

Healthy U Mission:

**To create a culture
of health for our
team members and
their families.**

IMPORTANT NOTE – This Focus on Benefits booklet is designed to provide a summary of information on the team member benefit plans and programs available in 2012 at Orlando Health. It does not detail all of the provisions, restrictions and exclusions of Orlando Health's various benefit programs described herein. This booklet does not constitute a Summary Plan Description (SPD) or Plan Document as defined by the Employee Retirement Income Security Act and does not supersede any Company approved SPDs or Plan Documents currently in effect at Orlando Health.

Orlando Health reserves the right to amend, modify, discontinue or terminate any of its team member benefit programs at any time in keeping with applicable state or federal law. This publication and the programs it describes do not create a contract of employment or coverage between Orlando Health and any person. Contact the Benefits Office or Human Resources Customer Service Center for additional program information or for a copy of the appropriate SPD or Plan Document.



When it matters most.

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Welcome to the Orlando Health Focus on Benefits!

Orlando Health is committed to your health and the health of your family.

Exciting Changes for 2012

There are a number of exciting changes and enhancements to Orlando Health's Benefits Programs effective January 1, 2012. Listed below is a summary of the significant changes to the benefits programs offered to you. These changes are a result of Orlando Health's continuous effort to assist you in meeting the various and unique needs of you and your family and represent a continuing commitment to the health and wellness of our team members. The changes are listed below under the specific benefit program they affect.

Please take the time to read these changes thoroughly. It is important that you take the time to study this Focus on Benefits booklet so you have an understanding of the various benefits available to you. The better you understand your benefit choices the better decisions you can make for you and your family. Please refer to the specific summary plan description (SPD) for more detailed benefit information.

Medical Benefit Plan - PPO

- The previous two Medical PPO plans (\$500 and \$1000 Plans) have been combined into one \$750 deductible PPO plan for 2012. If you are currently enrolled in one of the two PPO plans for 2011 your enrollment will be defaulted into the new \$750 deductible PPO plan for 2012. If you wish to drop your coverage or to change your coverage to the Select Plan you must make an active on-line election during open enrollment. If you do not want to make a change from the new \$750 deductible PPO plan or change coverage level, you do not need to make an active election.

Medical Benefit Plan - Select

- Approved and covered occupational therapy, speech therapy and physical therapy treatments will have a reduced co-pay of \$10 per treatment instead of the current \$25 co-pay. Additionally, there is an individual co-pay annual out-of-pocket maximum of \$250.
- If you choose to use an in-network laboratory for outpatient lab work that is not an Orlando Health laboratory your co-pay will be \$10. The co-pay will be waived if using an Orlando Health Laboratory for covered services.
- If you wish to seek a second surgical opinion as outlined in the plan document the co-pay will be \$35, as with any physician specialist visit.
- The co-pay for utilization of an emergency department visit has been increased from \$100 to \$150 per visit.

Medical Benefit Plans - Select and PPO

(These changes apply to both the Select and PPO Plans)

- There is no longer a co-pay or co-insurance required for covered in-network annual preventative or wellness care under either the Select or PPO plan.
- The co-pay required for generic prescription drugs has been reduced to \$10 from the current \$15 co-pay for a 30 day supply. If you purchase your generic drugs from any of the Orlando Health Pharmacies, located in the lobbies of MD Anderson Cancer Center Orlando, Dr. P. Phillips or the new location at Arnold Palmer Hospital, you will receive a \$5 per prescription discount, lowering your generic co-pay to only \$5.
- All maintenance prescription drugs after the initial dispensing of up to a 30 day supply must be filled under a mandatory 90 day supply. You will receive a 90 day supply for the price of two 30 day co-pays. Please see the pharmacy benefit section in this Focus on Benefits booklet for more details.
- Coverage will be available for the Roux-en-Y bariatric surgical procedure. Specific criteria must be met and a separate co-pay is applicable. Please refer to your 2012 medical benefit plan SPD for detailed information.

Voluntary Short Term Disability Benefit

- If you do not enroll in one of the voluntary short term disability (STD) benefit plans when first eligible you may enroll during open enrollment. You may also change the STD benefit plan in which you are currently enrolled. The completion of an Evidence of Insurability form will no longer be required to secure or change coverage.

It is important to understand that the pre-existing condition provision does remain in effect. If you receive treatment or are diagnosed with a medical condition within the 3 months prior to your coverage effective date, that condition or diagnosis is generally not covered during the first 12 months of your coverage.

Please thoroughly review the STD section in this booklet for more detailed information on the pre-existing provision prior to enrolling or making changes in your current coverage during open enrollment.

Orlando Health Focus on Benefits cont'd.

Healthy U Initiatives

- Healthy U incentives for premium reduction opportunities will continue for 2012! There are important changes that will be applicable for 2012. The five dollar (\$5) per bi-weekly pay period premium reduction for the annual flu shot will continue. In addition, if you participate and complete **both** the biometric screening **and** the health risk assessment you will receive an additional five dollar (\$5) per bi-weekly pay period premium reduction.
- An exciting new initiative will be announced early in 2012 which will allow for a one time reimbursement for up to \$100 for wellness center or gym memberships.

To qualify for this latest initiative you must participate in both of the two established incentives; the flu shot, and the combined biometric screening with completion of the health risk assessment. Further details on this new incentive and how it will be administered will be announced in early 2012.

New Dental Benefit Provider

- We are excited to announce that CIGNA will be the new dental benefit provider. CIGNA is a well-respected provider of quality

How to Enroll

New Hires or Newly Eligible Team Members

As a new hire you will be mailed an enrollment guide, a user ID and a password that will enable you to access your personal benefits online. After you receive your password, you can access the enrollment site at orlandohealth.com or by using the Team Member Intranet, **SWIFT** on any Orlando Health computer. For your convenience, this access is available 24 hours a day, seven days a week. Web enrollment provides easy access to online information about all benefit options available, the ability to visualize your selections, and the option to print your elections or any benefits information you may need. At the end of your 45-day window as of your hire date you will be mailed a confirmation statement of your benefit elections. If you do not receive a confirmation statement, please contact the nearest Human Resources office or the Human Resources Customer Service Center at 321.841.8623 for assistance.

Current Team Members

For current team members Open Enrollment is your opportunity to make changes to your benefits. The 2012 Open Enrollment will be October 31, 2011 through November 14, 2011. You can access the enrollment site at orlandohealth.com or by using the Team Member Intranet, **SWIFT** on any Orlando Health computer. For your convenience, this access is available 24 hours a day, seven days a week. This site contains information on coverage you already have or the benefits in which you can enroll, based on your employment status. The site also contains links to the websites of each benefit vendor, so you may obtain the most up-to-date provider listings and any other information specific to each plan. At the end of open enrollment you will be mailed a confirmation statement of your benefit elections. If you do not receive a confirmation statement, please contact the nearest site Human Resources office or the Human Resources Customer Service Center at 321.841.8623 for assistance.

dental benefits. They offer CIGNA Healthy Rewards which includes special discounts on products and services, as well as an Oral Health Integration Program. Both of these programs are designed to help you enhance your health and wellness.

- Your current dental benefit election will default or remain the same for 2012, unless you wish to make a change. **It is important if you are enrolled in the DHMO plan that you actively reselect your dental provider on-line.** Most of the dental providers under the current carrier are also participants in the CIGNA dental network. Please review the dental benefit section of your Focus on Benefits booklet for detailed information.

Healthcare Flexible Spending Account Benefit

- Eligibility to participate in the voluntary health care flexible spending account is now aligned with our other benefit offerings. All benefit eligible team members can elect to participate as a new hire as of the first of the month following 60 days of employment and annually during open enrollment.
- Remember that flexible spending accounts must be actively re-elected annually during open enrollment.

Benefits Enrollment Instructions

1. Please log onto SWIFT or the Orlando Health website at orlandohealth.com to review your benefit elections and premiums for 2012. Simply click on HR/C.H.R.I.S. on SWIFT and For Team Members/C.H.R.I.S. on orlandohealth.com
2. Once you have accessed C.H.R.I.S. and have entered your user ID and password, click on Employee Self Service/Benefits/Benefits Enrollment and click on the SELECT button in the Open Benefits Events section.
3. Make your benefit selection, then click the SUBMIT button to tentatively save your elections. You will be required to click on the SUBMIT button again, in order to finalize your enrollment. **If you do not click SUBMIT the second time, your benefit elections will not be submitted to the Benefits Department and benefits will not become effective.**
4. Print a copy of your elections page for your records as verification of your enrollment choices.

Address Update

In order to ensure that you receive all important benefits information, it is your responsibility to keep your address updated. Address changes can be updated online or by contacting the Human Resources Customer Service Center at 321.841.8623

You Have Three Major Sources Of Benefits

1

Core Benefits

Core Benefits are fully paid by Orlando Health and are provided to all regular full-time, variable full-time and part-time team members. (Eligible variable full-time team members work 32-39 hours per week and eligible part-time team members work at least 24 hours per week.)

Core Benefits (company paid)

- Basic Life Insurance
- Paid Time Off
- Extended Leave Bank
- Long-Term Disability (FT and VFT only)
- Retirement Savings Plan 401a (employer basic and matching contributions - eligibility requirements must be met)

2

Optional Benefits

Optional benefits are available so you can design a benefits package that meets your individual needs. For some optional benefits, you and Orlando Health share the cost of coverage. For other benefits, such as supplemental life insurance, short-term disability, dental and vision you pay the full cost, if elected. However, at reduced group rates.

Optional Benefits (team member paid)

Benefits you pay for on a pre-tax basis:

- Medical (shared cost)
- Dental
- Vision
- Retirement Savings Plan 403b (team member contribution)
- Healthcare Flex Spending Account
- Dependent Daycare Flex Spending Account

Benefits you pay for on an after-tax basis:

- Supplemental Life Insurance
- Dependent Life Insurance
- Short-Term Disability (FT and VFT only)

3

Statutory Benefits

These benefits are paid by Orlando Health on your behalf:

- Social Security
- Workers' Compensation
- Unemployment Insurance

New Enrollees

As a new team member, you have 45 calendar days as of your date of hire or the date you are in a benefits eligible position to enroll in benefits. Your coverage becomes effective the first day of the month following 60 days of continuous employment. Dependents who are currently covered under the Orlando Health medical, dental and vision plans and who are hired by Orlando Health in a benefits eligible status are eligible immediately for these coverages. If you do not make your choices within the required 45 days, you must wait until the next open enrollment period to elect coverage, unless you have a qualified life event.

Changing Your Benefit Choices

Generally, your benefit choices will stay in effect for a full calendar year. However, if you have a change in lifestyle status, you *may qualify* to make "some" changes to your elections. Qualified lifestyle status changes include:

- Marriage or divorce
- Birth, adoption or legal custody of an eligible dependent
- Death of your spouse or dependent
- Dependent covered by the plan becomes ineligible
- Change from full-time to part-time status, or vice versa, by you or your spouse (transfer to spouse's plan)
- Unpaid leave of absence by you or your spouse
- Significant change in your spouse's group coverage attributable to employment status

If you experience one of the lifestyle status changes listed above during the plan year, you must notify the Human Resources Customer Service Center in writing within 31 days of the date of your change in lifestyle status and attach proper documentation. Contact the Human Resources Customer Service Center at 321.841.8623, if uncertain of allowable changes.

Paying for Optional Benefits

Each benefit option has a cost for coverage. Generally, the cost depends on three factors:

- The type of plan
- Number of covered dependents
- Your annual base pay

The team member contribution schedule located on page 33 indicates the per pay period costs for each benefit plan.

The cost of your benefits will be deducted from your pay on a per paycheck basis. During the open enrollment election period your premiums will be based on your "base annual pay" as of October 21, 2011. Please note that any changes in pay at anytime during the year may affect your benefit premiums.

Choosing Your Healthcare Plan

Choosing a healthcare plan that best meets you and your family's needs is important. To help you choose the best coverage for you and your family, a summary of the plan features is listed below.

Health Plan Choices for 2012

Effective January 1, 2012, Orlando Health team members can choose from the following health plans:

- **Healthchoice Select**
- **Healthchoice PPO - \$750 deductible**

Healthchoice Select, an EPO (Exclusive Provider Organization), provides the highest level of benefits using in-network providers. There are no out-of-network benefits in this plan (except in emergency situations while traveling outside the network area).

Healthchoice Select features:

- No deductibles
- Healthcare providers file claims for you
- Minimal co-payments
- A primary care physician of your choice (PCP) coordinates your care
- Specialty care is available
- PCP obtains pre-certifications for you. **(However, you are responsible for confirmation of pre-certification)**
- Team members and their family may have a different PCP and can change at any time
- Preventive and wellness healthcare coverage
- Service area includes Orange, Osceola, Seminole, and Lake counties
- No referrals necessary to in-network specialists

When you choose **Healthchoice Select**, you may have lower out-of-pocket costs because there are no deductibles. You pay only \$25 for each primary care office visit and low co-payments for hospital visits and other specialty care visits.

Healthchoice PPO, a Preferred Provider Organization, is a large network of physicians and hospitals which also gives you direct access to network physicians and specialists without a referral.

Healthchoice PPO features:

- In-network and out-of-network benefits
- You must meet a deductible before your insurance pays for medical expenses

In-network PPO benefits are considered for reimbursement at 75% of plan-allowable costs after your deductible is met; you are responsible for the remaining 25%. You may visit any of the doctors participating in the **Healthchoice PPO Plan**, without a referral to receive in-network benefits.

Out-of-network PPO benefits are paid at 40% of the plan allowable costs after your deductible has been met. The PPO plan may be a good choice for team members who live or utilize providers outside the service area of Orange, Osceola, Seminole, and Lake counties.

Eligibility

You are eligible to participate in the Orlando Health medical benefit plans if you are a regular full-time, variable full-time or part-time team member at Orlando Health. Your dependent children are eligible until their 26th birthday, or if deemed totally disabled by a physician, and proper medical documentation has been submitted to the plan for determination of continued eligibility within 30 days of their 26th birthday. Refer to the Summary Plan Description (SPD) for more information for disabled dependents. For dependent eligibility requirements pertaining to the additional benefit plans, please refer to the specific SPD for further details.

Dependent Eligibility Verification

Upon enrollment in any Orlando Health Medical Plan, all team members must provide required documentation verifying their dependent's eligibility. Our eligibility verification vendor will notify you of the documents needed in order for your dependents to remain on the plan. You will have 45 days from the date of the letter to submit the required documents. **Inability to supply the requested documentation may result in loss of coverage for your dependent and possible disciplinary action. Please direct all questions to the Dependent Verification Center at 800.725.5810.**

Eligible Dependents

- Legal Spouse
- Child/Children (up to age 26)
- Children under Legal Guardianship
- Foster Children
- Step Children



Healthchoice Physician Listing

Below are four easy steps to review your personalized Healthchoice provider directory:

1. Locate the website at healthchoiceorlando.org
2. Click on "Physician Finder"
3. Choose your health plan and Employer:
 - Healthchoice Select
 - Healthchoice PPO
4. Search among the following options:
 - Individual Search: physicians, hospitals, specialists, or by county
 - Download Provider Directory
 - Tailor your search by county or print the entire directory. Simply click on "Create a PDF of The Directory" to view and/or print

Beechstreet is a provider network that can be used by team members who are covered under the PPO plan and live outside the four county areas of Orange, Seminole, Osceola, and Lake. To see a listing of providers in your area, log on to: beechstreet.com

Healthchoice Health Management Programs

Healthchoice Select and Healthchoice PPO members may participate in one or more of our "Take Charge of Your Health" Health Management Programs:

- Baby Phases – a prenatal program that provides written materials, classes, and financial incentives for active participation
- Asthma
- Hypertension (high blood pressure)
- Diabetes
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)

For information on these programs, please call Healthchoice at 407.481.7158 or 800.635.4345 or log onto: healthchoiceorlando.org

When You Need a Hospital

The Healthchoice Select and PPO hospital providers include:

- Arnold Palmer Hospital for Children
- Dr. P. Phillips Hospital
- Health Central
- M.D. Anderson Cancer Center Orlando
- Orlando Regional Medical Center
- Orlando Health South Seminole Hospital
- South Lake Hospital
- St. Cloud Medical Center
- Winnie Palmer Hospital for Women & Babies
- Leesburg Regional Medical Center
- The Villages Regional Hospital

Orlando Health Summary Plan Descriptions (SPD) and/or Summary of Material Modifications (SMM) are distributed by FMH CoreSource upon enrollment and upon request. The SPDs can also be found on the Orlando Health Team Member Intranet, SWIFT.



Medical Plan Comparison

The following benefit comparison should be used only as a guide in understanding your health plan options. A detailed listing of plan benefits is included in the SPD/Plan Document. Healthchoice Select Plan benefits are similar to those of an HMO. To receive in-network benefits (Select & PPO), you must use the doctors and facilities participating in the plan. The Healthchoice service area includes Orange, Osceola, Seminole, and Lake counties. If you have questions regarding Select or PPO benefits, please call FMH CoreSource at 866.500.5048.

	Select Plan	PPO \$750 Plan	Out-of-Network PPO Benefits
	In-Network	In-Network	
Deductible (Calendar Year)			
Individual	Rates removed for client confidentiality		
Family			
Out-of-Pocket Maximum (Calendar Year) - includes deductible			
Individual			
Family			
Physician Office Visit			
Primary Care Provider			
Specialist			
Other Types of Office Visits			
Well Child Care	100% covered	Members pay 0% Benefit pays 100% after deductible	Members pay 0% Benefit pays 0% after deductible
Well Woman Exam	100% covered	Members pay 0% Benefit pays 100% deductible waived	Members pay 0% Benefit pays 0% after deductible
Annual Physical Exam	100% covered	Members pay 0% Benefit pays 100% deductible waived	Members pay 0% Benefit pays 0% after deductible
Second Surgical Opinion	100% covered	Members pay 20% Benefit pays 75% deductible waived	Members pay 0% Benefit pays 0% after deductible
Maternity Care	100% covered	Members pay 20% Benefit pays 75% after deductible	Members pay 0% Benefit pays 0% after deductible
Hearing Aids	\$500 Calendar year maximum	Members pay 20% Benefit pays 75% after deductible to a calendar year max of \$500	Members pay 0% Benefit pays 0% after deductible to a calendar year max of \$500

	Select Plan	PPO \$750 Plan	Out-of-Network PPO Benefits
Inpatient Hospitalization			
Inpatient Services & Observation	Rates removed for client confidentiality		
Skilled Nursing <i>(60 days per calendar year)</i>			
Rehabilitation — Outpatient			
PT/OT/ST <i>(pre-cert after 12 visits per service type)</i>			
Hospice			
Outpatient Services			
Minor Diagnostic Lab			
X-ray			
Major Diagnostic Services			
Outpatient Surgery <i>(per operative session)</i>			
Cardiac Cath			
Durable Medical Equipment			
Home Health			
Emergency Services			
Emergency Department Visit			

Emergency Services, cont'd.

Ambulance Services	Rates removed for client confidentiality		
Urgent Care Center			
Walgreens Take-Care Clinic			

Wellness Benefit

Tobacco Cessation <i>*Annual Maximum</i>			
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Prescription Drugs — Retail
(up to a 30-day supply)

Tier 1 Generic Drugs			
Tier 2 Preferred Brand Name			
Tier 3 Non-preferred Brand			
Tier 4 Injectables <i>(when cost exceeds \$500)</i>			

Prescription Drugs — Mail Order or Advantage 90 (mandatory for maintenance drugs)
(up to a 90-day supply)

Tier 1 Generic Drugs			
Tier 2 Preferred Brand Name			
Tier 3 Non-Preferred Brand			
Tier 4 Injectables <i>(when cost exceeds \$500)</i>			

Rates removed for client confidentiality

Pharmacy Plan

Retail pharmacies are used for prescriptions that you need filled immediately or for a short time only. Prescriptions may be filled at these locations for up to a 30-day supply. Healthchoice Select and PPO members must have prescriptions filled at a pharmacy within the network. To locate the nearest participating pharmacy call 800.207.2568 or refer to WalgreensHealth.com, and click on pharmacy locator (Rx Group #656320). All maintenance medications must be filled under a mandatory 90-day supply through an Orlando Health on-site pharmacy after the initial dispensing of up to a 30-day supply. Orlando Health offers two methods to fill these prescriptions. Team members can choose from the following programs that will be most convenient for them.

Prescription Drug-Mail Order Service

Mail order Pharmacy services enable you to obtain up to a 90-day supply of maintenance medications (drugs you use on a regular basis for chronic or long-term health conditions). You pay two retail co-payments for the 90-day supply. In other words, you pay for the first 60 days and get an additional 30 days free.

- For your first prescription only, your doctor should write a prescription for up to a 90-day supply of your medication. A mail order form is located on SWIFT for your convenience.
- Refills from other pharmacies will be accepted. Please call 407.237.6337 (MEDS) to provide information to have your prescription transferred.
- Your doctor's office can also fax prescriptions to 321.841.9102 using an original Orlando Health Scripts mail order form, located on SWIFT. Simply click on HR/Benefits Departmental website/Benefit Forms/Orlando Health Scripts Mail Order Form.
- Once your prescription is established with Orlando Health Scripts, refills can be ordered online at orlandohealthscripts.com.

Please allow two weeks for delivery from the date you mail your order. Prescriptions are delivered via UPS (Ground), but can be shipped overnight at an additional charge to you. Please contact the HR Customer Service Center for more information concerning your mail order prescription at 321.841.8623.

Prescription Drug-Advantage 90

The Advantage 90 program allows team members walk-in service for their 90-day maintenance medications. This benefit is currently only available through the Orlando Health on-site pharmacies, Scripts Pharmacy at M.D. Anderson Cancer Center Orlando, Scripts Pharmacy at APH or DPH Scripts.

Prescription Period

With the exception of maintenance drugs, each prescription is limited to a maximum of a 30-day supply, 100 dosage units or a maximum allowed dosage as prescribed by law, whichever is less. Your prescription may be filled up to the plan maximum when allowed by your physician, the law, and in accordance with pharmacy practice. Some medications that may only be dispensed for the exact quantity as written by your physician include controlled substances and antidepressants.

Co-payments

For each prescription you have filled, you will pay a minimal out-of-pocket amount, called a co-payment. You may have various levels of co-payments, depending on the type of drug you receive. Your co-payment amounts for retail prescriptions can be found on your Healthchoice Select

or PPO ID card. For more details about your pharmacy benefits, refer to your SPD. The formulary list is available at WalgreensHealth.com. Remember to show your Healthchoice Select or PPO ID card to your pharmacist each time you have a prescription filled.

Pharmacy Discount

You will receive a \$5.00 discount on all 30-day supply prescriptions when purchased at any Orlando Health on-site retail pharmacy (currently DPH Scripts and Scripts Pharmacy, located in the lobby of M. D. Anderson Cancer Center Orlando and Scripts Pharmacy, located in the lobby of Arnold Palmer Hospital).

Brand vs. Generic

Drugs have two names: a trademark or "brand" name, and a chemical or "generic" name. By law, brand and generic drugs must meet the same standards for safety and effectiveness. Generic equivalents of prescription drugs will be dispensed if an equivalent is available. If you or your physician request the brand name drug when a generic is available, you will be responsible for the entire cost of your prescription. Ask your doctor to prescribe generic drugs whenever possible.

Prescription drugs that have an over-the-counter equivalent:

Please note that the plan does not cover prescription drugs when the drug prescribed is also available in an over-the-counter form. For example, Zantac is available in a prescription form but can also be purchased in another form over-the-counter and would not be a covered drug under the plan.

Formulary – The formulary provided by Catalyst Rx is a list of preferred medications. The formulary guide is subject to change. Co-payments and coverages of medications and categories can vary by plan. The formulary is meant to be a source of general information and not a guarantee of coverage or co-payment.

Disclaimer – This book contains a brief overview of the benefits currently offered by Orlando Health. The information in this book does not replace the SPD or the Plan Document for each plan. Please refer to your SPD for more details.

Medical Definitions

Annual Out-of-Pocket Maximum - Including the deductible, this is the most you will pay for covered services within the plan provisions during the plan year.

Co-Insurance - You and Orlando Health share in the cost of your medical expenses. For example, if you have Team Member Only coverage with the PPO, once you have met your \$750 deductible, Orlando Health pays 75% and you pay 25% of in-network charges. That percentage is called the co-insurance.

Deductible - The annual amount of your claim(s) that you must pay before benefits begin to pay. For example, if you have Team Member Only coverage on the PPO, you would have an annual deductible of \$750. This means you would be responsible for paying the first \$750 of in-network claims before becoming eligible for the 75% in-network co-insurance amount.

In-Network - Any Physician, medical professional or medical facility that participates in the Healthchoice Select and PPO network.

Out-of-Network - Any Physician, medical professional or medical facility that does not participate in the Healthchoice Select and PPO network.

Pre-Existing Condition (medical plan definition) - A condition (except pregnancy) for which you received medical advice, diagnosis, care or treatment within the six-month period prior to your hire date in a benefits eligible position or if you are a late enrollee the first day of coverage. **Does not apply to dependents up to age 19.**

Preferred Provider Organization (PPO) - A medical plan that offers services at a discounted, predetermined level if you use the in-network providers. If you choose to have the services performed outside the Healthchoice network, benefits are payable at usual, customary and reasonable levels, with a greater deductible and co-insurance.

Primary Care Physician (“PCP”) - A Physician chosen by the Member to manage their health needs. The PCP is chosen from the list of Healthchoice Physicians by the Team Member at the time they enroll in the Healthchoice Select Plan. If one is not chosen during enrollment, **FMH CoreSource** will assign one for you. You can change your PCP at anytime by contacting **FMH CoreSource** at 866-500-5048.



Dental Plan

Eligibility

You are eligible to participate in the Orlando Health dental benefit plan if you are a regular full-time, variable full-time, or a part-time Team Member. Your coverage becomes effective the first day of the month following 60 days of continuous employment while in a benefits eligible position (as a new hire or a Team Member changing from a non-eligible status to a benefits eligible status (Example: pool to FT/VFT), you have 45 calendar days to enroll in this benefit). If you do not choose to elect coverage when eligible, you must wait until the next open enrollment period to elect coverage, unless you have a qualified change in lifestyle (see “Changing Your Benefit Choices”).

CIGNA DPPO

The two DPPO plans you're being offered during your enrollment period are called Option A and Option B. Both plans are based on CIGNA's Core Network, one of the largest networks in the country. The plans are different in regards to the co-insurance levels and the amounts of the calendar year deductible and plan maximum. Please refer to the comparison chart in this packet for details.

With the CIGNA DPPO, you have the freedom to visit any licensed dentist, but you can save money if you visit a Core Network dentist. Why? Because CIGNA Core Network dentists agree to offer discounts to CIGNA customers; and they cannot charge you more than the contracted rates for covered services. Out-of-network dentists, however, are not obligated to offer discounted fees. In addition, they can bill you for the difference between the payment they receive from your plan and their full price. This is called “balance billing.”

CIGNA DHMO

With the DHMO, customers select a network general dentist who will handle all of their dental care needs. Note that family members can choose their own DHMO network dentist as there is no limit per household.

If necessary, a customer's general dentist will refer them to network specialists. However, there is no referral needed for a pediatric dentist for your child under the age of 7, or orthodontic specialty care.

After enrolling in the DHMO, a customer will receive a Patient Charge Schedule (PCS) that lists the exact payments that will need to be made for specific procedures (co-pays). These co-pays are special, reduced fees that only apply to treatment provided by a DHMO network dentist or specialist. The PCS is beneficial because there are no hidden charges - customers know up front what they will need to pay for their dental care.

Note that there is no out-of-network coverage under the DHMO.

Finding a Dentist

- **Go to the online directory at www.cigna.com** - 1.) Click “Provider Directory” at the top of the page. 2.) Click “Dentist” and enter your search criteria - name, location, etc. - and click “Next.” 3.) Select either “CIGNA Dental Care (DHMO)” or “CIGNA Dental PPO.” 4.) If you select “CIGNA Dental PPO,” in the drop-down menu, select “Core Network” and the type of dentist you're looking for.
- **Call us at 1.800.CIGNA24 (1.800.244.6224)** - Dial this number to speak to a customer service representative for help locating a DHMO or DPPO dentist or specialist. You can also request a customized directory based on the type of dentist or specialist you're looking for in your area.
- **Call your current dentist to see if he or she participates** - When you call, be sure to ask if your dentist participates in the CIGNA DHMO Network or the CIGNA DPPO Core Network.

Plan comparison on the next page.



Dental Definitions

Dental Health Maintenance Organization (DHMO) - A pre-paid dental plan alternative to PPO plan options, which offers no or low co-pays for preventative services. You are required to use an in-network provider to receive benefits allowable under the plan.

Dental Preferred Provider Organization (DPPO) - Dental plan option that offers services at reduced, contracted fees. This plan allows you the freedom to choose any dentist in or out-of-network and does not require a referral to seek care from a specialist. You are not required to use a network dentist, but by doing so you can stretch your dental benefits by getting more services for your benefit dollars.

Plan Comparison

Below is a summary of benefits for your two DPPO options - Option A and B - and your DHMO option. Note that these are only brief summaries, and that plans may be subject to exclusions and limitations. Please consult your plan materials for full details regarding your benefit options.

	Option A (DPPO)	Option B (DPPO)		Option C (DHMO*)
	In-Network & Out-of-Network	In-Network	Out-of-Network	In-Network Only
Calendar Year Max				
Applies to Class I, II & III Expenses	Rates removed for client confidentiality			
Calendar Year Deductible				
Per Individual				
Per Family				
Class I Expenses - Preventative & Diagnostic Care				
Oral Exams; Cleanings; Routine X-Rays; Flouride Application; Sealants; Space Maintainers (limited to non-orthodontic treatment); Non-Routine X-Rays; Emergency Care to Relieve Pain				
Class II Expenses - Basic Restorative Care				
Fillings; Oral Surgery; Surgical Extraction of Impacted Teeth; Anesthetics; Major Periodontics; Minor Periodontics; Root Canal Therapy/Endodontics; Relines; Rebases and Adjustments; Repairs - Bridges, Crowns, Inlays, and Dentures				
Class III Expenses - Major Restorative Care				
Crowns/Inlays/Onlays; Dentures; Bridges				
Class IV Expenses - Orthodontia				
Coverage for Eligible Children and Adults				
Lifetime Maximum				

Rates removed for client confidentiality

Additional Plan Features

Oral Health Integration Program® (OHIP)

The CIGNA Dental Oral Health Integration Program (OHIP) was the first to enhance dental coverage for people with diabetes, heart disease and for pregnant women - because research shows that oral health may have an impact on overall health. And as the associations between oral and overall health continue to grow, so does our program. We've added certain procedures for specialized dental needs at no additional cost to you - and other perks too!

CIGNA Dental continues to follow current clinical research indicating associations between oral health and medical conditions. As a result, we've enhanced our program to reflect the latest medical and dental research. If you have any of the medical conditions below, you qualify for 100% reimbursement of your co-pays or co-insurance for certain related dental procedures. There's no additional charge for the Program - if you qualify, you get reimbursed! The table below shows covered dental services by medical condition:

Covered Dental Services	Cardio	Stroke	Diabetes	Maternity	Chronic Kidney Disease	Organ Transplants	Head & Neck Cancer Radiation
Periodontal Treatment & Maintenance (D4341, D4342, D4910) ¹	✓	✓	✓	✓	✓	✓	✓
Periodontal Evaluation (D0180)				✓			
Oral Evaluation (D0120, D0140, D0150) ²				✓			
Cleaning (D1110) ³				✓			
Emergency Palliative Treatment (D9110) ⁴				✓			
Flouride - topical application & varnish (D1203, D1204, D1206) ⁵					✓	✓	✓
Sealants (D1351) ⁵					✓	✓	✓

¹Four times per year ²One additional evaluation ³One additional cleaning ⁴No limitations ⁵Age limits removed, all other limitations apply

Using OHIP is as easy as 1, 2, 3...

1. Simply visit your dentist for the covered service and pay the dentist your usual co-pay or co-insurance amount for that procedure.
2. Fill out the Reimbursement Form. You can find the form on www.mycigna.com, www.cigna.com or by calling 1.800.CIGNA24.
3. Mail in your completed form AND required documentation (proof of payment, itemized receipt from dentist, EOB, OR dentists' completed claim form) to CIGNA at the address listed on the Reimbursement Form.

CIGNA Healthy Rewards®

The CIGNA Healthy Rewards program provides discounts and amenities to encourage and promote healthy behaviors and lifestyles as an included part of your plan. Healthy Rewards can make staying healthy easier and more affordable, with up to 62% off a variety of health and wellness products and services. No referrals. No claim forms. No catch.

If you're enrolled in a CIGNA dental plan, you can take advantage of generous discounts from Healthy Rewards. Your employer can give you more information about how to access the program. Healthy Rewards programs are separate from your plan benefits; co-payments and co-insurance do not apply. If your dental plan includes coverage for any of these services or products, Healthy Rewards discounts are in addition to - not instead of - your plan benefits. Because Healthy Rewards programs are separate from your plan benefits, you must pay the entire discounted charge.

Not all Healthy Rewards programs are available in all states, so please check your plan materials for details. Healthy Rewards offers more choices for members, more ways to lead a healthier lifestyle, and more ways to focus on wellness and prevention.

24/7 Customer Service. Remember that CIGNA is always here when you need us. So give us a call at 1.800.CIGNA24 on any day of the week and at any hour of the day and a customer service representative will be able to assist you.

Vision Plan

Eligibility

You are eligible to participate in the Orlando Health vision plan if you are a regular full-time, variable full-time or part-time team member. Your coverage becomes effective the first day of the month following 60 days of continuous employment while in a benefits eligible position (as a new hire or a team member changing from a non-eligible status to a benefits eligible status (Example: pool to FT/VFT), you have 45 calendar days to enroll in this benefit). If you do not choose to elect coverage when eligible, you must wait until the next open enrollment period to elect coverage unless you have a qualified change in lifestyle (see page 4 “Changing Your Benefits Choices”).

Our vision program provides a great way to save money. In-network vision providers can provide eye exams as well as eye wear. You may also visit an out-of-network doctor, but please keep in mind that you will receive more from your benefit if you see an in-network provider.

After you enroll, you will receive your Vision ID card. A more detailed plan overview is available on SWIFT.

Plan Features

- Freedom to select any in-network provider or you can choose an out-of-network provider
- Out-of-network benefits reimbursed according to a set schedule
- Tinted lenses (Pink and Rose, #1 and #2) are covered in-network at no extra charge
- Transition lenses are covered in-network at no extra charge
- Polycarbonate lenses are covered
- Type 1, 2, and 3 progressive lenses are covered under the plan

Your plan provides a 20% discount on a second pair of prescription glasses (lenses and frames), including prescription sunglasses. Simply return to the same doctor who performed your last covered eye exam within 12 months of the date of the exam.

Locating Your Vision Plan Doctor

When you obtain services from an in-network doctor, you get the most value from your benefits. There are two convenient ways to locate a doctor near your home or office, or to verify that your doctor participates in the plan:

- Simply register as a user on the carrier’s website to view your benefits, view providers, or order an ID card
- Contact the vision carrier’s Member Services Department for further assistance or questions regarding your vision benefits. Please refer to the Benefits Contact Information page for more information

Out-of-Network Doctors

You have the option of seeing an out-of-network doctor. If you see an out-of-network doctor, be aware that your out-of-network benefits do not guarantee full payment. You will pay the entire bill when you receive services. To obtain partial reimbursement, you should mail or fax your itemized receipt to the vision plan carrier within 60 days of the date service was rendered. Please be sure to keep a copy for your own records.

If selected, the vision plan provides you to the following benefits:

Frequency of Service		
Exam	Every 12 months	
Eyeglasses		
Lenses	Every 12 months	
Frames	Every 12 months	
Contact Lenses (in lieu of frames & lenses)	Every 12 months	
Co-payment		
Exam and Materials (Lenses/Frames)	\$0	
Benefits		
	Coverage from a Network Provider	Coverage from an Out-of-Network Provider**
Eye Exam	Rates removed for client confidentiality	
Single Vision Lenses		
Bifocal Lenses		
Trifocal Lenses		
Progressive Lenses		
Polycarbonate Lenses		
Frames		
Contact Lenses		

Rates removed for client confidentiality

Disability Insurance

Short Term Disability (STD)

If you are hired into a full-time or variable full-time position you are eligible to enroll in the Short Term Disability (STD) plan through The Hartford at affordable group rates. The cost of this benefit is outlined on the contribution schedule page. Your effective date for this coverage will be the first of the month following 60 days of continuous employment while in a benefits eligible position (as a new hire or a team member changing from a non-eligible status to a benefits eligible status (Example: pool to FT/VFT), you have 45 calendar days to enroll in this benefit). Failure to do so will delay your enrollment until the next open enrollment period. Short Term Disability is voluntary and contributions are paid by the team member.

New for 2012

Evidence of insurability will no longer be required for Short Term Disability (STD) benefits. However, your STD coverage or any increases to existing coverage will be subject to the pre-existing condition limitation.

Pre-Existing Conditions

The pre-existing condition limitation will apply to your coverage during the first 12 months of your STD coverage election per the following:

- A pre-existing condition is defined as any sickness, medical condition or injury for which treatment was provided, recommended or prescribed within the three months immediately preceding the date your coverage went into effect.
- If you are treatment free for 3 consecutive months for the identified pre-existing condition after your coverage becomes effective under the plan then your condition would not be deemed as pre-existing.
- If your sickness or injury is identified as a pre-existing condition you may receive a limited benefit of up to four weeks of STD benefits.
- Please refer to the Summary Plan Description (SPD) for more detailed information on pre-existing conditions and their application under the policy.

Why Purchase STD Insurance?

Short Term Disability insurance offers you the opportunity to insure that you will receive 60% of your gross earnings based on your weekly standard hours if you are unable to work due to a non-work related injury or illness during the first six months of your disability. This first six months (180 calendar days) is the “waiting period” for your Long Term Disability (LTD) benefits. Without STD insurance you would not receive any income replacement unless you have accumulated enough PTO and ELB hours to cover you through this period. For full-time team members it would take 1,040 hours of PTO and ELB combined to cover the entire 180-day LTD waiting period.

When Am I Considered Disabled?

Totally disabled means you are prevented by injury, sickness, mental illness, substance abuse, or pregnancy from performing the essential duties of your occupation and, as a result, you are earning less than 20% of your pre-disability earnings.

You are considered partially disabled (disabled and working) when you are prevented by injury, sickness, mental illness, substance abuse, or pregnancy from performing some, but not all of the essential duties of your occupation, are working on a part-time or limited duty basis, and as a result, your current weekly earnings are more than 20% but less than 80% of your pre-disability earnings.

Exclusions

Benefits will not be paid for any period of disability that is work related. Benefits will not be paid for any other disability that exists at the same time as a work-related injury. Work related injuries should be filed under the Workers' Compensation program. Other exclusions apply. Please refer to the SPD for more details.

Choosing Your Waiting Period

When you become ill or are injured away from work, the first 24 hours of your absence are covered by your available PTO hours. For example:

- If you choose a 30-calendar-day waiting period, it accounts for approximately 24 PTO hours and 152 ELB hours (22 workdays at eight hours a day) for a total of 176 PTO/ ELB hours.
- If your PTO and ELB combined balance is two or three times higher than 176 hours, you may want to consider the 60-calendar-day waiting period, which has a lower premium than the 30-day option. After your waiting period ends and you begin to receive disability benefits, your remaining ELB hours stay in your bank until the next time you need them. If you have STD coverage you must apply for benefits while on a medical leave of absence. Under no circumstances may you receive ELB/PTO pay and STD benefits concurrently.

How to file a Claim

If you become totally disabled:

- Notify your supervisor
- Call The Hartford at 1.800.741.4306

A representative will assist you with your disability claim.

STD Exclusions

Benefits will not be paid for any period of disability:

- 1) unless you are under the regular care of a physician;
- 2) that is caused or contributed to by war or act of war, whether declared or not;
- 3) that is caused by your commission of or attempt to commit a felony;
- 4) that is caused or contributed to by your being engaged in an illegal occupation; or
- 5) that is caused or contributed to by an intentionally self-inflicted injury; or
- 6) for which workers' compensation benefits are paid or may be paid, if duly claimed; or
- 7) sustained as a result of doing any work for pay or profit for another employer.

Part-time team members are not eligible to participate in this benefit. Other exclusions may apply. Please refer to the SPD or Plan Document.

Long Term Disability (LTD) Eligibility

Orlando Health pays the total cost of this benefit. LTD insurance provides a monthly benefit that equals 60% of your pre-disability base earnings up to a \$10,000 monthly maximum.

Your coverage becomes effective the first day of the month following 60 days of continuous employment while in a benefits eligible position.

You are eligible to receive this benefit after 180 days of continuous total or partial disability.

Definition of Disability

You are disabled when the carrier determines that:

- You are prevented from performing one or more of the essential duties of your occupation during the elimination period and for the 24 months following the elimination period; and as a result
- Your current monthly earnings are less than 80% of your indexed pre-disability earnings

After 24 months of payments, you are disabled when the carrier determines that due to the same sickness or injury, you are prevented from performing one or more of the essential duties of any occupation.

Your disability must result from accidental bodily injury, sickness, mental illness, substance abuse, or pregnancy. Your failure to pass a physical examination required to maintain a license to perform the duties of your occupation alone does not mean you are disabled.

Survivor Support

If you have been totally disabled and die while receiving LTD benefits, a benefit equal to three months of your gross monthly benefit will be paid in a lump sum to your surviving spouse or children under age 25. If there is no surviving spouse or children, no benefit will be paid.

Maximum Benefit Duration

Benefits are payable to your normal retirement age under the Social Security Act. However, if you become disabled at age 60 or later, benefits may continue beyond your normal retirement age, as follows:

Age of Disability	Maximum Benefit Duration
Less than age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months
Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Mental and nervous conditions are limited to 24 months, and disability due to self-reported symptoms are limited to 24 months.

Pre-Existing Conditions

You will be subject to pre-existing condition rules during the first 12 months of your LTD coverage. A pre-existing condition is defined as a sickness or injury for which treatment, diagnosis or charges were incurred within three months immediately preceding the date the coverage went into effect. If your sickness or injury is a pre-existing condition, you will not receive LTD benefits for the disability within the first 12 months of coverage (including pregnancy) or until you have not received medical care for three months while covered under this policy. Please refer to the SPD or Plan Document for more information.

Cancellation/Termination of Coverage

Coverage is provided under a group insurance policy. Coverage under this policy terminates at the earliest of the last day of the pay period following the date:

- You retire
- The group contract is terminated
- You are no longer employed by Orlando Health
- You choose to withdraw from the plan due to a qualified lifestyle status change
- You cease to be a full-time active team member in a benefits eligible status for any reason; unless continued in accordance with any of the Continuation Provisions outlined in the policy

If you choose to move to a pool, part-time or any other benefits ineligible status, your disability benefits will terminate. If you return to a benefits eligible position within 12 months, your benefit will be reinstated as of your rehire date.

If you meet the eligibility requirements, you will receive further details of plan provisions in your Coverage Summary.

LTD Exclusions

The policy does not cover, and we will not pay a benefit for any disability:

- 1) unless you are under the regular care of a physician;
- 2) that is caused or contributed to by war or an act of war (declared or not);
- 3) caused by your commission of or attempt to commit a felony;
- 4) caused or contributed to by your being engaged in an illegal occupation;
or
- 5) caused or contributed to by an intentionally self inflicted injury.
or
- 6) If you are receiving or are eligible for benefits for a disability under a prior disability plan that:
 - a) was sponsored by your employer; and
 - b) was terminated before the effect date of the policy; no benefits will be payable for the disability under this policy

STD & LTD Definitions

Short Term Disability Waiting Period - the time required to wait before Short Term Disability benefits are payable.

Coverage Effective Date - the date when your insurance coverage starts.

Long Term Disability Survivor Benefits - a 3 month lump sum benefit equal to your gross wages paid to your survivor beneficiary after you are rendered totally disabled, collecting LTD benefits and die.

Maximum Benefit Duration - the amount of time LTD benefits are payable as long as you continue to meet the definition of Total disability as defined under the policy.

Partial Disability - you are able to work part-time after being totally disabled, are under the regular care of a doctor and earning between 20% and 80% of your pre-disability earnings.



Life Insurance

Basic and Supplemental Life Eligibility

You are eligible to participate in the Orlando Health Basic and Supplemental Life plans, if you are a regular full-time, variable full-time or a part-time team member. Your coverage becomes effective the first day of the month following 60 days of continuous employment while in a benefits eligible position (as a new hire you have 45 calendar days from your date of hire to enroll in this benefit). If you do not choose to elect coverage when eligible, you must wait until the next open enrollment period to elect coverage unless you have a qualified change in lifestyle. Supplemental Life is voluntary and contributions are paid by the team member on an after-tax basis.

Basic Life and AD&D (Orlando Health pays full cost)

- For regular full-time team members: your annual base pay based on 40 hours per week
- For variable full-time team members: your annual base pay based on your weekly standard hours
- Part-time team members: \$5,000

Supplemental Coverage (You pay full cost)

You may purchase Supplemental Life Insurance coverage in the amount of:

- One times your annual base pay (rounded to the next highest \$1,000)
- Two times your annual base pay
- Three times your annual base pay

Amounts above three times your annual base pay require medical underwriting

- Four times your annual base pay
- Five times your annual base pay

Basic plus Supplemental Life Insurance coverage may not exceed \$1,000,000. If you terminate employment, you may wish to convert your coverage to a universal life policy or choose portability coverage by contacting the insurance carrier.

Medical Underwriting

Under certain circumstances, a Personal Health Application (PHA) and blood/urine profile may be required to obtain approval for Supplemental or Dependent Life Insurance coverage.

Personal Health Applications (PHA) are required:

- If you are electing four or five times your annual base pay
- If you are electing more than \$750,000
- If you increase your Supplemental coverage
- If you are electing Spouse Life coverage in excess of \$20,000
- If you are electing Child Life coverage in excess of \$10,000
- If you increase your Dependent Life elections
- If you initially decline coverage when first eligible and want to enroll during open enrollment or any qualifying event

You will receive a Personal Health Application (PHA) along with instructions on how to complete the application directly from the insurance carrier for coverage that is subject to medical underwriting.

The PHA must be completed and returned to the carrier within 60 days of the date on the cover letter. If you fail to return the application within this timeframe, it will not be processed and your coverage will not become effective.

Once you have completed your PHA and if necessary, applicable testing, and your coverage has been approved, your Supplemental Life coverage is automatically renewable on an annual basis. You will only have to submit new information if you are electing to change your coverage according to one of the guidelines described above.

Living Benefits

The living benefit feature allows you to receive some portion of your Life Insurance benefit if you are terminally ill. You may receive up to 80% of your Basic and Supplemental Insurance, not to exceed \$500,000. The amount of benefit may be subject to income tax upon receipt. Please consult your tax advisor for further information.

Age 70 Reduction Rule

As of January 1 of the next year following a team member's 70th birthday, all Team Member Life and AD&D and Spouse Life coverage will be reduced by 50% and premiums will increase substantially. Spouse's amount will reduce to the minimum allowable amount.

Taxable Income

You must pay federal income tax on the value of any Orlando Health Basic Life Insurance coverage over \$50,000. This value is called "imputed income" and is included on your paycheck and on your W-2 form at the end of the year. The amount of imputed income depends on your age, the amount of insurance coverage and the premiums the Internal Revenue Service has established to measure the value of your insurance.

Costs

The cost for Supplemental Life Insurance coverage is based on your age, annual base pay and the amount of coverage, and whether or not you are a smoker. If you do not smoke, you can take advantage of lower non-smoker rates that reflect a trend toward rewarding individuals for practicing a healthy lifestyle. You qualify as a non-smoker if you have not smoked for the last 12 consecutive months.

Calculate Your Deduction

To calculate your deduction for Supplemental Life Insurance, follow these steps:

1. Your annual base pay	\$ _____
2. Choose one of these options:	
Option 1: Your annual base pay x 1=	\$ _____
Option 2: Your annual base pay x 2=	\$ _____
Option 3: Your annual base pay x 3=	\$ _____
Option 4: Your annual base pay x 4=	\$ _____
Option 5: Your annual base pay x 5=	\$ _____
Round to the next higher 1,000	
3. Divide this amount by 1,000	
4. Find your Life Insurance rate factor on the following chart	
5. Multiply answer no. 3 by no. 4 to get your premium:	\$ _____

Life Insurance Rates – Supplemental

Rates Per \$1,000 of Coverage

Age	Non-smoker Bi-Weekly Deduction	Smoker Bi-Weekly Deduction
<30	Rates removed for client confidentiality	
30-34		
35-39		
40-44		
45-49		
50-54		
55-59		
60-64		
65-69		
70+		

Dependent Life Insurance

You may also enroll your spouse and dependent children for Life Insurance coverage. You pay for the coverage with after-tax dollars from your pay, and you are automatically the beneficiary of any Dependent Life Insurance coverage. The Life Insurance benefit, when you receive it, is not taxable. The effective date for dependent coverage may be deferred if on the date you enroll your dependent, he or she is confined in a hospital or unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance, and has not engaged in all the normal and customary activities of a person of like age and gender, in good health, for at least 15 consecutive days. This deferred effective date does not apply to disabled children who qualify under the definition of dependent children. Refer to your SPD.

2012 Dependent Life Insurance Options

Option	Spouse Life*	Bi-Weekly Deduction
Rates removed for client confidentiality		
1	\$10,000	
2	20,000	
3	30,000***	
4	40,000***	
5	50,000***	
6	60,000***	
7	70,000***	
8	80,000***	
9	90,000***	
10	100,000***	
*Spouse cannot be a benefits eligible team member of Orlando Health		
Option	Child Life**	Bi-Weekly Deduction
Rates removed for client confidentiality		
1	\$5,000	
2	10,000	
3	20,000***	
4	30,000***	
5	40,000***	
**If both parents are employed at Orlando Health, only one parent may cover the children		
***Must complete evidence of insurability		

2012 Dependent Life Insurance Options

Spouse

- \$10,000 increments to a maximum of \$100,000.
- Spouse rate: \$0.19 per \$1,000. Spouse cannot be covered if also a benefits eligible team member**

Child

- \$5,000, then increments of \$10,000, to a maximum of \$40,000.
- Child rate: \$0.19 per \$1,000**

Children between the ages of birth to 14 days are eligible for \$1,000 in coverage. See SPD or Plan Document for coverage when a child becomes disabled. If you choose Dependent Life Insurance coverage, you will receive coverage for each eligible dependent child, no matter how many children you have.

Life Insurance Definitions

Earnings - your regular annual rate of pay, not counting bonuses, commissions, tips and tokens, shift differentials, overtime pay or any other fringe benefits or extra compensation, in effect on the date you were last actively at work.

Guaranteed Issue Amount - the amount of life insurance guaranteed for which the carrier does not require a Personal Health Application.

Dependent Spouse - must not be legally separated or divorced and must be a citizen or legal resident of the United States, its territories and protectorates.

Dependent Child(ren) -

- Your unmarried children, stepchildren, legally adopted children or foster children or
- Any other children related to you by blood or marriage who:
 1. live with you in a regular parent-child relationship; and/or
 2. you claimed as a dependent on your last filed federal income tax return.

Provided such children are primarily dependent upon you for financial support and maintenance and are:

- at least 15 days old but under age 26; or
- age 26 or older and disabled. Such children must have become disabled before attaining age 26. You must submit proof, satisfactory to us, of such children's disability.
- children in full-time active military service are not eligible.



Flex Spending Accounts

Orlando Health offers two additional voluntary benefits that provide you with a way to save on taxes. You can choose to contribute to one or both of these accounts, or you may choose not to participate. You pay money into the accounts on a pre-tax basis, thus reducing your taxable income.

Dependent Daycare Spending Account

You are eligible to enroll in the **Dependent Daycare Flexible Spending Account** as a new hire or during open enrollment. Your effective date for this coverage will be the first of the month following 60 days of continuous employment. As a new hire or a team member changing from a non-eligible status to a benefit eligible status, you are given 45 calendar days to enroll in this benefit. Failure to do so will result in a delay of your enrollment until the next open enrollment period. This account is funded based on your pre-tax payroll contributions and is voluntary.

You may **not** elect this benefit and also apply for the child tax credit on your income tax return. Seek the advice of a tax consultant before you make your decision to enroll in this benefit.

You may choose to contribute up to \$5,000 per family (\$2,500 if married filing separate income tax return) in pre-tax payroll contributions annually into the Dependent Daycare Flexible Spending Account. These funds can then be used to reimburse you for covered child care expenses incurred for children under the age of 13 and other qualified dependents (See section "Eligible Dependent Daycare Expenses"). Your payroll contribution will be divided by the number of paychecks remaining for the year to determine a per paycheck cost. This is determined based on your effective date of coverage, and the remaining paychecks to be paid for the calendar year.

Reimbursements, Account Balance and Plan Changes

Reimbursement can be made for any allowable expenses as long as they are incurred during your participation in a Flexible Spending Plan.

Dependent Daycare Flexible Spending Account:

Claims can be submitted for expenses incurred any time after the start of your participation in the plan through December 31st of the current year.

You can only make changes to elections during the year under one of the following conditions:

- 1) A change in dependent care provider.
- 2) A change in employment status for you and/or your spouse.
- 3) A change in family status (such as birth or adoption).

Each claim requires a copy of an itemized receipt with the incurred date of the expense, type of expense, and the provider name. You may fax your claim to FMH CoreSource at 866.514.8287 or mail claim to: PO Box 25946 Overland Park, KS, 66225-5946. Reimbursements are processed on a weekly basis.

Your reimbursement check will indicate your current account balance. You will also receive statements throughout the plan year indicating the balances at that time. You may also contact FMH CoreSource at 866.500.5048 for more information on your account.

Participation in the Flexible Benefit Plan does require a little planning on your part, but the reward for your efforts is realized throughout the year. Take some time to consider this benefit, and see how much money you can save!

You have three months after the end of the plan year to submit claims incurred during the previous year.

Claims for eligible expenses incurred in 2012 need to be submitted by March 31, 2013.

Reduce Your Taxes: An Example

If you make \$24,000 a year and redirect \$4,320, your W-2 Form (your earnings statement that you receive end of year) will show that you earned \$19,680 that year. This is not a tax deferral, a retirement plan, or a savings account, but it is a way for you to save money.

The example below illustrates savings available to participants of the Flexible Benefit Plan (e.g., pre-tax Medical, Dental, and Vision Premiums).

Rates removed for client confidentiality

Without Flexible Benefit Plan	With Flexible Benefit Plan
Taxable Wages	Wages
(15% federal tax)	Health insurance
(7.56% SS tax)	Dependent care
Net take home	Taxable Wages
Health insurance premium	(15% federal tax)
Dependent care	(7.56% SS tax)
Net take home pay	Net take home pay
Save	monthly and annually

Using the Account - How to File a Claim

For dependent daycare reimbursements, attach the receipt from the dependent daycare provider. You can obtain necessary claim forms via SWIFT.

Plan Your Contributions Carefully

You'll want to carefully estimate the amount you put into your account because the IRS requires that you forfeit any money left in your account after all eligible expenses have been reimbursed for the year (use it or lose it). You may not transfer money between the Dependent Daycare and Healthcare Flexible Spending Accounts.

Don't let these rules stop you. The account is best used for predictable expenses.

Reminders

- You cannot transfer balances from the Dependent Daycare and Healthcare Flexible spending accounts.
- The IRS mandates that you forfeit any unused dependent care flexible spending account balance on December 31st of each year.
- In order to participate, reenrollment is required.

Eligible Dependent Daycare Expenses

You can use the dependent daycare account to reimburse yourself for:

- Child care for children under age 13 who qualify as dependents on your federal income tax return
- Child care for children of any age who are physically or mentally unable to care for themselves and who qualify as dependents

Daycare Expenses That Are Not Eligible

- Child support payments
- Food, clothing and entertainment
- Cleaning and cooking services not provided by the daycare provider
- Overnight camp
- Educational supplies and activity fees

Child Care Tax Credit vs. Spending Account

Dependent care expenses that are eligible for reimbursement are also eligible for a federal income tax credit. You can apply only one of these two favorable tax treatments, but not both, for the same expenses.

Therefore, you must decide which will give you the greater advantage:

- paying with tax-free dollars through the flex spending account or
- taking the child care tax credit

Generally the dependent daycare flex spending account approach is more advantageous if your household annual income is \$24,000 or more. However, you may want to consult a tax advisor to determine if this approach would be most advantageous to you.

To make sure the childcare expenses you expect are eligible expenses, refer to IRS Publication 503, Child and Dependent Care Credit. For more information about the federal income tax credit, see IRS Publication 596. Both can be found at: irs.gov.

Points to Consider

- Are your family's dependent daycare expenses fairly predictable?
- Would the dependent daycare spending account make more sense for you than the federal tax credit currently available for daycare expenses?

Healthcare Spending Account

You are eligible to enroll in the **Healthcare Flexible Spending Account** as a new hire or during open enrollment. Your effective date for this coverage will be the first of the month following 60 days of continuous employment. As a new hire or a team member changing from a non-eligible status to a benefit eligible status, you are given 45 calendar days to enroll in this benefit. Failure to do so will result in a delay of your enrollment until the next open enrollment period. This account is funded based on your pre-tax payroll contributions and is voluntary.

You can choose to contribute from \$200 to a maximum of \$4,000 in pre-tax payroll contributions into the Healthcare Flexible Spending Account annually. These funds can then be used to reimburse you for covered healthcare expenses that you or your dependents incur up to two and one-half months into the following calendar year, that are not reimbursed by the health plan (See the listing of eligible expenses). Your payroll contribution will be divided by the number of paychecks remaining for the year to determine a per paycheck cost. This is determined based on your effective date of coverage.

Reimbursements, Account Balance and Plan Changes

Reimbursement can be made for any allowable expenses as long as they are incurred during your participation in a Flexible Spending Plan.

Healthcare Flexible Spending Account:

- Claims can be submitted for expenses incurred anytime after the start of the plan year and up to 2 1/2 months into the next calendar year.
- You can only make changes to elections during the year under one of the following conditions:
- 1) A change in employment status for you and/or your spouse. (If you anticipate an employment status change, please call for assistance. This plan is COBRA eligible).
 - 2) A change in family status (such as marriage, birth, adoption, divorce, or death).

Each claim requires a copy of an itemized receipt with the incurred date of the expense, type of expense, and the provider name. You may fax your claim to FMH CoreSource at 866.514.8287 or mail claim to: PO Box 25946 Overland Park, KS, 66225-5946. Reimbursements are processed on a weekly basis.

Your reimbursement check will indicate your current account balance. You will also receive statements throughout the plan year indicating the balances at that time. You may also contact FMH CoreSource at 866.500.5048 for more information on your account.

Participation in the Flexible Benefit Plan does require a little planning on your part, but the reward for your efforts is realized throughout the year. Take some time to consider this benefit, and see how much money you can save!

You have three months after the end of the plan year to submit claims incurred during the previous year.

Claims for eligible expenses incurred in 2012 need to be submitted by March 31, 2013.

Reduce Your Taxes: An Example

If you make \$24,000 a year and redirect \$4,320, your W-2 Form (your earnings statement that you receive end of year) will show that you earned \$19,680 that year. This is not a tax deferment, a retirement plan, or a savings account, but it is a way for you to save money.

The example below illustrates savings available to participants of the Flexible Benefit Plan (e.g., pre-tax Medical, Dental, and Vision Premiums).

Rates removed for client confidentiality

Without Flexible Benefit Plan		With Flexible Benefit Plan	
	Taxable Wages		Wages
	(15% federal tax)		Health insurance
	(7.56% SS tax)		Reimbursable medical
	Net take home		Taxable Wages
	Health insurance premium		(15% federal tax)
	Reimbursable medical		(7.56% SS tax)
	Net take home pay		Net take home pay
Save \$82 monthly and \$984 annually			

Using the Account - How to File a Claim

When filing a claim, you must submit a claim form for eligible healthcare, dental or vision expenses by attaching an Explanation of Benefits from the insurance company that indicates patient responsibility. Include all receipts for reimbursement. You can obtain necessary claim forms via SWIFT.

Autoflex

If you are enrolled in either the Healthchoice Select or the PPO medical plan, your in-network claims for these plans will be processed automatically through Autoflex. Autoflex identifies that a member has an unreimbursed medical expense, such as a deductible, and automatically forwards it to the flex system to issue a reimbursement check. Eligible in-network pharmacy expenses are also processed automatically through Autoflex on a monthly basis. If you do not want to participate in Autoflex, please contact FMH CoreSource at 866.500.5048.

Plan Your Contributions Carefully

You'll want to carefully estimate the amount you put into your account because the IRS requires that you forfeit any money left in your account after all eligible expenses have been reimbursed for the year (use it or lose it). You may not transfer money between the Dependent Daycare and Healthcare Flexible Spending Accounts.

Don't let these rules stop you. The account is best used for predictable expenses. If you know that you'll need medical care and the deductible is \$750, you may want to contribute that amount to the healthcare account and reimburse yourself for your deductible expenses with tax-free dollars. You should be sure that your expenses will be at least \$750 if you contribute that amount, otherwise, you will forfeit the excess dollars you contributed.

Reminders

- You cannot transfer balances from the Dependent Daycare and Healthcare Flexible spending accounts.
- The IRS mandates that all healthcare expenses must be incurred prior to March 15th of the following year. All eligible expenses must be submitted for reimbursement by March 31st of that year
- In order to participate, reenrollment is required

Eligible Healthcare Expenses

The general rule is that any medical expense that is deductible on your federal income tax return may be reimbursed through the healthcare flex spending account.

Eligible Expenses Include	
Acupuncture	Alcoholism treatment
Artificial limbs	Birth control pills
Car control for the handicapped	Chiropractor fees
Christian Science practitioner fees	Vision fees
Crutches	Dental fees
Doctor fees	Eyeglasses
Guide dog	Hearing aids, batteries, exams
Hospital services	In vitro fertilization
Lab fees	Learning disability tuition, if referred by a physician
Nursing services	Optometrist fees
Orthopedic shoes	Oxygen
Orthodontics	Psychoanalysis
Special school for the disabled	Sterilization
Surgery	Telephone for the deaf
Therapy (medical)	Transplant of organs
Transportation for medical care	Wheelchairs
X-rays	Smoking cessation program
Prescribed Weight Loss Programs (food excluded)	

Healthcare Expenses That Are Not Eligible	
Health clubs, spas and non-prescribed weight-loss programs	Cosmetic surgery (unless medically necessary)
Teeth whitening	Expenses covered by another plan
Electrolysis	Hair transplants
Over the counter drugs	

For further information and a more complete listing of eligible expenses, see SWIFT or IRS Publication 502, Medical and Dental Expenses at: irs.gov

Points to Consider

- Are your family's healthcare expenses fairly predictable?
- Would you be better off selecting a lower cost medical option and paying for some expenses through the healthcare flex spending account?
- Would you be better off declining dental or vision coverage and paying for some expenses through the healthcare flex spending account?
- Do you have regular healthcare expenses that aren't covered by any other benefit plan?

Worksheet for Healthcare Flexible Spending Account

Use the worksheet below to assist you in determining your eligible expenses for your Healthcare Flexible Spending Account. Calculate projected amounts for the entire calendar year. Add up your regular medical expenses first, and then estimate any additional amounts you might need for illnesses or medical emergencies.

Medical		Estimated Annual Expenses and Tax Savings	
Deductibles	\$	Total medical expenses	\$
Co-pays	\$	Tax bracket percentage	x %
Co-insurance	\$	Annual tax savings	\$
Prescription	\$	Number pay periods per calendar year	÷
Other ()	\$	Estimated savings per pay period	\$
Dental		Tax Estimate Table	
Deductibles	\$	Annual household estimated earnings	Tax Rate
Co-pays	\$	< \$30,000	25%
Orthodontics	\$	\$30,000 - \$40,000	29%
Fillings, Crowns	\$	\$40,000 - \$70,000	31%
Other ()	\$	> \$70,000	33%
Vision		Based on Social Security, federal and state income taxes. Rate estimates are based on national averages and may not reflect your actual tax rate.	
Exams	\$		
Lenses, Solutions	\$		
Eye surgery	\$		
Other ()	\$		
Total annual election	\$		
Number of pay periods per year	÷		
Payroll deductions per pay period	\$		

PTO and ELB

The Paid Time Off (PTO) program gives you flexibility in taking paid time off from work. The Extended Leave Bank (ELB) provides you protection against using all of your PTO hours for an extended personal illness.

Under the PTO program, you decide, with your supervisor's approval, when and how you will use your PTO hours. The number of eligible hours in your PTO "bank" will be printed on your paycheck stub following the pay period of your 90th day of employment.

Here's How It Works

Under the PTO plan, you may take time off for vacation, holidays, personal business or personal and family illness. In case of a personal illness, you may use ELB hours following your first 24 consecutive hours of missed work for FT/VFT or after 12 consecutive hours for part-time team members.

Eligibility

As a regular full-time, variable full-time, or part-time team member, you accrue PTO and ELB hours based on the number of actual hours worked.

You may schedule time off based on your available PTO hours. You may not borrow against PTO or ELB hours to be earned in the future, or be paid in advance of the regular payday for PTO and ELB hours. Refer to the PTO policy 5916-1001, or ELB policy 5916-1019, for more information.

Payment Method

PTO and ELB hours are paid at your base hourly rate of pay in effect at the time you use the hours. You may use PTO hours at your current base hourly rate in minimum increments of 15 minutes (0.25). However, in order to maintain your employment status of full-time, variable full-time or part-time the number of PTO hours used plus hours worked must equal the standard number of hours required for your status.

Scheduling Time Off

To receive pay for your PTO, you must schedule the time off in advance. Your request will be reviewed by your supervisor, who has the final authority to approve your request based on departmental demands.

To ensure adequate staffing within your department, you should schedule time off well in advance for vacation, holidays, personal business and extended lengths of absence such as for pregnancy, scheduled surgery, illness or other types of absence you may be planning.

Time Off for Personal Illness

While your PTO plan is designed to give you flexibility in scheduling time off for relaxation as well as family emergencies, it also provides you some flexibility in case of a personal illness. When you are unable to report to work because of a personal illness, you are required to notify your supervisor according to your department's policy.

Method of Accrual

You accrue hours each pay period to a maximum amount based upon your Continuous Service Date (CSD). Your CSD will change if your status changes from or to a benefits eligible status or non-benefits eligible status (Example: FT to temporary VFT, or pool to FT).

PTO Accruals		
Years of Service	Maximum Accrual per bi-weekly pay period	FT/VFT/Part-Time per hour worked
0-5	7.08 hours	0.0885 hours
6-10	8.64 hours	0.108 hours
11-15	10.16 hours	0.127 hours
16+	11.68 hours	0.146 hours

ELB Accruals		
Team Member Status	Maximum Accrual per bi-weekly pay period	FT/VFT/Part-Time per hour worked
Full-Time/ Variable Full-Time/ Part-Time	1.232 hours per pay period	0.0154 hours per pay period

PTO Automatic Cash-Out Provisions

There is an annual PTO cash-out for all hours that exceed 240 for eligible team members. The cash-out will occur in the pay period following the one that includes February 1 of each year.

Upon Resignation / Status Change

If you resign from Orlando Health your PTO available balance will be paid to you according to PTO policy #5916-1001. If you terminate within your first year of employment all PTO balances will be forfeited. In case of termination for cause your PTO balance will be forfeited.

If you have a status change to pool your accrued PTO hours will be paid to you in full, unless you do so before the end of your first year. If you do not qualify for a PTO pay out any hours banked will be reactivated if you have another status change to a benefits eligible status.

Extended Leave Bank (ELB)

The ELB provides you with protection against using all of your PTO hours in case of a personal illness. ELB works this way:

- **Full-Time and Variable Full-Time Team Members**

The first 24 consecutive hours of work you miss due to a personal illness will be taken from your available PTO hours. If you don't have 24 PTO hours you won't receive ELB pay for this time. Beginning with the 25th consecutive hour of absence due to a personal illness, time will be deducted from your available ELB hours.

- **Part-Time Team Members**

The first 12 consecutive hours of work you miss due to personal illness is taken from your available PTO hours. If you don't have 12 PTO hours you won't receive pay for this time. Beginning with the 13th consecutive hour of absence due to a personal illness, time will be deducted from your available ELB hours.

If you have a status change to pool your ELB hours will be banked and reactivated if you have another status change to a benefits eligible status.

Remember: **Your ELB hours may only be used for your personal illness.**

Retirement

Upon retirement you may receive a contribution to your 401(a) account from your available ELB hours up to a maximum of \$5,000. To be eligible your age and consecutive years of Orlando Health service must equal at least 75, with the minimum age being 55, and you must also be 100% vested in the Orlando Health Retirement Savings Plan.



Retirement Savings Plan (RSP)

Turn Your Dreams into Reality! The Orlando Health Retirement Savings Plan (RSP) is offering you the opportunity to save for retirement while enjoying great tax advantages and employer contributions. This summary of the retirement savings program will explain why you should enroll today.

Why is it Important to Save?

Medical breakthroughs mean that people are living longer than ever before. This means you may spend many years in retirement. While Social Security savings may replace some of your income, most of your income may have to come from your personal savings. There is no better way to build that savings than by taking advantage of the retirement savings plan made available to you at Orlando Health.

Automatic Deductions Make Saving Hassle-Free

The Orlando Health RSP can be a great way to fund your retirement dreams. You may begin to make personal contributions into the plan as soon as you are hired. Orlando Health offers advantages including the convenience of automatic, salary reduction contributions and income tax deferral. Your gross salary is reduced by the amount of your contribution, making your taxable income lower. Pre-tax investing allows for potentially larger account accumulation since tax payments are deferred until the money is withdrawn. Withdrawals are subject to ordinary income tax. Withdrawals before age 59½ may be limited and are generally subject to a 10% tax penalty.

You may make personal, before-tax contributions up to 50% of your pay, subject to the current IRS annual limit, which is \$16,500.* If you are age 50 or older during 2012, you may contribute an additional \$5,500 for a maximum of \$22,000.* If you are eligible and wish to enroll, please contact the Retirement Savings Plan office at 407.237.6366.

** 2012 IRS limits were not available at the time of printing this communication and may be subject to change.*

Orlando Health Matches Your Contribution!

Once eligibility requirements are met Orlando Health matches \$0.50 for every \$1 you put into your retirement account up to 6% of your total eligible annual compensation. You can take full advantage of this important contribution to your retirement account by making a contribution of at least 6%.

Orlando Health will also contribute an additional 1.25% of your eligible pay, even if you choose not to make personal contributions to your plan.

Incentives to Rollover

Orlando Health permits the rollover of assets from former employer qualified retirement plans into the Retirement Savings Plan. By rolling your existing assets into your Orlando Health Retirement Savings Plan, you may gain greater control of your overall retirement savings. In addition, it will be easier for you to monitor your investments, as you will just receive one quarterly statement. You are always 100% vested in any assets rolled into the Orlando Health Retirement Savings Plan.

To receive more information on transferring your plan assets or to schedule an appointment with a Financial Services Representative please contact the Retirement Savings Plan office at 407.237.6366.

Vesting

Vesting means ownership. You are always 100% vested in your own personal before-tax contributions into your 403(b) account. You gain greater ownership of Orlando Health basic and matching contributions in the 401(a) account as your years of service with Orlando Health increase. Please refer to the Summary Plan Description (SPD) for details.

Changes in Contributions

You can change the amount of your contributions at any time during the calendar year. You may also stop your contributions at any time.

Statements and Account Information

Approximately three weeks after the end of each calendar quarter, (March 31, June 30, September 30 and December 31) you will receive a personal statement showing your account balance plus all contributions, withdrawals, and investment activity during the quarter.

You may also review your account balance at any time by accessing the website: mlr.metlife.com and entering your personal identification number.

Loans

Orlando Health permits loans from your Retirement Savings Plan. The maximum allowable loan is the lesser of 50% of your account balance or \$50,000 and a minimum loan amount of \$1,000.

Hardship Withdrawal

Withdrawal of assets from your 403(b) account is allowed under the financial hardship provision as established by the IRS. To qualify for hardship withdrawal, you must exhaust all plan loan options and meet one of the seven hardship qualifiers. No personal contributions are permitted for one full year following the hardship withdrawal. Hardship withdrawals do not have to be repaid, but are taxable and will carry an IRS penalty for early withdrawal before age 59½.

For more information on loans or hardships, please contact the Retirement Savings Plan office at 407.237.6366.

Additional Benefits

Sniffles, Ouches and Sneezes (SOS)

SOS is Orlando Health's on-site sick child care center, located at 74 Bonnie Loch Court, adjacent to Arnold Palmer Hospital. The SOS clinic cares for children ages 12 weeks (providing the first immunization has been received) through 11 years old who are too sick to attend school or daycare, but well enough for their parents to leave them with special caregivers. The clinic is open from 6:00am to 7:30pm, Monday through Friday. To reserve a space, team members can call 407.843.7671 anytime and requests will be handled according to order of call, illness of child, compliance with admission guidelines and available space. Walk-ins are not accepted. The charge for team members to use SOS is \$1 per hour, payroll deducted. Team members can find more information on SOS, such as registration forms, FAQs and guidelines on the department page on SWIFT listed under "Departments".

Orlando Health Wellness Center

The Orlando Health Wellness Center, conveniently located within walking distance of many downtown campus facilities, is a low cost, effective way for team members to maintain and improve their health and fitness. The Wellness Center is available to all team members on a membership basis that includes unlimited access to cardiovascular and strength training equipment, over 30 group fitness classes a week, locker and shower facilities, and complimentary towel service. Every member receives two complimentary sessions with our highly trained fitness staff. They will ensure that you have a fitness program designed specifically for you and that will meet your needs and goals. Team members are also encouraged to take part in additional services offered by the Wellness Center that include massage therapy, personal training, fitness and body fat evaluations, and the Premier Personal Training Weight Management program. Get fit and feel good for a great price! Team members pay an initial fee of \$25 and a monthly payment of \$22 (or \$10 a pay period).

EAP

The Employee Assistance Program (EAP) is a confidential counseling service provided as a **free** benefit to you, your spouse, or family member living with you.

Master's level therapists, licensed by the State of Florida, provide confidential counseling and support. After an initial assessment, your counselor will determine if your needs will best be served with short-term counseling at the EAP or with a referral to another resource.

Team members come to talk about:

- Relationship or family difficulties
- Depression
- Anxiety
- Job Stress
- Grief
- Trauma
- Substance Abuse
- Other life challenges

The EAP does not inform Orlando Health about anyone who visits or why they come for help which makes us a **SAFE PLACE** to talk about any subject matter no matter how large or small. Please call 407-237-6352 to schedule an appointment.

Tuition Reimbursement

Orlando Health offers financial assistance to eligible team members who wish to further their education at a regionally accredited college or university. Team members must have a minimum of six months of service to the organization prior to application for tuition reimbursement, meet all requirements of job performance in a satisfactory manner, and hold a full-time, variable full-time or part-time (at least 24 hours per week) position. The purpose of the tuition reimbursement benefit program is to assist team members in obtaining a degree in an area that would enhance their career with Orlando Health. For further information please contact HR Customer Service at 321-841-8623.

Cafeteria Discount

Orlando Health gives all team members a 25% discount on cafeteria meals and beverages. All Orlando Health cafeterias feature daily Wellness Combos for lunch and dinner at all hospital sites as part of Orlando Health's Lifestyle Medicine Initiative. These items will bear the mark of Healthy U to ease the process of making a healthy choice.



Benefits Contact Information

Benefits Department

Contacts removed for client confidentiality

**Retirement Savings Plan
Provider**

Medical

Dental

Additional Benefits

Vision

Life Insurance Provider

**Short Term / Long Term
Disability Provider**

Summary Of Benefits

Benefit	Premiums Paid By	Eligibility	Features
Medical			Information removed for client confidentiality
Dental			
Vision			
Basic Life Insurance			
Supplemental Life Insurance			
Dependent Life Insurance			
Short Term Disability			
Long Term Disability			
Dependent Daycare Flexible Spending Account			
Healthcare Flexible Spending Account			
Paid Time Off			
Extended Leave Bank			
Retirement Savings Employer Basic & Matching Contributions			
Retirement Savings TM Contribution			
Bereavement			
Tuition Reimbursement			
Sniffles, Ouches and Sneezes			

2012 Medical Bi-Weekly & Monthly Payroll Contribution Schedule

Coverage Tier Team Member (TM)	Healthchoice Select Bi-Weekly	Healthchoice Select Monthly	Healthchoice PPO \$750 Deductible Bi-Weekly	Healthchoice PPO \$750 Deductible Monthly
Full-Time/Variable Full-Time (Salary under \$30,000)				
TM Only	Rates removed for client confidentiality			
TM + Child(ren)				
TM + Spouse				
TM + Family				
Full-Time/Variable Full-Time (Salary between \$30,000 and less than \$60,000)				
TM Only				
TM + Child(ren)				
TM + Spouse				
TM + Family				
Full-Time/Variable Full-Time (Salary between \$60,000 and less than \$90,000)				
TM Only				
TM + Child(ren)				
TM + Spouse				
TM + Family				
Full-Time/Variable Full-Time (Salary over \$90,000)				
TM Only				
TM + Child(ren)				
TM + Spouse				
TM + Family				
Part-Time Team Members (Work at least 24 hours per week)				
TM Only				
TM + Child(ren)				
TM + Spouse				
TM + Family				

Dental DPO & Dental HMO Bi-Weekly & Monthly Payroll Rates

Coverage Tier Team Member (TM)	Dental \$25 Deductible PPO Option A Bi-Weekly Rates	Dental \$25 Deductible PPO Option A Monthly Rates	Dental \$50 Deductible PPO Option B Bi-Weekly Rates	Dental \$50 Deductible PPO Option B Monthly Rates	Dental DHMO Option C Bi-Weekly Rates	Dental DHMO Option C Monthly Rates
TM Only						
TM + 1						
TM + 2 or More						

Vision Bi-Weekly & Monthly Payroll Rates

Coverage Tier Team Member (TM)	Vision Bi-Weekly Rates	Vision Monthly Rates
TM Only		
TM + 1		
TM + 2 or More		

Please Note: The rates listed for the medical plan reflect a \$5 discount for non-smokers as a reward for practicing a healthy lifestyle. Therefore, if you have used tobacco products in the last twelve months, your rates will be \$5 more per pay period than those listed above.

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Healthy U Initiatives

To continue our focus on wellness for team members and their eligible dependents who are enrolled in an Orlando Health medical plan, Healthy U Initiatives will continue for calendar year 2012 which encourages a healthy lifestyle. This plan includes:

- \$5 co-pay discount on all 30-day supply prescriptions purchased at the Orlando Health on-site pharmacies, Scripts Pharmacy at M.D. Anderson Cancer Center Orlando, Scripts Pharmacy at APH or DPH Scripts. .
- \$5 medical benefit premium reduction (per bi-weekly pay period) for team members who complete both an on-line Health Risk Assessment (HRA) and biometric screening (during open enrollment only).
- \$5 medical benefit premium reduction (per bi-weekly pay period) for team members who receive a seasonal flu shot during the Orlando Health Flu Campaign.

Premium reductions earned through Healthy U Initiatives will be effective on January 1, 2012, or within the first pay period after a team member receives the seasonal flu vaccination.

Healthy U Includes the Following Team Wellness Programs

healthcare&U

Orlando Health Scripts Pharmacy at MD Anderson Cancer Center Orlando and Dr. P. Phillips Hospital

Team members and their dependents with Healthchoice insurance may take advantage of the following services offered at any Scripts Pharmacy:

- Pay \$4 for a 30-day supply and \$9 for a 90-day supply of certain prescriptions
- Fill three-month maintenance medications for only two co-pays when filling the prescriptions at any Scripts Pharmacy or by mail order
- Diabetic supplies including meters, strips and lancets are available at no cost to Select members; PPO members can fill at 25% co-insurance after deductible has been met
- A \$500 maximum allowance toward the purchase of prescription medications to quit smoking, if team member uses any Scripts Pharmacy. Eligible medications include Chantix, Zyban and Nicotrol

To contact Orlando Health Scripts Pharmacy at MD Anderson - Orlando, call 321.841.2818; or at Dr. P. Phillips Hospital, call 321.842.7230.

Healthchoice

Healthchoice, one of the oldest and more respected community-based healthcare provider networks in the area, offers the following free *Take Charge of Your Health*- Health Management programs to eligible team members and dependents: Diabetes, Asthma, Hypertension, Heart Failure, and Chronic Obstructive Pulmonary Disease.

Please call 407.481.7158 for more information or to participate in the *Take Charge of your Health*- Health Management programs.

Baby Phases Program

The health of mothers and their babies is the primary goal of Baby Phases program. For women who are pregnant, or even thinking of having a baby, Baby Phases helps them take the first step toward a healthy pregnancy. Expectant mothers are provided with personalized education and support as well as free gifts, coupons, educational materials and financial incentives for joining.

For more information or to register, call 407.481.7160

Occupational Health

Services of the Occupational Health Clinic include work-related injury/illness care, immunizations, postexposure care and preventative care (Tuberculin Skin Test (TST), flu vaccines, titers and other vaccines). The Occupational Health Clinic also provides all post-offer physical examinations for new team members.

For more information on the services offered at Occupational Health, call 321.841.5212

Quit Smoking Now - Tobacco Cessation Program

Tobacco is the single greatest cause of disease and premature death in America today. MD Anderson - Orlando, in collaboration with the Central Florida Area Health Education Center, offers a free five-week course designed to help and support your efforts to quit smoking. Facilitated by trained smoking cessation experts, this class is designed to provide counseling and the tools you need to quit.

Please call 321.841.7246 for more information or to register for a class.

nutrition&U

"Your Healthy Choice" - Orlando Health Hospital Cafeterias

All Orlando Health hospital cafeterias feature daily Wellness Combos for lunch and dinner as part of Orlando Health's Lifestyle Medicine Initiative. Items that meet Orlando Health's nutrition guidelines will bear the mark of Healthy U to ease the process of making a healthy choice. For more information on healthy menu options, go to the Food and Nutrition department on SWIFT.

R-AskRD@orlandohealth.com

Orlando Health's clinical dietitian team has developed the R-AskRD@orlandohealth.com email box for team members. Team members can use this resource to send nutrition questions to our team of dietitians for guidance. Nutrition experts will not be able to offer individual caloric prescriptions or specific diet instructions, but team members are invited to email the team those everyday nagging questions that cloud our minds when trying to make better food choices.

balance&U

Employee Assistance Program (EAP)

When team members need help with private concerns, they can turn to the EAP for professional, short-term counseling, and rest assured that their privacy is maintained. Every counselor at the EAP is licensed by the state of Florida and follows the legal and ethical statutes regarding confidentiality, so the corporation is never informed about who uses this program. This service is free to each team member and to his or her immediate family. When a referral is needed for another professional or to a community resource, the EAP can help with this as well. The EAP offices are located at 44 Lake Beauty Dr., across from the Ronald McDonald House. **Appointments may be made by calling 407.237.6352 or 800.231.7866.**

Mind Body Medicine

Mind Body Medicine, the human side of medicine... inspiring wellness. Through education, various therapies and research, we seek to reduce symptoms, promote well-being, nurture hope and prevent disease. We are excited to offer the best in eastern and western medicine in an integrative manner to our community. Please join us for these educational and effective classes. **For more information and to register, please call 321.8HEALTH (321.843.2584) or register online at orlandohealth.com/classes**

Spiritual Care

Developed by the Spiritual Care Department in collaboration with the San Pedro Retreat Center, spiritual direction is a process in which team members are invited to explore, at their own pace, the important questions of their lives. In as many one-hour sessions as a team member chooses, a duly trained spiritual director facilitates an environment of listening, personal awareness and discovery. **For more information, call 321.841.5322.**

Healthy U

Healthy U, a Lifestyle Medicine Initiative, was developed to provide information about wellness programs, products, plans, or services that impact the health and well-being of benefit eligible team members and their dependents. The Healthy U team believes that by providing comprehensive services, extensive on-site activities, and daily living resources, we can help team members and their families live healthier lives.

The mission of Healthy U, a Lifestyle Medicine Initiative, is to enhance the achievement of healthy living among Orlando Health team members through programs, initiatives and resources that will enable team members to live a healthier, active lifestyle.

In the next few pages, you will find tools that we believe will help you monitor your health and encourage you to make informed choices to better your health. It does not replace medical advice or treatment. Follow your doctor's or health care provider's advice.

Diabetes

Diabetes is often called "having too much sugar." It is really too much sugar (glucose) in the blood and not enough in the body's cells. Glucose needs to get into the cells to be used for energy. Insulin, produced by the pancreas gland, is a hormone needed for glucose to get from the blood into the cells.

activity&U

Campisi Health Centers – An Affiliate of Dr. P. Phillips Hospital

The Campisi Health Centers specialize in performance, health maximization, weight management and nutrition, and lifestyle improvements. Good health incorporates all aspects of wellness, including nutrition, aerobic capacity, strength training, behavioral health, stress management and smoking cessation. We are ready to help you reduce your risk of disease and make your life healthier and happier. **To learn more about the Campisi Health Centers services, call 407.354.2570.**

Wellness Center

The Wellness Center is a medically supervised, hospital-based exercise facility that offers membership opportunities to team members, community members and seniors. The Wellness Center offers weight management programs, exercise classes and much more. Team members also enjoy discounted membership rates. **For more information, call 407.237.6351.**

family&U

Sniffles, Ouches and Sneezes (S.O.S.)

S.O.S. is a service primarily for Orlando Health team members, although it is open to the community as well. Team members can bring their children to S.O.S. when they are mildly ill and unable to attend daycare or school. S.O.S. accepts children from 12 weeks through 11 years of age, and is staffed by licensed nurses. **Please call 407.843.7671 if you want to make a reservation for your child, have questions or need more information.**

There are 4 forms of Diabetes Mellitus

Type 1 - With this type, the pancreas gland either makes no insulin or very small amounts. Often the pancreas has fewer cells that make insulin. This type most often occurs in children and young adults. It can happen at any age, though.

Type 2 – The pancreas still makes insulin, but does not make enough. Or, the body does not use insulin the right way. This type often occurs in persons who are over age 40, are overweight, and/or don't exercise. This type of Diabetes can also occur in adolescents and young adults due to childhood obesity and lack of exercise.

Diabetes is diagnosed when fasting blood glucose levels are 126 mg/dL and higher. A confirmatory test should be done on another day.

Pre-Diabetes - Pre-diabetes is often referred to as “glucose intolerance.” With this type, fasting blood glucose levels are 100 to 125 mg/dL. Many people with pre-diabetes develop Type 2 diabetes within 10 years. Modest weight loss and moderate physical activity can help delay or prevent type 2 diabetes.

Gestational – The stress of a pregnancy may cause a temporary case of diabetes. This type usually ends when the pregnancy ends. It is important to follow up with your physician as women with gestational diabetes are at increased risk for developing type 2 diabetes mellitus.

See your doctor if you have one or more of these symptoms of diabetes:

- Frequent urination
- Excessive thirst
- Extreme hunger
- Unusual weight loss
- Increased fatigue
- Irritability
- Blurry vision

Pre-diabetes and diabetes can be present without any of these symptoms, so get tested to screen for diabetes as advised by your doctor. Early treatment may reduce other health problems related to diabetes, such as heart disease, stroke, kidney disease, and blindness.

For more information, contact:
American Diabetes Association
800.232.3472
www.diabetes.org



Control Your Blood Pressure

Categories for Blood Pressure Levels in Adults*

Blood Pressure Level (mm Hg)			
Category	Systolic		Diastolic
Normal	Less than 120	and	Less than 80
Pre-hypertension	120-139	or	80-89
High Blood Pressure (Hypertension)			
Stage 1	140-159	or	90-99
Stage 2	160 or higher	or	100 or higher
*Source: National Heart, Lung, and Blood Institute			

To Prevent and Control High Blood Pressure

- Get your blood pressure checked at each office visit, at least every 2 years, or as your doctor advises. If instructed to, take your own blood pressure readings. Record these readings in the following “Blood Pressure Record.”
- Get to and/or stay at a healthy weight.
- Don’t smoke or use tobacco products. If you do, quit.
- Limit alcohol to 2 drinks or less a day if you are male; 1 drink or less a day if you are female or age 65+.
- Be physically active 30-60 minutes each day, on all or most days.
- Manage stress.
- Reduce your intake of salt and foods high in salt.
- Take prescribed medication as directed. Don’t stop taking it unless your doctor tells you to. Tell your doctor if you have any side effects (e.g., dizziness, faintness, skin rash, or dry cough in the absence of a cold).
- Limit caffeine.
- Ask your doctor or pharmacist which over-the-counter drugs are safe for you to use. Ask if you need to avoid any food items, due to drug and food interactions.

For more information, contact:
National Heart, Lung, and Blood Institute
800.575.WELL(9355) English/Spanish
www.nhlbi.nih.gov

Control Your Cholesterol

High blood cholesterol is diagnosed by checking levels of cholesterol in your blood. It is best to have a blood test called a lipoprotein profile to measure your cholesterol levels.

The lipoprotein profile will give information about your:

- Increased total cholesterol
- Low-density lipoprotein (LDL) bad cholesterol: the main source of cholesterol buildup and blockage in the arteries
- High-density lipoprotein (HDL) good cholesterol: the good cholesterol that helps keep cholesterol from building up in arteries
- Triglycerides: another form of fat in your blood

If it is not possible to get a lipoprotein profile done, knowing your total cholesterol and HDL cholesterol can give you a general idea about your cholesterol levels. Testing for total and HDL cholesterol does not require fasting. If your total cholesterol is 200 mg/dL or more, or if your HDL is less than 40 mg/dL, you should ask your physician about having a lipoprotein profile done.

Cholesterol levels are measured in milligrams (mg) of cholesterol per deciliter (dL) of blood. See how your cholesterol numbers compare to the tables below.

Total Cholesterol Level	Total Cholesterol Category
Less than 200 mg/dL	Desirable
200–239 mg/dL	Borderline High
240 mg/dL and above	High

LDL Cholesterol Level	LDL Cholesterol Category
Less than 100 mg/dL	Optimal
100–129 mg/dL	Near Optimal/Above Optimal
130–159 mg/dL	Borderline High
160–189 mg/dL	High
190 mg/dL and above	Very High

HDL Cholesterol Level	HDL Cholesterol Category
Less than 40 mg/dL	A major risk factor for heart disease
40–59 mg/dL	The higher, the better
60 mg/dL and above	Considered protective against heart disease

Triglycerides can also raise your risk for heart disease. If you have levels that are borderline high (150–199 mg/dL) or high (200 mg/dL or more), you may need treatment. Things that can increase triglyceride levels include:

- Overweight
- Physical inactivity
- Cigarette smoking
- Excessive alcohol use
- Very high carbohydrate diet
- Certain diseases and drugs
- Genetic disorders

Ways to Reduce Cholesterol

- Read food labels to select foods low in saturated fat and total fat.
- Limit foods that have trans fatty acids, found in hydrogenated oil in foods, such as stick margarine and snack foods (e.g., crackers).
- Choose lean cuts of beef, pork and lamb, chicken and turkey. Limit meat serving sizes.
- Eat a variety of fruits and vegetables (5 to 7 or more servings/day) and grain products (6 or more servings/day).
- Get 20 to 35 grams of dietary fiber a day. Good food sources are oat bran, oatmeal, kidney and other beans, lentils, apples, oranges, and carrots.
- Eat fish 2 to 3 times a week, especially those high in omega-3 fatty acids (e.g., salmon).
- Use nonfat and low-fat dairy products.
- If you drink alcohol, do so in moderation.
- Be physically active 30–60 minutes each day, on all or most days.
- Take medications, if prescribed.

For more information, contact:

National Heart, Lung, and Blood Institute
800.575.WELL(9355) English/Spanish
www.nhlbi.nih.gov



Control Your Weight

Being overweight or obese increases your risk for high blood pressure, high blood cholesterol, heart disease, stroke, diabetes, certain types of cancer, arthritis, and breathing problems. Aim for a healthy weight.

Some doctors use waist circumference to better understand your health status or risk for certain health problems. Use a measuring tape to measure your waist just above your hip bone.

Goals for waist circumference

Men < 40 inches

Women < 35 inches

BMI (kg/m ²)	19	20	21	22	23	24	25	26	27	28	29	30	35	40
Height (in.)	Weight (lbs.)													
58	91	96	100	105	110	115	119	124	129	134	138	143	167	191
59	94	99	104	109	114	119	124	128	133	138	143	148	173	198
60	97	102	107	112	118	123	128	133	138	143	148	153	179	204
61	100	106	111	116	122	127	132	137	143	148	153	158	185	211
62	104	109	115	120	126	131	136	142	147	153	158	164	191	218
63	107	113	118	124	130	135	141	146	152	158	163	169	197	225
64	110	116	122	128	134	140	145	151	157	163	169	174	204	232
65	114	120	126	132	138	144	150	156	162	168	174	180	210	240
66	118	124	130	136	142	148	155	161	167	173	179	186	216	247
67	121	127	134	140	146	153	159	166	172	178	185	191	223	255
68	125	131	138	144	151	158	164	171	177	184	190	197	230	262
69	128	135	142	149	155	162	169	176	182	189	196	203	236	270
70	132	139	146	153	160	167	174	181	188	195	202	207	243	278
71	136	143	150	157	165	172	179	186	193	200	208	215	250	286
72	140	147	154	162	169	177	184	191	199	206	213	221	258	294
73	144	151	159	166	174	182	189	197	204	212	219	227	265	302
74	148	155	163	171	179	186	194	202	210	218	225	233	272	311
75	152	160	168	176	184	192	200	208	216	224	232	240	279	319
76	156	164	172	180	189	197	205	213	221	230	238	246	287	328

Check off the weight group you are in:

- Healthy Weight = BMI from 18.5 to 24.9
- Overweight = BMI from 25 to 29.9
- Obese = BMI of 30 or higher

To Control Your Weight

- Be physically active 30-60 minutes each day, on all or most days.
- Select sensible portion sizes.
- Check out the website at www.choosemyplate.gov to download the brochure on making healthy choices.
- Eat to satisfy hunger, not emotions.
- Consume foods that are low in fat.
- Eat at regular times each day. Consume at least half of your food in the first half of your day.
- Put smaller portions of food on your plate and limit second helpings.
- Eat slowly, taking at least 20 minutes to finish a meal.

For more information, contact:

Weight-control Information Network (WIN)

www.niddk.nih.gov

Click on "Weight Control" under "Health Information"

10 tips

Nutrition Education Series

choose MyPlate

10 tips to a great plate



Making food choices for a healthy lifestyle can be as simple as using these 10 Tips.

Use the ideas in this list to *balance your calories*, to choose foods to *eat more often*, and to cut back on foods to *eat less often*.

1 balance calories

Find out how many calories YOU need for a day as a first step in managing your weight. Go to www.ChooseMyPlate.gov to find your calorie level. Being physically active also helps you balance calories.

2 enjoy your food, but eat less

Take the time to fully enjoy your food as you eat it. Eating too fast or when your attention is elsewhere may lead to eating too many calories. Pay attention to hunger and fullness cues before, during, and after meals. Use them to recognize when to eat and when you've had enough.



3 avoid oversized portions

Use a smaller plate, bowl, and glass. Portion out foods before you eat. When eating out, choose a smaller size option, share a dish, or take home part of your meal.

4 foods to eat more often

Eat more vegetables, fruits, whole grains, and fat-free or 1% milk and dairy products. These foods have the nutrients you need for health—including potassium, calcium, vitamin D, and fiber. Make them the basis for meals and snacks.



5 make half your plate fruits and vegetables

Choose red, orange, and dark-green vegetables like tomatoes, sweet potatoes, and broccoli, along with other vegetables for your meals. Add fruit to meals as part of main or side dishes or as dessert.

6 switch to fat-free or low-fat (1%) milk

They have the same amount of calcium and other essential nutrients as whole milk, but fewer calories and less saturated fat.



7 make half your grains whole grains

To eat more whole grains, substitute a whole-grain product for a refined product—such as eating whole-wheat bread instead of white bread or brown rice instead of white rice.

8 foods to eat less often

Cut back on foods high in solid fats, added sugars, and salt. They include cakes, cookies, ice cream, candies, sweetened drinks, pizza, and fatty meats like ribs, sausages, bacon, and hot dogs. Use these foods as occasional treats, not everyday foods.

9 compare sodium in foods

Use the Nutrition Facts label to choose lower sodium versions of foods like soup, bread, and frozen meals. Select canned foods labeled “low sodium,” “reduced sodium,” or “no salt added.”



10 drink water instead of sugary drinks

Cut calories by drinking water or unsweetened beverages. Soda, energy drinks, and sports drinks are a major source of added sugar, and calories, in American diets.

Be Physically Active

Make physical activity a part of your daily routine. Physical activity helps build and maintain healthy bones, muscles, and joints; lowers risk factors for heart disease, colon cancer, and Type 2 diabetes; helps control blood pressure and weight; and promotes well-being and self-esteem.

Do three types of physical activity:

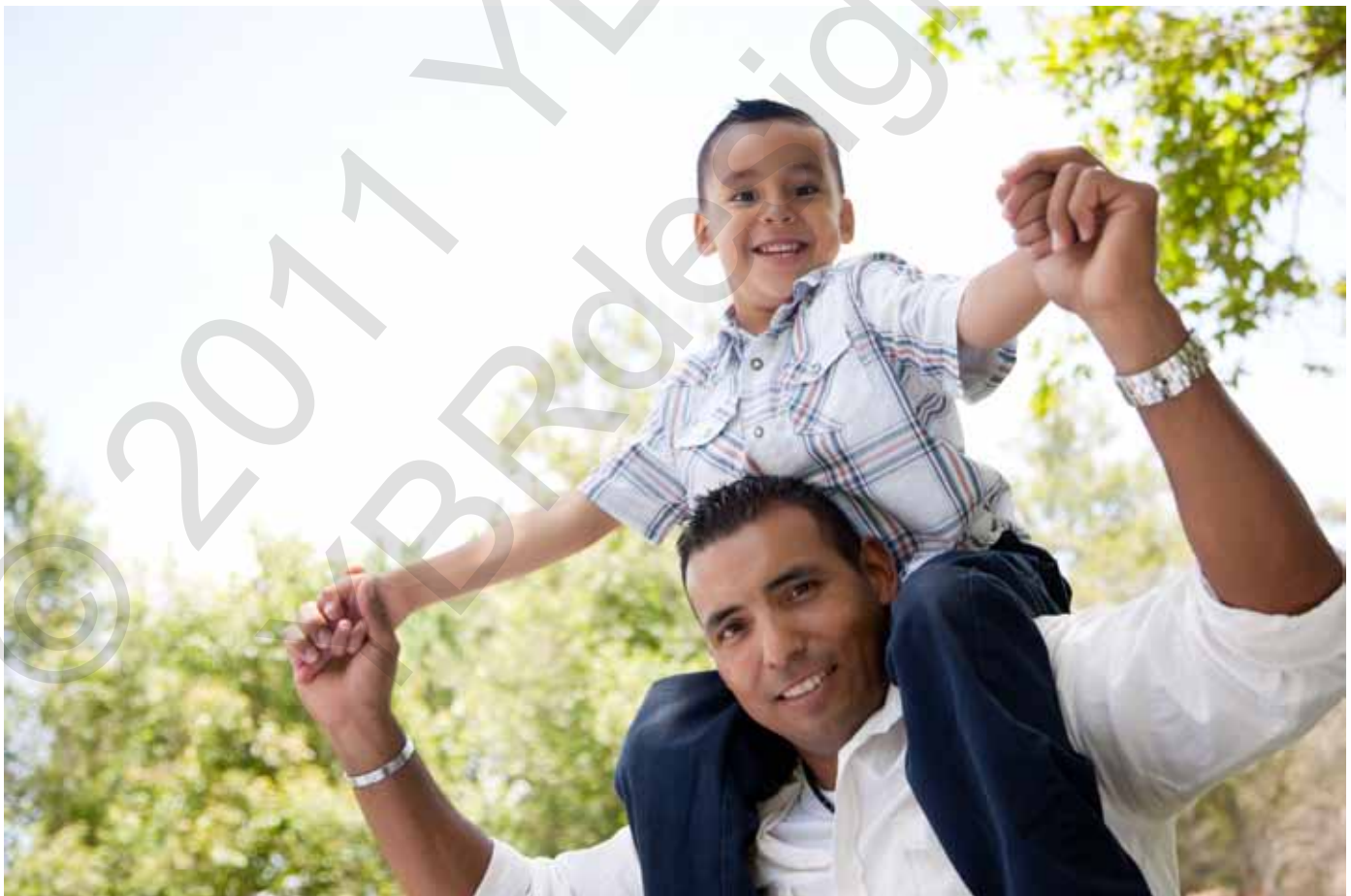
Aerobic (Cardiovascular) Activity. These activities speed your heart rate and breathing, promoting cardiovascular fitness. Aerobic activities burn calories and can help you maintain or lose weight. Examples include brisk walking, jogging, dancing and biking. Do aerobic activity for 30 minutes on most days of the week. Splitting the recommended 30 minutes of exercise into smaller increments throughout the day is still beneficial. If you can't find 30 minutes in your day – do 10 minutes in the morning, 10 minutes at lunch and 10 minutes in the evening.

When doing aerobic exercising, it's important to monitor your intensity to make sure you're working at a pace that is challenging enough to help you reach your goals, but not so hard that you harm yourself. You can rate your level of intensity by using a Perceived Exertion Scale of 1-10. Level 1 would be equal to relaxing and watching TV. Level 10 would be like the hardest thing you've ever done. In general, for most workouts you want to be at around Level 5-6.

Strength Activity. Developing strength will help build and maintain your muscles and bones. Strength training can help boost your metabolism and help you maintain a good quality of life. Examples include lifting weights, using strength bands or doing exercises with your own body weight (push-ups and crunches). You should do some type of strength activity 2-3 times a week for 20-30 minutes.

Stretching Activity. Being flexible can help decrease the risk of injury and help maintain a good quality of life. Stretching can reduce muscular pain and tightness. Doing stretching exercises can also decrease stress and relax you. Gentle stretching at your home or desk, some types of Yoga moves and/or deep breathing should be done every day of the week.

For more information, contact:
www.healthierus.gov



Stress Management

Each person reacts to stress differently. Changing jobs might be overwhelming for some persons, while others welcome the change. How stress affects your health depends on how often and how much stress you have and how well you tolerate stressful situations.

Your Stress Factors	
Next to each of the following questions, put the number 1 to 5, using this scale: 1=Never; 2=Rarely; 3=Sometimes; 4=Often; 5=All the Time	
1. One or more major changes are occurring in my life (e.g., divorce, new baby, etc.)	
2. I am exposed to physical danger where I live or work.	
3. I fear that I may lose my job.	
4. I do not get positive feedback from people I work or live with.	
5. I feel powerless to change my workload and/or working conditions.	
6. My workspace and/or home is disorganized or messy.	
7. I am unable to pay my bills on time.	
8. I don't think that I will be able to handle future financial needs.	
9. I or a person I live with has a serious illness or injury.	
10. I am not able to get appropriate child care or take care of loved ones who depend on me.	
11. I sense a lot of conflict and/or hear a lot of arguments at home and/or work.	
12. Persons close to me expect me to solve their problems.	
13. I don't have time to do things that I enjoy or to relax.	
14. I am not accomplishing what I expect of myself.	
15. My energy is drained at the end of the day.	
Total Your Score	
A score less than 38 indicates a lower-stress life. A score of 38 or more indicates a higher-stress life. You may need to make changes in your life to reduce and help you manage stress.	
<i>Adopted from "Is Stress Putting Your Health at Risk" in the Self-Care Advisor, Time Inc. Health, 2000.</i>	

Ways to Manage Stress

- Maintain a regular program of healthy eating, good health habits, and adequate sleep. Limit caffeine and alcohol.
- Exercise regularly.
- Don't let your emotions get "bottled up" inside. Share your feelings with others.
- Learn to manage your time efficiently.
- Avoid unnecessary arguments or quarrels.
- Practice a relaxation technique daily.
- Balance work and play.
- Engage in activities you enjoy and look forward to.
- Accept the things you cannot change in yourself or others.
- Forgive yourself for mistakes.
- Develop and maintain a positive attitude.

Common Health Tests and Records

Test	When to Have	Test Date
Dental Checkup	Every 6-12 months	
Physical Exam	Every 5 years (ages 18-29)	
	Every 2-4 years (ages 30-49)	
	Every 1-2 years (ages 50+)	
Diabetes Mellitus Type II	Sustained BP greater than 135/80 or taking medications to control BP or as advised by doctor.	
Blood Pressure	At every office visit or at least every 2 years	
Cholesterol Blood Test	Every 5 years starting at age 35 (men); 45 (women) or as advised	
Vision	Every 1-2 years (age 18-60)	
	Annually (ages 61+)	
Testicular Self-Exam (Males)	As advised (ages 15+)	
Abdominal Aortic Aneurysm	One-time screening in men aged 65 to 75 who have ever smoked	
Pap Test (Females)	At least every 3 years from ages 21-65 as advised.	
	After age 65, consult doctor.	
Chlamydia Screening (Females)	As advised for all sexually active females (ages 25 and younger; ages 25+ at high risk ¹)	
Clinical Breast Exam (Females)	Discuss with Doctor	
Mammogram (Females)	Every 2 years (ages 40-74 years)	
Prostate Cancer Screening ² (Males)	As advised (ages 50+)	
Colorectal Cancer Screening ³ (Males and Females)	As advised (ages 50+)	
Osteoporosis Screening	Starting at age 65 (60 if at increased risk for fractures) as often as advised	

Note: These are general guidelines. Adults should also be screened for alcohol misuse, depression, obesity, and tobacco use. If you are at an increased risk for an illness, tests may need to be done sooner or more often. Extra tests, such as ones that screen for diabetes and glaucoma, may also be needed. Follow your doctor's advice for tests and exams.

¹ High risk – Having more than one sex partner, having had an STD, or not using condoms consistently and correctly.

² African American men should discuss this with their doctors at ages 45+. So should men with a family history of prostate cancer.

³ Screening tests include stool blood test, double contrast barium enema, sigmoidoscopy, and colonoscopy. How often tests are needed depends on which test(s) are given.