or treatment of weak or flat feet, fallen or high arches, for instability or imbalance metatarsalgia not caused by disease (except for bone surgery), bunions, (except for capsular or bone surgery), corns or calluses, or toenails (except for complete or partial removal of nail root); unless needed in treatment of a metabolic or peripheral vascular disease.
8. Routine hearing examinations, routine physical examinations, premarital examinations, preemployment physicals, preschool examinations, routine immunizations, annual boosters, etc. except as indicated in the Schedule of Benefits unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
9. Artificial aids including, but not limited to, corrective orthopedic shoes, garter belts, corsets, hearing aids and dentures.
10. Routine eye examination for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
11. Charges for or in connection with medical, surgical or other health care procedures and treatments which are experimental or investigational, as determined by CG in accordance with consensus derived from peer-reviewed medical and scientific literature and the practice of the national medical community, including (a) any procedures or treatments which are not recognized as conforming to accepted medical practice; (b) any procedures or treatments in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness has not been established; and (c) any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are rendered; for Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by CG, to be: (a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or (b) the subject of review or approval by an Institutional Review Board for the proposed use; or (c) the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or (d) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
12. For nonmedical ancillary services, including but not limited to vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
13. For charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
14. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including medical and surgical services to alter appearances or physical changes that are result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

Continues on next page




Medical Plan Exclusions, cont'd

14. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including medical and surgical services to alter appearances or physical changes that are result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
15. Prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products. For personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
16. Hospitalization primarily for X-ray, laboratory, diagnostic study, physical therapy, hydrotherapy, medical observation, convalescent or rest cure, or any other medical examination or test not connected with an actual illness or injury.
17. For consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Covered Expenses."
18. For charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this policy.
19. Those which the Covered Person is not, in the absence of this coverage legally obligated to pay, such as private membership clubs, clinics or other organizations paid through group membership clubs or services, or by traditional "Fault" contract, "No Fault" contracts, or any other form of liability insurance providing medical coverage.
20. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
21. For or in connection with an Injury or Sickness which is due to war, declared or undeclared.
22. Illness or injury to which a contributing cause was the commission of, or attempted commission of, an act of aggression or a felony, or participating in a riot by the Covered Person.
23. For charges that are not Medically Necessary, except as specified in any certification requirement shown in The Schedule.
24. To the extent that payment is unlawful where the person resides when the expenses are incurred.
25. For fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in CG's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery; for blood administration for the purpose of general improvement in physical condition.
26. Expense incurred in connection with any intentionally self-inflicted injury or illness whether person is sane or insane.
27. Any charges incurred for the purpose of Acupuncture.

Prescription Drug Program — Expenses for the following are excluded and/or limited:

1. Drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products.
2. Drugs available over-the-counter that do not require a prescription by federal or state law, and any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.
3. Any drugs that are labeled as experimental or investigational.
4. Each Prescription Order or refill shall be limited as follows:
   - to up to a consecutive 30-day supply, at a retail Pharmacy unless limited by the drug manufacturer's packaging; or
   - to up to a consecutive 90-day supply at a mail-order Participating Pharmacy unless limited by the drug manufacturer's packaging; or
   - to a dosage and/or limit as determined by the P & T Committee.
5. Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis.
6. Diet pills or appetite suppressants (anorectics).
7. Prescriptions more than one year from the original date of issue.
8. Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.
9. Prescription drugs which may be properly received without charge under local, state or federal programs including Worker's Compensation.
10. Any fertility drug.
11. Medication required for services not covered under the HIP, Open Access Plus In-Network, or CIGNA Choice Fund HRA Medical Plans will not be covered by the Prescription Drug Program.
12. Injectable drugs including injectable infertility other than injectables, included on the Formulary, used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation. However, upon prior authorization by CG, injectable drugs may be covered subject to the required Copayment.

New Military Extended FMLA Regulation

An employee who requests FMLA leave to care for a spouse, son, daughter, parent, or next of kin who sustained serious illness or injury in the line of duty is entitled to up to 26 weeks of leave in a single 12-month period.




Leaves of Absence

Going on a leave of absence? You can keep your District benefits while on a District-approved leave.

Paying Premiums

Employees who are granted a Leave of Absence (LOA) may elect to continue coverage through the District. Employees will be responsible for paying the full cost of premiums. This includes Board-Paid Health and Life Insurance, medical dependent coverage, supplemental life insurance, dental, vision, disability insurance and flexible spending account contributions.

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

A Leave at the End of the School Year

Employees who are granted a Leave at the end of the school year will continue to have Board-Paid benefits until September 1st. If an employee has optional benefits, August 31st premiums are due in order to continue benefits until September 1st. Employees can either contact your assigned Benefits Specialist to arrange to have the premiums deducted through payroll deduction before the end of the year, or pay the premiums directly to the Risk & Benefits Management office.

A Leave During the School Year

Employees who are granted a Leave during the school year will be responsible for paying all premiums, including the Board-Paid portion, from the date the Leave begins.

Family Medical Leave Act (FMLA) Eligibility

FMLA requires SDOC to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for the District for at least one year, and have worked for 1,250 hours over the previous 12 months. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Your Rights Under FMLA

- 12 weeks maximum duration
- Job protection
- Continuation of Board-Paid benefits. (Employee is responsible for optional benefits including dependent coverage, life insurance, dental, vision, disability insurance and flexible spending account contributions.)

FMLA Approved Circumstances

- Birth of a child
- Adopting a child or becoming a foster parent
- To care for the employee's seriously ill spouse, child or parent
- An employee's serious health condition
- To care for a covered service member who is recovering from a serious illness or injury sustained in the line of active duty.
- Any "qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation.

Requesting FMLA Leave

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

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

Important Information About FMLA

- FMLA is an unpaid leave. Employees can choose to use accrued paid vacation or personal leave, which will run concurrent with the FMLA leave.
- FMLA may run concurrent with a worker's compensation absence when the injury is one that meets the FMLA criteria for a "serious health condition."
- An eligible employee is entitled to take up to 12 weeks for FMLA leave in a "rolling" calendar year. So, when an employee requests FMLA leave, leave eligibility is determined by counting back 12 months from the date the leave is requested. If you have incurred a leave during the 12 months, your FMLA will be reduced by the time previously used.
- If an employee is receiving a paycheck during the FMLA, their benefit premiums will be deducted from their checks. If the employee is not receiving a paycheck, premiums for optional insurance are due on the missed pay period. If the employee does not make the premium payment within 30 days of the missed pay period, the District will terminate the optional benefits. However, an employee can arrange to pay their premiums when they return to work by contacting their Benefits Specialist to make arrangements.
- FMLA may be taken intermittently or on a reduced-leave schedule.
- The District may recover premiums for Board-paid insurance if the employee fails to return to work for 30 days and terminates his/her employment except due to: his/her own serious health condition, circumstances beyond his/her control, denial of restoration due to key employee status.
- If both husband and wife work for the District, FMLA limits the Leave that may be taken to a combined total of 12 workweeks during any 12-month period if the Leave is taken for birth or placement for adoption or foster care. This limitation does not apply to Leave taken:
  - to care for the other spouse who is seriously ill and unable to work.
  - to care for a child with a serious health condition.
  - for his or her own serious illness.
- For Leaves due to serious health conditions, a periodic status report will be required.
- Upon return to work, the employee who was on FMLA due to a personal illness will be required to provide a fitness-for-duty notice from his/her physician. If the fitness-for-duty documentation is not provided, the employee may not return to work.
- Employees on FMLA for maternity may extend the Leave beyond six weeks to the full 12 FMLA weeks.




Continuation of Coverage

COBRA Benefits After Termination

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

Through federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may choose to continue coverage by paying the full monthly premium cost plus an administrative charge of 2%. Each individual who is covered by an SDOC 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 SDOC 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

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

End-of-School-Year Insurance End Dates

Non-Renewed Employees

For employees who do not have a continuing contract for the next school year: your insurance ends the last day you work. If an Action Form is submitted terminating your employment and you later secure a position for the coming year, you are considered a new hire and may be required to work a probationary period in your new position.

Employees Who Resign

Active employees who do have a contract for the next school year and work until the end of the current school year: your insurance ends the day before you are due to report back to work. Example: Teachers return for the '08-'09 school year on Aug. 12th, so your insurance would end August 11th.

Employees who resign and do not complete the current school year: your insurance ends the last day you work.

HIPAA—Continuation of Coverage

- The Health Insurance Portability and Accountability Act (HIPAA) helps protect your rights to medical coverage during events such as changing or losing jobs, pregnancy and childbirth, or divorce.
- Depending upon your group health plan limitations, HIPAA may also make it possible for you to get and keep medical coverage even if you have past or present (pre-existing) medical conditions.
- If you were covered under a medical plan, you will receive a certificate of creditable coverage upon termination.

HIPAA—Privacy Act Legislation

- SDOC and your health insurance carrier(s) are obligated to protect your confidential protected health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses.
- SDOC and your health insurance carrier(s) are required to notify you and your beneficiaries about our policies and practices to protect the confidentiality of your protected health information.

Women's Health and Cancer Rights Act

- The Women's Health and Cancer Rights Act of 1998 requires your health insurance plan to provide benefits for mastectomy-related services.
- These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edemas).
- Coverage for these benefits or services will be provided in consultation with the participant's or beneficiary's attending physician.
- If you are receiving or in the future receive benefits under a group medical contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above if you elect breast reconstruction.
- Your qualified dependents are also entitled to coverage for those benefits or services on the same terms.
- Coverage for the mastectomy-related services or benefits required under the Women's Health law are subject to the same deductibles and coinsurance or copayment provisions that apply to other medical or surgical benefits your group medical contract provides.

Maternity And Newborn Length Of Stay

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

InfoBit

Important Notice about Mammograms

Due to increased medical liability insurance costs and fewer radiologists available to read mammograms, women can expect delays in obtaining a screening mammogram appointment because many radiologists have left the state or decided to discontinue reading mammograms. Please be proactive and schedule mammogram appointments as early as possible. Currently, the average wait for a routine screening mammogram in Central Florida is three to six months.




Notice About Your Creditable Prescription Drug Coverage and Medicare Part D

January 1 – December 31, 2009

About This Notice

Please read this notice carefully. This notice has information about your current SDOC prescription drug coverage and the prescription drug coverage available through Medicare. Important highlights of this notice are:

- Medicare prescription drug coverage is available to those eligible for Medicare.
- Your 2008-2009 prescription drug coverage offered through your SDOC medical insurance plan is creditable coverage, based on our determination. This means your SDOC medical insurance plan expects to pay for all plan participants covered by the plan in 2008-2009, as much as or more, on average, than the standard Medicare prescription drug coverage for 2008-2009.

Your Prescription Drug Coverage Options

If you are eligible for Medicare, you have the option of continuing your existing prescription drug coverage through the District or enrolling in the Medicare prescription drug coverage.

If you choose to enroll in the Medicare prescription drug coverage, you must enroll between November 15, 2008 and December 31, 2008. However, because your existing prescription drug coverage is creditable coverage, you can choose to join a Medicare prescription drug plan later without having to pay a higher premium due to late enrollment. You have the opportunity to enroll in a Medicare prescription drug plan each subsequent year between November 15th and December 31st.

IMPORTANT: If you decide to enroll in a Medicare prescription drug plan and drop your existing prescription drug coverage through SDOC, be aware you may not be able to get your SDOC coverage back.

Even though your current prescription drug coverage with the SDOC is creditable, if you drop it and have a break in creditable coverage of 63 days or more before enrolling in the Medicare prescription drug coverage, you could be subject to paying higher premiums for coverage.

Limited Income Assistance

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information about this additional help is available from the Social Security Administration (SSA). Visit SSA online at *www.socialsecurity.gov*, or call 1-800-772-1213 (TTY 1-800-325-0778).

For More Information About This Notice

Contact Risk & Benefits Management at 407-870-4899 if you require further information about this notice. You may receive this notice at other times in the future, such as before the next enrollment period for Medicare prescription drug coverage, or if this coverage changes. You may also request a copy of this notice.

NOTE: It is important that you keep this notice. If you are eligible for Medicare and you enroll in one of the plans approved by Medicare that offers prescription drug coverage, you may need to provide a copy of this notice when you join to show that you are not required to pay a higher premium.

Employee's Responsibilities

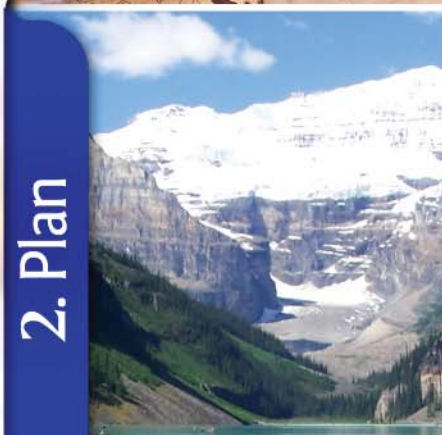
You are responsible for:

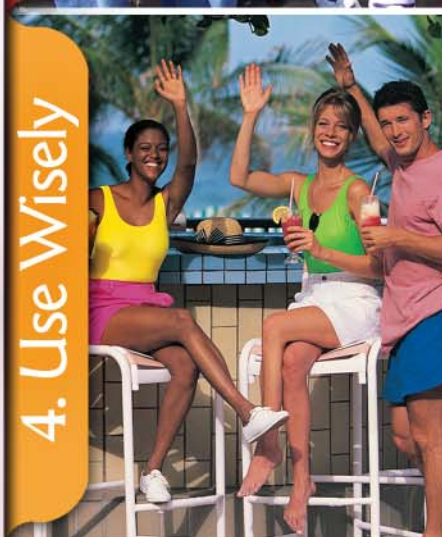
1. Reading this benefits guide thoroughly and prior to enrolling in benefits.
2. Making informed decisions when you enroll or decline enrollment.
3. Reviewing your paycheck stub when your benefits become effective and verifying that your deductions are for the benefits you elected.
4. Notifying the Risk & Benefits Management department within 30 days of your benefits effective date if the premiums for benefits you elected are not being deducted from your paycheck, or the deduction amounts are not correct.
5. Enrolling only eligible dependents, as described in the "Eligible Dependents" section on page 4.
6. Notifying the Risk & Benefits Management department within 30 days of the date a covered dependent no longer meets dependent eligibility requirements.

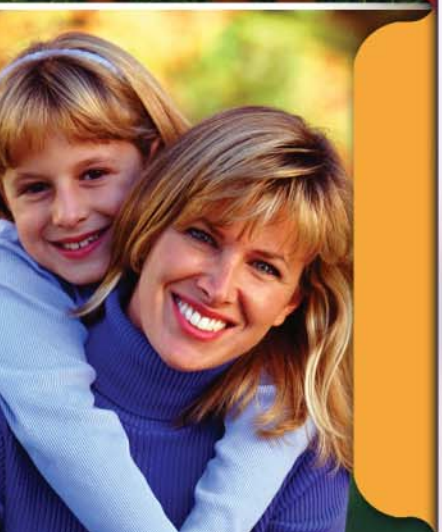
Frequently Called Telephone Numbers and Websites

CIGNA Member Services	1-800-244-6224
CIGNA Online Provider Directory	www.cigna.com
myCIGNA.com	www.mycigna.com
CIGNA Tel-Drug (Mail Order)	1-800-835-3784 www.teldrug.com
CIGNA Behavioral Health	1-800-274-4573 www.cignabehavioral.com
CIGNA Dental	1-800-244-6224 www.mycigna.com
Humana/CompBenefits VisionCare	1-800-749-5855 www.visioncare.com
UNUM Provident Disability	1-800-527-4572
Dependent Life *- Colonial Life & Accident Insurance Co.*	1-800-325-4368
Employee Assistance Program *- Horizon Health*	1-800-272-7252
Flexible Spending Accounts *- CIGNA HealthCare*	1-800-244-6224 www.mycigna.com
Worker's Compensation *- Risk and Benefits Management*	407-870-4057
Florida School Board Insurance Trust	1-800-790-2118
Florida Retirement System	1-866-446-9377 myFRS.com
Risk and Benefits Management	407-870-4899 benefits.osceola.k12.fl.us Email: Insurance@osceola.k12.fl.us

Visit the Online Enrollment System at *benefits.osceola.k12.fl.us*







YOUR Benefit

This guide is a summary of the benefit programs offered through the School District of Osceola County for the plan year October 1, 2008 through September 30, 2009. 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.

SCHOOL DISTRICT OF OSCEOLA COUNTY

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