YOUR GUIDE TO

OPEN ENROLLMENT

BENEFITS GUIDE 2017 – 2018

SUPERINTENDENT'S MESSAGE

Dear District Employees,

Please let me begin by expressing my thanks for the hard work you do every day.

Our school system is built around passion and a fundamental belief in our talented employees and students, supportive School Board and engaged community. We know that the resulting, and continued, excellence of our. District is due to the tireless efforts of all our staff throughout the school year. To keep supporting you as you support the District, the Osceola County School Board and I are keen to share with you your benefit choices for the year ahead.

We know how important these programs are for life both in and away from work, and we want to ensure we're constantly improving the benefits we offer. This year, we've changed some of our providers to provide extra discounts and increased coverage at no additional cost to you. You will benefit from enhanced disability coverage, and savings on eye care – and we don't want you to forget the ComPsych Employee Assistance Program (EAP) that we introduced last fall. We believe that living life well is paramount – and as such, we want to help you overcome life's challenges and maximize your career, by providing you with this professional and external support. You can read more about this fantastic new benefit, provided at no cost to you, on page 18 of this guide.

To provide you with year-round support, we continue to partner with Florida Hospital to provide an onsite Center for Employee Health which gives you access to high quality health care services at little or no cost to you. It's an excellent facility that provides services such as physical therapy, nutrition counseling, and many more of the services you'd normally receive at your primary care physician's office.

As we approach Open Enrollment, you'll notice that we've made some big changes to how you enroll this year. You'll be able to enroll online, allowing you the freedom to make your elections when (and where) you want.

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

Dr. Debra Pace

Superintendent

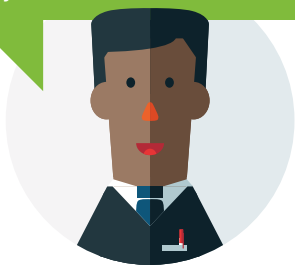
This guide is a summary of the benefit programs offered through the School District of Osceola County for the plan year October 1, 2017 through September 30, 2018.

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

CONTENTS

RATES
AT A GLANCE

Remember, the District absorbs 100% of the Employee Only premiums for those selecting the LocalPlus and Wellness LocalPlus, and there will be no increases to the deductible or out of pocket maximum this year.



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

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

Medical:

	LocalPlus	Wellness LocalPlus	Wellness Open Access Plus
Employee Only	$0.00	$0.00	$45.00
Employee + Spouse	$275.00	$335.00	$410.00
Employee + Child(ren)	$127.00	$145.00	$200.00
Employee + Family	$402.00	$480.00	$610.00
Half Family Primary	$127.00	$145.00	$200.00
Half Family Secondary	$0.00	$0.00	$0.00
Each Adult Dependent Child Aged 26-30	$275.00	$335.00	$410.00

Half Family status – If you and your spouse meet all the following criteria, your status is considered "Half Family".

a. both work for SDOC;
b. are both eligible for benefits; and
c. have children.

If this applies to you and you choose family coverage under one of the medical plans, only one spouse will have a payroll deduction for medical insurance. This doesn't apply to employees with spouses in other school districts or government offices.

Job share – Job share employees pay half the Board contribution ($159.95) plus the premium listed, based on your choice.

Dental:

	HMO	PPO	
		Low Option	High Option
	Rate per pay	Rate per pay	Rate per pay
Employee	$8.35	$10.67	$17.47
Employee + One	$14.62	$21.87	$35.81
Employee + Family	$22.97	$38.26	$62.64

Vision:

Employee	$3.67
Employee + Family	$11.23

Other benefits:

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

HOW TO **ENROLL**

We take pride in the rich variety of benefits we offer, and work hard to ensure that your medical benefits continue to be provided at the best possible cost to you. August 31 through September 15, 2017 is YOUR opportunity to select your benefits for the coming year.

This year, Open Enrollment can only be completed online. To help you through the process, here are the steps you need to take during this year's enrollment window.

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

For the Trustmark products, see page 16 for information on how to enroll or change.

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

Key Dates:

August 31, 2017
The enrollment window opens.

September 15, 2017
The enrollment window closes at 4.30pm.

October 1, 2017
Your benefit elections are effective.

NEW TO THE DISTRICT?

If you join the District mid-year, you'll be invited to a Benefits Orientation to provide you with important information about the benefits you can choose from.

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

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

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

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

QUALIFYING **EVENTS**

Qualifying events include, but are not limited to:

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

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

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

Who's eligible to be a dependent?

Eligible dependents are defined as:

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

YOUR MEDICAL PLANS **MADE SIMPLE**

We take your health seriously. The School Board contributes $6,398 per employee each year for benefits, including the Center for Employee Health, above and beyond your regular salary or hourly wage.

Selecting your medical benefits could be the most important decision you make each year. To help you understand the different plans and select the right one for you and your family, we've provided a summary and a comparison of the three medical plan options, all of which offer comprehensive medical coverage and are provided by Cigna.

Although the District covers 100% of the premium for Employee Only coverage for those selecting LocalPlus and Wellness LocalPlus, you'll still need to meet a deductible, copays or co-insurance payments when receiving treatment. If you do not make an election, you'll be enrolled in the LocalPlus plan, with Employee Only coverage.

The LocalPlus and Wellness LocalPlus Plans

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

So what's the difference?

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

With the Wellness LocalPlus Plan, you don't need to meet a deductible unless you're having a procedure or visit outside your doctor's office. Co-pays for your primary care physician are $30 per visit and specialists are $35 per visit.

This is the default plan so if you don't elect your benefits by the deadline, you'll automatically be enrolled in the LocalPlus Plan with Employee Only coverage.

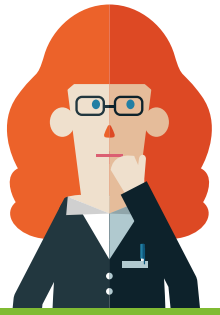
The Wellness Open Access Plus Plan

The Wellness Open Access Plus Plan offers a larger network of providers as well as out-of-network coverage. This plan is not fully funded, so if you elect Employee Only coverage, you'll need to pay the difference. Since this plan has a larger network and offers out-of-network coverage, premiums are the highest for both the employee and their dependents.

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

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

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



Concerned about medical fees? Find out more about how you can save tax free with a Flexible Spending Account to cover your medical expenses on page 8.

Visit www.mycigna.com for more tools and resources to help you live life well!

	LocalPlus	Wellness LocalPlus	Wellness Open Access Plus	
Network	LocalPlus network only and no out-of-network coverage		Open Access Plus	Out-of-network
	Default Plan, Coinsurance Plan	Copay and Coinsurance Plan	Copay and Coinsurance Plan	
Deductible (Individual/Family)	$500 / $1,000	$350 / $700	$500 / $1,000	$1,000 / $3,000
Coinsurance level	30%	25%	30%	50%
Out of Pocket Maximum (Individual/Family)	$6,300 / $12,600	$4,700 / $9,400	$5,000 / $10,000	$10,000 / $30,000
Preventive Care	$0	$0	$0	Deductible + 50%
Primary Care Physician	Deductible + 30%	$30 copay	$35	Deductible + 50%
Specialist Physician	Deductible + 30%	$35 copay	$50	Deductible + 50%
Urgent Care	Deductible + 30%	Deductible + 25%	Deductible + 30%	Deductible + 50%
Emergency Room	Deductible + 30%	Deductible + 25%	Deductible + 30%	Deductible + 50%
Lab and X-ray • PCP/Specialist • Independent Lab • All other facilities	Deductible + 30%	$30/$35 25%, no deductible Deductible + 30%e	$35/$50 30% Deductible + 30%e	Deductible + 50%
Advanced Imaging	Deductible + 30%	Deductible + 25%	Deductible + 30%	Deductible + 50%

Prescription benefits	LocalPlus		Wellness LocalPlus		Wellness Open Access Plus	
Deductible	$200 (waived for generics)		$50 (waived for generics)		$50 (waived for generics)	
Copays	30 day supply	90 day supply	30 day supply	90 day supply	30 day supply	90 day supply
Generic	$20	$55	$15	$40	$15	$40
Preferred	$45	$130	$35	$100	$35	$100
Non-preferred drugs	50% up to $150	50% up to $445	45% up to $100	45% up to $295	45% up to $100	45% up to $295
Specialty drugs	75% up to $250	75% up to $250	5% up to $200	55% up to $595	55% up to $200	55% up to $595

Cigna resources

As a Cigna medical plan participant, you also have access to a number of other features, programs and more.

Health Information 24/7

Health Information 24/7 gives you access to a specialist trained as a nurse, 24 hours a day, seven days a week. Whenever there's a question about health, just call the Health Information line for help finding the answer. Call 1-800-CIGNA24 (1-800-244-6224) or visit www.mycigna.com for more information.

Free Lifestyle Management Programs

Whether you're looking for help with weight management, tobacco cessation or stress management, Cigna's Lifestyle Management Programs are easy to use, available where and when you need them, and are always at no cost to you. Call or go online for easy enrollment – just call 1-866-417-7848 or visit www.mycigna.com and enter your User ID and Password.

MANAGE
YOUR EXPENSES

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

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

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

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

Healthcare FSA

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

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

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

Dependent Care FSA

- ✔ Set aside money to pay for eligible non-medical dependent day care expenses such as child care or adult care center, a nursery school, summer day camp, or a caregiver for an elderly or incapacitated dependent.

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

- The dependent's name(s);
- The period during which the services were rendered; and
- 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.

Annual FSA contribution limits

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

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

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

If you already have an FSA, you must re-elect the amount you want deferred every year during enrollment.

How much could I save with setting aside an FSA?

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

Example 1: **Amy**

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

Amy saves in an FSA

Amount Amy needs to save each year	$1,000
Her tax bracket	25%
Federal Income Tax applied	$0
Money available to spend on medical expenses	$1,000

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

Amount Amy needs to save each year	$1,333
Her tax bracket	25%
Federal Income Tax applied	$333
Money available to spend on medical expenses	$1,000

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

Example 2: **Michael**

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

He will have the maximum of $5,000 in his Dependent Care FSA and $450 in his Healthcare FSA. Based on his tax bracket of 33%, he saves $1,798.50 – enough to make one mortgage payment!

Healthcare FSA	$450
Dependent Care FSA	$5,000
Total contributions	$5,450
His tax bracket	33%
Savings	$1,798.50

Example 3: **Angie**

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

Personal savings account	$1,300
Dependent Care FSA	$0
Total contributions	$1,300
Her tax bracket	25%
Savings	-$325

CENTER FOR **EMPLOYEE HEALTH**

We care about you, and that's why we've partnered with Florida Hospital to provide an onsite Center for Employee Health which gives you access to high quality, affordable health care services.

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

Primary Care

- Men's and women's specific health care;
- Chronic disease management;
- Complete annual physicals;
- School and sports physicals;
- Flu vaccines and immunizations;
- Health screening and testing; and
- Laceration care.

Physical Therapy

- Orthopedic conditions; and
- Lower back pain.

Medical Nutrition Therapy

- One-on-one consultations for individualized nutrition and lifestyle plans;
- Eight-week weight management program; and
- Group nutrition classes.

Occupational Health

- Drug and alcohol testing; and
- Workers' compensation.

On-Site Prescription Dispensing

On-Site X-Ray and EKG

Appointments

To make an appointment, just call 407-483-5757 or visit SDOCEmployeeHealthCenter.net.

1-800-638-6420

SDOCEmployeeHealthCenter.net

Address

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

Opening times

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

For a complete list of our wellness resources and events this upcoming school year, please refer to your Wellness Guide.

Got a question? Erin Lysik, our Communications Liaison, is available to answer all your questions concerning the Center. Simply email her at AskErin@FLHosp.org.

MEDICAL INSURANCE
OPT OUT CREDIT

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

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

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

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

Dental premiums			
	HMO	**PPO**	
		Low option	**High option**
	Opt out credit Rate per pay	**Opt out credit Rate per pay**	**Opt out credit Rate per pay**
Employee	$ 0.00	$ 0.00	$ 0.00
Employee + One	$ 6.27	$11.20	$16.90
Employee + Family	$14.62	$27.59	$45.17
Vision premiums			
	Rate per pay		
Employee	$0.00		
Employee + Family	$7.56		

If you chose to take the opt out credit in an FSA contribution only – due to Healthcare Reform Regulations – the District is limited to a $500 contribution. The full $750 contribution can be made by the District if you also contribute a minimum of $375 to your Healthcare FSA.

It's up to you whether you use your opt out credit to purchase dental, vision, and/or disability coverage. If you do, any remaining balance, up to $500, will be deposited into your Healthcare FSA.

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

KEEPING YOU **SMILING**

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

We've provided a comparison of the plans below, but this is only a brief summary. Check out page 3 for more information about the premiums you could pay for these plans and find full details about the plans at **www.deltadentalins.com** or visit the District benefits website.

DeltaCare® USA Dental HMO

DeltaCare USA Dental HMO gives you and your covered family members access to the dental care you need through DeltaCare USA's network of quality dentists.

Each covered family member can choose their own general dentist from the network, from whom you'll need a referral to see any specialist, such as an endodontist, oral surgeon, pediatric dentist, or orthodontist.

Delta Dental PPO

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

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

Coverage comparison

	HMO	**PPO**	
		Low option	**High option**
Network	In-network	In- and out-of-network	
Annual deductible	None	$50 per subscriber, $150 per family	
Annual maximum	None	$2,000 per covered person	
Class 1 - Diagnostic and Preventative			
Routine cleaning	No charge	20%	No charge
Fluoride application			
X-rays			
Sealants	$5	No charge	
Office visit fee			
Class 2 - Basic Restorative Care			
Periodontal maintenance cleanings	$30 for 2 cleanings per year (add'l $55)	40% (Four cleanings a year)	20% (Four cleanings a year)
Amalgam fillings	$10-$20	40%	20%
Surgical extraction of impacted teeth	$45-$100		
Class 3 - Major Restorative Care			
Crowns	$145 - $340	50%	50%
Dentures	$210 - $360		
Bridges	$235 - $360		
Implants	Not covered		
Class 4 - Orthodontics			
Evaluation	$0	Dependent children – 50% Adults – Not covered	Dependent children – 50% Adults – Not covered
Orthodontic treatment	Dependent children – $1,900 Adults – $2,100		
Lifetime orthodontic maximum	N/A	$1,000	$1,000

NEW!

YOUR VISION **OUR FOCUS**

Regular eye exams are an important part of health maintenance, no matter what your age. And if you or your family members wear glasses or contact lenses, you know that the cost of vision care can quickly add up. This year, we are introducing a new vision provider, EyeMed, so you can receive improved coverage at no additional cost to you.

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

For a complete list of in-network providers, visit www.eyemed.com or call 1-866-804-0982.

The District receives services on the Insight network.

Summary of benefits

Exam with dilation as necessary (once every 12 months)	$10 Co-pay
Frames (once every 24 months)	$0 Co-pay; $130 allowance; 20% off balance over $130
Single Vision Lenses (once every 12 months)	$15 Co-pay
OR	
Contacts (disposable, once every 12 months)	$0 Co-pay; $120 allowance; plus balance over $120

Still not sure if it's worth electing vision coverage?

Joshua has Employee coverage and needs an eye exam during the year.

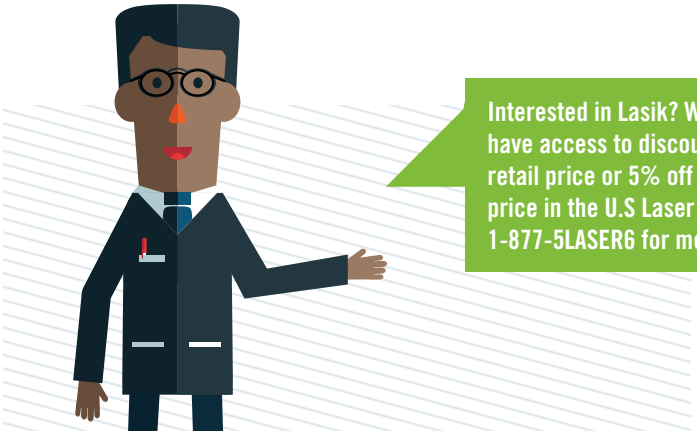
He visits an in-network provider and is told he needs a new pair of glasses. As he leads an active life, he chooses to add UV treatment and scratch coating to his lenses.

We've summarized his costs here, compared to if he did not have coverage with EyeMed.

		With EyeMed	**Without insurance***
Exam		$10 Co-pay	$106
Frame		$163 – $130 allowance = $33 – $6.60# =$26.40	$163
Lens	Lens	$15 Co-pay	$78
	UV treatment	$15	$23
	Scratch coating	$15	$25
Total		$81.40	$395
Annual premium		$73.40	$0
Final cost		**$154.80**	**$395**

#20% discount off balance.

*Based on industry averages.



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

PROTECTING YOUR WORLD

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

Basic Life and AD&D Insurance

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

Supplemental Life Insurance

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

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

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

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

For more information about these benefits:

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

Premiums are based on your salary or salary schedule, and did increase for 2018 so please review your elections carefully. Visit the Benefits Enrollment System for specific rates.

NEW!

Disability Insurance

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

You have three considerations when electing coverage:

1. How much coverage do you need?

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

2. When would you want coverage to start?

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

3. How long will coverage last?

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

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

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

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

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

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

For more information about these benefits:

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

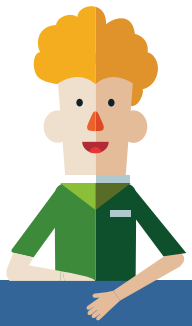
Universal LifeEvents® Insurance

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

If elected, you'll receive coverage for:

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

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



You can contact Trustmark Customer Care if you want to cancel or decrease existing coverage, drop a dependent from an existing plan, surrender an existing Universal LifeEvents policy, request policy information, or change the information on your existing policy (address, name, beneficiary information) by calling 1-800-918-8877.

Primary Care

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

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

Living benefits

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

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

Accident Insurance

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

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

- Hospital Admission;
- Hospital Confinement;
- Hospital Intensive Care Unit; and
- Emergency Room Treatment.

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

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

	Rate per pay
Employee	$10.40
Employee + Spouse	$16.08
Employee + Children	$24.75
Employee + Family	$30.43

HOW TO ENROLL

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

1. Call **888-815-3949**
2. Email **osceolaschools@simplenroll.net**
3. Visit **www.selectmybenefitsnow.com**

Username: SDOC and the last 4 digits of your SSN (example: SDOC1234)

Password: Date of birth MMDDYEAR (example: 07081989)

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

Tax Sheltered Annuities

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

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

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

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

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

You can contribute to the following investment vehicles:

Fixed interest and variable annuities

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

Service-based mutual funds and custodial accounts

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

No-load/low-fee mutual funds

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

For an up-to-date listing of agents who can help you select the best product to help you reach your financial goals, visit http://osceolaschools.net/departments/risk_and_benefits_management/tax_sheltered_annuities/

This website also has information if you wish to suspend a current deduction and the Salary Reduction Form.

Employee Assistance Program (EAP)

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

As a District employee, you and any immediate family members living in your home have access to a number of services, all at no cost, including:

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress;
- Grief, loss and life adjustments; and
- Relationship/marital conflicts.

You can receive ten counseling sessions per person, per issue, per year as part of this service.

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care;
- Hiring movers or home repair contractors; and
- Planning events, locating pet care.

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including divorce, adoption, family law, wills, trusts and more.

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes;
- Relocation, mortgages, insurance; and
- Budgeting, debt, bankruptcy.

All of these services and more are available to all employees and immediate family members at no cost to you, strictly confidential and accessible 24 hours per day, 365 days per year.

Contact information:

888-882-0797

800-697-0353 (TTY)

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

GuidanceResources® Now

OTHER **INFORMATION**

Leaves of Absence

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

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

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

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

The Family Leave Medical Act (FLMA)

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

- The birth of a child;
- Adopting a child or becoming a foster parent;
- Caring for a seriously ill spouse, child or parent;
- A serious health condition;
- Caring for a covered service member who is recovering from a serious illness or injury sustained in the line of active duty; or
- 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.

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

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

COBRA Continuation of Coverage

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

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

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

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

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

End of school year insurance end dates

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

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

- **You resign at the end of the current contract** – If you would have been reappointed for the coming year, but you know you will not be returning for the new contract year, you can resign your position now and have insurance benefits available to you until August 5, 2018.
- **You would have been reappointed; however, a position is not available due to a reduction in force (RIF)** – Benefits will terminate August 5, 2018.
- **You are granted an LOA for the coming year** – Your benefits will continue until August 5, 2018. Employees on LOAs will then have the option of keeping their benefits during the leave. A letter detailing insurance options will be sent to the LOA employee automatically.
- **You retire at the end of your current contract** – Your benefits will remain in effect until August 1, 2018. Retirees will then have the option of keeping their benefits. A letter detailing insurance options will be sent to the retiree automatically.

Your benefits will terminate immediately if:

- **You resign your position before the end of your current contract** – Your insurance benefits will terminate on your last day.
- **Your employment is terminated by the District (except for RIF employees as noted above) at the end of your current contract** – Your insurance benefits will terminate the day your contract ends as follows:

187 & 188 Day Employees	May 24, 2018
196 Day Employees	May 25, 2018
197 Day Employees	May 30, 2018
200 Day Employees	June 01, 2018
217 Day Employees	June 13, 2018
230 Day Employees	June 21, 2018
11 Month "A" Employees	June 14, 2018
11 Month "B" Employees	June 21, 2018
12 Month Employees	June 29, 2018

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.

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

Section 125

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

ANNUAL **NOTICES**

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

HIPAA Special Enrollment Rights

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

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

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

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

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

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

Florida Medicaid

Website: **www.flmedicaidtplrecovery.com**

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

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

U.S. Department of Labor
Employee Benefits Security Administration

Website: **www.flmedicaidtplrecovery.com**

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

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

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

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

Section 111

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

Women's Health and Cancer Rights Act of 1998

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

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

Newborns' and Mothers' Health Act

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

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

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

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

The exemption from these Federal requirements will be in effect for the 2017-18 plan year beginning 10/1/17 and ending 9/30/18. The election may be renewed for subsequent plan years.

HIPAA Privacy Act Legislation

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

Patient Protection

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

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

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

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

KEY CONTACTS

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

Medical	CIGNA Member Services (includes FSA)	1-800-244-6224 www.mycigna.com
	CIGNA Online Provider Directory	www.cigna.com
	CIGNA Technical Support	1-800-284-8346
	CIGNA Home Delivery Pharmacy (Mail Order)	1-800-835-3784
	CIGNA Behavioral	1-800-274-4573 www.cignabehavioral.com
Center for Employee Health	Florida Hospital	407-483-5757 SDOCEmployeeHealthCenter.net
Dental	Delta Dental	HMO: 1-800-422-4234 PPO: 1-800-521-2651 www.deltadentalins.com
Vision	EyeMed	1-866-804-0982 www.eyemed.com
Life and AD&D	MetLife	1-800-638-6420 www.metlife.com/mybenefits
Universal LifeEvents Accident Insurance	Trustmark	1-800-918-8877 www.trustmarkins.com
Disability	Lincoln	1-800-423-2765, prompt 1 www.lincolnfinancial.com
Retirement benefits	Florida Retirement System	1-866-446-9377 myFRS.com
EAP	ComPsych	888-882-0797 800-697-0353 (TDD) guidanceresources.com (web ID: OCSOCS)
Worker's Compensation Linda Scheuer		407-870-4057; Internal Extension 67598 workcomp@osceola.k12.fl.us
Johns Eastern Company, Inc.		1-800-749-3044

RECORD YOUR CHOICES

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

Medical:

	Plan type
☐	Local Plus
☐	Wellness Local Plus
☐	Wellness Open Access Plus

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

☐ **Healthcare FSA:**

$ _____ per year

☐ **Dependent Care FSA:**

$ _____ per year

Basic Life and AD&D Insurance: ✔ $0

Supplemental Life Insurance:

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

Accident insurance:

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

Dental:

	Plan type
☐	DeltaCare® USA Dental HMO
☐	Delta Dental PPO (Low option)
☐	Delta Dental PPO (High option)

	Coverage level
☐	Employee
☐	Employee + One
☐	Employee + Family

Vision:

☐	Employee
☐	Employee + Family

Disability insurance:

Monthly benefit amount $ _____

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

Tax Sheltered Annuities:

$ _____ per _____

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

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

Risk and Benefits Management	407-870-4899 http://osceolaschools.net/departments/risk_and_benefits_management insurance@osceola.k12.fl.us
Onsite CIGNA Representative **Pam Aguiar**	407-870-4900; Internal Extension 67559 PAguiar@osceola.k12.fl.us
4theHealthofit! **Brittany Dixson, Cigna Wellness**	407-870-4840 CignaW@osceola.k12.fl.us
COBRA Administrator **Discovery Benefits**	1-866-451-3399 (then, option 1 and option 2)

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