

2009~2010

Employee

# Benefit

Highlights

- 
- Medical Insurance
  - Dental Insurance
  - Vision Insurance
  - Life Insurance



# Employee Benefits Resource Directory

Martin County School District	
<b>Risk Management / Employee Benefits Department</b> Telephone: (772) 219-1200, extension 30478 E-mail: <a href="mailto:benefitshotline@martin.k12.fl.us">benefitshotline@martin.k12.fl.us</a>	<b>CIGNA On-Site Representative</b> Telephone: (772) 219-1200, extension 30313
Benefits Online at the Employee Benefits Center: <a href="http://sbmc.myebconline.com">sbmc.myebconline.com</a>	
Medical Insurance	Employee Assistance Program (EAP)
<b>CIGNA HealthCare</b> Customer Service: (800) CIGNA-24 (244-6224) CIGNA 24 Hour Information Line: (800) CIGNA24 Tel-Drug Mail Order: (800) 835-3784 <a href="http://www.CIGNA.com">www.CIGNA.com</a> ; Members: <a href="http://www.MyCIGNA.com">www.MyCIGNA.com</a>	<b>CIGNA Behavioral Health</b> Customer Service: (877) 622-4327 <a href="http://www.CIGNABehavioral.com">www.CIGNABehavioral.com</a> Employer ID: martinschools
Dental Insurance	Vision Insurance
<b>CIGNA Dental</b> Customer Service: (800) CIGNA-24 (244-6224) <a href="http://www.CIGNA.com">www.CIGNA.com</a> ; Members: <a href="http://www.MyCIGNA.com">www.MyCIGNA.com</a>	<b>Davis Vision</b> Customer Service: (888) 343-3466 <a href="http://www.davisvision.com">www.davisvision.com</a>
Short Term Disability Insurance	Long Term Disability Insurance
<b>CIGNA Group Insurance</b> To Report a Claim: (800) 362-4462	<b>CIGNA Group Insurance</b> To Report a Claim: (800) 362-4462
Core Life and AD&D Insurance Supplemental Term & Dependent Life Insurance	Flexible Spending Accounts
<b>The Standard</b> Customer Service: (800) 628-8600 <a href="http://www.standard.com">www.standard.com</a>	<b>Eagles Benefits by Design</b> Customer Service: (772) 334-3995 Fax Your Claim: (772) 334-7059 <a href="http://www.eaglesbenefits.com">www.eaglesbenefits.com</a>
Supplemental Insurance	Other Alternate Programs
<b>AFLAC</b> Customer Service - Loire Lucas: (772) 708-5931 Fax Claims: (772) 286-3031 Corporate: (800) 99-AFLAC <a href="http://www.aflac.com">www.aflac.com</a>	<b>Florida KidCare (Healthy Kids)</b> Information: (888) 540-5437 <a href="http://www.floridakidcare.com">www.floridakidcare.com</a>  <b>Cover Florida Health Care</b> <a href="http://www.coverfloridahealthcare.com">www.coverfloridahealthcare.com</a>
COBRA	Employee Benefits Agent of Record
<b>Eagles Benefits by Design</b> Customer Service: (772) 807-8474 Fax: (772) 873-1441 <a href="http://www.eaglesbenefits.com">www.eaglesbenefits.com</a>	<b>Gehring Group</b> Customer Service: (800) 244-3696 BenTek Hotline: (877) myEBC-44 (693-2244) <a href="http://www.gehringgroup.com">www.gehringgroup.com</a>



# Table of Contents

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Introduction .....	1
Online Enrollment: The <u>E</u> mployee <u>B</u> enefits <u>C</u> enter .....	1
Employee Agreement for Participation in the District Benefit Program .....	2
Confirmation Statements .....	2
Eligibility Requirements.....	3
Dependent Eligibility Requirements.....	3
Dependent Eligibility Documentation Requirements.....	4
Two Employee Family .....	5
Leave Policy .....	5
Default Benefits .....	5
Qualifying Events .....	6-7
Appeal Process .....	7
Medical Insurance.....	8-10
Pre-Existing Conditions .....	11
Medicare Secondary Payer (Active Employees).....	11
Employee Assistance Plan (EAP).....	12
Dental Insurance .....	12-14
Vision Insurance.....	15-16
Core Life and AD&D Insurance.....	16-17
Supplemental Group Life Insurance .....	17-18
Disability Insurance.....	18
Short Term Disability (STD) .....	19
Long Term Disability (LTD) .....	20-21
Coordination of Disability & Leave Benefits.....	21
Benefit Dollars .....	22
Section 125.....	22
Flexible Spending Accounts .....	23-25
Supplemental Insurance - AFLAC.....	26
COBRA .....	27-29
Notice of Privacy Practices .....	30-31
Medicare & Prescription Drug Coverage .....	31-32



# Introduction

The Martin County School District offers a wide range of benefits to our benefit eligible employees. This booklet will describe those programs which include medical, dental, vision, life, disability, flexible spending accounts and supplemental policies. During open enrollment, all benefit eligible employees can make changes to their current elections or add new coverages. Details regarding your benefit options may be found by logging on to the Employee Benefits Center. Further questions may be directed to the Risk Management / Employee Benefits Department by using the contact information on the inside front cover.

*MCS D highly recommends that all employees participate in Open Enrollment which will be held April 6, 2009 - May 1, 2009*

Please note that there are certain situations in which you **MUST** take action. **If you wish to enroll, modify or cancel your AFLAC insurance products, you must meet with an AFLAC Representative.** Please note that if you previously participated in a voluntary flexible spending account and do not complete the enrollment process online or with a Benefits Counselor, your 2008-2009 voluntary FSA benefits **WILL NOT** continue for the 2009 - 2010 Plan Year.

**If you DO NOT participate in Open Enrollment either via the Internet or at an onsite scheduled session, you will be enrolled in the plans most similar to your prior year's elections as well as continue most other optional benefits with any new adjusted premium.**

➡➡ Remember, it is your responsibility to review the open enrollment information. ⬅️⬅️

How To Enroll	
Option 1	Option 2
<p align="center"><b>Enroll On Your Own Via The Internet at <a href="http://sbmc.myebconline.com">sbmc.myebconline.com</a>:</b></p> <p>By exercising this option, you are <b>not</b> required to meet with a Benefits Counselor to complete the enrollment process. You may enroll anywhere you have Internet access by logging onto the Employee Benefits Center.</p>	<p align="center"><b>By Enrollment Appointment With a Benefits Counselor:</b></p> <p>If you prefer to meet one-on-one with a Benefits Counselor, you must make an appointment for a scheduled Open Enrollment session at any of the designated locations. The Benefits Counselor will review your current benefit selections and assist with any changes that you wish to make.</p>



## Online Enrollment: The Employee Benefits Center

**Support Hotline: (877) MyEBC- 44 (693-2244) - Monday through Friday 9 a.m. to 5 p.m.**

Online enrollment option: The Employee Benefits Center (EBC) is an Internet based benefits enrollment system. Benefit eligible employees have the ability to make benefit elections and changes online during open enrollment for the 2009-2010 Plan Year. The EBC is accessible 24 hours a day during the open enrollment period.

### Accessing the Employee Benefits Center (EBC)

- ◆ Log on to [sbmc.myebconline.com](http://sbmc.myebconline.com).
- ◆ Follow the instructions to set up your own username and password.
- ◆ Navigate to the Open Enrollment section of the EBC to review your current elections, learn about your benefit options, and make any elections or changes.
- ◆ You may also update your life insurance beneficiary designation(s).
- ◆ Print out your confirmation statement containing all your benefit elections for you and your family including your life insurance beneficiary designations.

Information about of all your employee benefits election options, including premiums and carrier contact information, are available to help you make informed decisions. Once the new plan year begins July 1<sup>st</sup>, you will be able to return to the EBC to review your new benefits, access carrier links, update life insurance beneficiaries, and report qualifying events.



# Employee Agreement for Participation in the District Benefit Program

**Be aware that when you participate in the District benefit program, you are automatically making the following affirmations:**

1. You authorize the District to deduct premiums for the benefits rolled over or elected for the plan year.
2. You certify that the information you supplied on the Employee Benefits Center is true and complete to the best of your knowledge.
3. You understand that health, dental, vision and AFLAC insurance premiums and Flexible Spending Account(s) contributions will be pre-taxed to the extent possible and that your income subject to federal income tax and Social Security withholding (FICA) will be reduced, and that this may slightly affect your Social Security benefits in the future.
4. You acknowledge that you cannot stop or change benefits paid for on a pre-tax basis during the plan year unless you experience a relevant qualifying event.
5. You agree to provide documentation evidencing dependent status or student status for any person covered under a District insurance plan within 30 days of request for such verification. Failure to supply any requested documentation may cause the individual to be removed from coverage.
6. All benefits in this booklet are subject to change. This is an Employee Benefits Highlights Summary and not a contract. All benefits are subject to the provisions and exclusions of the master contract.
7. You understand that a Section 125 Flexible Spending Account (Medical Expense and Dependent Care) can be used only to reimburse payment of eligible expenses incurred during the plan year while participating in the plan and that any amount remaining in either spending account, that is not used during the plan year, will be forfeited. Funds in one spending account cannot be used to reimburse expenses covered by another account. Expenses for which you are reimbursed cannot be claimed.
8. You understand and agree that the District and the third party flex administrator will not incur any liability resulting from failure to read all rules pertaining to benefit enrollment; to enroll online accurately or to submit elections; or in the administration of your flexible spending accounts. You also understand that elections for benefits on a pre-tax basis are irrevocable and cannot be changed after the established deadline date. Subsequent changes can only be made upon experiencing a relevant qualifying event.
9. You agree for yourself and covered members of your family and others covered under District insurance plans to be bound by the benefits, deductibles, co-payments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements and plan documents for the plans in which you enroll.



## Confirmation Statements

You will receive a "Confirmation Statement" after the close of Open Enrollment at your worksite. It is **YOUR** responsibility to verify that the benefit selections made **during** Open Enrollment are correct. You can also verify this information during a scheduled enrollment session or by logging onto [sbmc.myebconline.com](http://sbmc.myebconline.com) to view your benefits prior to the close of enrollment on May 1, 2009. Approvals for AFLAC changes or new AFLAC policies are pended until the end of open enrollment. Approved policies will appear on your confirmation statement that will be sent to your worksite at the conclusion of open enrollment.

### IMPORTANT REMINDERS

- ◆ Confirmation statements are for verification purposes only. All changes must be made during open enrollment.
- ◆ No changes will be permitted after open enrollment ends May 1, 2009.
- ◆ FSA account elections must be renewed every year - previous elections do not carry forward into the new plan year.
- ◆ Payroll Changes: if you are a 10 or 11 month employee, adjustments will be made to your multi-checks this year to reflect changes made during Open Enrollment.



# Eligibility Requirements

The District's group insurance plan year is July 1<sup>st</sup> through June 30<sup>th</sup>. For new hires eligible to participate in the District's group insurance plans, coverage will be effective the first of the month following 30 days of employment. Example: if you are hired on February 11<sup>th</sup>, your coverage will be effective on April 1<sup>st</sup>. If you separate employment with the District, your health insurance will continue through the end of the month in which the separation occurred. Contact Risk Management/Employee Benefits Department if further clarification regarding group insurance eligibility is required.

## Employee Coverage:

Eligible Employees are:

- ◆ Full-time employees who work 7.5 hours or more per day
- ◆ Part-time employees who work at least 4 or more hours per day, but less than 7.5 hours per day
- ◆ Interim teachers who are hired for a minimum of half the school year (99 contract days)
- ◆ Retiring employees - please contact Risk Management/Employee Benefits Department prior to retirement to discuss your benefit options



# Dependent Eligibility Requirements

## Dependent Coverage:

Dependents eligible to participate in the District's plan are defined as the participant's legal spouse and / or an unmarried dependent child of the participant or the participant's spouse. The term "child" includes:

- ◆ A natural child
- ◆ A stepchild
- ◆ A legally adopted child
- ◆ A foster child
- ◆ Grandchild(ren)
- ◆ A child for whom legal guardianship has been awarded to the participant or the participant's spouse

### Dependent Eligibility Age Requirements

Coverage may continue to the end of the calendar year in which the dependent reaches the age of 25 if:

- ◆ The child is dependent upon the policyholder for support, and
- ◆ The child is living in the household of the policyholder, or the child is a full-time or part-time student.

Medical Coverage may continue past the age of 25 to the end of the calendar year in which the dependent reaches the age of 30, if:

- ◆ The child is unmarried with no dependents, and
- ◆ The child is a resident of Florida or a full-time or part-time student, and
- ◆ The child is otherwise uninsured and not entitled to Medicare.

If you elect coverage for a dependent age 25 - 30, you will be subject to an **additional** premium payroll deduction **over and above** the applicable family premium deduction based on your selected tier of coverage. This additional premium deduction will also be deducted on a "post-tax" basis.

## Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age of 30 if the dependent is physically or mentally disabled, coverage began prior to age 19, and dependent has continuously been insured.



# Dependent Eligibility Documentation Requirements

All dependents must have an established legal relationship to the employee or spouse to be covered under a District benefit program. Eligibility based on financial dependency upon the employee, living in the employee's home and being claimed as a dependent on the employee's income tax return. The types of documentation accepted are as stated in the chart below. **NOTE: Religious documents and registration cards are not acceptable proof. You may "black out" financial information.**

Dependent Relationship	Documentation Required
Spouse	Copy of State issued marriage certificate <b>AND</b> copy of 2008 IRS tax return (1040 or 1040A) - front & back pages.
Child(ren)	Copy of State issued birth certificate(s) <b>OR</b> copy of legal guardianship court documents listing the District employee or retiree as legal guardian <b>AND</b> copy of 2008 IRS tax return (1040 or 1040A) - front & back pages.
Dependent Child(ren): Ages 19 -25	Copy of State issued birth certificate <b>OR</b> copy of legal guardianship court documents listing employee as legal guardian <b>AND</b> copy of child(ren)'s driver's license or State issued ID card <b>AND</b> Financial & Residential Affidavit <b>AND</b> copy of child's or parent's 2008 IRS tax return (1040 or 1040A) - front & back pages <b>AND</b> copy of child's current school schedule (Spring or Summer 2009 only).
Dependent Child(ren): Ages 25 -30	Copy of State issued birth certificate <b>OR</b> copy of legal guardianship court documents listing employee as legal guardian <b>AND</b> copy of child(ren)'s driver's license or State issued ID card.
Step-Child(ren)	Copy of State issued marriage certificate (in addition to the appropriate dependent child documentation listed above).
Child(ren) under Legal Guardianship, Custody or Foster Care under age 30	Copy of legal guardianship document from courts <b>OR</b> copy of legal custody documentation from courts <b>OR</b> copy of foster care documentation from courts.
Child(ren) Adopted or in the process of Adoption under age 30	Copy of legal adoption documentation showing relationship to employee and placement in the employee's home <b>OR</b> adoption certificate issued through courts.
Grandchild(ren) OR other Child(ren) not related	Copy of State issued birth certificate of child(ren) stating child was born to an insured dependent child of employee or retiree (in addition to the appropriate dependent child documentation listed above).



## Two Employee Family

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If both you and your spouse are employed by MCSD and have benefit-eligible dependents, you are defined by MCSD as a “two employee family” and enrollment for your insurance benefits is different from the standard procedure.

One employee becomes the primary insured (the person in which the insurance coverage is under). If you are unsure who this is, this information is located on your insurance ID card. The primary insured is the one who enrolls or requests changes to the family’s insurance benefits and their spouse is considered a dependent along with the child(ren). In addition, it is the primary insured who pays the premiums associated with the “two employee family” rate via payroll deduction. The primary insured can elect to have the \$200 premium off-set provided by MCSD applied to their insurance premium to subsidize a portion of the cost, but they cannot use their spouse’s \$200 premium off-set for these benefits. The other spouse must use their money toward the purchase of other benefits for themselves or an FSA.

If both of you are employees of MCSD but are *NOT* insuring dependent children, you are not considered a “two employee family”. Each of you must enroll separately and select your own plan(s). **All “two employee families” are encouraged to meet with an Benefits Counselor or enroll online at the same time.**



## Leave Policy

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Employees on leave of absence are eligible for certain benefits depending on the type of leave. There are two types of leave:

- 1) **MCSD Approved Medical Leave WITHOUT Pay and WITH Benefits (FMLA)** – MCSD continues to pay existing employer contributions to the applicable insurance plans if you go on medical leave that results from your own disability, including disability resulting from pregnancy. MCSD will pay for these benefits up to 12 weeks. After 12 weeks, you may continue these benefits by paying the total premium amounts under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- 2) **MCSD Approved Leave WITHOUT Pay and WITHOUT Benefits** – In this situation, MCSD does not contribute towards your insurance premiums. Contributions end at the end of the month following the date of your leave. Your benefits may be continued if you pay premiums under COBRA. Within 30 days of returning to work from an approved, unpaid leave of absence, you can re-enroll in your benefits by logging onto the Employee Benefits Center at [sbmc.myebconline.com](http://sbmc.myebconline.com).



## Default Benefits

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New employees who do not make timely elections for health, dental, vision, supplemental policies and core life benefits before the date of eligibility will be assigned the following Default Benefits:

- ◆ CIGNA HealthCare Open Access Plus In Network employee only health coverage
- ◆ CIGNA Dental PPO Low Option employee only dental coverage
- ◆ Davis Vision employee only vision coverage
- ◆ The Standard employee core group term life insurance benefits
- ◆ Benefit Dollars/Medical FSA - full-time employee \$200 per year OR part-time employee \$100 per year.

If assigned, Default Benefits will be effective the first day of the month following 30 days of employment. Changes to Default Benefits will not be allowed until the next applicable Open Enrollment period unless the employee can demonstrate a family status change (Qualified Event) as explained in this booklet.



# Qualifying Events

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, such as adding or deleting dependents, depending on whether or not you experience an “eligible” qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125. You may change a benefit election upon the occurrence of a valid qualifying event only if the event affects your own, your spouse’s, or your dependent’s coverage eligibility.

If approved, most election changes will be effective on the first of the month following the qualifying event for additions (except for newborns & adoptions); cancellations will be processed at the end of the month in which the event occurred.

**IMPORTANT!**

If you experience a relevant qualifying event, it is **YOUR** responsibility to log on to the Employee Benefits Center and make notification within 30 days of the event. Beyond 31 days, changes will be denied and you will be responsible both legally and financially for any claims and/or expenses incurred if any dependent(s) fails to meet the eligibility requirements.

**Examples of Qualifying Events Include:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>◆ The birth / adoption / legal custody of a child</li> <li>◆ A marriage</li> <li>◆ A divorce</li> <li>◆ A covered dependent is no longer eligible for coverage</li> <li>◆ A dependent returns to full-time student status</li> <li>◆ Gain or Loss of Medicare or Medicaid coverage</li> </ul> | <ul style="list-style-type: none"> <li>◆ A spouse or dependent child dies</li> <li>◆ An increase in your work hours from part-time to full-time</li> <li>◆ A decrease in your work hours or leave of absence</li> <li>◆ A spouse obtains or loses coverage as a result of termination of employment</li> <li>◆ A child gains or loses coverage with an ex-spouse</li> <li>◆ Gain or Loss of Florida KidCare coverage</li> </ul> |
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**Continuation of Medical Coverage Benefits (COBRA)**

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees may be eligible to continue their enrollment in certain medical plans, such as health and dental, if coverage is terminated by reason of a qualifying event.

**Qualifying Event Q&A:**

<p><i>Can I add or delete dependent coverage and make changes to my benefit elections during the year?</i></p>	<p>A participant is permitted to make changes to his or her elections mid-plan year only for a legitimate Qualifying Event, meaning, “on account of and corresponding with a Qualifying Event that affects eligibility for coverage”. If you experience a Qualifying Event, the election changes must be requested within 30 days from the Qualifying Event date and the change must be consistent with the type of event. Based on the event, you may add or delete dependents to your existing coverage, however, you cannot change your medical or dental plan insurance provider.</p>
<p><i>If I experience a Qualifying Event, how and when must I request the change?</i></p>	<p>Within 30 days of the Qualifying Event, log on to <a href="http://sbmc.myebconline.com">sbmc.myebconline.com</a> and navigate to the Qualifying Event section. You will be asked to complete a simple questionnaire and will be required to furnish supporting documentation to Risk Management/Employee Benefits Department office at the conclusion of the process. Upon the approval and completion of processing your election change request, your existing benefit elections will be stopped or modified. Requests made later than 30 days from the date of the event will not be approved</p>



# Qualifying Events

Qualifying Event Q&A:	
<i>If I add dependents due to a Qualifying Event, when does their coverage become effective?</i>	Coverage for your dependents becomes effective for Birth or Adoption of a child, on the date of the Qualifying Event OR for all others, first of the month following the date of the Qualifying Event subject to approval by Risk Management/Employee Benefits Department. You must log on to the Employee Benefits Center to make notification of the Qualifying Event and provide documentation to Risk Management/Employee Benefits Department within 30 days.
<i>If I delete a dependent due to a Qualifying Event, when does their coverage end?</i>	Coverage for your deleted dependent ends effective the last day of the month in which the Qualifying Event occurred subject to approval by Risk Management/Employee Benefits Division. You must log on to the Employee Benefits Center to make notification of the Qualifying Event and provide documentation to Risk Management/Employee Benefits Department within 30 days.
<i>If I waive District healthcare coverage but I lose my other group health coverage, can I enroll in a District health plan mid-year?</i>	Yes, you can enroll in a District plan mid-year if you have lost other group insurance coverage subject to approval by Risk Management/Employee Benefits Department. You must log on to the Employee Benefits Center to make notification of the Qualifying Event and provide documentation to Risk Management/Employee Benefits Department within 30 days.



# Appeal Process

If your election change request is denied, you will have 30 days from the date that you receive the denial to file an appeal. Your request will be reviewed by a third party. If approved, arrangements must be made with Risk Management / Employee Benefits Department to pay any past due premiums. You have the right to appeal the decision by faxing a written request to Eagles - Benefits by Design (fax: (772) 334-7059) within 30 days of the denial for review. The appeal must contain:

- ✓ Employee name
- ✓ Date of service for which the request was denied
- ✓ Copy of the denied request
- ✓ The denial letter you received
- ✓ The reason you think your request should not have been denied
- ✓ Any additional documents, information or comments that you think may have a bearing on your appeal.

Appeals are approved only if extenuating circumstances and supporting documentation are within IRS regulations governing the plan.



# Medical Insurance

## CIGNA Healthcare

Customer Service: (800) CIGNA24 (244-6224)

Website: [www.cigna.com](http://www.cigna.com)

### Open Access Plus In-Network Plan (OAPIN)

The Open Access Plus In-Network Plan (OAPIN) requires you receive services from providers and facilities that participate in the CIGNA OAPIN plan network. However, the "Open Access" feature allows you to visit any provider or facility in the network without having to receive a referral from a Primary Care Physician (PCP). The OAPIN plan will not coordinate benefits with any other medical plan.

### Open Access Plus (OAP)

The Open Access Plus (OAP) Plan does not require you to select or coordinate your care through a Primary Care Physician (PCP); Specialist referrals are not required. In addition, you have the freedom to seek services of any provider regardless of their participation in the CIGNA OAP network. However, you will pay less out-of-pocket by seeking care from a participating provider. Providers that do not participate in CIGNA's OAP network may "balance bill". Balance billing is the amount above discounted charge for any service received and the out-of-network provider's retail charge. You are responsible for any balance billing that occurs when an out-of-network provider is used.

### MyCIGNA.com

MyCIGNA.com is CIGNA's member self-service website. This secure website provides you with 24-hour access to many self-service choices and other health related information. Personalized and convenient, log on to MyCIGNA.com to:

- ◆ Verify your personal information
- ◆ Find a provider / facility
- ◆ Search frequently asked questions
- ◆ Review your / dependent coverage
- ◆ View the status of claims
- ◆ Order a new ID card or print a temporary one
- ◆ Learn about your plan's benefits
- ◆ Communicate with Customer Service
- ◆ Learn about CIGNA's value-added programs

### Healthy Rewards

CIGNA's Healthy Rewards program provides access to a full range of health and wellness programs which are often not covered by traditional benefits. To learn about these programs, simply call 1-800-870-3470 or log in to [www.cigna.com](http://www.cigna.com). Healthy Rewards discounts are available by participating providers for such services as:

- ◆ Acupuncture
- ◆ Smoking Cessation
- ◆ Massage Therapy
- ◆ Fitness Clubs
- ◆ Natural Supplements
- ◆ Weight Management
- ◆ Laser Vision Care
- ◆ Hearing Exams and Aids
- ◆ and much more!

### 24-Hour Health Information Line: (800) 564-8982

The CIGNA 24-Hour Health Information Line provides you access to helpful, reliable information on a wide range of topics 24 hours a day, any day of the year. You can listen to tapes on topics that include aging, woman's health, nutrition and surgery. The tapes are regularly updated to include new treatments and medical data. You can also speak with a health information nurse at any time during the call - even if you are in the middle of a health information library tape. Note: for emergencies, you will be directed to call 911.

**Prescription Drug Mail Order Program**  
**Tel-Drug Rx Home Delivery: (800) 835-3784 - Website: [www.teldrug.com](http://www.teldrug.com)**

If you are prescribed certain maintenance medications, you have the opportunity to maximize your savings by participating in CIGNA's prescription drug mail order program.

For example, Generic prescriptions will cost \$7 per prescription or \$21 if you obtain your prescription from a retail pharmacy over a 3 month period. However, the same prescription may be eligible for the mail order program which allows you to receive a 3 month supply of your generic medication, by mail, for only \$14. You save a month's copay as well as enjoy the convenience of having your medication delivered to your home.

Additional information including claim forms and mailing envelopes for the prescription mail order program may be obtained by contacting Risk Management/Employee Benefits Department or visiting [ww.mycigna.com](http://ww.mycigna.com).



# Medical Insurance

The District offers two health insurance plan options through CIGNA HealthCare. A Summary of the plan's schedule of benefits are provided on the next page. For details regarding the entire plan's coverages, exclusions and stipulations, please refer to your CIGNA benefit summary available through the Employee Benefit Center or please contact CIGNA Customer Service at (800) 244-6224. The District pays the entire cost of single coverage for the Open Access Plus In-Network (OAPIN) Plan for full-time employees. Part-time employees are eligible to receive 50% of the cost of the OAPIN Plan. All employees who select the Open Access Plus (OAP) Plan are responsible for the difference in premium from the OAPIN Plan. In addition, if you choose to cover your dependents, you are responsible of the difference between the family and single rate.

## 2009 - 2010 Plan Year: 24 Deductions

Full-Time Employee		
Coverage Tier	Open Access Plus In-Network (OAPIN)	Open Access Plus (OAP)
Employee Only	\$0.00	\$128.61
Employee + Family	\$255.90	\$556.61
2 District Employee Family	\$0.00	\$298.07
2 District Employee Family (1 full-time / 1 part-time)	\$126.63	\$427.34
Dependent Age 25-30*	\$123.98	\$196.45

\*Additional deduction per pay for each dependent age 25 - 30 in addition to the family deduction

Part-Time Employee		
Coverage Tier	Open Access Plus In-Network (OAPIN)	Open Access Plus (OAP)
Employee Only	\$129.27	\$257.88

## 2009 - 2010 Plan Year: Hourly Deductions

Full-Time Employee		
Coverage Tier	Open Access Plus In-Network (OAPIN)	Open Access Plus (OAP)
Employee Only	\$0.00	\$140.30
Employee + Family	\$279.16	\$607.21
2 District Employee Family	\$0.00	\$325.17
2 District Employee Family (1 full-time / 1 part-time)	\$138.14	\$466.19
Dependent Age 25-30*	\$135.25	\$214.31

\*Additional deduction per pay for each dependent age 25 - 30 in addition to the family deduction

Part-Time Employee		
Coverage Tier	Open Access Plus In-Network (OAPIN)	Open Access Plus (OAP)
Employee Only	\$141.02	\$281.32



# Medical Insurance

## CIGNA HealthCare

**NOTE:** The coinsurance percentage listed in the OAP is what the plan pays after the Calendar Year Deductible (CYD) is satisfied.

Summary of Benefits	OAPIN	OAP	
Calendar Year Deductible (CYD)	In-Network Only	In-Network	Out-of-Network
Per Member	No Deductible		\$300
Per Family	No Deductible		\$600
Out of Pocket Maximum	In-Network Only	In-Network	Out-of-Network
Per Member	\$2,000	\$1,000	\$4,000
Per Family	\$4,000	\$3,000	\$12,000
Prescriptions - Retail (30 Day Supply)	In-Network Only	In-Network	Out-of-Network
Generic	\$7 Copay	\$7 Copay	Not Covered When Filled at Out-of-Network Pharmacies
Preferred Brand Name	\$30 Copay	\$30 Copay	
Non-Preferred Brand Name	\$50 Copay	\$50 Copay	
Mail-order (90 Day Supply)	2x Retail Copay	2x Retail Copay	Not Covered
Physician Services	In-Network Only		
Preventative Care	\$20 Copay	80% After CYD	Not Covered
Physician Office Visit	\$20 Copay	80% After CYD	60% After CYD
Specialist Office Visit	\$40 / \$55	80% After CYD	60% After CYD
<i>OAPIN: Specialist copay is \$40 when the Specialist seen participates in the CIGNA "Care" Network</i>			
Outpatient Services	In-Network Only	In-Network	Out-of-Network
Clinical Lab (Blood Work)	No Copay	80% After CYD	60% After CYD
Diagnostic Services	No Copay	80% After CYD	60% After CYD
Advanced Imaging (MRI, MRA, CT)	\$100 Copay	80% After CYD	60% After CYD
Rehabilitation Services	Physician/Specialist Copay	80% After CYD	60% After CYD
<i>Rehabilitation Services - Combined 120 Day Maximum Per Calendar Year</i>			
Hospital Services	In-Network Only	In-Network	Out-of-Network
Inpatient	\$150 per Day (Not to Exceed \$750 per Calendar Year)	80% After CYD	60% After CYD + \$500 per Admission
Outpatient	\$150 per Procedure	80% After CYD	60% After CYD
Physician Services at Hospital	No Charge	80% After CYD	60% After CYD
Emergency Room	\$150 Copay	80% After CYD	60% After CYD
Urgent Care Center	\$40 Copay	80% After CYD	60% After CYD
Mental Health / Alcohol & Substance Abuse	In-Network Only	In-Network	Out-of-Network
Inpatient	\$200 per Admission	80% After CYD + \$200 per Admission	60% After CYD + \$200 per Admission
Outpatient	\$20 Copay	\$20 Copay	60% After CYD
<i>Combined Calendar Year Benefit Maximum: 30 days or 30 visits; Alcohol / Substance Abuse Benefit is for Detoxification Only.</i>			
Lifetime Maximum	In-Network Only	In-Network	
Per Member	Unlimited	\$5 million	

\* For the OAPIN, the out-of-pocket maximum includes all co-pays excluding prescriptions. For the OAP, the out-of-pocket maximum excludes certain services such as expenses over reasonable and customary limits, prescriptions, and procedures deemed not medically necessary.



# Pre-Existing Conditions

You may be subject to pre-existing conditions unless you can show proof of continuous creditable coverage. To learn how to obtain a “certificate of creditable coverage” from your former insurance carrier, please contact the Risk Management/Employee Benefits Department.



## Medicare Secondary Payer (Active Employees)

If the Patient...	And this Condition Exists...	Then this Program Pays First...	And this Program Pays Second
<i>Is age 65 or older, and is covered by a Group Health Plan through current employment or spouse's current employment...</i>	The employer has less than 20 employees...	Medicare	Group Health Plan
	The employer has 20 or more employees, or at least one employer is a multi-employer group that employs 20 or more individuals....	Group Health Plan	Medicare
<i>Is disabled and covered by a Large Group Health Plan through his or her own current employment or through a family member's current employment...</i>	The employer has less than 100 employees...	Medicare	Large Group Health Plan
	The employer has 100 or more employees, or at least one employer is a multi-employer group that employs 100 or more individuals...	Large Group Health Plan	Medicare
<i>Has End Stage Renal Disease and Group Health Plan coverage...</i>	Is in the first 30 months of eligibility or entitlement to Medicare...	Group Health Plan	Medicare
	After 30 months...	Medicare	Group Health Plan
<i>Has End State Renal Disease and COBRA coverage...</i>	Is in the first 30 months of eligibility or entitlement to Medicare...	COBRA	Medicare
	After 30 months...	Medicare	COBRA
<i>Is covered by Workers' Compensation because of job-related illness or injury...</i>	The patient is entitled to Medicare...	Workers' Compensation (for health care items or services related to job-related illness or injury). Payment may be made from a Workers' Compensation Medicare Set-Aside Arrangement.	Medicare
<i>Has been in an accident or other situation where no-fault or liability insurance is involved...</i>	The patient is entitled to Medicare....	No-fault or liability insurance for accident or other situations related to health care services	Medicare
<i>Is age 65 or older OR is disabled and covered by Medicare and COBRA...</i>	The patient is entitled to Medicare...	Medicare	COBRA



# Employee Assistance Plan

## CIGNA Behavioral Health

Website: [www.cignabehavioral.com](http://www.cignabehavioral.com)

Customer Service: (877) 622-4327

The District provides a comprehensive Employee Assistance Program (EAP) at no cost for you and each member of your family through CIGNA Behavioral Health. The EAP offers access to licensed mental health professionals through a confidential program that is protected by State and Federal Laws. The EAP allows for 5 confidential short-term therapy sessions at no cost to you. Conditions that cannot be treated within 5 sessions may be referred to your health plan.

Examples of the issues addressed by the EAP are provided below.

EAP Areas of Service		
♦ Marital	♦ Family	♦ Depression
♦ Alcohol / Drugs	♦ Financial	♦ ...or other personal issues
♦ Emotional	♦ Stress	affecting your quality of life



# Dental Insurance

## CIGNA Dental

Customer Service: (800) 244-6224

Website: [www.CIGNA.com](http://www.CIGNA.com)

Option 1:	DHMO Dental Plan
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The DHMO is a “pre-paid” dental plan that features no deductibles and offers lower out-of-pocket costs for your dental care needs. **The DHMO requires you to first select a Primary Dental Provider (PDP) to coordinate your dental care prior to receiving services.** If you do not select a PDP, you will not be able to access care until a PDP is selected. You will be able to change your PDP in any given month by calling CIGNA Dental customer service. The change will be effective the 1st of the month following the date of your request. Benefits are only provided when services are received by an in-network dental provider. The specific copay amount that you pay the dentist for covered procedures is listed on your benefits schedule which can be found by logging on to [www.MyCIGNA.com](http://www.MyCIGNA.com). There are no additional charges, pre-existing conditions, or maximum allowances because the in-network dentists have agreed to provide the comprehensive benefits outlined in the plan and accept a set fee schedule; you know how much each covered procedure will cost in advance. Orthodontia is available for both adults and children. Examples of covered services and their corresponding copays are provided below.

Note: this plan does NOT coordinate coverage and benefits with any other plan.

Office Visit	\$0	Extraction		Fillings		Root Canal	
Periodic Exam	\$0	Single Tooth	\$10	Amalgam - 1 surface	\$0	Anterior	\$10
Prophylaxis	\$0	Partial Impaction	\$55	Resin - 1 surface	\$0	Bicuspid	\$15
Full Mouth X-rays	\$0	Boney Impaction	\$100	Sedative	\$10	Molar	\$230
Crown & Bridge		Dentures		Peridontic Therapy		Orthodontia*	
Full High Noble Metal	\$360	Partial Denture	\$490	Root Planning (1/4)	\$80	Child	\$2,280
Porcelain fused to Metal	\$360	Complete Denture	\$425	Gingivectomy (1/4)	\$165	Adult	\$2,880

\*Includes initial visit, banding and 24 month treatment plan



# Dental Insurance

<i>Option 2:</i>	<b>Low PPO Dental Plan</b>
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The Low PPO Dental Plan allows you to use any dentist of your choice. If you use a CIGNA network dentist, your out-of-pocket expenses will be lower than if you seek services from a provider not in the CIGNA network. Once your deductible is satisfied (if applicable), your coinsurance responsibility will be based on the type of services received as provided in the Summary of Benefits table below. For services received out-of-network, the percentage of coinsurance the Low Option PPO will reimburse the provider will be based on **CIGNA’s PPO fee schedule** which means a lower out-of-pocket cost for you. Any amount billed above the PPO fee schedule will be the member’s responsibility.

<i>Option 3:</i>	<b>High PPO Dental Plan</b>
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The High PPO Dental Plan also allows you to use any dentist of your choice. If you use a CIGNA network dentist, your out-of-pocket expenses will be lower than if you seek services from a provider not in the CIGNA network. Once your deductible is satisfied (if applicable), your coinsurance responsibility will be based on the type of services received as provided in the Summary of Benefits table below. For services received out-of-network, the percentage of coinsurance the High Option PPO will reimburse the provider will be based on the **usual & customary charge**. Any amount billed above the usual & customary charge will be the member’s responsibility.

*NOTE: The coinsurance percentage listed is what the plan pays after the Calendar Year Deductible is satisfied (if applicable).*

Summary of Benefits	Option 2: Low PPO Plan		Option 3: High PPO Plan	
<b>Calendar Year Benefit Maximum</b>	<b>In &amp; Out-of-Network Combined</b>		<b>In &amp; Out-of-Network Combined</b>	
Per Member	\$1,000		\$1,000	
<b>Calendar Year Deductibles</b>	<b>In &amp; Out-of-Network Combined</b>		<b>In &amp; Out-of-Network Combined</b>	
Per Member	\$50		\$50	
Per Family	\$100		\$100	
Waived for Preventative Services?	Yes		Yes	
<b>Benefits / Service Types</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Class I - Diagnostic & Preventative	100%	80%	100%	100%
Class II - Basic Restorative	80%	60%	80%	80%
Class III - Major Restorative	50%	40%	50%	50%
Class IV - Orthodontia	50%	50%	50%	50%
<i>Orthodontia Lifetime Benefit Max.</i>	\$500		\$1,000	
<b>Service Information</b>				
Out-of-Network Benefits Payable Level	PPO Fee Schedule		90% Usual & Customary	
Endodontics / Periodontics Services Classification	Major		Basic	

**PLEASE NOTE:** For both the DHMO and PPO Dental Plans, Orthodontia treatment that is already in progress will be handled differently than listed in the Summary of Benefits tables. For further information regarding “Orthodontics in Progress,” please see a Benefits Counselor or contact the Risk Management / Employee Benefits Department.



# Dental Insurance

As a full-time District employee, your employee-only dental coverage will be fully funded as a core benefit no matter which plan you select. Part-time employees who enroll in dental coverage are eligible to receive 50% of the cost from the District. You can decide which dental coverage best suits your needs and can select it separately from your medical plan. Your dental election does not have to match your election for medical coverage. For example, if you elected single medical coverage, you do not have to select single dental coverage. You may elect to cover only yourself for medical and your family for dental.

## 2009 - 2010 Plan Year: 24 Deductions

Full-Time Employee			
Coverage Tier	DHMO	DPPO Low Option	DPPO High Option
Employee Only	\$0.00	\$0.00	\$0.00
Employee + Family	\$15.53	\$16.67	\$25.53
2 District Employee Family	\$4.74	\$6.13	\$9.38
2 District Employee Family (1 full-time / 1 part-time)	\$10.14	\$11.40	\$17.46

Part-Time Employee			
Coverage Tier	DHMO	DPPO Low Option	DPPO High Option
Employee Only	\$5.40	\$5.27	\$8.08

## 2009 - 2010 Plan Year: Hourly Deductions

Full-Time Employee			
Coverage Tier	DHMO	DPPO Low Option	DPPO High Option
Employee Only	\$0.00	\$0.00	\$0.00
Employee + Family	\$16.94	\$18.19	\$27.85
2 District Employee Family	\$5.17	\$6.69	\$10.23
2 District Employee Family (1 full-time / 1 part-time)	\$11.06	\$12.44	\$19.04

Part-Time Employee			
Coverage Tier	DHMO	DPPO Low Option	DPPO High Option
Employee Only	\$5.89	\$5.75	\$8.81



# Vision Insurance

## Davis Vision

Website: [www.davisvision.com](http://www.davisvision.com)

Customer Service: (888) 343-3466

The District pays the entire cost of single coverage for full-time employees. Part-time employees are eligible to receive 50% of the cost from District (you must enroll to receive this contribution).

When services are received by a Davis Vision network provider, eye exams, frames and spectacle lenses are covered at 100% after a \$10 copay (service frequencies provided below). Contact lenses (in lieu of eyeglasses) are also covered at 100% including lens fitting and evaluation fees. To find the names and addresses of the Davis Vision providers nearest you, log on to [www.davisvision.com](http://www.davisvision.com).

<b>In-Network Copay Schedule</b>	Exam - \$10 Copay Lenses, Frames or Contact Lenses* - \$0 Copay
<b>Services Frequency</b>	Comprehensive Exam - Every 12 Months Lenses - Every 12 Months Contact Lenses* - Every 12 Months Frames - Every 24 months
<b>Network Providers</b>	Private Offices and Retail Outlets

\* Contact Lenses In Lieu of Eyeglasses.

The Davis Vision plan also provides a benefit for services received by a vision provider not in the Davis Vision network. You will first be required to pay for services received out-of-network and then file a claim to Davis Vision for reimbursement. The out-of-network reimbursement schedule is provided in the Summary of Benefits table below. Any fees charged in excess of the out-of-network reimbursement will be the member's responsibility.

Summary of Benefits	After Copay	Plan Reimbursement
<b>Eye Examinations</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Ophthalmologist	Paid in Full	Up to \$35
Optometrist	Paid in Full	Up to \$35
<b>Lenses (per pair)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Single	Paid in Full	Up to \$25
Bifocal	Paid in Full	Up to \$40
Trifocal	Paid in Full	Up to \$60
Lenticular	Paid in Full	Up to \$100
<b>Contact Lenses</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Elective (Exam + Lenses)	Up to \$130 credit + 15% Discount on Overages	Up to \$120
Medically Necessary	Paid in Full	Up to \$210
<b>Frames</b>	<b>In-Network</b>	<b>Out-of-Network</b>
"Designer Collection"	Paid in Full	Up to \$40
Provider Frame	Up to \$130 credit + 20% Discount on Overages	Up to \$40
<b>Lasik Discount</b>	25% Off Regular or 5% Off Any Special Pricing	Not Available



# Vision Insurance

## 2009 - 2010 Plan Year 24 Deductions

Full-Time Employee	
Employee Only	\$0.00
Employee + Family	\$4.80
2 District Employee Family	\$2.32
2 District Employee Family (1 full-time / 1 part-time)	\$3.56

## 2009 - 2010 Plan Year Hourly Deductions

Full-Time Employee	
Employee Only	\$0.00
Employee + Family	\$5.24
2 District Employee Family	\$2.53
2 District Employee Family (1 full-time / 1 part-time)	\$3.88

Part-Time Employee	
Employee Only	\$1.24

Part-Time Employee	
Employee Only	\$1.35



# Core Life and AD&D Insurance

## The Standard

Website: [www.standard.com](http://www.standard.com)

Customer Service: (800) 628-8600

## Basic Term Life

The District provides Basic Life insurance to all benefit eligible employees through The Standard and pays 100% of the premium for full-time employees.

- ♦ All active full-time employees are covered for a life insurance benefit amount of \$35,000, excluding administrative employees, eligible retirees excluding retirees previously classified as administrative employees, and active permanent part-time employees excluding administrative employees.
- ♦ All active full-time administrative employees and retirees previously classified as administrative employees are covered for a benefit amount of two (2) times their annual salary up to a maximum of \$75,000 rounded to the next higher \$1,000. Administrative employees include confidential secretaries, extended day managers, food service managers, and plant operators.
- ♦ All employees who are covered under the core term life insurance policy with The Standard, are also covered for AD&D. This means that if death results from an accident, the designated beneficiary will receive an additional payment equal to the life insurance benefit amount. For example, if an employee dies as a result of a car accident, the beneficiary receives a total of \$70,000 (\$35,000 life insurance plus \$35,000 AD&D insurance).
- ♦ In addition to an additional benefit amount for death resulting from an accident, AD&D insurance also provides partial payments to the insured for loss of certain limbs or paralysis which results from an accident.
- ♦ An accelerated benefit of 75% of the benefit amount may also be payable in the event the insured is terminally diagnosed.

**It is important to note that there is a benefit reduction schedule based on age for both active employees and retirees. Benefit amounts reduce by 35% of the original amount at age 65 and by 50% of the original amount at age 70.**



# Core Life and AD&D Insurance

## Accidental Death & Dismemberment

Also at no cost to the employee, the District provides accidental death & dismemberment (AD&D) insurance which pays in addition to the basic life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the basic term life benefit amount. A partial benefit is also payable based on the schedule below.

100% of the AD&D Benefit Will be Paid for the Loss of:	One Half the AD&D Benefit Will be Paid for the Loss of:
<ul style="list-style-type: none"> <li>◆ Life (accidental); or</li> <li>◆ Both hands or both feet; or</li> <li>◆ Sight of both eyes; or</li> <li>◆ Any two or more: one foot, one hand, or the sight of one eye.</li> </ul>	<ul style="list-style-type: none"> <li>◆ One hand; or</li> <li>◆ One foot; or</li> <li>◆ Sight of one eye; or</li> <li>◆ Thumb and index finger of the same hand.</li> </ul>

### IMPORTANT REMINDER

Please keep your beneficiary information up to date. Life insurance beneficiary designations can be updated at any time online by visiting the Employee Benefits Center. Paper forms may be requested by contacting Risk Management/Employee Benefits Department.

### 2009 - 2010 Plan Year Deductions

Coverage Tier	24 Deductions	Hourly Deductions
Full-Time Employee	\$0.00	\$0.00
Part-Time Employee (\$35,000)	\$2.06	\$2.24



# Supplemental Group Life Insurance

## The Standard

Website: [www.standard.com](http://www.standard.com)

Customer Service: (800) 628-8600

## Supplemental Life

At your own cost, you may purchase additional life insurance coverage, above and beyond the basic coverage provided by the District. Supplemental life insurance may be purchased to cover yourself. In addition, you may purchase a Dependent Life Insurance rider that is a "family unit" policy. You must be enrolled in the Core Life to purchase Supplemental Life Insurance. The supplemental life premium rates are based on the amount of coverage you elect (the "family unit" rate remains the same regardless of how many children you may cover). A snapshot explaining the plan's coverages is provided below.

- ◆ You may elect coverage for yourself in increments of \$10,000 up to \$100,000.
- ◆ Open Enrollment: Guarantee Issue for Supplemental Life is \$10,000 per year. New Hires: Guarantee Issue for your Supplemental Life is \$100,000.
- ◆ You may elect coverage for a "family unit" in the amount of \$10,000 for your spouse and /or \$5,000 per child.
- ◆ Amounts applied for over the Guarantee Issue amount will require evidence of insurability and be subject to carrier approval.



# Supplemental Group Life Insurance

2009 - 2010 Plan Year  
24 Deductions

Employee Rates	
Benefit	Deduction
\$10,000	\$1.45
\$20,000	\$2.90
\$30,000	\$4.35
\$40,000	\$5.80
\$50,000	\$7.25
\$60,000	\$8.70
\$70,000	\$10.15
\$80,000	\$11.60
\$90,000	\$13.05
\$100,000	\$14.50
"Family Unit" Deduction	
\$1.31	

2009- 2010 Plan Year  
Hourly Deductions

Employee Rates	
Benefit	Deduction
\$10,000	\$1.58
\$20,000	\$3.16
\$30,000	\$4.75
\$40,000	\$6.33
\$50,000	\$7.91
\$60,000	\$9.49
\$70,000	\$11.07
\$80,000	\$12.65
\$90,000	\$14.24
\$100,000	\$15.82
"Family Unit" Deduction	
\$1.43	

**PLEASE NOTE:** For further information on these life insurance benefits such as waiver of premium, accelerated benefit, conversion, portability privileges, and to receive a beneficiary form or change a beneficiary designation, please contact the Risk Management / Employee Benefits Department. Beneficiary designations may also be made or changed by visiting the Employee Benefits Center online.



# Disability Insurance

## CIGNA Group Benefits

Customer Service: (800) 362-4462

Website: [www.CIGNA.com](http://www.CIGNA.com)

The District provides benefit eligible employees the opportunity to purchase short-term disability (STD) and long-term disability (LTD) insurance. Disability insurance pays you a percentage of your weekly or monthly base earnings if you cannot work due to a disabling non-work related accident or sickness. Participation in this program is voluntary and all premiums are paid by you through post-tax payroll deductions for your convenience. Your premium will depend on the level of coverage for which you are eligible based on your base annual salary. Commonly asked questions about STD and LTD and their answers are provided on the next two pages.



# Short Term Disability (STD) Insurance

Short-Term Disability Questions & Answers	
<i>Do I qualify as disabled?</i>	You qualify as disabled if you are: <ul style="list-style-type: none"> <li>♦ Totally disabled due to sickness or injury, you are not working, and cannot perform the duties of your normal occupation;</li> <li>♦ Working part-time or on a limited basis due to disability. You will qualify as residually disabled if you are working but cannot perform the duties of your normal occupation.</li> </ul>
<i>When does the STD benefit begin?</i>	The STD benefit begins after you are disabled for 14 continuous days. <i>Disability coverage will be coordinated with District leave policies.</i>
<i>What is the STD benefit?</i>	The STD benefit equals 60% of your weekly predisability earnings, up to the Maximum Weekly Benefit amount listed below.
<i>How long does the STD benefit last?</i>	To a maximum of 13 weeks as long as you qualify as disabled.

Level	Annual Base Salary	Weekly Benefit	Maximum Weekly Benefit
Level 1	Less than \$24,000	60% of base weekly earnings	\$275
Level 2	\$24,000 - \$29,999	60% of base weekly earnings	\$350
Level 3	\$30,000 - \$35,999	60% of base weekly earnings	\$425
Level 4	\$36,000 - \$49,999	60% of base weekly earnings	\$575
Level 5	\$50,000 - \$74,999	60% of base weekly earnings	\$850
Level 6	Greater than \$75,000	60% of base weekly earnings	\$1,150

For example, when enrolling in this coverage, you should select coverage Level 3 if your base annual salary is between \$30,000 - \$35,999.

**2009 - 2010 Plan Year  
24 Deductions**

Weekly Benefit	Annual Base Salary	Deduction
Level 1 (\$275)	Less than \$24,000	\$7.45
Level 2 (\$350)	\$24,000 - \$29,999	\$8.02
Level 3 (\$425)	\$30,000 - \$35,999	\$8.54
Level 4 (\$575)	\$36,000 - \$49,999	\$9.00
Level 5 (\$850)	\$50,000 - \$74,999	\$9.63
Level 6 (\$1,150)	Greater than \$75,000	\$10.32

**2009 - 2010 Plan Year  
Hourly Deductions**

Weekly Benefit	Annual Base Salary	Deduction
Level 1 (\$275)	Less than \$24,000	\$8.13
Level 2 (\$350)	\$24,000 - \$29,999	\$8.75
Level 3 (\$425)	\$30,000 - \$35,999	\$9.32
Level 4 (\$575)	\$36,000 - \$49,999	\$9.82
Level 5 (\$850)	\$50,000 - \$74,999	\$10.51
Level 6 (\$1,150)	Greater than \$75,000	\$11.26

**Note: premiums for this coverage will be payroll deducted on a post-tax basis. (Benefits paid will not be subject to taxes).**



# Long Term Disability (LTD) Insurance

Long-Term Disability Questions & Answers	
<i>Do I qualify as disabled?</i>	<p>You qualify as disabled for the first 2 years of disability if:</p> <ul style="list-style-type: none"> <li>◆ You are not working and cannot perform the duties of your normal occupation due to injury or illness; or</li> <li>◆ You are working part-time or on a limited basis due to injury or illness.</li> </ul> <p>Thereafter, you qualify as disabled if:</p> <ul style="list-style-type: none"> <li>◆ You are not working and cannot perform any occupation you are reasonably qualified to perform based on your background, training, or education;</li> <li>◆ You are working part-time or on a limited basis due to injury or illness.</li> </ul>
<i>When does the LTD benefit begin?</i>	The LTD benefit begins after you have been disabled for 90 days.
<i>What is the LTD benefit?</i>	The LTD benefit equals 60% of your monthly predisability earnings, up to the Maximum Weekly Benefit amount listed on the next page. This benefit may be reduced by other income (on next page).
<i>What is the LTD benefit if I am disabled but working?</i>	If you are disabled and working on a limited or part-time basis, the “Work Incentive Benefit” is equal to the total disability benefit as long as the sum does not exceed your weekly predisability pay.
<i>How long does the LTD benefit last?</i>	The benefit will continue while continuously disabled with a maximum period determined based on your age at the time of disability.
<i>What other income may reduce the LTD benefit?</i>	<ul style="list-style-type: none"> <li>◆ Retirement payments or disability payments from Social Security or other government agencies;</li> <li>◆ Payments from pension plans;</li> <li>◆ Workers’ Compensation.</li> </ul>
<i>What would cause the LTD benefit to terminate?</i>	<p>Benefits end when your disability ends or you:</p> <ul style="list-style-type: none"> <li>◆ Reach the maximum benefit payment period;</li> <li>◆ Fail to provide any proof of disability;</li> <li>◆ Death;</li> <li>◆ Cease to be under the care of a physician;</li> <li>◆ Fail to report income from other sources;</li> <li>◆ Fail to pursue Social Security Disability Income (SSI) benefits (when appropriate);</li> <li>◆ Fail to submit to required medical exams.</li> </ul>
<i>What disabilities does the LTD plan exclude?</i>	<p>The LTD benefit does not pay a benefit for disabilities resulting from:</p> <ul style="list-style-type: none"> <li>◆ Willful self-injury;</li> <li>◆ War or act of war;</li> <li>◆ Participation in an assault or felony;</li> <li>◆ A sickness or injury covered by Workers’ Compensation or arising out of or in the course of employment for wage or profit;</li> <li>◆ A new or continuing disability after the benefit payment period ends and the insured has not returned to active work;</li> <li>◆ Preexisting condition.</li> </ul>



# Long Term Disability (LTD) Insurance

Level	Annual Base Salary	Monthly Benefit	Maximum Monthly Benefit
Level 1	Less than \$24,000	60% of base monthly earnings	\$1,200
Level 2	\$24,000 - \$29,999	60% of base monthly earnings	\$1,500
Level 3	\$30,000 - \$35,999	60% of base monthly earnings	\$1,800
Level 4	\$36,000 - \$49,999	60% of base monthly earnings	\$2,500
Level 5	\$50,000 - \$74,999	60% of base monthly earnings	\$3,750
Level 6	Greater than \$75,000	60% of base monthly earnings	\$5,000

**Example:** when enrolling in this coverage, you should select coverage Level 3 if your base annual salary is between \$30,000 - \$35,999.

You must be continuously disabled for 90 days before you are eligible to receive long term disability benefits. You will not be required to pay any premiums while monthly LTD benefits are being paid to you by CIGNA. If you are considered disabled and approaching the end of your LTD benefit period, CIGNA will continue processing claims for potential LTD Benefits. If you become disabled at age 63 or older LTD benefits will continue for 36 months and/or as long as you remain disabled.

**NOTE:** This plan can be converted to an individual policy if you terminate employment or if coverage ends for any reason except non-payment of premium. You must apply for this conversion within 31 days of termination. Evidence of your health status is not required if you apply within this specified timeframe. Please contact CIGNA/LINA at (800) 362-4462 to request a copy of the conversion application.

2009 - 2010 Plan Year  
24 Deductions

Monthly Benefit	Annual Base Salary	Deduction
Level 1 (\$1,200)	Less than \$24,000	\$7.95
Level 2 (\$1,500)	\$24,000 - \$29,999	\$9.11
Level 3 (\$1,800)	\$30,000 - \$35,999	\$9.26
Level 4 (\$2,500)	\$36,000 - \$49,999	\$9.68
Level 5 (\$3,750)	\$50,000 - \$74,999	\$9.87
Level 6 (\$5,000)	Greater than \$75,000	\$10.26

2009 - 2010 Plan Year  
Hourly Deductions

Monthly Benefit	Annual Base Salary	Deduction
Level 1 (\$1,200)	Less than \$24,000	\$8.67
Level 2 (\$1,500)	\$24,000 - \$29,999	\$9.93
Level 3 (\$1,800)	\$30,000 - \$35,999	\$10.10
Level 4 (\$2,500)	\$36,000 - \$49,999	\$10.56
Level 5 (\$3,750)	\$50,000 - \$74,999	\$10.77
Level 6 (\$5,000)	Greater than \$75,000	\$11.19

**Note:** premiums for this coverage will be payroll deducted on a post-tax basis (Benefits paid will not be subject to taxes).



# Coordination of Disability & Leave Benefits

During an illness or recovery period, MCSD employees receive income replacement in the following order:

Paid Sick Leave ➡ Sick Leave Bank (if eligible) ➡ Short Term Disability ➡ Long Term Disability

Maintaining a "paid status" extends the time that the District continues to pay your individual insurance benefits. Calculation of your FMLA time period begins when your paid sick leave is exhausted. The FMLA maximum time period is 12 weeks.



# Benefit Dollars

Benefit dollars are just like real dollars provided by the District to eligible employees that must be spent on pre-tax benefits. Full-time employees receive \$200 per year and part-time employees receive \$100 per year.

You can use these benefit dollars towards the cost of any pre-tax medical, dental, vision or AFLAC coverage for yourself or dependents or participation in a Health Care Flexible Spending Account (FSA) under the District’s employee benefits plan. You will be given an opportunity to choose from the following options as to how your Benefit Dollars are allocated:

<b>OPTION 1:</b>	100% of Benefit Dollars will be used toward pre-tax premium deductions (medical, dental, vision, or AFLAC). Medical premiums will be offset first, followed by dental deductions, vision deductions, then pre-tax AFLAC deductions. If premium deductions are less than the offset; the balance is then forfeited. <u>If you do not have any pre-tax premium deductions then Option 2 applies.</u>
<b>OPTION 2:</b>	100% of Benefit Dollars will be contributed to a Health Care FSA (Dependent Care is not an option). See pages 23-25 for more information on Health Care FSAs.

**PLEASE NOTE:** All medical, dental, and vision premium deductions are deducted on a pre-tax basis. Also, the following AFLAC policy premiums are deducted on a pre-tax basis:

- ✓ Specified Health Event Protection
- ✓ Personal Accident Indemnity Plan
- ✓ Personal Sickness Indemnity Plan
- ✓ Personal Cancer Indemnity



# Section 125

Premiums for medical, dental, vision insurance, and/or certain AFLAC policies and contributions to reimbursement accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-taxed benefits can be made ONLY during an Open Enrollment period unless you or your qualified dependents experience a relevant qualifying event and request, within 30 days, a change or enrollment consistent with that qualifying event.

When a coverage change is requested due to a relevant qualifying event, the change will be effective the first of the month following the date that paperwork is received and approved by the Risk Management / Employee Benefits Department. The only qualifying event change that will be made retroactive are birth, adoption or placement for foster care through the court system. See the Qualifying Events section for additional information.



# Flexible Spending Accounts

**Administered by: Eagles Benefits by Design**

**Customer Service: (772) 334-3995**

**Fax Your Claim: (772) 334-7059**

**www.eaglesbenefits.com**

Flexible Spending Accounts (FSAs) allow you to set aside a certain amount of your paycheck through payroll deductions into an account before paying income taxes. During the year, you have access to this account for reimbursement of expenses you regularly pay such as health care and daycare. This allows you to have substantial tax savings and increase your spending power. You must re-elect the dollar amount you wish to have deducted each plan year.

## Why an FSA?

Most of the money you spend on routine medical expenses comes from your after-tax income. This means you earn money, then pay taxes, and spend what is left. By using FSAs, you can avoid paying taxes on certain qualified expenses, assuming you follow the rules as established by the IRS.

For example, an employee in a 14% federal income tax bracket also has to pay 7.65% in FICA taxes. This is an effective tax rate of 21.65%. By paying your expenses with tax-free income, you can save up to 21.65% on those expenses. How can this help you? Assume that in 2009, you will need to pay \$200 for eyeglasses, \$400 in prescription copays and \$1,000 in orthodontia expenses. By using FSAs, you could save over \$340 in taxes. These taxes are a hidden cost of everything you buy, so why not avoid taxes when possible to give yourself more spendable income? There are two accounts in which you can participate:

Health Care Reimbursement Account	Dependent Care Reimbursement Account
<p>This account allows you to set aside up to an annual <b>minimum amount of \$200 and maximum amount of \$5,000</b> during open enrollment only. This money will not be taxable income to you and can be used to offset the cost of a wide variety of health-related expenses incurred by you or your qualified dependents under medical or dental insurance plans. Examples of these expenses include copays for physician office visits, inpatient hospital stays, prescription drugs, over the counter drugs and other expenses not covered by insurance that generate an out of pocket cost to the employee.</p> <p>Employees can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). Other common expenses that qualify for reimbursement are: deductibles, copays, mental healthcare, dental services and orthodontics, lasik surgery, eye exams, glasses and contacts.</p> <p><b>*NOTE: The entire Health Care FSA election is available to you on the first day coverage is effective.</b></p>	<p>This account reimburses you for day care expenses up to an <b>annual maximum of \$2,500 if you file single or \$5,000 if you are married and filing a joint tax return</b> for eligible children and adults. Qualified expenses include adult and child daycare centers, preschool, and before/after school care.</p> <p>Please note that if your family’s annual income is over \$20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be:</p> <ul style="list-style-type: none"> <li>◆ a child under the age of 13 or,</li> <li>◆ a child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least 8 hours a day in your household.</li> </ul> <p><b>*NOTE: Unlike the Health Care FSA, you will only be reimbursed up to the amount that has been payroll deducted for Dependent Care expenses.</b></p>



# Flexible Spending Accounts

## Is an FSA Right For You?

1. Do you have predictable medical expenses for yourself or your family such as deductibles and copayments?
2. Do you have predictable dental, vision or hearing expenses for yourself or your family?
3. Do you have any work-related day care expenses?

If you answer "Yes" to any of the above questions, you can increase your spendable income by reducing your income taxes and FICA taxes.

Sample List of Qualified Expenses ( <i>must be medically necessary</i> ):		
◆ Acupuncture	◆ Drug addiction/alcoholism treatment	◆ Nursing services
◆ Ambulance service	◆ Prescription drugs	◆ Optometrist fees
◆ Birth control pills and devices	◆ Experimental medical treatment	◆ Orthodontic fees
◆ Chiropractic care	◆ Eyeglasses	◆ Over-the-counter items
◆ Contact lenses (corrective)	◆ Guide dogs	◆ Smoking cessation programs
◆ Dental fees	◆ Hearing aids and exams	◆ Surgery
◆ Diagnostic tests/health screenings	◆ Injections and vaccinations	◆ Transportation for medical care
◆ Doctor fees	◆ In vitro fertilization	◆ Weight-loss programs/meetings



Log on to <http://www.irs.gov/publications/p502/index.html> for additional details regarding qualified and non-qualified expenses.

## What Are The Rules?

- ◆ You may enroll in a Health Care or Dependent Care FSA during the District's open enrollment period only.
- ◆ You can not transfer money between FSAs or pay a dependent care expense from your Health Care FSA or vice versa.
- ◆ You can not deduct reimbursed expenses for income tax purposes.
- ◆ You may not receive insurance benefits or other compensation for expenses which are reimbursed through your FSAs.
- ◆ You may not be reimbursed for a service which you have not yet received.
- ◆ You have a 90-day grace period (until September 28, 2010) at the end of the plan year to claim reimbursement for eligible expenses incurred during your period of coverage within the 2009 plan year.

**Be conservative when estimating your medical and/or dependent care expenses for 2009. IRS regulations state that any unused funds which remain in your FSA after a plan year ends and all claims have been filed can not be returned to you nor carried forward to the next plan year. This is known as the "USE IT OR LOSE IT" rule.**

## How Do I File a Claim?

As you incur expenses, you will submit a signed claim form with the appropriate documentation to Eagles - Benefits by Design via fax at (772) 334-7059. Documentation is a legible receipt for the expense or an Explanation of Benefits (EOB) showing a description of the service or a list of supplies furnished, service charge, date of service, and name of person receiving the service. Your service provider's signature on the claim form can be substituted for a receipt. To avoid reimbursement delays, follow the instructions for submitting your requests located in the FSA materials that you will receive following enrollment. You may enroll in direct deposit to ensure that your reimbursement checks are automatically deposited into your checking or savings account within 2-3 business days. For more information on enrolling in direct deposit, please contact Eagles Benefits by Design.

## Debit Card Option

FSA participants are given the opportunity to take advantage of the debit card option for payment of eligible expenses. If elected, participants would be able to pay for most qualified services and products at the point of sale versus paying out of pocket and requesting reimbursement via mail or fax. The VISA debit card is accepted at a number of medical providers and facilities and most pharmacy retail outlets (the debit card cannot be used for dental or vision services). A \$15 fee is charged for the first card and all additional cards for dependents or replacement cards (if lost or stolen) are free of charge.



# Flexible Spending Accounts

## How do I plan my Health Care FSA contribution?

You need to first understand what your insurance plans will pay. The FSA will not reimburse you for expenses paid by insurance.

The worksheet on the right may help you to carefully estimate your annual contributions to cover certain medical expenses for yourself and any dependents. You may want to talk to your doctor, dentist, or other providers as well as your qualified dependents to help you estimate your expenses.

The entire Health Care FSA election amount balance is available on the 1st day of the plan year; however, if the entire balance is used, your Health Care FSA contribution per pay period will still remain the same.

Health Care FSA Worksheet	
Deductible	
Copay	
Coinsurance	
Contact Lenses	
Dental Care	
Eyeglasses/Contacts	
Prescription drugs	
Surgery	
Other	
<b>Total amount to consider contributing to the Health Care FSA</b>	
Divide by the Number of Pay Periods	
Health Care FSA Contribution Per Pay Period	

## How does the Dependent Care FSA work?

Like the Health Care FSA, you must decide how much to contribute. This is usually fairly easy with the Dependent Care Account because expenses are somewhat predictable. You just figure out what you spend on a per-pay basis for preschool, after-school or care for older dependents that is necessary for you to work, or if you are married, for both you and your spouse to work.

The day care can be provided in a licensed day care center or by an individual in your home or the day care provider's home. Day camps are also eligible if the services are used in lieu of regular day care.

The other major difference is that you may obtain reimbursement for expenses only up to the amount you have contributed. If you have contributed \$100 and you request \$150 in reimbursements for eligible expenses, you will only receive \$100 until future contributions are received (in the same plan year).

Dependent Care FSA Worksheet	
Child Day Care Expenses	
Pre-school Expenses	
Summer Day Camp Expenses	
Adult Day Care Expenses	
Other	
<b>Total amount to consider contributing to the Dependent Care FSA</b>	
Divide by the Number of Pay Periods	
Dependent Care FSA Contribution Per Pay Period	



# Supplemental Insurance - AFLAC

## AFLAC

AFLAC Agent: Loire Lucas: (772) 708-5931

Fax Claims: (772)286-3031

[www.aflac.com](http://www.aflac.com)

Employees of the District may elect to purchase supplemental insurance on a voluntary basis through AFLAC via payroll deduction. AFLAC coverages pay you in addition to any other insurance coverages you may have. Descriptions of the available AFLAC coverages are provided below. Payroll deducted premiums may be either pre- or post-tax depending on the coverage you select. To learn more about these coverages or to schedule a personal appointment, contact the District's AFLAC Agent at the phone number listed above.

### ◆ Personal Sickness Indemnity Plan

Illness, whether "routine" childhood occurrences or serious diseases, can require doctors' visits, hospital stays (including maternity), testing, surgeries, ambulance, etc. This usually entails time out of work, co-pays and deductibles and that means money out of your pocket. AFLAC can help with the extra expenses that an illness can cost your family.

### ◆ Specified Health Event Protection

About every 29 seconds an American will suffer a coronary event. Coronary Bypass Surgery is performed 49% of the time on people under age 65. On average someone in the United States suffers a stroke every 53 seconds. This protection can assist you with recovering financially from serious illness with first occurrence, reoccurrence, hospital confinement, travel, lodging and many more benefits.

### ◆ Personal Accident Indemnity Plan (off the job occurrences)

Did you know that about 2,340 disabling injuries happen every four seconds? And a disabling injury occurs in the home about every four seconds? Accidents happen 24 hours a day, 7 days a week. They can happen to you, your spouse or your children. AFLAC's accident plan has you covered.

### ◆ Personal Cancer Indemnity Plan

According to the American Cancer Society, men have a 1 in 2 lifetime risk of developing cancer while a woman's risk is 1 in 3. Cancer treatment can cause out-of-pocket expenses that are not covered by your insurance health insurance such as travel, lodging, special food and supplements, special beds, household help and more. All of these extra expenses happen on top of your regular bills at a time when you are likely to be at least one income down, if not two. AFLAC can help you to keep on top of your bills, not the other way around.

### ◆ Life Protector

Life insurance is not "what if" insurance, but "when." Protect your loved ones with the money they will need in your absence. 10, 20 and 30 year term and whole life policies are available. Face amounts are now available for up to \$200,000. You can also provide policies for your spouse and child(ren). Premiums for this coverage will be payroll deducted on a post-tax basis.

If you are interested in purchasing, changing or canceling an AFLAC policy, you must meet with an AFLAC Representative during Open Enrollment to discuss how these plans work and the associated premiums. **You will not be able to enroll, modify or cancel an AFLAC policy on your own via the Internet.**

**Please contact the Risk Management/Employee Benefits Department  
for an appointment today!**

Approvals for AFLAC changes or new AFLAC policies are pended until the end of open enrollment. Approved policies will appear on your confirmation statement that will be sent to your worksite at the conclusion of open enrollment.



# COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that most employers sponsoring group medical plans offer employees and their families the opportunity for a temporary extension of group insurance coverage at group rates in certain instances where coverage under the plan would otherwise end. These coverages include health, dental, vision, and Medical FSA. If you or a family member experience any of the events provided below and you wish to continue coverage, **you must contact the Risk Management / Employee Benefits department within 30 days from when the event occurred.**

<b>Employee:</b>	1) Reduction in hours of employment (that disqualifies group insurance participation eligibility); or 2) Termination of employment (for reasons other than gross misconduct).
<b>Spouse of an Employee:</b>	1) The death of your spouse; or 2) A termination of your spouse’s employment (for reasons other than gross misconduct) or a reduction in your spouse’s hours of employment; or 3) Divorce or legal separation from your spouse; or 4) Your spouse becomes entitled to Medicare.
<b>Dependent Child of an Employee:</b>	1) The death of a parent; or 2) A termination of the parent’s employment (for reasons other than gross misconduct) or a reduction in the parent’s hours of employment with the Martin County School District; or 3) Parent’s divorce or legal separation; or 4) A parent becomes entitled to Medicare; or 5) The dependent child ceases to be a “dependent child” according to the plan’s eligibility definition.

**PLEASE NOTE:** For more information about COBRA, please call 772-807-8474 to speak to a COBRA representative or go to [www.eaglesbenefits.com](http://www.eaglesbenefits.com) and click on the COBRA link.

**IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS**

What follows is your COBRA Rights Notification as provided by the District’s COBRA Administrator.

**Who is the District’s COBRA Administrator?**

**Eagles Benefits by Design**  
P.O. Box 880397  
Port St. Lucie, FL 34978-0397  
Telephone: 772-807-8474

**What is continuation coverage?**

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee. Continuation coverage is the same coverage that the Plan gives to other participants of beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from **Eagles Benefits by Design**.



## How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries. Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

## How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Eagles Benefits by Design of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

**Disability:** An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify Eagles Benefits by Design of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify Eagles Benefits by Design of that fact within 30 days of SSA's determination.

**Second Qualifying Event:** An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify Eagles Benefits by Design within 60 days after a second qualifying event occurs.

## How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.



## What if I am eligible for trade adjustment assistance?

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act.index.asp](http://www.doleta.gov/tradeact/2002act.index.asp).

## When and how must payment for continuation coverage be made?

**First payment for continuation coverage:** If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Eagles Benefits by Design to confirm the correct amount of your first payment. Your first payment for continuation coverage should be sent to **Eagles Benefits by Design**.

**Periodic payments for continuation coverage:** After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. Periodic payments for continuation coverage should be sent to **Eagles Benefits by Design**.

**Grace periods for periodic payments:** Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

## For more information:

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from **Eagles Benefits by Design**.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## Keep your plan informed of address changes!

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.



# Notice of Privacy Practices

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## HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT ADMINISTRATIVE SIMPLIFICATION (HIPAA-AS) NOTICE OF PRIVACY PRACTICES

### OUR LEGAL DUTY

As the Employer/Plan Sponsor of a Group Health Plan, the District must comply with applicable federal and state laws to maintain the privacy of your protected health information (PHI). We want you to be aware of our privacy practices, our legal duties, and your rights concerning your PHI. This notice took effect April 14, 2003, and will remain in effect until a revised notice is issued.

We reserve the right to change our privacy practices and the terms of this notice at any time and to make the terms of our notice effective for all PHI that we maintain. Before we make a significant change in our privacy practices, we will change this notice and communicate the notice to employees.

### USES AND DISCLOSURES OF PHI

The District will use and disclose PHI only as permitted under HIPAA:

- A. The District as a Health Plan Sponsor (HPS) may receive PHI from employees as needed to enroll participants in a plan or specific benefit.
- B. The District may receive information directly from employees in coordinating the receipt of benefits such as pre-certification or authorization, eligibility, claims issues, treatment payments, billing and similar services.

1. *Minimal disclosure of Protected Health Information (PHI)*

The District takes steps to limit the amount of PHI we disclose or request to the minimum necessary. To help ensure that only the minimum amount necessary is provided, District employees are required to verify the extent of information required before providing the information. Similarly, when requesting information from entities outside of the District, District employees will limit their request to only the amount of information that is necessary for completing the task at hand. The District will not disclose PHI to outside entities for marketing or business purposes.

2. *Limited employee access to Protected Health Information (PHI)*

The District further protects PHI in our offices from unintentional disclosure by identifying those individuals who are permitted to handle such information and helping to ensure through technical, organizational, and electronic mechanisms that guidelines for handling, uses, and disclosure of information are followed.

### AUTHORIZATION AND CONSENT

The District may not use or disclose PHI for purposes other than enrollment, treatment, payment, operations and disclosures required by HIPAA law without a valid authorization. The authorization is a document requested and signed by the employee for a specified purpose and time frame.

### INDIVIDUAL RIGHTS

With respect to any employee's protected health information, the employee has the right to:

- A. Request restrictions on uses and disclosures;
- B. Receive copies of and review original confidential communications;
- C. Inspect and receive a copy of their own protected health information;
- D. Receive an accounting of any disclosures;
- E. Amend any records that contain PHI; and
- F. Receive a paper copy of the notice of the District's Privacy Practices or the District's Privacy Policy.



# Notice of Privacy Practices

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## PRIVACY OFFICIAL

Linda King, Risk Management / Employee Benefits Manager is the Privacy Official for the District. The Privacy Official is responsible for the development and implementation of policies and procedures relating to privacy, including but not limited to this Privacy Policy. The Privacy Official shall be authorized to sign all notices, agreements and other HIPAA related documents required by law or implementing regulations.

## CONTACT PERSON

Employee Benefits, will serve as the Contact Person for participants who have questions, concerns or complaints about the privacy of their PHI.

## COMPLAINTS

The District takes privacy concerns seriously. If an employee believes that the District may have violated their privacy rights, with respect to his or her PHI, or if the employee has other related inquiries or concerns, the employee may complain to us using the contact information in the front of this booklet. The employee is encouraged to put his or her concern in writing to Employee Benefits, who is the designated Contact Person for the District. The employee also has the right, at any point, to notify the Secretary of the U.S. Department of Health and Human Services of his or her complaint.



# Medicare & Prescription Drug Coverage

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## IMPORTANT NOTICE FROM THE MARTIN COUNTY SCHOOL DISTRICT ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and **keep it for your records**. This notice has information about your current prescription drug coverage with the Martin County School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

## KEY FACTS

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The Martin County School District has determined that the prescription drug coverage with CIGNA HealthCare is creditable coverage. That means the drug benefit is expected to pay out as much as the standard Medicare prescription drug coverage pays.

Because your existing coverage with the Martin County School District is, on average, at least as good as the standard Medicare prescription drug coverage, you can keep this coverage and not pay a penalty (higher premium) if you later decide to join a Medicare drug plan in the future.

## HOW IS THE MEDICARE PENALTY CALCULATED?

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.



# Medicare & Prescription Drug Coverage

## MEDICARE ENROLLMENT OPTIONS

Should you decide to join a Medicare prescription plan you would be eligible to enroll when you first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>. If you have a coverage gap between the period when your creditable coverage ends and when your Medicare prescription coverage begins you may pay a penalty (higher premium). You may be required to pay the higher premium as long as you have the Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) to join a Part D plan because you lost creditable coverage. In addition, if you decide to drop employer sponsored coverage you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the available plans offering Medicare prescription drug coverage in your area.

## HOW WOULD ENROLLING IN MEDICARE PART D IMPACT YOUR MEDICAL BENEFITS WITH THE MARTIN COUNTY SCHOOL DISTRICT?

If you decide to join a Medicare drug plan, your coverage with the Martin County School District will be affected. For those individuals who elect Part D coverage, your medical and prescription coverage with the Martin County School District will terminate for the individual and all covered dependents.

You should also know that if you drop or lose your coverage with the Martin County School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a penalty (higher premium) to join a Medicare drug plan later.

You will receive this notice each year. For more information about this notice or your current prescription drug coverage with the Martin County School District, please contact the Risk Management/Employee Benefits Department at (772) 219-1200 extension 30206.

## FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE.....

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at (800) 772-1213 (TTY 1-800-325-0778).

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

# Your Employee Benefits are online!

District employees have access to a variety of employee benefits related information online 24 hours a day, 7 days a week.

- ! *View Current Benefit Elections*
- ! *Obtain Benefit Plan Highlights*
- ! *Confirm Payroll Deductions*
- ! *Learn About Qualifying Life Events*
- ! *Find Carrier Contact Information*
- ! *Find Administrator Contact Information*
- ! *Access District Forms*
- ! *And Much More*



Visit the **E**mployee **B**enefits **C**enter online at:

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