Taylor County School District

10/1/2023-9/30/2024 Benefit Summary

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If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 22–23 for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

First Things First

Choosing Your Benefits

During the year, you have limited opportunities to make your benefit choices. **Make your selections carefully!** The choices you make now will be effective October 1, 2023 through September 30, 2024.

When you're first hired	When you are first hired, your coverage begins on your **benefit eligibility date**: the first day of the month following your 30th day of full-time employment. The choices you make as a new hire will be in effect through **September 30, 2024**.
At Annual Enrollment	Annual Enrollment is your opportunity once each year to evaluate your benefit options and make selections for the following plan year. Benefits selected at Annual Enrollment are effective **October 1 through September 30**.
If you have a life event	Certain life events may allow you to change your coverage during the year. You have **30 days** from the date of the event to contact Human Resources and request applicable changes to your benefits. Life events include: marriage or divorce, adopting a child, custody status change of a child, a change in Medicare or Medicaid eligibility, or a change in your or your spouse's work affecting benefits eligibility.

Covering Your Family

Your Spouse

You may cover your legal spouse on your benefit plans including medical, dental, and vision.

Your Children

Your natural, adopted, foster, step children and children in your custody due to a court order are eligible for benefits with Taylor County School District:

Medical	Through the end of the **calendar year** when they reach **age 30**.
Dental & Vision	Dental to the end of the calendar year they turn **age 30**. Vision to the end to the calender year they turn **age 26**.
Child Life	**To age 30.**

Disabled dependents: children who became disabled before age 26 and rely on you for support may be eligible for coverage through the end of the calendar year they turn 30. Contact Human Resources for coverage information.

New Employees

What Open Enrollment Means:

Open Enrollment provides us an opportunity to re-familiarize ourselves with the many benefits offered. This is also your once-a-year opportunity to enroll or make changes to core benefit plans for Medical, Dental and Vision in addition to any supplemental coverages. Once the annual enrollment period ends, you **will not** have any further opportunities to make changes for the benefit plan year unless you experience a Qualifying Life Event (QLE).

How to Enroll with Explain My Benefits

Open Enrollment will take place **August 7 - August 18**. All employees can self enroll at **www.tcsd-benefits.com** or call the Enrollment Center at **850.273.4651** Hours 9am - 6pm.

All Benefit Eligible employees will be able to have a 1 on 1 telephonic enrollment meeting with an Explain My Benefits Enrollment Counselor. During your enrollment meeting, you will have the opportunity to take the following actions: Enroll/Cancel/Waive coverages. Add/Remove Dependents and Elect Beneficiaries.

Watch your email for additional information about Open Enrollment and scheduling an open enrollment telephonic meeting.

Benefits Resource Website

www.TCSD-Benefits.com

Taylor County Schools values and appreciates all that you do. We know that Open Enrollment can be stressful and confusing. We are using Explain My Benefits again this year to support our open enrollment process. The Benefit Resource website is **www.TCSD-Benefits.com**.

Additionally, this will also be where you go to schedule your individual enrollment meeting with ***Explain My Benefits*** Enrollment Counselors. If you have done so - please make sure you have scheduled your meeting in order to confirm your elections.

For more information about the Open Enrollment process, to review a digital copy of the Benefit Guide or any other important information regarding the available benefits, please visit our Benefit Resource Website. **www.TCSD-Benefits.com**

Chris Olson or Shanna Dodimead
Benefits Coordinator
Taylor County School District
318 North Clark Street
Perry, FL 32347
Chris.Olson@taylor.k12.fl.us
Shanna.Dodimead@taylor.k12.fl.us
850.838.2500

How To Enroll

Open Enrollment will take place **August 7-August 18**. We are using ***Explain My Benefits EMB*** again this year as our Benefit Administration system. This year you can self-enroll by logging into the EMB website **www.TCSD-Benefits.com** or using the mobile app [see QR code below] or call the enrollment center at **850.273.4651** during the **Hours of 9am – 6pm**. This is your once-a-year opportunity to re-enroll or make changes to core benefit plans for Medical, Dental and Vision coverages in addition to any supplemental coverages.

If you decide to actively enroll online or talk with an ***Explain My Benefits*** Enrollment Counselor, you will have the opportunity to take the following actions for Plan Year 10/1/2023-9/30/2024: Enroll/Cancel/Waive coverages and Add/Remove Dependents. You may also change Beneficiaries. This will be your opportunity to speak with an insurance professional and have a clear understanding of the benefits offered in order to make the best decisions for you and your family.

This year is a **Passive Enrollment**. All currently enrolled benefit eligible employees can decide to have your benefits remain the same without having to login to EMB or call in to the enrollment center. If you are already enrolled and you do not enroll in the 10/1/2023 benefits, your current elections will roll over for the upcoming year.

Please NOTE: if you are making your initial enrollment as a new hire - passive enrollment is not an option, you must self enroll via the EMB website **www.TCSD-Benefits.com,** mobile app [see QR code below] or call the enrollment center at **850.273.4651**.

Once the annual enrollment period ends, you will not have any further opportunities to make changes for the benefit year unless you experience a Qualifying Life Event.

Benefits Overview

At Taylor County School District, we believe that benefits are an integral part of your total compensation—that is why it's important that you get the maximum value from your benefit plans.

Taylor County School District is proud to offer a comprehensive benefits package to eligible, full-time employees who work 20 hours or more per week and have 30 days of service.

Benefit Plans Offered

» Medical—Florida Blue
» Dental—Florida Combined Life
» Vision—Standard Insurance
» Basic Life—USAble Life
» Voluntary Life—USAble Life
» Short-Term Disability—Standard Insurance
» Long-Term Disability—Standard Insurance
» Voluntary Benefits:
  - Accident Insurance—Standard Insurance
  - Critical Illness—Standard Insurance
  - Hospital Indemnity—Standard Insurance

Examples of Qualifying Events

» Marriage/Divorce
» Death
» Change in full-time status
» Loss of employment
» Dependent no longer eligible
» Spouse obtains or loses employment

If you experience a qualifying event during the plan year, it is your responsibility to contact your Human Resources Department to report the change within 30 days or 60 days in the case of a Children's Insurance Program Reauthorization Act of 2009 (CHIPRA) special enrollment. Otherwise, you will not be able to make your changes and will have to wait until the 2024/2025 Annual Open Enrolment Period to make the change.

BENEFITS ENROLLMENT APP

Taylor County School District has provided you a benefits app to manage your benefits that allows you to:

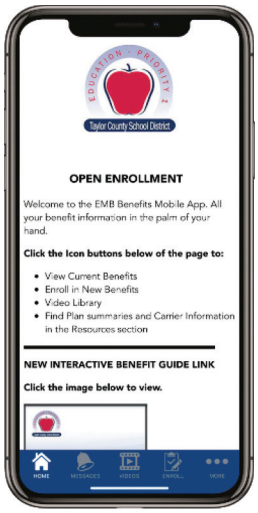
- ✓ Enroll in your insurance benefits from your phone
- ✓ View your current benefits
- ✓ Watch benefit education videos, and review insurance brochures
- ✓ Receive important message notifications about your benefits.

Please be sure to Enable Push Notifications

TO DOWNLOAD:

1. Text emb to 71441
2. Download by clicking the link for iOS or Android
3. Enter Company Code: tcsd

Download on the App Store | GET IT ON Google Play



GET THE APP

Accuracy of Enrollee Information

As we all work toward managing the Taylor County School District's overall health plan costs. It is important that only individuals eligible for benefits are actually enrolled. This helps make coverage more affordable for active employees and retirees who pay the full cost for their benefits.

It is also very important when a dependent no longer qualifies for Taylor County School Districts benefits coverage, the dependent is removed and has the opportunity to continue benefit through COBRA.

Eligibility

All full-time newly hired employees are eligible to participate in the Taylor County School District's group insurance plans effective the 1st day of the month following 30 days of employment. Questions regarding eligibility should be directed to Chris Olson or Shanna Dodimead, **850.838.2500 ext 107**.

Dependent Eligibility

Employee's spouse under a legally valid existing marriage, as defined under Florida Law

- The Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the covered employee has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 26 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Plan Participant, whether the dependent child resides with the Covered Plan Participant, or whether the dependent child is eligible for or enrolled in any other group health plan.
- The newborn child of a covered dependent child who has not reached the end of the calendar year in which he or she becomes 26. Coverage for such child will automatically terminate 18 months after the birth of the newborn child.

Extension of Eligibility for Dependent Children

A covered dependent child is covered through the end of the calendar year in which they turn 26. A covered dependent child may continue coverage through the end of the calendar year in which they reach 30, provided they are:

- Unmarried and does not have a dependent
- A Florida resident or a full-time or part-time student
- Not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.

Handicapped Children

In the case of a handicapped dependent child, such child is eligible to continue coverage as a covered dependent, beyond the age of 26, if the child is:

- Otherwise eligible for coverage under the Group Health Plan;
- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 26th birthday.

This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

Exception for Students on Medical Leave of Absence from School

» A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a physician certified medically necessary leave of absence from school, will still be considered a student for eligibility purposes the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage.

Dental

» Employee's legal spouse.

» Employee's dependent children.

» **Dependent child** refers to:

a. each child through the end of the year in which they turn age 30, for whom the Insured or the Insured's spouse, is legally responsible, including:
   i. natural born children, adopted
   ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code
   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

The child must be dependent upon the certificate holder for support and either living in the household of the certificate holder or is a full or part-time student.

b. each child age 30 or older who:
   i. is Totally Disabled due to mental or physical reasons; and
   ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limit age. Any costs for providing continuing proof will be at our expense.

PPO Blue Options—05770 and 05901

The PPO Plans offer services outside the network and provide for freedom of choice for care within the network. **Services rendered outside the network are subject to balance billing, which means the member may be responsible for the difference between the Florida Blue negotiated fee and the provider or facility's retail charge.** The physician network for this plan is Blue Options. The PPO Plans do not require members to choose a Primary Care Physician.

A brief summary is as follows:

	Blue Options 05770		Blue Options 05901	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (CYD) (Individual/Family) (PBP)	$1,000/$3,000		$2,000/N/A	$6,000/N/A
Coinsurance	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance
Out-of-Pocket Maximum (Individual/Family)	$3,000/$6,000	$5,000/$10,000	$6,350/$12,700	$30,000/$30,000
OFFICE SERVICES				
Primary Care Provider Office Visit—PCP	$35 copay	40% coinsurance after CYD	$35 copay	50% coinsurance after CYD
Specialist Office Visit	$65 copay	40% coinsurance after CYD	$75 copay	50% coinsurance after CYD
Convenient Care	$35 copay	40% coinsurance after CYD	$35 copay	50% coinsurance after CYD
PREVENTIVE SERVICES				
Preventive Care—Adult and Children Wellness Service	$0 copay	40% coinsurance	$0 copay	50% coinsurance
Mammogram	$0 copay	$0 copay	$0 copay	$0 copay
Routine Colonoscopy (See Age)	$0 copay	$0 copay	$0 copay	$0 copay
EMERGENCY MEDICAL CARE				
Urgent Care Facility	$65 copay	$65 copay after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Ambulance Service	20% coinsurance after CYD	20% coinsurance after INN CYD	50% coinsurance after CYD	50% coinsurance after INN CYD
Emergency Room Facility Services (Per Visit)	$100 copay	$100 copay	$50% coinsurance after INN CYD	
OUTPATIENT DIAGNOSTIC				
Independent Diagnostic Testing Facility Services (per visit)				
Diagnostic Service (Except AIS)	$100 copay	40% coinsurance after CYD	$50 copay	50% coinsurance after CYD
Advanced Imaging Services (AIS) CT/ CAT/MRA/MRI,PET Scans	$100 copay		$200 copay	

Sign Up for Teledoc:

» General Medicine and Urgent Care Service through Teledoc is $10

» Covered Dermatology Service through Teledoc is $20

Florida Blue

Group #: 46073
www.floridablue.com
1.800.352.2583

Download Florida Blue's mobile app for claims information, to access your ID card, find a doctor, and more!

	Blue Options 05770		Blue Options 05901	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Independent Clinical Lab	$0 copay	40% coinsurance after CYD	$0 copay	50% coinsurance after CYD
Outpatient Hospital Facility Services (Blood Work, X-Rays) Option 1 Option 2	 $100 copay $300 copay	 40% coinsurance after CYD	 $300 copay $400 copay	 50% coinsurance after CYD
HOSPITAL SURGICAL				
Ambulatory Surgical Center Facility	$100 copay	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Outpatient Hospital Facility Services—therapy services (per visit) Option 1 Option 2	 $100 copay $300 copay	 40% coinsurance after CYD	 $80 copay $90 copay	 50% coinsurance after CYD
Outpatient Hospital Facility Services—all other services (per visit) Option 1 Option 2	 $100 copay $300 copay	 40% coinsurance after CYD	 $300 copay $400 copay	 50% coinsurance after CYD
Inpatient—Hospital Facility and Rehabilitation Services (per admit) Option 1 Option 2	 $750 copay $1,000 copay	 40% coinsurance after CYD	 $2,000 copay $3,000 copay	 50% coinsurance after CYD*
MENTAL HEALTH/SUBSTANCE ABUSE				
Inpatient—Hospital (per admit) Option 1 Option 2"	 $750 copay $1,000 copay	 40% coinsurance after CYD	 $0 copay	 50% coinsurance
Outpatient Hospital Facility Services (per visit) Option 1 Option 2	 $100 copay $300 copay	 40% coinsurance after CYD	 $0 copay	 50% coinsurance
Emergency Room Facility Services (per visit) CYD	$100 copay		$0 copay	
OTHER SERVICES				
Rehabilitation Services Outpatient Rehab Center Outpatient Hospital Facility (per visit): Option 1: Option 2:	 $65 copay $100 copay $300 copay	 40% coinsurance after CYD	 $75 copay $80 copay $90 copay	 50% coinsurance after CYD
Home Health	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Skilled Nursing Care	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD

**Services rendered outside the network are subject to balance billing, which means the member may be responsible for the difference between the Florida Blue negotiated fee and the provider or facility's retail charge.*

**If admitted to Out-of-Network hospital from Emergency Room, the In-Network Option 1 Hospital Cost Share applies.*

**Option 1 applies to in-network providers. Option 2 applies to in-network providers that are specialty or research hospitals. Option 2 also includes Out-of-State BlueCard providers.*

	Blue Options 05770		Blue Options 05901	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Durable Medical Equipment	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Provider Services Hospital And ER *including Radiologists, Anesthesiologists and Pathologists at Hospital.	20% coinsurance after CYD	20% coinsurance after INN CYD	50% coinsurance after CYD	50% coinsurance after INN CYD
Provider Services Other Locations Other Than Office Hospital and ER	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
PRESCRIPTION DRUGS				
Pharmacy Deductible	$0		$0	
Generic	$10	Not covered	$15	Not covered
Brand Name	Not covered		Not covered	
	MAIL ORDER (90 days)			
Mail Order Pharmacy	Not covered		Not covered	
Monthly Medical Rates—Employee (10 month rate September - June)				
Employee Only	$400.87		$179.98	
Employee/Spouse	$1,174.62		$882.54	
Employee/Child(ren)	$1,031.41		$765.10	
Family	$1,501.31		$1,150.28	
School District's Contribution				
Employee Only	$455.00			
Employee/Spouse	$455.00			
Employee/Child(ren)	$455.00			
Family	$455.00			

CYD = Calendar Year Deductible

Under the new healthcare legislation, it is required to carry or maintain minimum essential medical insurance either through your employer or independently to avoid a penalty. Taylor County School District provides minimum essential health insurance coverage that meets minimum value standards and is affordable. If you choose to waive the District's medical plan and enroll in Marketplace coverage, you may not be eligible for a Marketplace subsidy or tax credit, and you will also lose the subsidy provided by the District towards District-provided medical insurance.

Choosing the **right** care at the **right** price

When you or your family needs care, it's important to fully understand your options and receive the right care at the right price. We offer three options for rapid care with our Florida Blue plans:

Use:	TELADOC®	Urgent Care Walk in Clinic	Emergency Room
For:	• Cold, flu, sore throat • Sinus pain or allergies • Mild burns • UTIs • Earache / toothache • Minor rashes and skin issues • Prescriptions	• Strep throat symptoms • Sprains / minor broken bones • Pneumonia symptoms • Cuts requiring stitches • Severe flu symptoms • Allergic reactions • Sports Medicine (X-rays)	• Chest pain / Heart Attack • Head injury • Spinal cord injury • Major broken bones • Major trauma • Stroke • Abdominal pain
Cost:	5770 - $10 copay 5901 - $10 copay	5770 - $65 copay 5901 - Calendar Year Deductible then 50%	5770 - $100 copay 5901 - Calendar Year Deductible then 50%
Hours:	Available for consultations 24 / 7 / 365	Weekdays; most also have weekend and evening hours - check their website. Partial Listing: • Coastal Complete - Closes at 7pm Mon - Thurs | 8pm Fri • Kids Street Urgent Care 2615 N. Monroe St. Ste 1B Tallahassee, FL Closes at 8pm	Available 24 / 7 / 365
Wait:	Less than 10 minutes	Usually less than 20 minutes	Average: 2 hours, 15 minutes
	• 1-888-283-6691 • Teladoc.com • Teladoc Mobile app	Typically a free-standing location not directly next to a hospital. No ambulance entrance.	Generally attached to a hospital, but may be free-standing. Has red '**EMERGENCY**' text.

Why this matters:
An estimated **71%** of Emergency Room visits can be avoided by using Urgent Care or Teladoc. Visiting the ER costs you more, takes more time, and exposes you and your family to a variety of airborne diseases and infection. When you use Urgent Care or Teladoc, you'll get the care you need without sacrificing time, cost, or your health.

Gallagher

» General Medicine and Urgent Care Service through Teledoc is $10

» Covered Dermatology Service through Teledoc is $20

TELADOC®

Florida Blue
Your local Blue Cross Blue Shield

Getting started **with Teladoc**

Cómo afiliarse **a Teladoc**

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It is a convenient and affordable option for quality medical care. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.

1. REGISTER

3 easy ways: download the mobile app, visit the Teladoc website or call the number below.

2. PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3. REQUEST A VISIT

That's it! A Teladoc doctor is now just a call or click away.

Teladoc® le da acceso 24 horas, 7 días a la semana todos los días del año a una lista de médicos especialistas certificados de Estados Unidos a través de su teléfono. Configure su cuenta ahora para que cuando necesite la atención inmediata, un médico de Teladoc esté a sólo una llamada de distancia.

1. REGÍSTRESE

Llame al teléfono que figura a continuación y un representante lo ayudará a registrar su cuenta.

2. PROPORCIONE SUS ANTECEDENTES MÉDICOS

Sus antecedentes médicos proporcionan a los médicos de Teladoc la información que necesitan para realizar un diagnóstico seguro.

3. SOLICITE UNA CONSULTA

¡Eso es! Un médico de Teladoc está a sólo un llamado de distancia.

Talk to a doctor anytime.
¡Hable con un médico en cualquier momento!

Teladoc.com
1-800-Teladoc (835-2362)

Available on the iPhone App Store

GET IT ON Google Play

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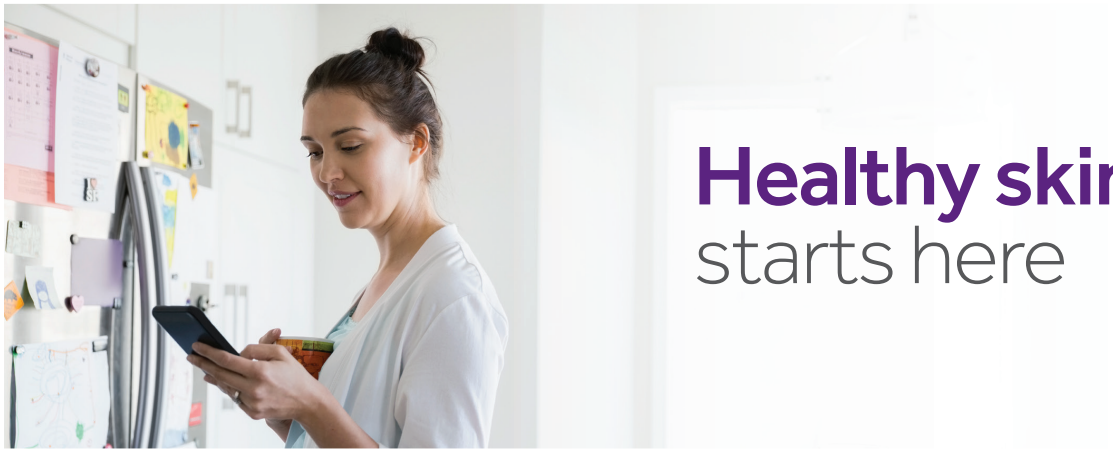
» General Medicine and Urgent Care Service through Teledoc is $10

» Covered Dermatology Service through Teledoc is $20

Florida Blue | TELADOC.



Healthy skin starts here

Get a diagnosis and treatment of your skin condition in just two business days or less

Welcome to the new way to get dermatology care that's easier than ever before. You no longer have to wait weeks for an appointment. Simply use your Teladoc account to upload images of your skin condition and one of our U.S. board-certified dermatologists will provide a diagnosis and treatment plan customized to fit your specific needs.

Please note

- Our Dermatology service uses images only. Communication with the dermatologist takes place through the message center.

- Although call center reps cannot schedule dermatology appointments, they can answer questions at 1-800-835-2362.

Here's how it works:

1. **Request a consult**
   Log in to your Teladoc account online or through the mobile app anytime, anywhere.

2. **Upload images**
   Take pictures of your skin condition and upload them to your account to share with the dermatologist.

3. **View results online**
   Within two business days, you'll receive a response online from a licensed dermatologist. If necessary, a prescription will be sent to your pharmacy.

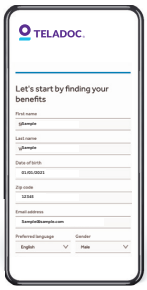
Get healthier skin

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

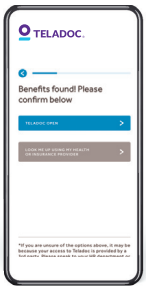
How to set up your **Teladoc account**

Simply download the Teladoc app and follow the four steps you see below.



1 Confirm benefits

Provide some information about yourself to confirm your eligibility.

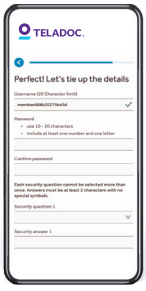


2 Benefit confirmation

We'll confirm that we found your benefits so you can finish creating your account.

3 Create account

Provide your contact information and preferred language.



4 Complete account

Create a username, password and pick security questions to ensure your account is secure.

Set up your Teladoc account today

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

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Dental Insurance

Taylor County School District offers a PPO dental program through Florida Combined Life. Members have the ability to receive services from both an in-network provider or an out-of-network provider. Members are not required to select a primary dental provider to coordinate their care. It is important to remember that members maximize savings when services are performed by an in-network dental provider. **Services performed outside the network are based on a "reasonable and customary" fee schedule and members will be subject to balance billing.**

BlueDental Choice Plus Benefit Summary	
Plan Benefit Preventive Basic Major	 100% 80% 50%
Deductible	$0
Maximum (per person)	$1,500 per plan year
Allowance	Based on the 90th percentile of U&C
Waiting Period (Major Services)	None
Annual Open Enrollment	Included

Dental Rates	Monthly (10 month rate September – June)
Employee	$41.18
Employee + Spouse	$80.10
Employee + Child(ren)	$93.26
Family	$131.03

Sample Procedure Listing		
Preventive	**Basic**	**Major**
• Routine Exam (2 per benefit period) • Bitewing X-rays (2 per benefit period) • Full Mouth/Panoramic X-rays • (1 in 3 years) • Periapical X-rays • Cleaning (2 per benefit period) • Fluoride for Children 18 and under (1 per benefit period) • Sealants (age 16 and under)	• Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia • Space Maintainers	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years) • Complete Dentures • Partial Dentures

Florida Blue

Group #: 46073
www.floridabluedental.com
1.888.223.4892

Download Florida Blue's mobile app for claims information, to access your ID card, find a dentist, and more!

Download on the App Store

Vision Benefits

The Standard Vision Plan

Plan 1: Balanced Care Vision II Plan H		
	EyeMed Access Network	**Out-of-Network**
Eye Exam, Lenses, Frames, Frequencies		
Annual Eye Exam	Covered in full	Up to $35
Lenses (per pair)		
Single Vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Lenticular	20% discount	No benefit
Progressive	See lens options	NA
Frame Allowance	$130	Up to $65
Frequencies		
Exam/Lens/Frames	12/12/24 Based on date of service	12/12/24 Based on date of service
Deductible, Maximum		
Deductibles	$10 Exam $10 Eye Glass Lenses	No deductible
Maximum		
per benefit period	None	None
Contact Lenses		
Fit & Follow Up	Standard: Participant cost up to $55	No benefit
Exams	Premium: 10% off of retail	No benefit
Contacts		
Elective	Up to $130	Up to $104
Medically Necessary	Covered in full	Up to $200
Monthly (10 Month rate September - June)		
Employee (EE)	$6.94	
EE + Family	$22.72	

Group # 169320
https://www.standard.com/employer/products-services/insurance-benefits/vision
1.800.547.9515

Plan 1: Balanced Care Vision II Plan H		
	EyeMed Access Network	**Out-of-Network**
Lens Options (participant cost)*		
Progressive Lenses	Standard: $65 + lens deductible Premium: lens cost - 20% discount - $120 allowance + Standard Progressive cost	No benefit
Std. Polycarbonate	$40	No benefit
Scratch Resistant Coating	$15	No benefit
Anti-Reflective Coating	$45	No benefit
Ultraviolet Coating	$15	No benefit
LASIK or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	No benefit

*Lens Option participant costs vary by prescription, option chosen and retail locations.

Additional Balanced Care Vision II Features (In-Network)	
Discounts	15% discount on the remaining balance in excess of the conventional contact lens allowance. 20% discount on the remaining balance in excess of the frame allowance. 20% discount on items not covered by the plan at network providers, which may not be combined with any other discounts or promotional offers. This discount does not apply to EyeMed Provider's professional services, or contact lenses.
Lens Options (Participant Cost)	$15 - Tint (Solid & Gradient)
Secondary Purchase Plan	Participants receive a 40% discount on a complete pair of glasses once the funded benefit has been exhausted. Participants receive a 15% discount off the retail price on conventional contact lenses once the funded benefit has been exhausted. Discount applies to materials only.
Contact Lens Replacement by Mail Program	After exhausting the contact lens benefit, replacement lenses may be obtained at significant discounts on-line. Visit **EyeMedvisioncare.com** for details.

TheStandard®

Group #: 169320
https://www.standard.com/employer/products-services/insurance-benefits/vision
1.800.547.9515

Employee Basic Life Insurance

Employee Life and Accidental Death and Dismemberment Insurance (AD&D)

The School District offers employee Basic Life Insurance through USAble Life. Each employee is covered for a flat amount of $20,000 for basic life and AD&D. The School District pays the cost of this insurance.

USAble Life Customer Service: 800.370.5856

Voluntary Group Term Life (Class 1)	
All active, Full-Time Employees of the Employer working a minimum of 20 hours per week	
Units of $10,000 up to the lesser of 5 times your annual compensation to a minimum benefit $10,000 maximum benefit $100,000	Guaranteed Issue—$100,000*

Group Term Life Retirees (Class 2)			
Retirees			
Option 1—$5,000	Option 2—$10,000	Option 3—$15,000	Option 4—$20,000

Voluntary Group Term Life Dependents (Class 3)		
Dependent: (employee must participate in the voluntary life plan for dependents to participate—Class 1 only		
• Spouse—Units of $5,000 to a maximum of $30,000 » Guaranteed Issue $10,000	• Infant—14 days to (6) six months $500	• Child—6 months to 30 years » Units of $2,000 to a maximum benefit of $10,000 » All are Guaranteed Issue

***As a newly eligible employee, you may elect up to the guaranteed issue limit with no medical questions required. Any requests to enroll or increase coverage after the first opportunity will require a medical questionnaire be submitted.**

USAble Life℠

Group #: 50036163
www.usablelife.com
custserv@usablelife.com
1.800.370.5856

Disability

Short-Term Disability Insurance

Short-Term Disability insurance through Standard provides you an option to purchase disability insurance, ensuring your paycheck is protected in the event you suffer an accident or illness that does not allow you to work for a period of time.

	Optional Plan
When benefits begin	**Accident / injury:** on the 1st day of your inability to work **Sickness / illness:** after 7 days of your inability to work
How much it pays	***60%*** of your income up to **$1,500** per week
How long payments last	Up to 180 days (about 26 weeks) if you remain unable to work

Disability is more common than you think

More than one in four of today's 20-year-olds can expect to be out of work for at least a year because of a disabling condition before they reach the normal retirement age.

Source: Social Security Administration

Please Note: A Medical Questionnaire is not required for New Hires. EOI is required for employees electing STD after the first opportunity as a New Hire.

Long-Term Disability Insurance

Long-Term Disability Insurance is designed to supplement your income should you be unable to work for an extended period of time. We offer you the opportunity to purchase this coverage through The Standard; your cost for coverage depends on your income.

After 90 days of inability to work, the plan pays 60% of your pre-disability base income to a maximum of $6,000 per month. Payments may continue for up to two years if you are not able to perform the duties of your own occupation, or until age 65 if you are not able to perform the duties of any occupation. If you become disabled after age 65, benefit payments depend on your age.

Please Note: A Medical Questionnaire is not required for New Hires. EOI is required for employees electing LTD after the first opportunity as a New Hire.

TheStandard®

Group #: 169320
https://www.standard.com/individual/products-services/workplace-benefits/insurance/disability
1.800.247.6888

Voluntary Benefits

Hospital Indemnity Coverage

Available for purchase through The Standard

» Designed to help offset your out-of-pocket expenses due to hospitalization from sickness or injury, and outpatient surgery.

» Benefit is Guaranteed Issue, meaning no medical questions asked

» ***Benefits available:***

- Hospital Admission - $1,000/Calendar year
- Hospital Confinement - $100/Day
- Critical Care Unit (CCU) Confinement - $100/Day
- Number of covered days per confinement – 31 days
- Health Maintenance Screening - $50
- Coverage for Pregnancy and COVID-19 included

Speak to a Benefit Counselor for additional details.

Critical Illness Coverage

Available for purchase through The Standard

» Pays a lump sum benefit for major illnesses including cancer, heart attacks, strokes, Kidney Failure, Brain Tumor, Advanced Alzheimer's Disease, and much more

» Choose a $10,000 or $20,000 Benefit Amount

» Benefit is Guaranteed Issue, meaning no medical questions asked

» Family Coverage is available

» Spouse and Child benefit is 50% of the Employee Amount

» **Wellness Benefit included**

- $50 per insured per calendar year

Speak to a Benefit Counselor for additional details

Accident Coverage

Available for purchase through The Standard

» Designed to help ease the financial pain of on-or-off the job covered accidents

» **Benefits are paid based on injuries and treatments**

- Hospital Admission: $2,500
- Daily Hospital Confinement: $700/day
- Emergency Room, Doctor's Visit, and Urgent Care: $600
- X-Ray: $400
- Follow Up Care: $450 (Up to 3 Visits)
- And Much More!

» **Wellness benefit included**

- $50 per member
- Family coverage is available

Speak to a Benefit Counselor for additional details.

TheStandard®

Group #: 169320
https://www.standard.com/employer/products-services/insurance-benefits/voluntary-products-and-services
1.866.851.2429

Federal Notices

Please find below notices regarding Taylor County School District's medical plan. If you'd like additional information about any of these notices or your rights under them, please contact Chris Olson, Employee Services Coordinator, at **850.838.2500**, **chris.olson@taylor.k12.fl.us**.

1. HIPAA Special Enrollment
2. Children's Health Insurance Program (CHIP)
3. Women's Health and Cancer Rights Act
4. Newborns' and Mothers' Health Protection Act
5. Michelle's Law
6. COBRA General Notice
7. Notice of Non-Creditable Drug Coverage
8. HIPAA Privacy Notice
9. USERRA Rights

HIPAA Special Enrollment

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

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

To request special enrollment or obtain more information, contact Chris Olson, Employee Services Coordinator, at **850.838.2500**.

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272)**.

If you live in Florida, you may be eligible for assistance paying your employer health plan premiums. The contact information is as follows:

Florida—Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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

If you would like more information on WHCRA benefits, call your plan administrator Chris Olson, Employee Services Coordinator, at **850.838.2500**.

Newborns' and Mothers' Health Protection Act

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

Michelle's Law

Michelle's Law requires group health plans to provide continued coverage for certain dependents who are covered under the School District's group health plan as a student if they lose their student status because they take a medically necessary leave of absence from school. This continuation of coverage is described below.

If your dependent is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your dependent may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your dependent was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions). For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the dependent at the institution, that:

1. begins while the dependent is suffering from a serious illness
   or injury,
2. is medically necessary, and
3. causes the dependent to lose student status for purposes of coverage under the plan.

The coverage provided to dependents during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your dependent had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed under the plan during this one-year period, the plan will provide the changed coverage for the dependent for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for these dependents.

If you believe your dependent is eligible for this continued coverage, the dependent's treating physician must provide a written certification to the plan stating that your dependent is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

COBRA General Notice of Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

» Your hours of employment are reduced, or

» Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

» Your spouse dies;

» Your spouse's hours of employment are reduced;

» Your spouse's employment ends for any reason other than his or her gross misconduct;

» Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

» You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

» The parent-employee dies;

» The parent-employee's hours of employment are reduced;

» The parent-employee's employment ends for any reason other than his or her gross misconduct;

» The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

» The parents become divorced or legally separated; or

» The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Taylor County School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified

beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Chris Olson, Employee Services Coordinator, at 850.838.2500.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Chris Olson, Employee Services Coordinator, **850.838.2500**.

Notice of Non-Creditable Drug Coverage

Important Notice from Taylor County School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Taylor County School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug

plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Taylor County School District has determined that the prescription drug coverage offered by Taylor County School District is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Taylor County School District. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage with the Taylor County School District. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options

When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you decide to drop your current coverage with Taylor County School District, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the School District's plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the School District's plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current School District's coverage will not be affected. You can keep the School District's coverage if you elect part D and the School District's plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current School District's coverage, be aware that you will not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Taylor County School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For More Information About Medicare Prescription Drug Coverage:

» Visit **www.medicare.gov**.

» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

» Call **1.800.MEDICARE (1.800.633.4227)**. TTY users should call **1.877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov,** or call them at **1.800.772.1213** (TTY **1.800.325.0778**).

Date:	10/1/2023
Name of Entity:	Taylor County School District
Contact Position/Office:	Chris Olson—Employee Services Coordinator
Address:	318 North Clark Street, Perry, FL 32347
Phone Number:	850.838.2500 ext 107

HIPAA Privacy Notice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

» Get a copy of your health and claims records
» Correct your health and claims records
» Request confidential communication
» Ask us to limit the information we share
» Get a list of those with whom we've shared your information
» Get a copy of this privacy notice
» Choose someone to act for you
» File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

» Answer coverage questions from your family and friends
» Provide disaster relief
» Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

» Help manage the health care treatment you receive
» Run our organization
» Pay for your health services
» Administer your health plan
» Help with public health and safety issues
» Do research
» Comply with the law
» Respond to organ and tissue donation requests and work with a medical examiner or funeral director
» Address workers compensation, law enforcement, and other government requests
» Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

» You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
» We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

» You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
» We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

» You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
» We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

» You can ask us not to use or share certain health information for treatment, payment, or our operations.
» We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

» You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
» We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

» If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
» We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

» You can complain if you feel we have violated your rights by contacting us using the information on page 1.
» You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1.877.696.6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
» We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

» Share information with your family, close friends, or others involved in payment for your care
» Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

» Marketing purposes
» Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

» We can use and disclose your information to run our organization and contact you when necessary.

» We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

» Preventing disease
» Helping with product recalls
» Reporting adverse reactions to medications
» Reporting suspected abuse, neglect, or domestic violence
» Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

» We can share health information about you with organ procurement organizations.
» We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers compensation, law enforcement, and other government requests

We can use or share health information about you:

» For workers compensation claims
» For law enforcement purposes or with a law enforcement official
» With health oversight agencies for activities authorized by law
» For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

» We are required by law to maintain the privacy and security of your protected health information.
» We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
» We must follow the duties and privacy practices described in this notice and give you a copy of it.
» We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Information

» Privacy Notice Effective Date: 10/1/2019
» Contact Information: Chris Olson, Employee Services Coordinator, **850.838.2500**, **chris.olson@taylor.k12.fl.us**

Your Rights Under USERA

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—October 2008

Important Contacts

Making sure your benefit questions are answered is important to us. We realize, however, that it is not always possible for you to call during business hours or for the Benefits Office to be available when you call. Alternatively, you may call the vendor directly at the customer service numbers listed below:

Benefit	Phone	Website
Benefit Services	850.838.2500	Chris Olson Employee Services Coordinator chris.olson@taylor.k12.fl.us
Medical Insurance— Florida Blue Group #46073	800.352.2583	www.floridablue.com
Dental Insurance—Florida Combined Life Group #46073	1.888.223.4892 1.877.325.3979	www.floridabluedental.com
Vision Insurance—The Standard Group #169320	1.800.547.9515	https://www.standard.com/employer/products-services/insurance-benefits/vision
Life Insurance—USAble Life Voluntary Life Insurance Basic Life Group #50036163	800.370.5856	www.usablelife.com Email: custserv@usablelife.com
Disability Insurance—The Standard Short-Term Disability Long-Term Disability Group #169320	1.800.247.6888	https://www.standard.com/individual/products-services/workplace-benefits/insurance/disability
Voluntary Benefits—The Standard Hospital Indemnity Coverage Critical Illness Coverage Accident Coverage Group #169320	1.866.851.2429	https://www.standard.com/employer/products-services/insurance-benefits/voluntary-products-and-services

Taylor County School Board Active and Retired Monthly Insurance Premiums 2023-2024

Plan #05770**

ACTIVE EMPLOYEE PREMIUMS COLLECTED OVER 10 MONTHS COVERAGE 12 MONTHS Plan #05770

Employee Health Insurance		New Rates	Board Contribution	Total Cost of Program	Change to Employee Cost
10-108 Employee	Plan C	$400.87	$455.00	$855.87	$52.29
10-109 Employee/Spouse	Plan C-1	$1,174.62	$455.00	$1,629.62	$153.21
10-110-Employee Child(ren)	Plan C-2	$1,031.41	$455.00	$1,486.41	$134.53
10-111-Employee/Family	Plan C-3	$1,501.31	$455.00	$1,956.31	$195.82
Employee Dental Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Employee Cost**
10-101 Employee	Plan A-1	$41.18		$41.18	No change
10-102 Employee/Spouse	Plan A-2	$80.10		$80.10	No change
10-103-Employee Child(ren)	Plan A-3	$93.26		$93.26	No change
10-104-Employee/Family	Plan A-4	$131.03		$131.03	No change
Employee Vision Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Employee Cost**
10-101- Employee		$6.94		$6.94	No change
10-102- Family		$22.72		$22.72	No change
10-103-Employee Plan A			$6.94	$6.94	No change
10-104-Employee Family		$15.78	$6.94	$22.72	No change

RETIREE PREMIUMS COLLECTED OVER 12 MONTHS

Under 65 Retiree Rates					
Non-Medicare/ Health		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$713.23			$89.41
Employee/Spouse		$1,358.02			$173.51
Employee/Child(ren)		$1,238.68			$157.94
Employee/Family		$1,630.26			$209.02
Dental Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$34.31			No change
Employee/Spouse		$66.75			No change
Employee/Child(ren)		$77.71			No change
Employee/Family		$109.19			No change
Vision Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$5.78			No change
Employee/Family		$18.94			No change
Over 65/Medicare					
Health		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$713.23			$220.02
Employee/Spouse		$1,358.02			$435.57
Dental Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$34.31			No change
Employee/Spouse		$66.75			No change
Vision Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$5.78			$(0.75
Employee/Spouse		$18.94			$(2.10)

High Deductible Plan $2,000 50/50 Payout Plan #5901**

ACTIVE EMPLOYEE PREMIUMS COLLECTED OVER 10 MONTHS COVERAGE 12 MONTHS

Employee Health Insurance		New Rates	Board Contribution	Total Cost of Program	Change to Employee Cost
10-108 Employee	Plan C	$179.98	$455.00	$634.98	$23.48
10-109 Employee/Spouse	Plan C-1	$882.54	$455.00	$1,337.54	$115.11
10-110-Employee Child(ren)	Plan C-2	$765.10	$455.00	$1,220.10	$99.80
10-111-Employee/Family	Plan C-3	$1,150.28	$455.00	$1,605.28	$150.04
Employee Dental Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Employee Cost**
10-101 Employee	Plan A-1	$41.18		$41.18	No change
10-102 Employee/Spouse	Plan A-2	$80.10		$80.10	No change
10-103-Employee Child(ren)	Plan A-3	$93.26		$93.26	No change
10-104-Employee/Family	Plan A-4	$131.03		$131.03	No change
Employee Vision Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Employee Cost**
10-101- Employee		$6.94		$6.94	No change
10-102- Family		$22.72		$22.72	No change
10-103-Employee Plan A			$6.94	$6.94	No change
10-104-Employee/Family		$15.78	$6.94	$22.72	No change

RETIREE PREMIUMS COLLECTED OVER 12 MONTHS

Under 65 Retiree Rates					
Non-Medicare/ Health		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$529.15		$529.15	$65.40
Employee/Spouse		$1,114.62		$1,114.62	$141.76
Employee/Child(ren)		$1,016.75		$1,016.75	$129.00
Employee/Family		$1,337.73		$1,337.73	$170.87
Dental Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$34.31		$34.31	No change
Employee/Spouse		$66.75		$66.75	No change
Employee/Child(ren)		$77.71		$77.71	No change
Employee/Family		$109.19		$109.19	No change
Vision Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$5.78			No change
Employee Family		$18.94			No change
Over 65/Medicare					
Health		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$529.15		$529.15	$65.40
Employee/Spouse		$1,114.62		$1,114.62	$141.76
Dental Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$41.18		$41.18	No change
Employee/Spouse		$80.10		$80.10	No change
Vision Insurance		**New Rates**	**Board Contribution**	**Total Cost of Program**	**Change to Retiree Cost**
Employee Only		$5.78			No change
Employee/Spouse		$18.94			No change

Notes

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting