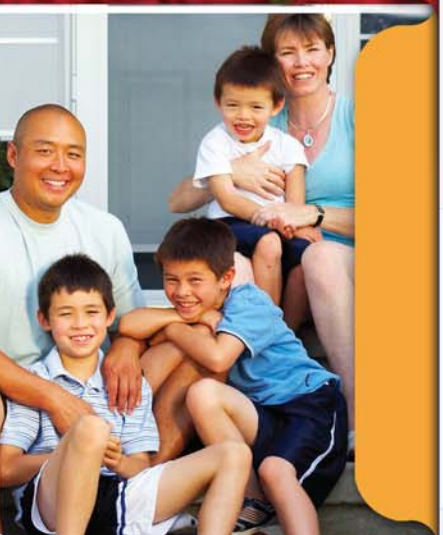
BENEFITS GUIDE

Professor POHP and the Quest for Savings

Volume: 2010-2011



Superintendent's Message

Dear District Employees,

Welcome to a new school year and a new opportunity to enroll in your benefit plans.

I'd like to introduce you to someone who will become increasingly familiar as the year goes on: **Professor POHP** (which stands for **P**rotect **O**ur **H**ealth **P**lan). She is a teacher here in the district and has been charged with helping you to understand your benefits and use them wisely, so that you can save money.

Please read through this benefits guide to learn about some changes to our plans. As you review the medical section, pay close attention to the In-Network Plus Plan. This is now the low-cost plan and may save you money. If you're currently enrolled in the Choice Fund HRA, be sure to compare the costs and services to determine which plan is better for you and your family.

This year, we are holding an active enrollment, meaning you must enroll online to select the plan you prefer, even if you want to continue your same exact plan. If you don't identify a selection online, your medical coverage will default to the Plus In-Network Plan with employee-only coverage. So please take the time to make an active choice and ensure that you'll have the benefits you want and need in the coming year.

While you're thinking about ways to save yourself money, consider this: staying healthy is the best way to save money. Take care of yourself all year long by maintaining a healthy weight, eating right, and being physically active. And use your free in-network preventive care benefits to detect problems early when they are easier to treat rather than having to endure the expense and suffering associated with treating a serious illness or complication.

Your benefits are a major component of the compensation you receive from the district. I encourage you to take the time to Learn, Plan, Enroll, and Use Wisely.

I wish you a safe and healthy school year.

Michael A. Grego, Ed.D.
Superintendent

FIT-FRIENDLY COMPANY • FIT-FRIENDLY COMPANY • FIT-FRIENDLY COMPANY • FIT-FRIENDLY COMPANY
start!

American Heart Association
Learn and Live
2010 PLATINUM ACHIEVEMENT

This workplace has been recognized by the American Heart Association for meeting criteria for employee fitness



What's Inside

Welcome to *4 Your Benefit*

Open Enrollment

September 3 to September 17, 2010

Benefits Effective:
October 1, 2010

Plan Year:
October 1, 2010 to September 30, 2011

See page 4 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.



Welcome to 4 Your Benefit 2010 - 2011

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 40. 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's New?

Overview

- **Mandatory Enrollment:** You must actively enroll to make sure you get the coverage you want in the new plan year. Unless you enroll in a medical plan or opt out of medical insurance, you will automatically default into the Plus In-Network Plan with employee-only coverage.
- **New! Employee-Only "Free" Plan:** The Plus In-Network Plan will become the "free plan" for employee-only coverage and offer lower premiums for dependent coverage than the Choice Fund HRA. While the deductible is lower, your share of coinsurance will be higher. In addition to becoming the free plan, other plan changes include:
  - **Lower Deductible:** You will only pay $100 for employee-only coverage or $200 for family coverage (compared to $300 and $600, respectively, last year) before you and the plan start paying coinsurance.
  - **Higher Coinsurance:** You will pay 30% coinsurance instead of 10%.
  - **No charge** for eligible preventive care services. **This means wellness visits are now covered at 100% with no cost to you.**
  - See pages 9-15 for more details.
- **Caution: If you are now enrolled in the Choice Fund HRA:**
  - And you want to stay enrolled in this plan, you must actively enroll online or you will default into the Plus In-Network Plan with employee-only coverage.
  - The amount you can roll over from your 2009-2010 HRA to your 2010-2011 HRA is now $1,500 for employee-only and $3,000 for family.
- **Medical plan premiums have changed** for both plans. See page 9.
  - **Board Contributions:** The Board Contribution in the amount of $305.40 per-pay period will continue for employee-only medical coverage. It's the Board's Contribution that allows your premiums to be free if you enroll in the Plus In-Network Plan with employee-only coverage, or only $25 per-pay period if you enroll in the Choice Fund HRA with employee-only coverage. While the District continues to subsidize dependent coverage for the Plus In-Network Plan, you will pay a larger share of the cost of dependent coverage for the Choice Fund HRA.
- **New rules for adult dependent medical insurance coverage:** If you have adult dependent children ages 19 to 30, please read pages 5-6 carefully to understand the coverage options available to you.
- **New Medical Insurance Opt-Out Credit:** The Alternative to Medical Plans option is being eliminated and replaced by an annual opt-out credit equal to $750.
  - If you are currently enrolled in either the Hospital Indemnity Plan or Disability Protection Program, your coverage will end at midnight on September 30, 2010.
  - You can use the Opt-Out Credit to purchase certain pretax benefits, fund a Health Care Flexible Spending Account (FSA), or a combination of both. See page 14.
- **MetLife is replacing CIGNA as the dental plan administrator**. You will notice lower premiums for DHMO and minimal changes to your three dental options. See page 16 to learn more about your dental coverage.
- The District will continue to offer **disability insurance** to employees but regrets there will be a 10% increase in rates this year.
- During this Open Enrollment, you will have a **one-time opportunity** to enroll in Supplemental Life Insurance without Evidence of Insurability (EOI).



Welcome Professor POHP

Professor POHP (which stands for **P**rotect **O**ur **H**ealth **P**lans and is pronounced "POP") may be the newest member of our staff, but she sure knows a lot about our benefit plans and ways to save money. In fact, she's a bit of a know-it-all, but we think you'll like her anyway, especially when she shares her money-saving ideas.

Like all superheroes worth their salt, Professor POHP has a nemesis … someone who tries to derail her efforts and waste the District's money. Watch out for **Mr. FLOP** (**F**inancial **L**oss **O**n **P**lans) and be alert to his dastardly ways.

Meanwhile, Professor POHP is here to guide you through open enrollment season and help you to protect our plans all year long. Look for her throughout this Guide for money-saving ideas.

A District Employee Asks:

Dear Professor POHP,

Why is the District self-insured?
And what the heck does self-insured mean anyway?

Professor POHP Answers:

It's simple really. Being self-insured means that the District sets aside a pool of money to pay the insurance claims for all of its employees. Any time you pay premiums (payroll deductions) for coverage, it goes into this pool along with the District's money. The District then uses this money to pay a share of your costs for health services.

So the less money we pay to doctors and other health care providers and prescriptions, the less money the District spends. That means it pays to shop around and always use network providers.

Why should we care how much the District spends? Because the less money the District spends on health care, the more money it has for our salaries and other benefits that help to make our work and personal lives easier.

I'm doing my part to save the District money. Are you? (Look for lessons throughout the Guide for more money saving ideas.)

Just FYI, the opposite of self-insured is fully insured. If we were fully insured, we would be paying a higher amount to the insurance company because they want to make some profits.

Today's Lesson Review: *If you don't think one person can make a difference, think again. When you save money, we all save – and that's money that can be spent on something else – like our salaries and programs to benefit our students!*



Eligibility and Effective Dates

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

- Medical Insurance
- Medical Insurance Opt-Out Credit
- Dental
- Vision
- Wellness Incentive
- Flexible Spending Accounts
- Employee Assistance Program
- Life Insurance
- Disability Insurance
- Tax-Sheltered Annuities

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.

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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 Benefits Corner.

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.

Take Action to Avoid Default Coverage

If you do not enroll in benefits by the appropriate deadline, you will automatically be enrolled in the Plus In-Network Plan (employee-only) and Board-paid Term Life Insurance. You will not be able to re-enroll until the next Open Enrollment unless you experience a qualified change-in-status event (see page 8).



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, 2010 through September 30, 2011.

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Proof of dependent status (legal guardianship or adoption, for example) is required to enroll eligible dependent children.

Eligible dependents are defined as:

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

Covering Dependent Children

The following criteria on the next page do not apply to adult dependent children who are mentally or physically incapable of supporting themselves. These children may qualify for coverage at any age by virtue of their incapacitation, as long as they became incapacitated prior to age 26 or 30 (See page 6).

$mart Tip!

Open Enrollment Resources

Medical:
1-800-401-4041
Monday - Friday,
7:00 a.m. - 9:00 p.m.
mycignaplans.com
ID: OsceolaSchools
Password: cigna

Dental PPO:
www.metlife.com/mybenefits
ID: School District of Osceola County

Dental HMO:
www.metlife.com
- Go to "Find a Dentist"
- Select Dental HMO
- Enter your ZIP Code
- Select SGX185A



Dependent Eligibility (cont'd)

Medical Plan Coverage

Through Age 26

Under the Health Care Reform Act, you may now cover your eligible adult dependent children up to age 26, regardless of marital, financial, or student status (this does not include spouses of adult children) and only if they are not eligible for coverage under their employer's group health insurance.

If you were previously denied coverage for your adult dependent child(ren) due to IRS guidelines, you will have a special 30-day enrollment window during the 2010-2011 Open Enrollment. Please contact Risk and Benefits Management **before September 3, 2010** to enroll your adult dependent child(ren).

Age 26 Through 30

Florida law allows employees enrolled in a District-sponsored medical plan to cover their adult dependent children, age 26 through the end of the year in which they turn 30. To qualify for this extended coverage, your adult dependent child must meet **all** of the following eligibility criteria. Your adult dependent child must:

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

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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."

Other Plans Offering Dependent Coverage (Dental, Vision, and Life Insurance)

Dependent eligibility varies by plan. Please refer to the summary plan descriptions for specific information on each plan.

- **Dental and Vision.** Coverage will cease at the end of the year in which your enrolled dependent children reach age 26.
- **Universal Life Insurance.** You can apply for coverage until your dependent children reach age 17, or at the end of the year in which they turn age 24 if dependent is a full- or part-time student and attends an accredited school, college, or university, and is dependent upon you for support. **Note:** Once your dependent is enrolled in the plan, coverage will not cease due to age.

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 8 for Section 125 and Benefit Changes or contact the Benefits Specialist assigned to your facility at 407-870-4899.



Paying for Your Benefits

Your 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 the 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 the Opt-Out Credit	Pretax or After-Tax, your choice
Medical Insurance Opt-Out Credit	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 (Choice Fund HRA 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 for the 2010 - 2011 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 Plus In-Network 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 Choice Fund HRA, you will pay a small premium (see page 9).

Medical Insurance Opt-Out Credit: The opt out credit is 100% funded by the Board Contribution.

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
- Voluntary or involuntary loss of other qualifying coverage or gaining other group coverage
- Your eligible child(ren) lose coverage under a federal or state-sponsored health program like Florida KidCare

* *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.

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The Value of Your SDOC Benefits

To maximize the value of your benefits package, you need to make good choices. The District pays a significant portion of the medical insurance premiums and 100% of the cost for basic life insurance. The Board Contribution alone equals $6,108 a year in addition to your salary!

Effective Date Following a Qualifying Event

Your benefits effective date following a qualified status change is the first month after paperwork is received and online enrollment is completed.

Medical Benefits

SDOC offers a choice of two medical plans: the Open Access Plus In-Network Plan **(Plus In-Network Plan)** and the Choice Fund Health Reimbursement Arrangement Open Access Plus Plan **(Choice Fund HRA)**. 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 12 as well as the Plan section of this Guide (pages 29-37) to also help you decide which plan is right for **you**.

Medical Plan Premiums - 20 Pays

Coverage Level	Plus In-Network Plan	Choice Fund HRA
Employee	$0	$25
Employee + Spouse	$229	$251
Employee + Child(ren)	$127	$259
Employee + Family	$315	$505
Half-Family Primary	$95	$259
Half-Family Secondary	$0	$0
Each Adult Dependent child age 26-30	$229	$251

Plus In-Network Plan

No Premiums for Employee-Only Coverage!

The Plus In-Network Plan is the "free" plan. If you elect employee-only coverage, you will have no payroll deductions for medical insurance. This is also the plan that you will default into (employee-only coverage) if you do not actively enroll, so it is recommended that you review the plans carefully and make an informed decision.

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

$mart Tip!

If You Waive Coverage

If you have other medical coverage, you can opt out of the District's medical insurance. When you waive coverage, $750 will be allocated to pay the employee-portion of certain pretax benefits, such as dental, vision, and disability insurance and/or to fund a Health Care Flexible Spending Account (FSA). If you do not already have a Health Care FSA, one will be opened for you for this purposes.

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 ($100 employee-only; $200 family), you pay coinsurance equal to 30% 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.
5. Although there is no out-of-network coverage, the Plus In-Network Plan uses a national provider network. This means you will be able to find in-network doctors and other health care providers like hospitals and labs across the country. You can access the Plus In-Network provider directory online at *www.mycigna.com* or by calling CIGNA Member Services at 1-800-244-6224.

* *Please read page 15 to understand your prescription drug coverage under the Plus In-Network Plan.*



Choice Fund Health Reimbursement Arrangement (HRA) Open Access Plus

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

The Choice Fund HRA uses the same network as the Plus In-Network Plan. However, with the Choice Fund HRA you can use any provider, in- or out-of-network. With the Open Access feature of both plans, you do not need referrals to see a specialist. (You will pay less when you use in-network providers.)

A District Employee Asks:

Dear Professor POHP,

What's the big deal if I don't enroll. All plans are basically the same, aren't they?

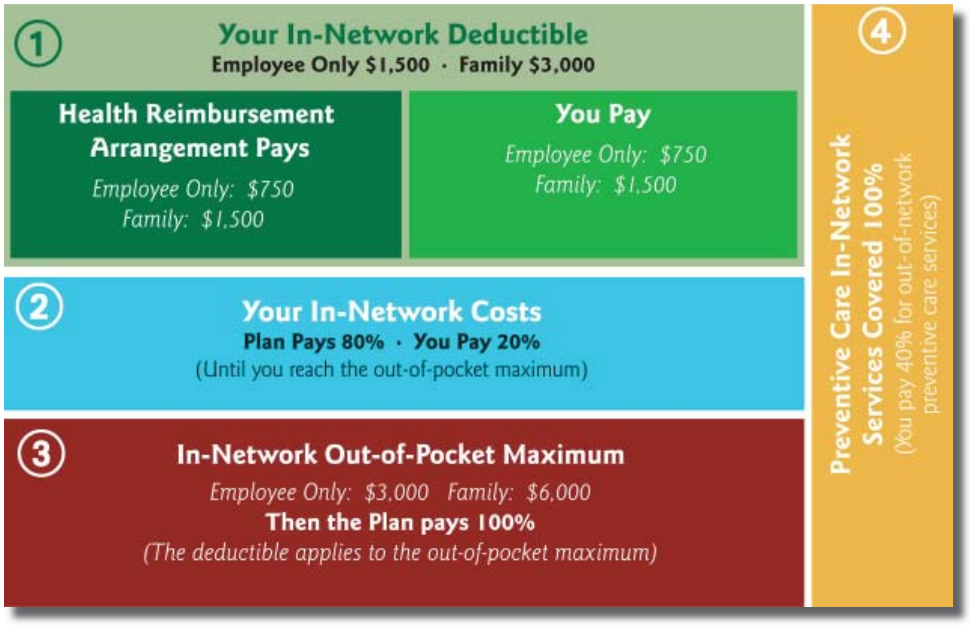
Professor POHP Answers:

Au contraire, my fellow employee. All plans are not equal. Sometimes you will pay more up front in terms of insurance premiums. Sometimes you'll pay more when you use a service through copays and coinsurance. Plans like the Plus In-Network do not offer out-of-network coverage, while the Choice Fund HRA lets you see any doctor, in- or out-of-network. (Hint: Out-of-network providers are more expensive.)

So don't be caught off guard. Read up on the medical plans by going to pages 9-15. Taking extra time now will save you a surprising amount of money throughout the year.

Today's Lesson Review: If you don't think one person can make a difference, think again. There are about 6,100 employees enrolled in a District medical plan. If each of you saves just $10 a year, the District could save $61,000 – and that's money that can be spent on something else – like our salaries and programs to benefit our students!

How the Choice Fund HRA Works In-Network



1. Your In-Network Deductible

The first half of your deductible is paid using the money in your Health Reimbursement Arrangement (HRA) 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 equal to half your deductible into an HRA 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 HRA and applied to your deductible.

Once your HRA 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 has been met.

If you don't spend all the money in your HRA 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 HRA balance cannot exceed $1,500 for employee-only coverage or $3,000 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 the network, you will pay 40% of reasonable and customary charges. You will always pay less for in-network care. See the $mart Tip at the bottom of page 13.

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 plan 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. If you choose to go out of network, the plan pays 60% of your covered preventive care.



Medical Plan Benefits At a Glance

Benefit	New! Plus (70/30) In-Network Plan	Choice Fund HRA	
	In-Network Only	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	$100 Individual $200 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 Family (includes deductible)	$6,000 Individual (includes deductible) $12,000 Family (includes deductible)
Lifetime maximum	Unlimited	Unlimited	
Physician services			
• Office visits	30% after deductible	20% after deductible	40% after deductible
• Specialist	30% after deductible	20% after deductible	40% after deductible
• Preventive Care: Mammograms, PSA, PAP Test	No charge for covered services	No charge for covered services	40% after deductible
• Other Preventive Care	No charge for covered services	No charge for covered services	40% after deductible
Emergency services, including urgent care facilities[1]	30% after deductible	20% after deductible	20% after deductible
Hospital services[2]	30% after deductible	20% after deductible	40% after deductible
Laboratory and radiology[3]	30% after deductible	20% after deductible	40% after deductible
Short-term rehab and chiropractic[4]	30% after deductible	20% after deductible	40% after deductible
Maternity[5]	30% after deductible	20% after deductible	40% after deductible
Pre-certification requirements[6]	Coordinated by your physician	Coordinated by your physician	Member's responsibility[7]

* *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 4). For example, if your benefits effective date is January 1, your HRA will be prorated over nine months (January 1- September 30).*

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.*

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).

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Need Help Dealing With Life's Challenges? Call the EAP

All District employees and members of their household are eligible for the Employee Assistance Program (EAP). Offered through Horizon Health, this free confidential program gives you access to professionals who can help you with life's challenges. See page 57 in the Use Wisely section for details and contact information.

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 54-55 in the Use Wisely section for more information.

$mart Tip!

A Note About Prescription Drug Coverage

Prescription drug coverage is included with your medical plan premium. See page 15 for details.

$mart Tip!

Use In-Network Providers and Save

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

Choice Fund HRA In-Network	Choice Fund HRA 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.)



Medical Insurance Opt-Out Credit

"Opting out" means you may choose to decline medical coverage for yourself and your family. Only employees who are covered under another medical plan, either as a dependent or through individually acquired coverage, can select this option. For example, you might consider opting out of medical insurance if your spouse has elected family medical coverage through his or her employer, or if you are covered under another medical plan. **Please note, active employees eligible for Medicare cannot opt-out of medical insurance. Those active employees must choose one of the two medical plan options available.**

You may opt out only when: enrolling for the first time as a new employee; as a current employee during Open Enrollment for the next plan year, or when you have an approved qualifying change in status. Your opt-out election will remain in effect through September 30, 2011 unless you or a qualified dependent experience an approved qualifying change in status event.

The Benefits of "Opting Out"

When you opt out, you will receive up to a $750 annual credit which you may apply toward voluntary pretax benefits, such as dental employee-only coverage, vision employee-only coverage, a Flexible Spending (FSA), and disability insurance. (**This is not a cash payout and can be used only for eligible expenses.** 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 pretax payroll deductions.)

If you do not purchase voluntary pretax benefits or have a remaining balance after choosing voluntary pretax benefits using your credit, the money will automatically be deposited into a Health Care FSA that the District sets up for you. You can be reimbursed from your Health Care FSA for eligible expenses not covered by a health plan. Please see page 23 for more information about the Health Care FSA.

Today's Lesson: Saving Money on Prescriptions

A District Employee Asks:

Dear Professor POHP, I love your ideas for saving money, but sometimes it's just not possible, like when your doctor prescribes an expensive medicine. What can I do about that?

Professor POHP Answers:

I am so glad you brought that up! There are almost always ways to save money and prescription drugs are no exception.

1. *First, tell your doctor that you can save some serious cash if he or she writes the prescription for a generic instead of a brand-name drug.*
2. *If the drug isn't available as a generic, don't fret. There's a website you can visit to find out where and how to get your prescription at a lower cost. Visit NeedyMeds.org, a nonprofit group that is not affiliated with any drug companies.*
3. *If you take a maintenance (ongoing) prescription, use our CIGNA Home Delivery Pharmacy to get a 90-day supply for a reduced copay.*
4. *If you're getting a generic antibiotic prescription filled, go to Publix. That's right, Publix. The grocery chain offers many common generic antibiotics for free!*
5. *Competition for your dollar is fierce, and other retail chains like Target and Wal-Mart offer a 30-day fill of some medications for $4, and a 90-day supply for $10.*
6. *Bottom line: Shop around!*

Today's Lesson Review: *If you don't think one person can make a difference, think again. Remember those 6,100 medical plan members? If each member has just one prescription filled using a generic instead of a preferred brand, they would save $18 per prescription, and the District would save thousands of dollars – and that's money that can be spent on something else – like our salaries and programs to benefit our students!*

Prescription Benefits

When you enroll in either CIGNA 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.
- 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 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 Home Delivery Pharmacy is part of your prescription benefits. CIGNA Home Delivery Pharmacy 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.mycigna.com*. To switch your current prescription, call CIGNA Home Delivery Pharmacy toll-free at 1-800-285-4812, Option 1.

Prescription Drug Coverages (In-Network Only)

Drug Tier (Level)	30-day supply	90-day supply
Generic	$10 copay	$25 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 MetLife dental plans described in this Guide. MetLife 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.

MetLife/SafeGuard DHMO

When you enroll in the MetLife/SafeGuard DHMO, you and your covered family members can access the dental care you need through MetLife'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 any specialist, such as an endodontist, oral surgeon, 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.
- Up to four cleanings per year: two at no charge; two additional at low cost for adults and children.
- Discounts on complex procedures.
- Specialty care provided at the same fee as general care with an approved referral.
- Orthodontic benefits for adults and children.
- Teeth whitening covered.

MetLife PPO

When you enroll in the MetLife PPO, you and your covered family members can access the dental care you need through MetLife'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.

MetLife 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 MetLife'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 19 or younger.
- New in 2010-2011, implants now covered at 50%.

Dental Premiums - 20 Pays

Coverage Level	DHMO	DPPO	
		Low Option	High Option
Employee	$7.51	$10.79	$17.65
Employee + One	$13.14	$22.11	$36.19
Employee + Family	$20.65	$38.66	$63.32
Employee Opt-Out*	$0.00	$0.00	$0.00
Employee + 1 Opt-Out*	$5.63	$11.33	$18.54
Employee + Family Opt-Out*	$13.14	$27.88	$45.67

* *This is the premium you will be responsible for if you elect the Medical Insurance Opt-Out Credit and Dental Coverage. See page 14 for more information.*

New Dental Plan Comparison Chart

Benefit	MetLife/SafeGuard DHMO*	MetLife Dental PPO PPO High Option In-Network	PPO High Option Out-of-Network**	PPO Low Option In-Network	PPO Low Option Out-of-Network***
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/calendar year)	No charge	No charge	No charge	20%	20%
Sealants	No charge	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					
Periodontal Maintenance Cleanings	$30 for 2 cleanings per year (add'l $55)	20% for 4 cleanings per year		40% for 4 cleanings cleanings per year	
Amalgam Fillings	No charge	20%	20%	40%	40%
Surgical Extraction of Impacted Teeth	$45-$100 (depending on complexity)	20%	20%	40%	40%
Class III • Major Restorative Care					
Crowns	$335 - $410†	50%	50%	50%	50%
Dentures	$210 - $365†	50%	50%	50%	50%
Bridges	$335 - $410†	50%	50%	50%	50%
Implants - NEW!	Not covered	50%	50%	50%	50%
Class IV • Orthodontics					
Dependent Children					
Evaluation	$0	50%	50%	50%	50%
Orthodontic Treatment (24 month routine)	$1,695	50%	50%	50%	50%
Adults					
Evaluation	$0	Not covered		Not covered	
Orthodontic Treatment (24 month routine)	$1,695	Not covered		Not covered	
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*

† *Includes lab fees*

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.

1-800-880-1800 for the DHMO • 1-800-942-0854 for the PPO



Choosing a Dental Plan

Does the DPPO offer any discounts on non-covered services?

Yes. MetLife's negotiated fees with DPPO (in-network) dentists extend to services not covered under your plan and services received after your plan maximum has been met. If you receive services from a DPPO dentist that are not covered under your plan, you are only responsible for the DPPO (in-network) fee.

Can I find out what my out-of-pocket expenses will be before receiving a service?

Yes. With pre-treatment estimates, you never have to wonder what your out-of-pocket expense will be. MetLife recommends that you request a pre-treatment estimate for services in excess of $300 (This often applies to services such as crowns, bridges, inlays, and periodontics.) To receive a benefit estimate, simply have your dentist submit a request for pre-treatment estimate online at *www.metdental.com* or call 1-877-MET-DDS9 (1-877-638-3379). You and your dentist will receive a benefit estimate (online or by fax) for most procedures while you're still in the office, so you can discuss treatment and payment options, and have the procedure scheduled on the spot. Actual payments may vary depending upon plan maximums, deductibles, frequency limits, and other conditions at time of payment.

Find a Provider

As you consider enrolling in one of the new MetLife dental options, consider if your current provider is in the MetLife network or locate a provider near you.

For the Dental HMO (DHMO):

- Go to *www.metlife.com*
- On the right side menu, select "Find a Dentist"
- Then select Dental HMO and enter your ZIP code
- To continue, select SGX185A

For the Dental PPO:

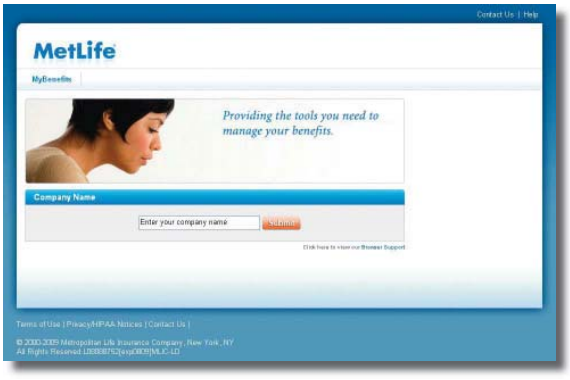
- Go to *www.metlife.com/mybenefits*
- Enter School District of Osceola County under Company Name and click Submit (no password required)

MetLife.com/MyBenefits

MyBenefits provides you with a personalized, integrated, and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information including planning tools and oral health awareness material.

- View, manage, and understand your benefits from work or home
- Quick and easy registration to use MyBenefits — it's safe & secured
- A homepage with access to personalized information and easy-to-read summaries of your dental benefits selection
- E-mail notifications that will keep you informed of claims and
  - important updates to your dental benefits information
- Provider lookup
- ID card download function

www.metlife.com/mybenefits



Vision Benefits

The SDOC offers you the option of purchasing vision insurance through Humana Specialty Benefits. When you enroll, you will choose a provider from the Humana Specialty Benefits 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.

Vision Care Premiums - 20 Pays

Coverage Level	Employee Cost
Employee	$3.85
Employee + Family	$11.77
Employee Opt-Out*	$0.00
Employee + Family Opt-Out*	$7.92

* *This is the premium you will be responsible for if you elect the Medical Insurance Opt-Out Credit and Vision Coverage. See page14 for more information.*

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 Specialty Benefits 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 Specialty Benefits Customer Care Department at 1-800-865-3676 or visit *www.compbenefits.com*.

	Vision Care Services	
Benefit	**In-Network**	**Out-of-Network**
Vision Exam	$10 copay	$35 reimbursement after copay
Materials Copay		
	$15 copay for lenses / frames	
Standard Lenses		
Single Vision	$15 copay	$25 reimbursement after copay
Bifocal	$15 copay	$40 reimbursement after copay
Trifocal	$15 copay	$60 reimbursement after copay
Frames		
	$15 copay	$45 reimbursement after copay
Contact Lenses		
Electives	Select brands: Covered at 100%* Outside brands: $120 allowance	$120 allowance
Medically Necessary (pre authorization required)	Covered at 100%	$210 allowance
Frequency		
Exams	Every 12 months	
Lenses or Contact Lenses	Every 12 months	
Frames	Every 24 months	
Other services		
Lasik	Special rates and discounts available when benefits accessed through preferred providers	

* *Visitint, Ciba, Optima 38, Wesley 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.

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

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, this year is a **one-time opportunity** to increase your coverage without submitting EOI. For more information, contact UNUM or the R&BM office.

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 and will be subject to a **10% increase** for the 2010-2011 plan year.

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 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.

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It is important to note that if you pay for your disability premium using the tax-free credit or through pretax payroll deductions and become disabled, any disability premiums you receive will be considered taxable income. If you elect to purchase disability insurance using after-tax payroll deductions, then any benefits you receive will not be taxable. Please consider the impact of paying premiums pretax vs. after tax before making your election.



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 injury or sickness 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.

There are three beneficiary designations for your policies:

1. You need to designate a beneficiary for the life insurance policy that the District provides.
2. You need to designate a beneficiary for the AD&D portion of your disability insurance, if you elect this coverage.
3. If you elect disability insurance, the beneficiary designation for the disability portion of that insurance is an automatic designation and goes to your surviving spouse (or children, if no spouse). No action required. See policy for more information.

Flexible Spending Accounts (FSAs)

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.

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.

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 36 to help you calculate your contribution amount.

Annual FSA Contribution Amounts

Health Care FSA (eligible health (care expenses)	• $240 minimum up to $4,000 maximum
Dependent Care FSA* (eligible day care and adult or elder care)	• 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.

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New OTC Regulations

Effective January 1, 2011 and in accordance with the Patient Protection and Affordable Care Act (PPACA) signed into law on March 30, 2010, individuals will be **prohibited from using a Health Care FSA for the cost of over-the-counter (OTC) medications** that are not prescribed by a physician.

You can still be reimbursed from your Health Care FSA for expenses the IRS considers a deductible medical expense if it's not reimbursed by your health insurance. Some examples of eligible expenses include deductibles, coinsurance, copays, bandages, contact lens solution, and other expenses that are not paid by your insurance. For a current list, go to *www.cigna.com/expenses*.

Note: Contact CIGNA for claims filing deadlines and other questions about OTC medications.

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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 FSA.

$mart Tip!

FSA 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"



Today's Lesson:
Getting the Most Out of Your Health Care FSA

A District Employee Asks:

Dear Professor POHP,

I'm thinking about enrolling in a Health Care Flexible Spending Account. Do you think it's a good idea?

Professor POHP Answers:

If you have medical, dental, and vision expenses that won't be covered by your medical, dental, and/or vision insurance in the year ahead, it's a smart idea to pay for them using a Health Care FSA since an FSA helps you save on your taxes. Once you choose your benefit plans, take the time to estimate what your eligible out-of-pocket expenses will be.

Anything that the IRS considers a deductible medical expense can be reimbursed from your Health Care FSA if it's not reimbursed by your health insurance. Some examples of eligible expenses include deductibles, coinsurance, copays, and other expenses that are not paid by your insurance.

Please note that, effective 1/1/2011, over-the-counter (OTC) medications will no longer be eligible for reimbursement under an FSA.

Here's an important caution: Set aside only the amount you think you will use. Any amount that you don't submit for reimbursement by the deadline will be forfeited. And you know how I, Professor POHP, hate to waste money!

Today's Lesson Review: *If you don't think one person can make a difference, think again. When you plan ahead and shop around for routine health care expenses, you will save money for yourself and the plan – and that's money that can be spent on something else – like our salaries and programs to benefit our students!*

Health Care Flexible Spending Account

Health Care FSA reimburses you for eligible medical, dental, or vision expenses for you, your spouse, or your eligible dependents. You can use it to pay for certain medical expenses not covered by another insurance plan for anyone you claim as a dependent on your tax return.

When you enroll in a Health Care FSA, your account is prefunded up to the amount you elect to contribute for the entire year. So even if you incur eligible expenses before the account is fully-funded, you can "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 the Medical Insurance Opt-Out Credit:

You will receive a CIGNA HealthCare Visa Flexible Spending Account debit card when you enroll in a Health Care FSA. 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 FSA, 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 $mart 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.

$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.

If You Are Enrolled in the Choice Fund HRA 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 HRA. Once your HRA is depleted, in-network expenses will automatically be deducted from your FSA.

Prescription drug copays will automatically be paid out of your FSA at the point of purchase. You will need to submit reimbursement requests and receipts for all other eligible health care expenses, including medical, dental, and vision expenses.



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.

If you want to be in charge of which claims get submitted through your FSA and which claims don't, you should elect to have your "autoclaim forwarding" feature turned off if you are enrolled in the Choice Fund HRA. To do this, simply call our CIGNA onsite representative (407-870-4900) after you have enrolled in an FSA.

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.

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.

$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, 2011 to be reimbursed for expenses incurred between October 1, 2010 and December 15, 2011.

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. 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 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

403(b)/403(b)(7) Accounts

Ameriprise Financial	1-800-862-7919
MetLife	1-800-560-5001
Pacific Life	1-800-722-2333

403(b)/403(b)(7) Accounts and 457(b) Deferred Compensation Plans

AIG (formerly VALIC)	1-800-369-0314
American Century	1-800-345-3533
AXA Equitable	1-800-628-6673
Fidelity Investments	1-800-343-0860
Great American (GALIC)	1-800-854-3649
Horace Mann Company	1-800-999-1030
ING Retirement Plans	1-800-584-6001
The Legend Group	1-800-749-4221
Life Ins. Of Southwest (LSW)	1-800-579-2878
Lincoln Investment Planning	1-800-242-1421
Oppenheimer Funds	1-800-525-7040
Plan Member Services	1-800-874-6910
Security Benefit Group/NEA	1-888-222-3003
Waddell & Reed Financial	1-888-923-3355

$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

* *Federal income tax + Social Security*

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

When deciding which plan to elect, think about the amount of money you normally spend on medical services every year. Do you expect this year to be similar or different? Are you covering yourself only, or your dependents as well?

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 12 to estimate your expenses. Make sure to include copays, deductibles, coinsurance, etc. The planner takes into consideration how the Health Reimbursement Arrangement (HRA) 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.*

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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 7 a.m. - 9 p.m.
   Available through September 30, 2010

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

   Open Enrollment ID: **OsceolaSchools**
   Password: **cigna**
   (Note: The password is case-sensitive.)

   Available through September 30, 2010

   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 12.	Plus In-Network Plan	Choice Fund HRA Plan	Your Spouse's Plan
Annual Payroll Deductions See page 9 and multiply by 20 pays	$0 for Employee-Only or $___ Spouse/Child(ren)/Family	$500 for Employee-Only or $___ Spouse/Child(ren)/Family	$ $
Annual Deductible (circle one)	$100 Individual or $200 Family	$1,500 Individual or $3,000 Family	$
Health Reimbursement Arrangement (HRA) (circle one)	None	-$750 Individual or -$1,500 Family	$
HRA Rollover Amount from this year**	$	$	$
Coinsurance or copay after you pay the deductible			
• Office visits	$	$	$
• Specialist visits	$	$	$
• Covered preventive care	$0 (Plan pays 100%)	$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 covers out-of-network care, but at significantly higher out-of-pocket costs than for in-network care.*

** *Your HRA balance cannot exceed $1,500 for employee-only coverage or $3,000 for family coverage.*

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Benefits Calculator for the Choice Fund HRA

During Open Enrollment you can access *mycignaplans.com* to use an interactive calculator that can help you choose a plan based on cost.




Today's Lesson: Evaluating the Plans

A District Employee Asks:

Dear Professor POHP,

I just got my enrollment materials and I'm overwhelmed. What should I do?

Professor POHP Answers:

First of all, stay calm. It's really not that complicated. Read through your materials with a clear head and think about these three things. The handy chart below can also help you evaluate the plans.

	Plus In-Network	Choice Fund HRA
Medical Costs	$750	$750
Premiums	$0	$500
Deductible	$100	$0
Coinsurance	$195	$0
Employee Cost	**$295**	**$500**
Medical Costs	$3,000	$3,000
Premiums	$0	$500
Deductible	$100	$750
Coinsurance	$870	$300
Employee Cost	**$970**	**$1,550**

	Plus In-Network	Choice Fund HRA
Medical Costs	$6,000	$6,000
Premiums	$0	$500
Deductible	$100	$750
Coinsurance	$1,770	$900
Employee Cost	**$1,870**	**$2,150**
Medical Costs	$10,000	$10,000
Premiums	$0	$500
Deductible	$100	$750
Coinsurance	$2,900	$1,500
Employee Cost	**$3,000**	**$2,750**

1. ***In most cases, if you elect employee-only coverage and you estimated that your annual medical costs will be $8,000 or less*** *(total costs, including your portion and what the plan pays), your out-of-pocket costs (including your payroll deductions) will be lower in the Plus In-Network Plan. If you expect your annual medical expenses will be $9,000 or more, you may be better off enrolling in the Choice Fund HRA.*
2. ***If you are planning on covering your spouse and/or dependent children****, you should take the time to estimate your family's needs plus the cost of your payroll deductions to determine which plan makes the most sense for you.*
3. ***If you are covered under your spouse's plan****, or if your spouse's employer offers coverage, consider enrolling in his or her plan in order to receive the medical insurance opt-out credit from the District in the amount of $750 (see the next page for more information).*

Today's Lesson Review: *If you don't think one person can make a difference, think again. When you take the time to choose the right plan, you could save yourself and the District hundreds or even thousands of dollars on premiums and health care costs – and that savings can be spent on something else – like our salaries and programs to benefit our students!*




Choosing the Medical Insurance Opt-Out Credit

You should consider opting out of medical insurance if you are covered under another major medical insurance plan, like a spouse's employer's plan. When you opt out, you become eligible for a $750 credit that you can use to pay employee-only pretax premiums under District-sponsored dental, vision, and long term disability plans. Any money you don't use for health insurance premiums, will be deposited into a Health Care FSA that you can use to pay for eligible health care expenses. (See page 25 for information about the Health Care FSA.)

What's In Your Opt-Out?

Use the worksheet below to determine what pretax benefits you can pay for using your opt-out credit. In the example, the employee elected the DPPO High Option dental coverage and employee-only vision coverage. You can calculate your annual premiums by multiplying the rates listed on the dental and vision rate charts (pages 17 and 19 respectively) by 20 pays.

	Example	Your Choices
If you opt out, you start with the annual Opt-Out Credit, then choose your plans	$750.00	$750.00
Dental: Subtract your annual dental premiums (either the DHMO, DPPO Low Option, or DPPO High Option; this example shows the DPPO High Option employee-only coverage)	-$353.00	-
Vision (one option)	-77.00	-
Subtotal of remaining credit amount, if any, will be deposited in a Health Care FSA or used to purchase disability insurance*	$320.00	

* *Disability Insurance: You can use your remaining credit to purchase disability insurance if the premium/payroll deduction amount does not exceed the remaining credit. If your disability premium is greater than your credit, you will have to pay for the entire disability premium through payroll deductions and have your remaining credit deposited into a Health Care FSA.*

It is important to note that if you pay for your disability premium using the tax-free credit or through pretax payroll deductions and become disabled, any disability premiums you receive will be considered taxable income. If you elect to purchase disability insurance using after-tax payroll deductions, then any benefits you receive will not be taxable. So, even if your disability premiums are less than your remaining credit, please consider the impact of paying premiums pretax vs. after tax before making your election.




Today's Lesson:
Choosing a Plan Other than a District-Sponsored Plan

A District Employee Asks:

Dear Professor POHP, My husband's employer offers benefits too. No offense, but all plans look the same to me. I'm inclined to just go with the cheapest one. Is there a secret decoder that will tell me which to choose?

Professor POHP Answers:

Mr. FLOP stole my secret decoder ring, but he can't stop me from answering your question. It's true that benefit programs often offer similar coverage. But what may look like a better buy at first glance may really be more expensive on closer inspection.

Which is Better: Cheaper Premiums or Lower Copays and Coinsurance?

It depends on your situation. If you're in good health, such as not needing maintenance medications, you can go for lower premiums and higher out-of-pocket costs like copays or coinsurance. But if you have a chronic health condition, or have young children who tend to see a doctor often, you may opt for higher premiums, and lower per-visit costs. You also have to weigh the value against the cost of your health plan. If you go with a less expensive health plan but it doesn't cover the services you need, you are not getting good value for your health insurance dollars.

How can you tell the quality of competing health insurance plans?

If you're like me and you like numbers and data, you'll want to check out accreditation groups, like the National Committee for Quality Assurance, that measure plans using a variety of quality standards. Ratings companies, such as Standard and Poor's, A.M. Best and Moody's, give you a picture of a health plan's financial strength. "Report cards" published by consumer groups, independent websites, and state insurance officials are also good measurements of consumer satisfaction with health plans.

Today's Lesson Review: Not all plans are alike! Take the time to research each plan available to you. A wise decision now can be a lifesaver later!




Choosing a Dental Plan

You can choose from two dental plans, the **MetLife 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 17 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 17. You may have to call your dental provider to get cost estimates for services if you are not currently enrolled in a MetLife dental plan..	Your Estimated IN-NETWORK Dental Expenses*		
	Dental HMO	**Dental PPO****	
		High Option	Low Option
Payroll Deductions See page 16 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 16-18 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.*

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 Specialty Benefits Vision Plan** covers you a set amount for materials like lenses and frames. You pay a low copay and any out-of-pocket charges. See the chart on page 19 for details.

Do I Need 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).

How Much Disability Insurance Do I Need?

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 the 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 21 for details.

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Free Online Calculators

Life Insurance

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

LifeHappens.org
http://www.lifehappens.org/life-insurance/life-calculator

Disability Insurance

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

LifeHappens.org
http://www.lifehappens.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 23-27 for details). The worksheets on this page will help you determine whether you should enroll in an FSA.

Consider enrolling in a **Health Care Flexible Spending Account** if you:

- Pay medical, dental, and/or vision deductibles, copays, and/or coinsurance..
- Have upcoming dental and/or orthodontia expenses.
- Buy prescription eyeglasses, contact lenses, or saline solution.

Consider enrolling in a **Dependent Care Flexible Spending Account** if you:

- 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.

Note: You do not need to enroll in both the Health Care and Dependent Care FSAs.

Health Care FSA Expense Budget Worksheet

Estimate your eligible out-of-pocket medical expenses for the plan year, which is October 1, 2010 through September 30, 2011. Remember, the "use it or lose it" rule applies.

		Estimated 2010/2011 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 $4,000.	$ _____
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 **(child care or adult care)** expenses for the plan year, which is October 1, 2010 through September 30, 2011. 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.		$ _____

* *If you were hired after October 1, 2010, the number of pay periods remaining in the year will be less than 20, 22, or 24.*

Tax-Sheltered Annuities and Retirement Planning

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 28 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 (FRS)**. 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 28 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* • 1-888-796-3786, Ext. 2
  Obtain employer-specific forms, the most up-to-date list of authorized vendors, benefit information, requests for loans and hardship withdrawals, 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.
- **Benefits Corner:**
  TSA Forms, including Transaction Processing Instructions and Transaction Routing Request Forms.



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 40.

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: Plus In-Network Plan, employee-only coverage.

Life Insurance: Board-Paid Term Life Insurance.

All elections (active and default) are final and cannot be changed until the next Open Enrollment unless you experience an IRS qualifying event (see page 8).

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 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 September 17, 2010
For the Plan Year October 1, 2010 – September 30, 2011

You must make your benefit elections for the new plan year during Open Enrollment. Your elections will be effective from October 1, 2010 to September 30, 2010. You cannot change your benefits during the year unless you experience an IRS qualifying event (see page 8).

You must use the Online Enrollment System to enroll by 4:30 p.m. on September 17, 2010. After that time, you will be locked out of the system.

If you were hired after June 30, 2010 the elections you made as a new hire will remain in effect through September 30, 2011. 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 8).

$mart Tip

Do I Need to Actively Enroll This Year?

Yes. If you do not actively enroll, you will default into the Plus In-Network Plan at the employee-only coverage level. Also, if you want an FSA, you must access the Online Enrollment System each year and elect the type of FSA(s) you want and the amount you want to contribute.

InfoBit • Open Enrollment Resources

Medical
1-800-401-4041
www.mycignaplans.com
ID: Osceola Schools • Password: cigna
Through September 30, 2010

Monday - Friday, 7:00 a.m. - 9:00 p.m. You can speak with a CIGNA benefit specialist and get answers to your questions about our medical plans.

Dental PPO
www.metlife.com/mybenefits
ID: School District of Osceola County
Password: N/A

Dental HMO
www.metlife.com
See page 18 for details.

Benefits Help Line
407-870-4944
Wednesday, September 8, 2010, 10:00 a.m. to 4:30 p.m.
Thursday, September 16, 2010, 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.



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 Plus In-Network 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).

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 — Register Today!

The Employee Portal Website

The Employee Portal is a website that gives you access to your personal information, including pay stubs and leave of absence history. See page 49 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.

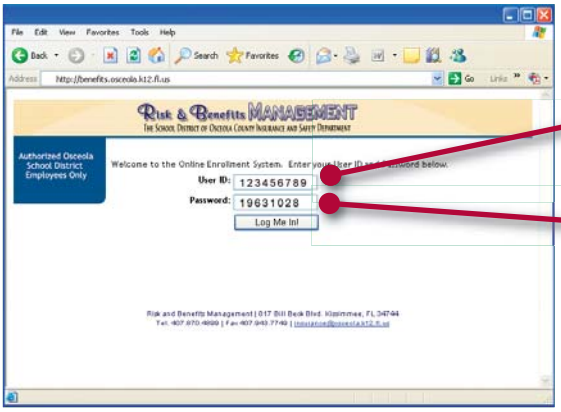
Questions?
Contact the Help Desk at 407-870-4037.

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 8).

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.

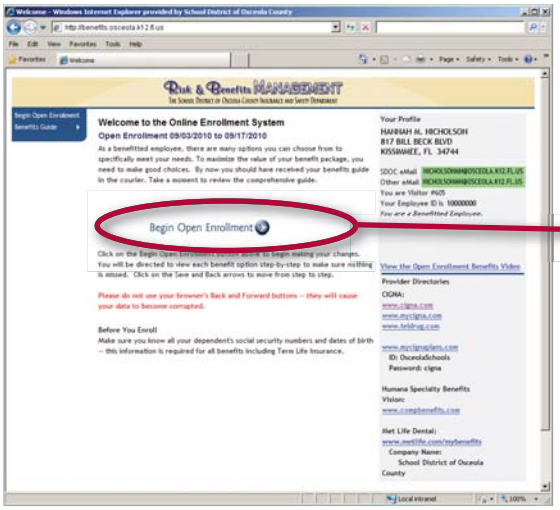
Screen Shots

Online Enrollment Instructions



Log-In

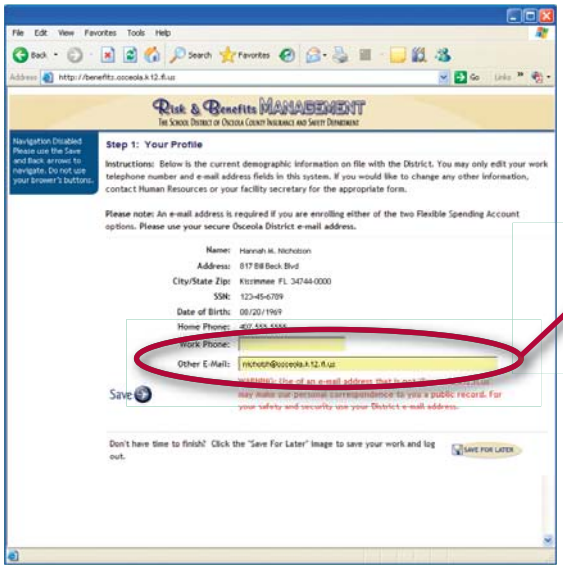
- Visit *http://benefits.osceola.k12.fl.us*
- Your Social Security number is your User ID (no dashes). Example: An employee with a Social Security number of 123-45-6789 would enter the number as 123456789.
- Your date of birth is your password (CCYYMMDD). Example: An employee with a birth date of October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



Welcome Screen

- When you first enter the system, you will see a welcome screen. During Open Enrollment or as a new hire, 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.

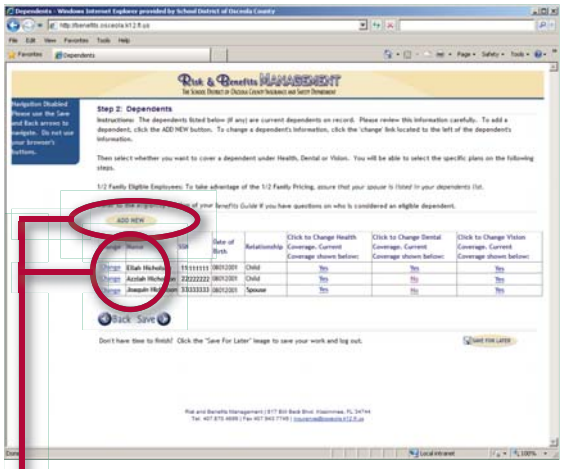


CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

Screen Shots

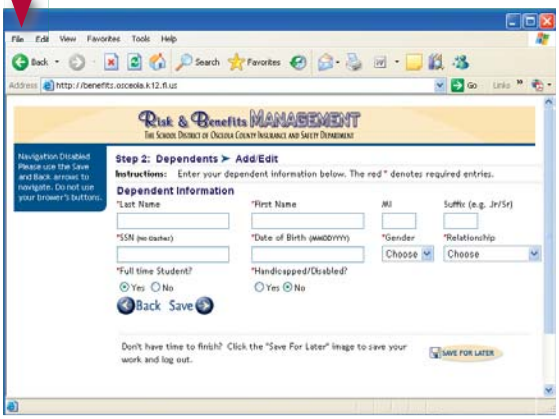
Online Enrollment Instructions

Dependents



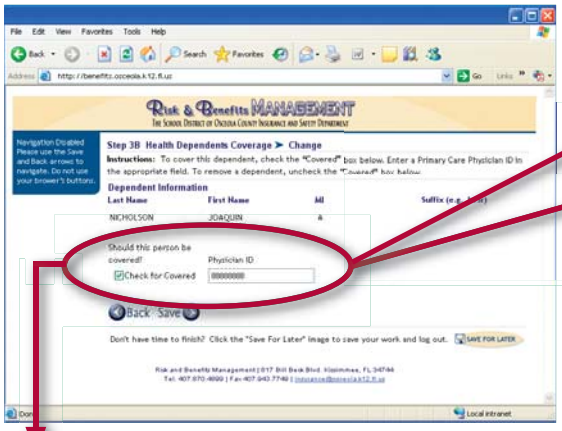
- You can add, but not delete, those eligible dependents you want to cover under the plans that offer dependent coverage. Click the *Add New* button to add a new eligible dependent. Click the "Change" link located to the left of a dependent's name to change his/her information. You only need to enter dependent information one time. Then, select whether you would like to cover each dependent under Health, Dental and Vision insurance.

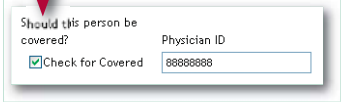
  TIP: You are not allowed to delete dependents from this screen. If you entered information by mistake, contact Risk & Benefits Management to correct the mistake.



- Enter or edit your dependents' demographic information
- Use the *Save* arrow to advance to the next step. You will be able to select the specific plans on the following steps.

  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.



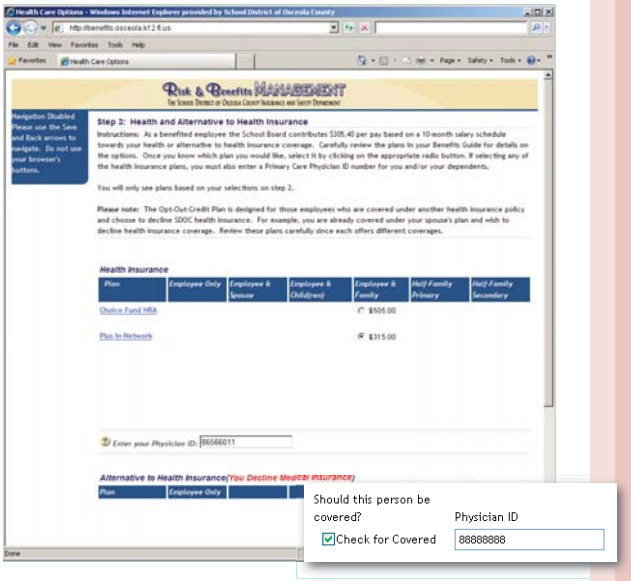


- To cover or drop a dependent under each option click the Yes/No link to the right of the dependent's relationship.
- To cover a dependent, click the "Check for Covered" box you will need to repeat this step for each plan.
- To drop a dependent, uncheck the "Check for Covered" box.
- Click the *Save* 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.

Screen Shots

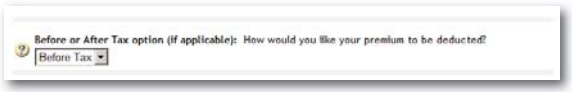
Online Enrollment Instructions



Health Insurance and Opt-Out Credit

- Choose your Health Insurance plan or Opt-Out Credit here. You will only see the plans and premiums you qualify for based on your selections in Step 2. 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.

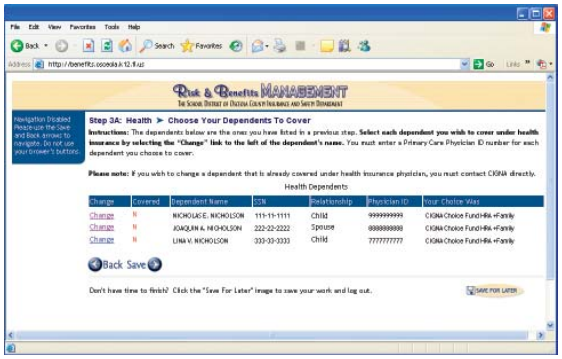
  TIP: Half-Family option is available only when the spouse's information you entered on the Dependent step matches another SDOC benefits-eligible employee.



- 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 the Opt-Out Credit 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 or Medicare, the page will display an error until you adjust your information.



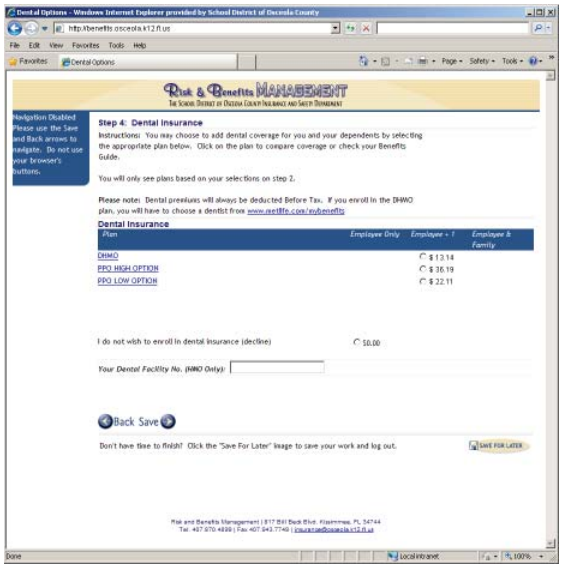
- If you select dependent coverage for a plan, your dependent list will display to confirm your earlier choices. If you make any changes on this step, you will click *Save* to move on to the *Dental* step.

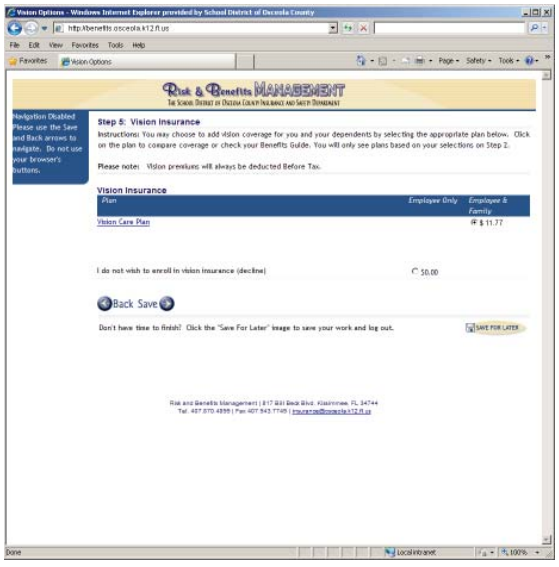
- The Covered column shows the dependents you are covering. "Y" for Yes displays in black text; "N" for No displays in red text.



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 based on your selection in Step 2. 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.

Vision Insurance

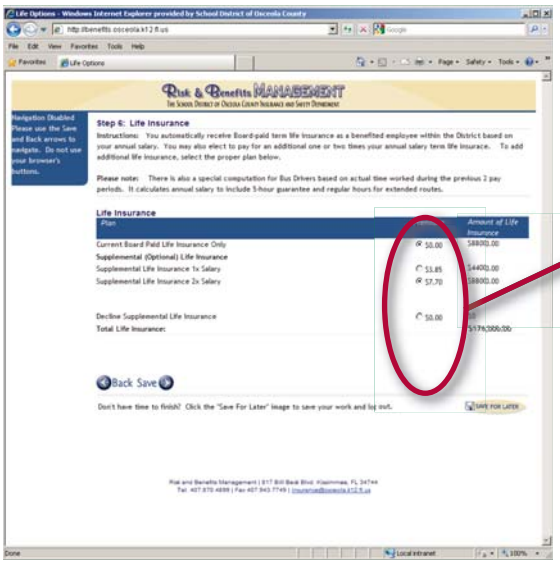
- The **Vision Insurance** screen lets you choose which vision insurance, if any, you would like to select or drop.
- You will only see plans and premiums you qualify for based on your selection in Step 2. So, if you did not add a spouse under your *Dependents* step, for example, you will not have the 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.

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.

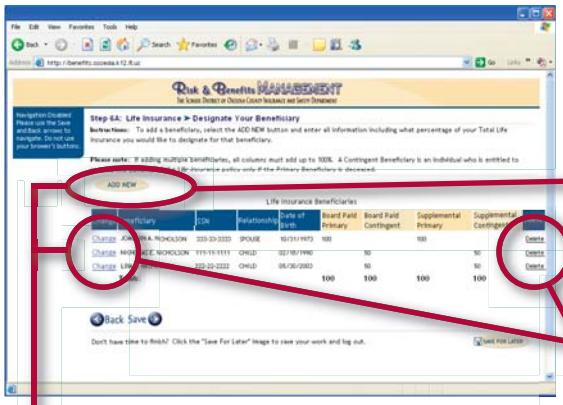
Screen Shots

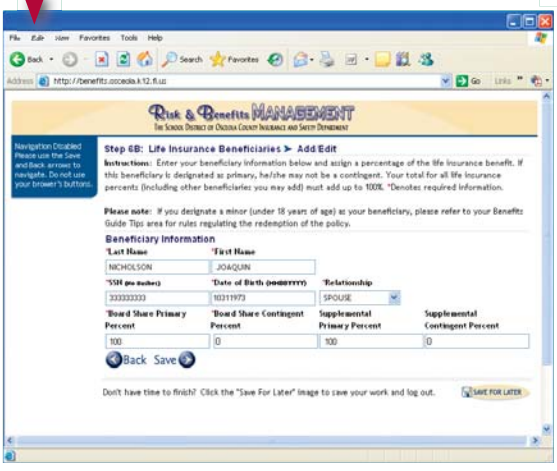
Online Enrollment Instructions



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. **There is not an Evidence of Insurability requirement for this year's Open Enrollment**. All increases will be automatically approved. Otherwise, generally when increasing coverage 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.

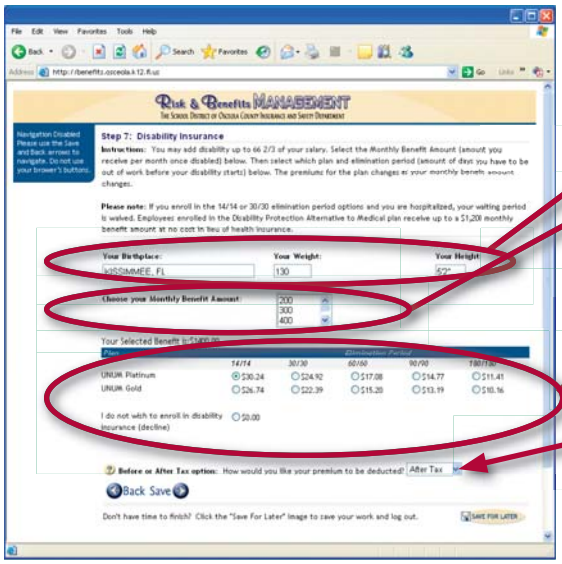
TIP: A Contingent Beneficiary is a person(s) you name to receive the life insurance benefit in the event that your primary beneficiary(ies) is (are) no longer alive. Example: You name your spouse as your primary beneficiary and your children as the contingents. If you and your spouse both die, the children 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.

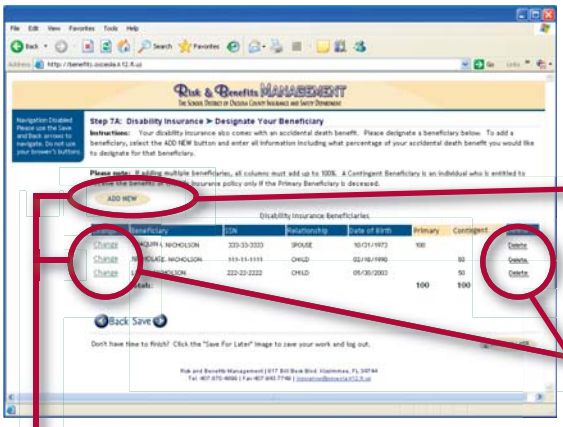
TIP: Dependent Life — If you would like to purchase a dependent life policy or change your current policy, you must contact Colonial Life Insurance directly.

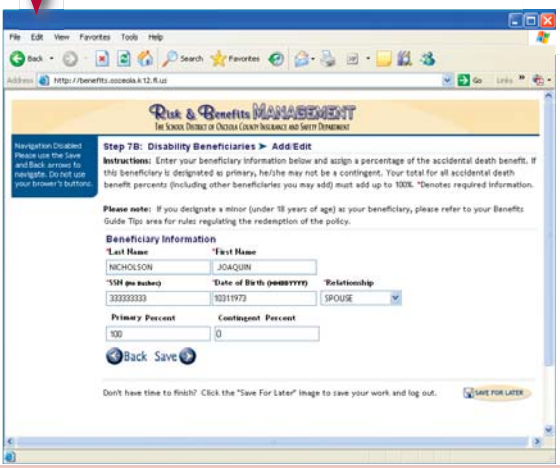


CAUTION! Do not use your browser's *Back* and *Forward* buttons. This will cause data to become corrupt.

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.

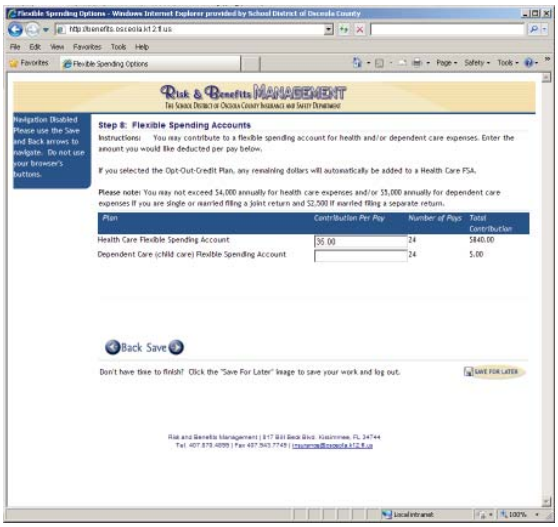
  TIP: Remember, if you select before tax and you are disabled, your disability benefit will be taxed. Most likely, the tax savings on your premium will be significantly less than the taxes you would pay on a disability benefit.

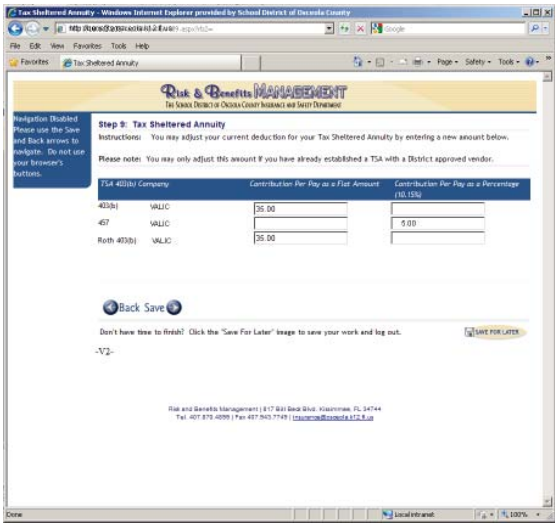
- When you elect disability coverage, you automatically receive Accidental Death and Disability coverage. This coverage requires you to designate a beneficiary (for the accidental death benefit), so you will be navigated to the *Designate Your Beneficiary* step.
- To add a beneficiary, click the *Add 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. If you are enrolled in the Opt-Out Credit, amounts highlighted in Pink will be at no cost to you but will be deducted from the $750 available in the fund. Those highlighted in White, you will have to pay the full cost of the premiums.




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.

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 (Day 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 are enrolled in the Opt-Out Credit, any remaining balance applied to your Health Care FSA will display on the screen.
- 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.

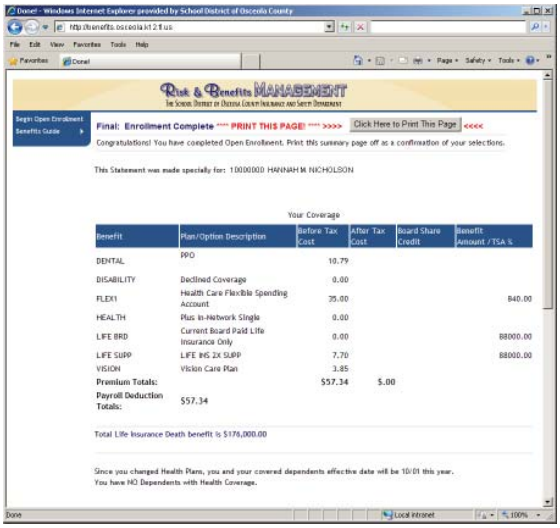
Tax Sheltered Annuity

- 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.



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

Screen Shots



Online Enrollment Instructions

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 17, 2010 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 8).

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 8).




Employee Portal – 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 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.
- **Links** — links to department websites including the Online Enrollment System.

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

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

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.

$mart Tip!

FSA Resources

Remember that starting January 1, 2011 over-the-counter prescriptions will not be reimbursable under the Health Care FSA without a prescription.

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"

InfoBit

Benefits Calculator for the Choice Fund HRA

During Open Enrollment you can access *mycignaplans.com* to use an interactive calculator that can help you choose a plan based on cost.

The District provides a number of tools to help you use your health care dollars wisely. Medical plans like the ***Plus In-Network Plan*** or the ***Choice Fund HRA*** and the ***Flexible Spending Accounts*** offer you options and resources to help you ***become a wiser health care consumer.***




A District Employee Asks:

Two years ago, my baby daughter fell and broke her front teeth. Blood was everywhere. I took her to the Emergency Room and everything turned out fine. But I ended up paying more for that one visit than I normally pay for medical expenses in a year. Was there a better way?

Professor POHP Answers:

I'm glad the baby is okay, and the answer to your question is yes! There is a better way.

This may sound crazy, but you have to plan for emergencies. While you are clear-headed and no one is bleeding, visit http://cigna.benefitnation.net/cigna/docdir.aspx and search for Urgent Care and Convenience Centers in your area.

Urgent care centers cost much less than emergency rooms. And if you haven't met your deductible yet – which was probably what happened in your case two years ago – you will be paying a large chunk out of your own pocket.

Print out or copy the addresses and phone numbers of local Urgent Care Centers from mycigna.com, keep it handy, and tell your family members about it. Hopefully, you'll never need one, but you're sure to feel better by just having the information.

Oh, and while you're at mycigna.com, look up the Convenience Care Clinics in your neighborhood. These are the providers you should use for common colds, cuts and scrapes, and those types of things, but only if it's after hours and your regular doctor is unavailable.

Barring a true emergency,* your in-network doctor should always be your first choice

* True emergency = life threatening situation.

Today's Lesson Review: If you don't think one person can make a difference, think again. Consider this: if you are in the Plus In-Network Plan and have a minor injury, you'll pay 30% of the costs (after your deductible).** Do the math. 30% of a $150 urgent care visit will cost you $45 and the plan $105. 30% of a $1,000 emergency room visit will cost you $300 and the plan $700! By going to the urgent care facility, you save $255 and the plan saves $595 – and that's money that can be spent on something else – like our salaries and programs to benefit our students!

** Example assumes that you have met your deductible.




$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. Visit *mycigna.com* for more information. See the Wellness Calendar on page 52 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 Choice Fund HRA and Plus In-Network Plan pay for 100% of eligible in-network preventive care.
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 provide prescription drug benefits. Generic drugs are the lowest in cost. Use CIGNA Home Delivery Pharmacy 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. Read page 15 for more information about your prescription drug coverage.
5. Open a Flexible Spending Account (FSA). You can save money by enrolling in one or both 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 23-27 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 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.

$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

Health and Wellness Program Activities for 2010-2011

- Three Wellness Fairs
- Health Information Centers
- 10 Fitness Trails
- Healthy Cooking and Nutrition Classes
- Fitness Boot Camps
- Lunch and Learn Seminars
- Online Health Assessments
- **4-Health Screening Kiosks** located at all Transportation centers and the Administration building. The kiosks let employees measure, manage and track blood pressure, pulse, weight, body mass index, and blood glucose.
- **Disease and Lifestyle Management Classes**: Offering Diabetes, Heart Disease, Stress Management, Smoking Cessation, Nutrition and Fitness classes.
- **Employee Wellness Garden**: Employees will learn the basics of vegetable gardening, soils, planting, propagation, irrigation, and pest control.
- **Bimonthly Farmers Market** will be held on the 15th and 30th of each month giving employees access to affordable fresh produce.

2010-2011 Wellness Fair Calendar

Date/Time	Location
October 25 10:00 a.m. to 2:00 p.m.	Osceola School for the Arts
February 18 **Rodeo Day!** 10:00 a.m. to 2:00 p.m.	District Administration Center
May 19 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, 2010 – June 10, 2011 (for the 2011 – 2012 school year).
- **Deadline:** June 10, 2011.
- **Reward:** When you qualify, your $100 reward will be deposited in a Health Care FSA in your name on October 1, 2011. 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 23-27 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, 2011 (Elementary School, Middle School, High School, and Departments). The winners will be contacted using the phone numbers on file.

3 Steps to Qualify

You have from July 1, 2010 through June 10, 2011 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 10, 2011.**
   - **CIGNA Medical Plan Participants:** Complete CIGNA's online, confidential Health Assessment. See page 54 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 **Medical Opt-Out Credit, 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, 2010 and June 10, 2011. 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, 2010 and June 10, 2011. 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 10, 2011

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

Earn Rewards and Get Healthier at the Same Time

The District's wellness program encourages employees to adopt healthy behavior that improve your overall health. In addition to the $100 Wellness Incentive, you can earn Wellness Cents! Each time you participate in a **4 the Health of it!** activity, you'll earn a Wellness Cent. Wellness Cents can be redeemed for valuable prizes, such as an iPod, Wii, cookbooks, pedometers, and t-shirts.

Special Offers

Each time you log an activity or attend a health fair, you'll receive a ticket to enter into a prize drawing. The prize? A 3 day/ 2 Night stay at either the TradeWinds Island Grand or Sandpiper Suites resort on Florida's gulf beaches in St. Petersburg.

The TradeWinds also offers discounts to our employees. Visit *http://www.JustLetGo.com/VseOsceola* and enter Promo code VSEOsceola or check out the discounts on Benefits Corner.

TradeWinds
ISLAND RESORTS ON ST. PETE BEACH




CIGNA Resources

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

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.

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.

About Your Preventive Care

Don't wait for a health problem to occur. As a CIGNA medical plan participant, preventive care is painless to your wallet. Your CIGNA plan covers the full cost of the services listed below when you use an in-network health professional.

For those preventive care services that are paid for by your plan, there is:

- No cost to you
- No cost to your fund (for those enrolled in the Choice Fund HRA)
- No plan deductible to meet

CIGNA defines preventive care as periodic "well" visits, routine immunizations, and routine screenings. Additional immunizations and screenings may be included for those individuals at increased risk for a particular disease. There is no copay charge when you visit the doctor for routine physicals, well-child visits, immunizations, gynecological exams, and mammograms.

Your doctor will determine the tests that are right for you and your family based on your age, gender, and medical history. Other services that are not classified as preventive care, but are generally covered under the medical plan, include tests to investigate existing symptoms, tests to follow up for results of screenings, and tests to monitor an ongoing condition or prevent a current condition from becoming worse. Deductibles and coinsurance will apply.

Coverage Exclusions

This document contains only highlights of preventive health services. The specific terms of coverage, exclusions and limitations, including legislated coverage, are included in the Summary Plan Description or Insurance Certificate.




Well-Child Care (through age 18)

Well-Baby and Well-Child visits

- Periodic visits, depending on age

Immunizations *(as appropriate by age such as)*

- Diphtheria, tetanus and acellular pertussis (DTaP)
- Haemophilus influenzae type b (Hib)- Hepatitis A and B
- HPV (human papilloma virus) in girls and women ages 9 – 26
- Influenza: annually between 6 and 59 months
- Measles-mumps-rubella (MMR)
- Meningococcal (MCV4): between ages 11 and 18- Pneumococcal (PCV) (pneumonia)
- Poliovirus (IPV)
- Rotavirus
- Varicella (chickenpox)

Screenings *(as appropriate by age such as)*

- Blood pressure
- Cholesterol: for those at risk
- Hearing and vision performed during the wellness visit
- Height and weight
- Hemoglobin or hematocrit: once a year for females after menarche
- Pap test and pelvic exam

CIGNA Customer Service

Questions About Your Medical Plan?
Call CIGNA's customer service

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

Adult Care (from age 18 on)

Well-Man and Well-Woman visits

- Periodic visits, depending on age

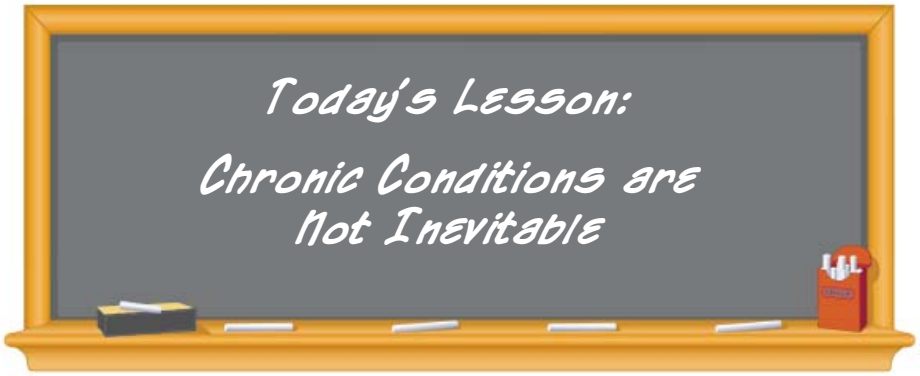
Immunizations *(as appropriate by age such as)*

- Hepatitis A and B (HBV): for those at risk
- HPV (human papilloma virus) in girls and women ages 9 – 26
- Influenza: ages 19 – 49, as your doctor advises; ages 50+, annually
- Pneumonia: once for those ages 65+ (or younger for those with risk factors)
- Rubella (German Measles) for women of childbearing age if not immune
- Tetanus-diphtheria (Td) every 10 years (or TdaP, as indicated)
- Varicella (chickenpox: if no evidence of prior immunization or chickenpox)
- Zoster: ages 60+

Screenings *(as appropriate by age such as)*

- Blood pressure
- Cholesterol ages 20+, every 5 years
- Diabetes screening ages 45+, or if history of risk factors, every 3 years
- Mammogram once a year for women ages 40+
- Osteoporosis screening for women ages 65+, 60 for women at high risk
- Pap test within 3 years of sexual activity, or ages 21 – 64, at least every 3 years
- Prostate screening (PSA) for men ages 50+, once per year
- Ultrasound for abdominal aortic aneurysm: men ages 65 – 75 who have ever smoked
- Colorectal cancer screenings ages 50+
  - Sigmoidoscopy every 5 years
  - Fecal occult blood test or fecal immunochemical test annually
  - Colonoscopy every 10 years
  - Barium enema every 5 years; or
  - Computed tomographic colonoscopy/ virtual colonoscopy every 5 years
- Chlamydia screening, sexually active women ages 24 and under



A District Employee Asks:

Dear Professor POHP,

I'm tired of hearing about disease prevention. Diabetes runs in my family, so I'm at high risk for getting it, and there's nothing I can do to stop it.

Professor POHP Answers:

You actually have more control than you think! Many of us have a family history that puts us at higher risk for a disease. But that doesn't mean that getting the condition is inevitable.

Most chronic diseases are caused by unhealthy behaviors. Overeating, for example, can lead to obesity which can lead to ...

- Heart disease and stroke
- High blood pressure
- High cholesterol
- Diabetes
- Cancer
- Osteoarthritis
- Gallbladder disease and gallstones
- Gout
- Breathing problems, such as sleep apnea and asthma

Smoking contributes to more than 440,000 deaths in the U.S. every year. This statistic is shocking when you consider the fact that smoking is also the single most preventable cause of death and disease. Examples of problems caused by tobacco use include:

- Many types of cancer
- Lung diseases
- Heart attack
- Stroke
- Blindness
- Blood vessel diseases
- Erectile dysfunction
- Miscarriage
- Early death

Being sick leads to ...

- More doctor visits
- Increased prescription medication usage
- Surgeries
- Lost days at work or being less productive at work

And it isn't just sick people who pay more. We all pay. More health insurance claims mean higher health insurance rates for everyone – both healthy and unhealthy.

So what can you do? First and foremost, stay healthy or take measures to improve your health. CIGNA medical plan participants can use the support tools at mycigna.com. Participate in the District's 4 the Health of It! activities. If you already have a health condition, talk to your doctor to learn how to manage your disease state and improve your health.

Today's Lesson Review: If you don't think one person can make a difference, think again. When you take better care of yourself and your family, you and the District can save money without compromising the quality of your health care – and that's money that can be spent on something else – like our salaries and programs to benefit our students!

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

UNUM Work-Life Balance EAP

All benefitted employees have an additional Employee Assistance Program (EAP) available to help you balance the demands of work with those of your personal life. It provides unlimited telephone consultations with master's-level consultants, web-based tools, and online information for you and anyone in your family who needs help. Find more information or help on:

- coping with stress, anxiety and depression;
- organization tips and prioritization ideas;
- caring for a child or elderly relative and finding child care or senior assistance;
- improving your health or controlling a chronic condition;
- getting out of debt and managing your finances;
- funeral cost estimator;
- relationship issues, legal issues, and much more.

Call or go online to access the Work-life balance EAP:

- English: 1-800-854-1446
  Spanish: 1-877-858-2147
  TTY or TDD: 1-800-999-3004
- www.lifebalance.net
  ID: lifebalance • Password: lifebalance

UNUM Travel Assist

If you or your dependent* is traveling on business or making a personal trip to a foreign country (or 100 miles or more from home) and a medical emergency arises, you have immediate access to an extensive, worldwide network of hospitals and clinics.

Call the numbers listed here and identify yourself as an employee of the District and provide the reference number on your ID card. Note: This service does not replace your medical coverage. Instead it provides services not covered by your medical plan such as transportation by air ambulance.

* *A spouse traveling on business for their own employer is excluded from coverage.*

UNUM Travel Assist Contact Information

Within U.S.: 1-800-872-1414
Outside the U.S.: + (U.S. access code) 609-986-1234
Email: medservices@assistamerica.com
Ref. Number: 01-AA-UN-762490




Legal Details

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.

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.

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.
- 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

COBRA Participants With FSAs

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

Loss of Coverage is Due to	Maximum COBRA Continuation		
	For You	For Your Covered Spouse	For Your 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

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

You will not lose your benefits at the end of the current contract if:

1. 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 over the summer. *Nine and Ten Month employees' benefits will terminate the day before the start of the new contract year.*
2. You would have been reappointed; however, a position is not available due to a reduction in force. *Nine and Ten Month employees' benefits will terminate the day before the start of the new contract year.*
3. You are granted a Leave of Absence (LOA) for the coming year. Your benefits continue until September 1, 2010; Employees on LOAs then have the option of keeping their benefits during the leave. A letter detailing insurance options will be sent to the LOA employee automatically. Insurance premiums that would have been collected on August 31st will be due from all new Leave of Absence employees who have optional benefits (Spouse, Children or Family coverage on health insurance, any dental, vision, and supplemental life or disability premiums). If you would like to make arrangements to have these premiums taken out of your paycheck before you begin your leave, contact the appropriate Benefit Specialist for your facility by calling 407-870-4899.
4. You retire at the end of your current contract. Your benefits will remain in effect until September 30, 2010; retirees then have the option of keeping their benefits. A letter detailing insurance options will be sent to the retiree automatically. Insurance premiums for August 31st, September 15th and September 30th will be due from all new retirees who have optional benefits (Spouse, Children or Family coverage on health insurance, and dental, vision and supplemental life). If you would like to make arrangements to have these premiums taken out of your paycheck before you retire, contact the appropriate Benefit Specialist for your facility by calling 407-870-4899.

Your benefits will terminate immediately if:

1. You resign your position before the end of your current contract. Your insurance benefits will terminate on your last day.
2. Your employment is terminated by the District (except for RIF employees as noted in 2 above) at the end of your current contract. Your insurance benefits will terminate the day your contract ends as follows:
   - 186 & 187 DAY EMPLOYEES – JUNE 9, 2011
   - 195 DAY EMPLOYEES – JUNE 15, 2011
   - 196 DAY EMPLOYEES – JUNE 10, 2011
   - 206 DAY EMPLOYEES – JUNE 17, 2011
   - 217 DAY & 11 MONTH EMPLOYEES – JUNE 21, 2011
   - 12 MONTH EMPLOYEES – JUNE 30, 2011

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.

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).

Special Enrollment Period

If you (or an eligible dependent) declined coverage in a District-sponsored health insurance plan because you had coverage under another plan, and that coverage ended, you may be eligible to enroll in a District-sponsored plan. Normally, you would have to wait until the next annual enrollment period to enroll, but you may be eligible for a special enrollment period if your other coverage ends because:

- Your employment ended, you had a change in work status or you became ineligible for coverage
- The other health insurance plan was terminated
- The other employer stopped paying a required contribution for coverage
- COBRA continuation coverage was exhausted

If your CHIP (Children's Health Insurance Program) or Medicaid coverage is terminated because you lose eligibility or you become eligible for group health plan premium assistance under a state CHIP or Medicaid program, you are eligible for a special enrollment period in a District-sponsored health insurance plan.

In addition, if you acquire new dependent(s) through marriage, birth, adoption or placement for adoption, you (or your eligible dependent(s)) may be eligible to enroll in a District-sponsored health insurance plan as long as you apply within 31 days following the day after your other coverage ends or the date you acquire a new dependent(s).

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

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 2010-2011 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 2010-2011, as much as or more, on average, than the standard Medicare prescription drug coverage for 2010-2011.

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, 2010 and December 31, 2010. 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

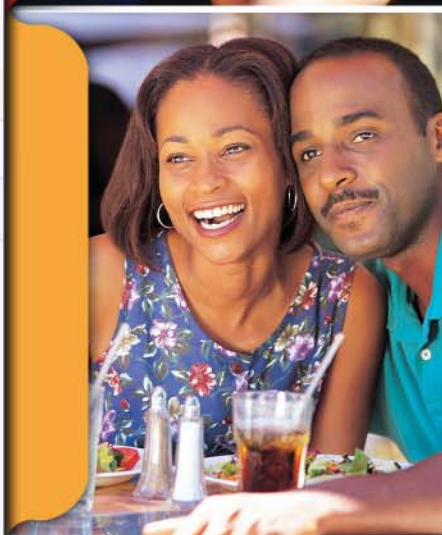
You are responsible for:

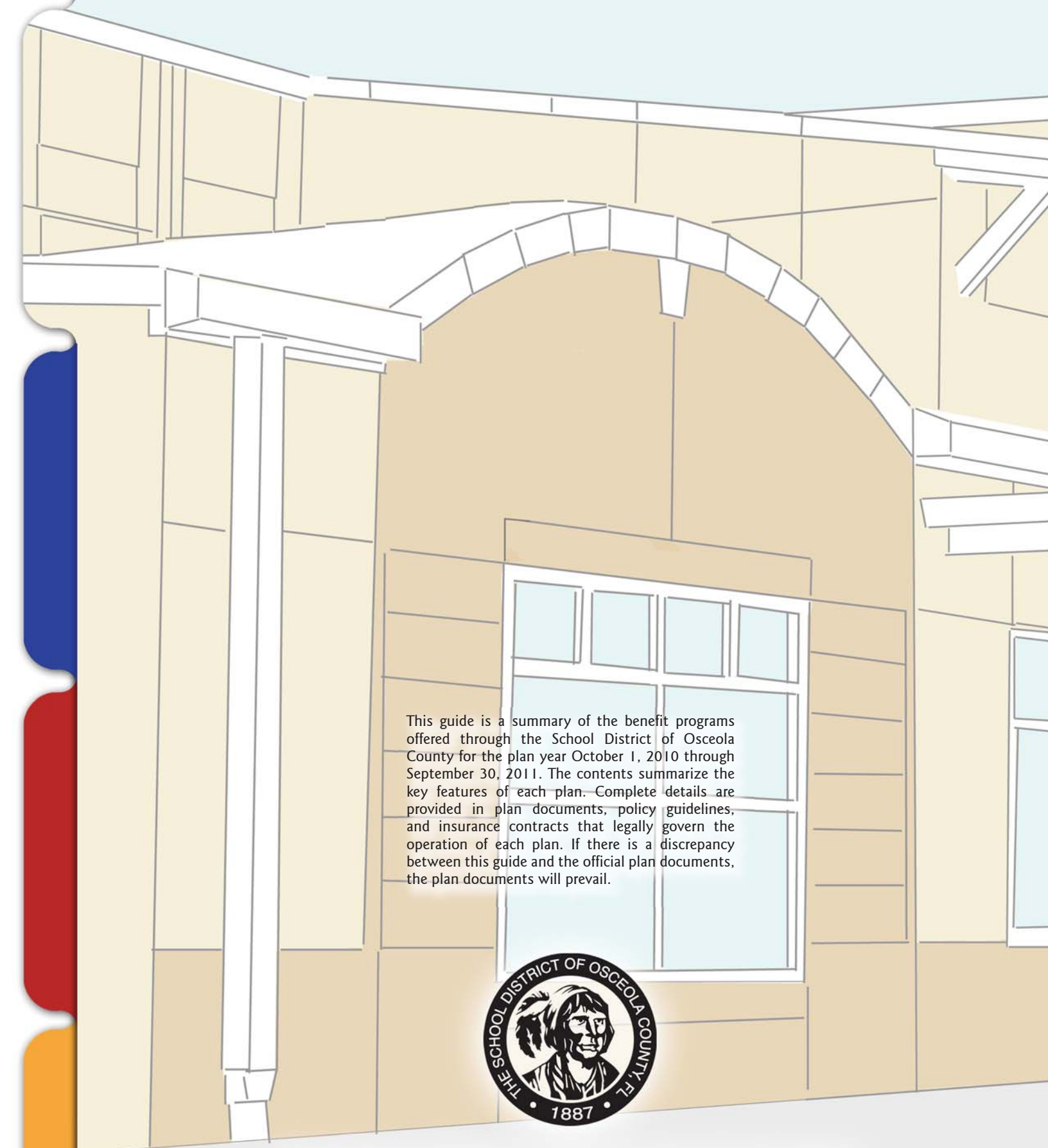
1. Reading this benefits guide thoroughly and prior to enrolling in benefits.
2. Making informed decisions when you enroll or decline enrollment.
3. Reviewing your paycheck stub when your benefits become effective and verifying that your deductions are for the benefits you elected.
4. Notifying the Risk & Benefits Management department within 60 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 5.
6. Notifying the Risk & Benefits Management department within 30 days of the date a covered dependent no longer meets dependent eligibility requirements.

Frequently Used Telephone Numbers and Websites

CIGNA Member Services	1-800-244-6224
CIGNA Online Provider Directory	www.cigna.com
mycigna.com	www.mycigna.com
CIGNA Technical Support	1-800-284-8346
Onsite CIGNA Representative	407-870-4900
CIGNA Home Delivery Pharmacy (Mail Order)	1-800-835-3784 www.mycigna.com
CIGNA Behavioral Health	1-800-274-4573 www.cignabehavioral.com
MetLife Dental	DHMO: 1-800-880-1800 • www.metlife.com PPO: 1-800-942-0854 www.metlife.com/mybenefits
Humana Specialty Benefits	1-800-749-5855 www.compbenefits.com
UNUM - *Disability* - *Life Insurance* - *EAP and Travel Assist*	www.unum.com 1-800-527-4572 1-800-445-0402 See page 57
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
COBRA Administrator - WageWorks	1-877-502-6272
Johns Eastern Company, Inc.	1-800-749-3044
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*





This guide is a summary of the benefit programs offered through the School District of Osceola County for the plan year October 1, 2010 through September 30, 2011. 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.

The School District of Osceola County, Florida
Student Achievement - Our Number One Priority

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