School District Of Madison County

Benefit Guide

October 1, 2023 through September 30, 2024

Updated September 1, 2023

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If you (and/or your dependent) 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. In addition, this guide contains information about the creditable status of the prescription drug coverage. Please see page 30 for more details.

We Appreciate You!

Benefits You Can Count On

The School District of Madison County is committed to providing employees with a benefits program that is both comprehensive and competitive.

Before you enroll, carefully examine all of your options. The School District of Madison County has designed a benefit program that offers health coverage and financial security for you and your family. Choose the plan that fits your needs, keeping in mind that other coverage may be available to you through your spouse's employer.

This guide is a general overview of your benefit choices to help you select the coverage that is right for you.

Important to Know

- Preventive care is covered at 100%
- There is an unlimited lifetime benefit maximum on the medical plan
- Premium contributions are taken out of your paycheck before taxes are applied, resulting in greater take home pay for you
- Choose carefully – the decisions you make cannot be changed until next October, unless you experience a qualifying change in status (see "Benefit Election Changes" on page 4).

Eligibility

As an active, full-time employee of the School District of Madison County who works at least 20 hours per week, you are eligible to participate in the benefit plans offered upon meeting eligibility requirements.

You may also elect coverage for your eligible dependents. Eligible dependents are defined as your legally married spouse and eligible children who reside in your household and depend primarily on you for support.

This includes: your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse to provide coverage. Age restrictions apply for the various benefits. Disabled children aged 26 or older who meet certain criteria may continue on your health coverage.

Please contact Human Resources for additional information.

Annual Open Enrollment

As a benefits eligible employee, you have an annual opportunity to enroll in or make changes to your benefit plans during the enrollment period. Annual enrollment elections are effective October 1st, except for the Health Savings Account (HSA) which runs January 1st through December 31st. If you do not wish to make any changes, your current elections will carry forward for 2023/2024, except for the HSA. **You must actively re-enroll in the HSAs each year. You are not automatically re-enrolled.**

If you are not yet enrolled or choose to make changes to any of your benefits, you must do so by **September X, 2023**.

The elections you make will remain in place until next Annual Open Enrollment unless you experience a qualified status change.

Whether you decide to enroll or decline coverage, you will need to complete the appropriate enrollment form(s) indicating your decision(s) and return them to Human Resources. If you waive all coverage, you will only receive the company-paid Basic Life/AD&D, Disability, and EAP benefits.

Enrollment Periods For New Employees

As a new employee of the School District of Madison County, your benefits will become effective the 1st of the month following 30 days of continuous full-time employment. If you fail to enroll within 30 days of hire, you will not be able to enroll until the next Annual Open Enrollment unless there is a qualifying event (change in status) during the year.

Benefit Election Changes

The School District of Madison County helps you save money by letting you pay for your medical, dental, vision, and voluntary benefits through automatic pre-tax payroll deductions. Therefore, mid-year changes to benefit elections cannot be made unless you experience an IRS-approved qualifying change in status event, which include, but are not limited to:

- Marriage or divorce
- Birth or adoption of a child
- Death of spouse or other dependent
- You lose coverage under your spouse's plan
- A spouse's employment begins or ends
- A Qualified Medical Child Support Order
- You gain access to state coverage under Medicaid or CHIP
- You or your spouse's enrollment in Medicare

You must notify Human Resources within 30 days of the event. Be prepared to show documentation of the event, such as a birth certificate, marriage license or divorce decree.

Human Resources will review your request and determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the qualified life event are permitted.

Paying For Your Benefits

Some benefits are provided to you at no cost, such as basic life and accidental death and dismemberment (AD&D), & long-term disability, and the Employee Assistance Program. The cost of other benefits are shared by you and the School District of Madison County, such as medical. Additional benefits, such as voluntary life/ad&d, dental and vision are paid for by you at discounted group rates.

Having options available means you can build a benefits program to meet your needs and your lifestyle.

Benefit	Who Pays
Basic Life/AD&D and Employee Assistance Program	School District of Madison County
Medical (excluding HSA employee only tier), Long Term Disability (depending on Eligible Class)	School District of Madison County & You
Dental, Vision, Voluntary Life / AD&D, Short Term Disability and Health Saving Account	You

Health Care Plan Information

In-Network Advantage

Consider your health care options highlighted in this guide. Within some of the medical, dental and vision plans, you have the freedom to use any provider. They all have both in-network and out-of-network benefits; however, when you use an in-network provider, the amount you pay out-of-pocket will be based on a negotiated fee, which is usually much lower than the actual charges. Out-of-network providers and facilities have not signed a contract with your health plan to provide services and may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

Preventive Care

Preventive care services are those that are generally linked to routine wellness exams and screenings. **Non-preventive** services are those that are considered treatment or diagnosis for an illness, injury, or other medical conditions. **Preventive benefits are covered at no cost to you**.

Preventive care is covered at 100% in-network in all three plans, but there may be limits on how often you can receive preventive care. You should ask your health care provider whether your visit is considered preventive or non-preventive care. Examples of preventive care include:

- Annual routine physicals
- Immunizations
- Bone-density tests
- Cholesterol screening
- PSA exams
- Mammograms
- Sigmoidoscopies
- Colonoscopies
- Pelvic exams
- Pap Smears

Co-payments and Co-insurance

A **co-payment** (copay) is the fixed dollar amount you pay for certain in-network services. You may be responsible for coinsurance after the copay is made.

Co-insurance is the percentage of covered expenses shared by the employee and the plan. In some cases, co-insurance is paid after the insured meets a deductible. For example, if the plan pays 90% of an in-network covered charge, you pay 10%.

.Out-of-Pocket Maximum

Your plan features an **out-of-pocket maximum**, which limits the total amount of co-payments (including the deductible) you will pay for eligible health care expenses. Once you reach that maximum, the plan will pay 100% of eligible expenses for the rest of the calendar year.

Annual Deductible

Your **annual deductible** is the amount of money you must first pay out-of-pocket before your plan begins paying for inpatient or outpatient services

Health Care Plan Information

ACA (Patient Protection and Affordable Care Act)

Also called Health Care Reform, the intent of the Affordable Care Act is to make affordable health care available to all Americans. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, free preventive care, etc.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Generic drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

Care Coordination

When you need hospital care or have complex health care needs, Florida Blue's Care Coordinators are available to assist you and your family. From handling benefit and approvals, to scheduling follow up care and connecting you with health programs and resources, you'll have extra help so you can focus on getting well and staying well. Call Florida Blue at **888-476-2227.**

Plan year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Employer Contribution

Madison County Schools provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

Nurses on Call 24/7:

When you need answers right away, call a nurse 24/7. Whether you or your family members have health concerns or general health questions, the **Nurse line** is available at no cost. Simply call **877-789-2583.**

Medical Benefits • Florida Blue

For 2023-2024, we are pleased to provide you with a choice of three plans from which to choose. Members can save money by going to in-network physicians. These providers can be found on the Florida Blue website at www.floridablue.com. **The accumulation period for the deductible and out of pocket maximum is calendar year.**

Benefits	HSA 5196/5197 In Network	HSA 5196/5197 Out of Network	PPO 5781 In Network	PPO 5781 Out of Network	PPO 5907 In Network	PPO 5907 Out of Network
Deductible (per calendar year)						
Annual Deductible - Individual	$3,500 Per Person	$7,000 Per Person	$1,500	$4,500	$7,500	$15,000
Annual Deductible - Family	$7,000 Per Person	$14,000 Per Person	$4,500	$13,500	$15,000	$30,000
Out-of-Pocket Maximum (per calendar year)						
Out-of-Pocket Limit - Individual	$6,850 Per Person	$13,700 Per Person	$5,500	$11,000	$8,200	$8,200
Out-of-Pocket Limit - Family	$14,000 Per Person	$27,400 Per Person	$11,000	$22,000	$16,400	$16,400
Coinsurance (member paid)	20%	40%	30%	50%	20%	50%
Physician Care Office Visits						
PCP	Ded + $30 copay	Ded + 40% coins	$30 copay	Ded + 50%	$0 Visits1-3, then $30 copay	Ded + 50%
Specialist	Ded + $75 copay	Ded + 40% coins	$55 copay	Ded + 50%	$60 copay	Ded + 50%
Hospital Services						
Inpatient Hospital	Ded + 20% coins	Per Admin Ded + Ded + 20% coins	Ded + 30% coins	Per Admin Ded + Ded + 50% coins	Ded + 20% coins	Ded + 50% coins
Outpatient Hospital	Ded + 20% coins	Surg Center: Ded + 40%; Hosp: In-Net Ded + 20%	Surg Center: $200 copay; Hosp: Ded + 30% coins	Per Admin Ded + Ded + 50% coins	Ded + 20% coins	Ded + 50% coins
Diagnostic Services						
Lab/X-ray	Ded + 20% coins	Ded + 40% coins	Value Choice Spclst: $20 copay; Ind Clinic Lab: No Charge; Ind Diag Lab: $50 copay	Ded + 50% coins	Value Choice Spclst: $20 copay; Ind Clinic Lab: No Charge; Ind Diag Lab: $60 copay	Deductible + 50% coins
Advanced Imaging	Ded + 20% coins	Deductible + 40% coins	Ded + 30% coins	Ded + 50% coins	Deductible + 20%	Deductible + 50%
Emergency Services						
Emergency Room	Deductible + $350 copay	In Net Deductible + $350 copay	$250 copay	$250 copay	Deductible + 20% copay	IN Net Deductible + 20% copay
Urgent Care	Deductible + $100 copay	Deductible + $100 copay	$60 copay	Deductible + $60 copay	$100 copay	Deductible + $100 copay
Pharmacy						
Deductible In-Net	Discount Only	N/A	$300 Brand, Non-Preferred	N/A	$300 Brand, Non-Preferred	N/A
Retail (30 day)	Discount Only	N/A	$10 / $60 / $100	50% Coins	$10 / $60 / $100	50% coins
Mail Order (90 day)	Discount Only	N/A	$25 / $150 / $250	50% coins	$25 / $150 / $250	50% coins

Mail-Order Prescription

Use PrimeMail, your health plan's mail order pharmacy, for up to a 90-day supply of medication for 2.5x your copay. If you take a daily maintenance medication to treat a chronic condition, such as arthritis, asthma, high cholesterol, blood pressure, heart condition or for contraceptives – it is a great way to save time and money. Refills are easy to order over the phone and online. Free shipping is available for standard delivery direct to you. Please call PrimeMail for questions or to speak with a pharmacist at **1-888-849-7865**, available 24/7.

BlueScript Pharmacy Benefits - $10/$60/$100 after In-Network Deductible

For BlueOptions Non-HSA Plans– Open Formulary (Home Delivery Available)

The BlueOptions® health benefit plan your employer is offering you is paired with our BlueScript® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain prescription drugs at a location convenient to you.

You may also be able to receive more savings on prescription drugs by purchasing your drugs through the home delivery program.

See below for your specific plan details.

Pharmacy Deductible (DED) .....In-Network DED

Drug Tier	In-Network Retail (One-Month Supply)	In-Network Home Delivery (Three-Month Supply)	Out-of-Network
Preferred Generic Prescription Drugs	$10	$25	50%
Preferred Brand Name Prescription Drugs	DED + $60	DED + $150	DED + 50%
Non-Preferred Prescription Drugs	DED + $100	DED + $250	DED + 50%
Oral Chemotherapy Drugs	$10	$25	50%

Specialty drugs are not available through home delivery.
Deductible is waived for Oral Chemotherapy Drugs, Generic Drugs and Condition Care Drugs.

Advantages of our Pharmacy Program
With our BlueScript Pharmacy Program, you'll receive coverage for Preferred Generic, Preferred Brand Name, and Non-Preferred Prescription Drugs, as well as self-administered injectables and specialty medications. You have easy access to Participating Pharmacies throughout Florida and to National Network Pharmacies with over 60,000 locations.

Save When Purchasing Your Prescription Drugs
You can reduce your out-of-pocket costs by purchasing Covered Prescription Drugs listed on our Preferred Medication List. These prescription drugs should cost you less than prescription drugs not on the list.

Generic Prescription Drugs
You pay a lower cost for Generic Prescription Drugs that appear on the Preferred Medication List. If you request a Brand Name Prescription Drug when a Generic is available, you will be responsible for:

1. The copayment applicable to Brand Name Prescription Drugs; and
2. The difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated on the BlueOptions Schedule of Benefits.

More Convenient Than Ever
Take your prescriptions to a participating pharmacy to have them filled. Or, if you are taking a prescription medication on an ongoing basis, you have a couple of convenient options:

1. Your doctor can prescribe a three-month supply and you can have it filled at select participating retail pharmacies. A three-month out-of-pocket cost (copay, coinsurance, and/or deductible) applies.
2. For additional savings, fill prescriptions via our home delivery program. This program allows covered members taking prescription drugs to receive up to a three-month supply for one Home Delivery Copayment, after Pharmacy Deductible, if applicable. Prescription drugs ordered through this program are provided by AllianceRx Walgreens Prime.

Vaccines at the Pharmacy
Certain vaccines which are covered under your Wellness Benefits can be administered by Pharmacists that are certified.

Condition Care Rx Program
Through the Condition Care Rx program, certain medicines to treat things like high blood pressure, cholesterol, diabetes, depression and respiratory conditions could cost little or next to nothing. Under this pharmacy plan, the deductible will waived for these drugs when received at an In-Network Pharmacy. A complete list of these medications is available in the Medication Guide and can be accessed online at floridablue.com.

Contraceptive Coverage
Generic oral contraceptives and diaphragms are covered under your pharmacy benefit and are available at no cost to you. These contraceptives must be prescribed and obtained from a participating pharmacy.

Diabetic Supplies
Diabetic supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/or syringes and needles are covered under your pharmacy benefit. Diabetic supplies require a prescription and can be obtained from a participating pharmacy.

Medication Guide
The Preferred Medication List, which is part of the Medication Guide,

HSA
Health Savings Account

Florida Blue

We are proud to offer you a choice among three different medical plans that provide comprehensive medical and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Following is a brief description of each plan.

Florida Blue HSA Plan 5196 / 5197

Like the PPO plans, a High Deductible Health Plan (HDHP) gives you the freedom to seek care from the provider of your choice. You will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the Blue Options Network. The calendar year deductible must be met before certain services are covered. In addition, the HDHP comes with a health savings account (HSA) that allows you to save pre-tax dollars[1] to pay for any qualified health care expenses as defined by the IRS, including most out-of-pocket medical, prescription drug, dental and vision expenses. For a complete list of qualified health care expenses visit https://www.irs.gov/pub/irs-pdf/p502.pdf

Here's how the plan works:

- Annual Deductible: You must meet the entire annual deductible before the Plan starts to pay for non-preventive medical and prescription drug expenses. NOTE: If you enroll one or more family members, you must meet the full FAMILY deductible before the Plan starts to pay expenses for any one individual.
- Coinsurance: Once you have met the Plan's annual deductible, you are responsible for a percentage of your medical expenses, which is called coinsurance. For example, the Plan may pay 80% and you may pay 20%.
- Out-of-Pocket Maximum: Once your deductible and coinsurance add up to the Plan's annual out-of-pocket maximum, the Plan will pay 100% of all eligible covered services for the rest of the calendar year. NOTE: If you enroll one or more family members, you must meet the full FAMILY out-of-pocket maximum before the Plan starts to pay covered services at 100% for any one individual.

Health Savings Account (HSA): You may contribute to your HSA through pre-tax payroll deductions to help offset your annual deductible and pay for qualified health care expenses. To be eligible for the HSA you cannot be covered through Medicare Part A or Part B or TRICARE programs. See the plan documents for full details.

Annual HSA Contribution Limits

2023:
Single coverage: $3,850
Family coverage: $7,750

2024:
Single coverage: $4,150
Family coverage: $8,300

Catch-up Contributions

The IRS allows a $1,000 catch-up contribution for individuals aged 55+ each year.

Important: Your contributions, in addition to the company's contributions, may not exceed the annual IRS limits listed. Your HSA is yours for life. The money is yours to spend or save, regardless of whether you change health plans[2] or leave the District. There is no "use it or lose it" rule. Your account grows tax-free over time as you continue to roll over unused dollars from year to year. You decide how, or if, you want to spend your HSA funds. You can use them to pay for you and your dependents' doctor's visits, prescriptions, braces, glasses, and even laser vision correction surgery.

[1] Tax free under federal tax law; state taxation rules may apply
[2] You must be enrolled in a qualified health plan to contribute to an HSA

Blue365® - Discount Program

Great discounts and valuable information that can be used all year long – Blue365®

You can save on a wide variety of healthy products and services through Florida Blue's members-only discount program – Blue365® Take advantage of exclusive discounts at select local companies and leading national brands for your everyday health and wellness or family care – even healthy vacation destinations! Save on nutrition and weight management programs and so much more!

Getting Started:

SIGN UP FOR NO-FUSS E-MAILS

Be the first to know about the latest deals to hit Blue365. One email a week, no spam. Visit www.floridablue.com and click on the login button in the top right of the home page. Then, select "Member", enter your user ID and password and select "Member Login."

2

TWO WAYS TO SAVE

Some deals will give you a coupon code instantly on the Blue365 site. Coupon codes can be applied directly to a purchase on a vendor's website or will provide a discounted option on a product or service.

Other deals may take you to a vendor's website directly to make a discounted purchase or enroll in a special discounted program instantly.

Blue365® Deal Categories:

- PERSONAL CARE
- FITNESS
- WELLNESS
- HEALTHY EATING
- FINANCIAL HEALTH
- LIFESTYLE

New products and services are being added to the member discount program all the time – so check back often for new savings opportunities.

To obtain more information on any of the products or services described please visit www.Blue365Deals.com/BCBSFL

TELADOC®

Florida Blue

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

Florida Blue Resources

Florida Blue understands that each person has unique health care needs and navigating the health care system is not always easy. So they have set up specialized care teams and personalized services to make it easier to manage your health and maximize your health plan benefits. These services are available at no extra cost to help you in your pursuit of health.

eLearning Tool

The eLearning Tool is your digital resource to assist you with health insurance benefit options available to you and your qualified dependents. Access to medical plan summaries, money-saving tips, claim forms, provider search, medical cost comparison, and more! There is no registration required to access the eLearning Tool site. Simply text "**Blue 16765**" to **269311** or visit https://gateway.bcbsfl.com/grp/16765

Care Consultations and Advocacy Program

Planning ahead can make important decisions easier, especially when you're dealing with a new diagnosis or managing a serious health condition. Florida Blue's Care Consultant Team will explain how your benefits work, locate helpful services, find specialists, compare health care options, and explore ways you can save money. Call a Care Consultant at **1-888-476-2227**.

Nurses on call 24/7

When you need answers right away, call a health coach 24/7. Whether you or your family members have health concerns or general health questions, the nurseline is available at no cost. Simply call **1-877-789-2583**.

Focus on Your Health Condition

Manage chronic and long-term health conditions with the help of specialized care teams. It is one more way you can stay ahead of your condition and help prevent other medical complications.

Call **1-888-476-2227** to let Florida Blue know how they can help you with your unique health care needs, including programs for diabetes, asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), heart failure, depression, and behavioral health.

Mobile App

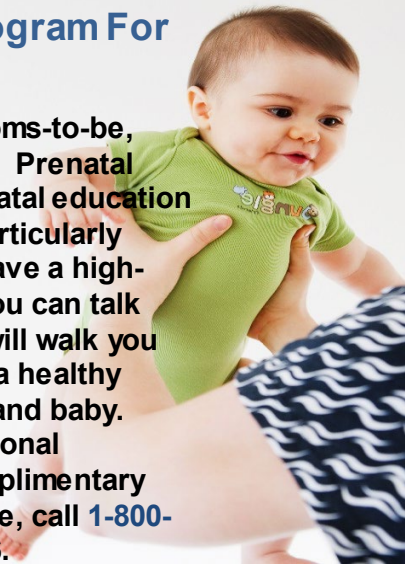
Find the information you need when you need it by downloading the Florida Blue mobile app. Or, by logging in to your member account at www.floridablue.com. You can compare the cost of medical services and prescription drugs and view patient reviews and quality measures for hospitals. The more you know, the more confident you'll be.

Care Coordination

When you need hospital care or have complex health care needs, our Care Coordinators are there to assist you and your family. From handling benefits and approvals, to scheduling follow-up care and connecting you with health programs and resources, you'll have extra help so you can focus on getting well and staying well. Call Florida Blue at **1-888-476-2227**.

If eligible, you may also have access to physician home care if you are confined to your home. Home services can include receiving palliative or pain management care to help relieve the pain, symptoms and other stressors of a serious illness or hospice care management for individuals and families dealing with a terminal illness

A Prenatal Program For Moms-To-Be



Available to all moms-to-be, Healthy Addition® Prenatal Program is a prenatal education program that is particularly important if you have a high-risk pregnancy. You can talk with nurses who will walk you through steps for a healthy pregnancy, birth, and baby. Enjoy free educational materials and complimentary gifts. To learn more, call 1-800-955-7635, option 6.

HELPING WITH YOUR MEDICAL COSTS

TRANSCONNECT® FOR FLORIDA SUPPLEMENTAL MEDICAL EXPENSE INSURANCE

This plan is only offered to those employees enrolled in Plan 5781 or 5907.

TransConnect for Florida, underwritten by Transamerica Life Insurance Company

Andrea was involved in a serious car accident. After the whirlwind of the ambulance ride, ER, surgery, and hospital stay, she's nervous about how much her major medical insurance will pay. It's a relief to remember that she signed up for *TransConnect* which can pay for out-of-pocket expenses like deductibles, co-insurance, and co-payments.

Monthly Premium
• You - $0.00 • You & your spouse - $20.96 • You and your children - $13.90 • You, your spouse and your children - $38.68

INPATIENT HOSPITAL BENEFITS $1,000

Your policy pays benefits for inpatient hospital stays, inpatient procedures, inpatient physician charges, and even routine nursery care for dependent children. Your employer determines your calendar year maximum benefit (multiplied by three for an insured family).

Visit:
transamerica.com

Customer Service:

OUTPATIENT HOSPITAL BENEFITS $500

Your policy also pays benefits (separate from the inpatient hospital benefits) for:

- Radiological diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility
- Radiation therapy or chemotherapy authorized by a radiologist, chemotherapist, or an oncologist for outpatient cancer treatment
- Outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office
- MRIs, CT scans, PET scans, diagnostic ultrasounds, and electrocardiogram (EKG) tests performed in a physician's office (X-rays and lab fees are not included)
- Cardiac catheterizations and stress tests
- Accident, injury, or emergency condition treatment in a hospital ER or urgent care center

ACCIDENT-ONLY AMBULANCE BENEFIT $1000

This benefit is payable when ambulance transportation (ground or air) is required to a hospital or emergency center for injuries sustained in an accident. Ambulance transportation must be within 72 hours of the accident and must be provided by a licensed professional ambulance company.

ELIGIBILITY

You must be actively employed qualifying as an eligible insured (defined by the employer) and have an employer's basic, major medical, or comprehensive medical plan.

TRANSAMERICA®

IMPORTANT POLICY PROVISIONS

Your employer selects benefit amounts, paid only for deductibles, co-insurance, and co-pays incurred when your major medical plan pays for specified treatments and care.

HOW TO SUBMIT A CLAIM

The ID card you'll receive after enrollment should be presented at time of service so providers are paid directly after your major medical carrier determines what you owe. If you don't do so at time of service, simply submit a *TransConnect®* claim form, UB92 or HCFA (the itemized service provider's bill), and the Explanation of Benefits (EOB) from the major medical carrier showing what you owe after what they paid.

EXCLUSIONS

No benefits are payable under this policy/certificate for any expenses incurred:

- Late enrollees subject to a 30-day waiting period
- During any period the insured person does not have coverage under another medical plan
- As the result of suicide or any attempted suicide, while sane or insane
- For any intentionally self-inflicted injury or sickness
- For rest care or rehabilitative care and treatment
- For voluntary abortion except, with respect to the insured or insured spouse where the insured or the insured's dependent spouse's life would be endangered if the fetus were carried to term; or where medical complications have arisen from abortion
- As a result of commission of a felony
- As a result of participation in a riot, civil commotion, civil disobedience, or unlawful assembly. Excludes loss occurring while acting in a lawful manner within the scope of authority.
- As a result of participation in a contest of speed in power-driven vehicles, parachuting, or hang gliding
- As a result of air travel, except as a fare-paying passenger on a commercial airline on a regularly scheduled route or as a passenger for transportation only and not as a pilot or crew member
- As a result of intoxication as determined and defined by the laws and jurisdiction of the geographical area in which the loss occurred
- For alcoholism or drug use, unless such drugs were taken on the advice of a physician and taken as prescribed while hospital confined as an inpatient
- For any loss incurred while on active duty status in the armed forces of any country. If you notify us of such active duty, we will refund any premium paid for any period for which no benefits are provided as a result of this exclusion.
- For pregnancy of a dependent child
- For sex changes
- For experimental treatment, procedures, devices, drugs, or surgery (except that bone marrow transplants will not be considered experimental in the treatment of cancer)
- For accident or sickness arising out of and in the course of any occupation for compensation, wage, or profit (does not apply to sole proprietors or partners not covered by workers' compensation)
- For mental illness or functional or organic nervous disorders — regardless of the cause — if the other medical plan does not cover these conditions
- For dental or vision services, including, but not limited to, treatment, surgery, extractions, or X-rays, unless resulting from an accident occurring while the insured person's insurance under this policy is in force and if performed within 12 months of the date of such accident; or due to congenital disease or anomaly of an insured newborn child; and to assure the safe delivery of necessary dental care provided to an insured person meeting certain criteria
- For routine physical examinations and rest cures

TERMINATION OF INSURANCE

INSURANCE ON AN INSURED WILL END ON THE EARLIEST OF THE FOLLOWING DATES:

- The end of the last period for which premium has been paid
- The policy is terminated
- The insured retires
- The insured ceases to be on active service
- The insured's coverage in the underlying medical plan ends

INSURANCE ON A DEPENDENT WILL END ON THE EARLIEST OF THE FOLLOWING DATES:

- The insured's insurance terminates
- The end of the last period for which premium has been paid
- The dependent no longer meets the definition of dependent
- The dependent's coverage in the underlying medical plan ends
- The policy is modified so as to exclude dependent insurance

THE COMPANY MAY END THE INSURANCE IF:

- Any insured person submits a fraudulent claim
- Participation requirements are not met
- On any premium due date, if the company or employer sends written notice 45 days in advance requesting termination
- If the underlying medical plan terminates

TRANSAMERICA®

If you do not participate in the group health insurance plan you are eligible for the Hospital Indemnity Plan.

HOSPITAL INDEMNITY SUBSIDY PLAN BENEFITS

This benefit is only available to active full-time employees who do **NOT** enroll in the Group Medical Plan

Coverage Includes:

Life Insurance

- $25,000 for active full-time employees

Long-Term Disability

- Benefit amount is 60% of your basic monthly salary
- Maximum monthly benefit of $5,000

Hospital Indemnity Benefit

- $250.00 per day for a hospital stay
- Maximum of 100 days

To file a claim:

HIP & Life Insurance
PO Box 45132
Jacksonville, FL 32232
Attn: Group Claims Dept.
Assistance: 1-800-696-8562

Long-Term Disability
Florida Combined Life
300 Southborough Drive, Suite 200
South Portland, ME 04106
Assistance: 1-877-254-0085

Dental Benefits ▪ Florida Combined Life

Dental coverage is important to your overall health and wellness. The School District of Madison County offers two Dental PPO Plan through Florida Combine Life. The PPO network allows members the freedom to choose any dentist they wish. Benefits are based on a percentage of allowable charges. It is always recommended that you seek services inside the network, if possible. Your out-of-pocket costs will be lower if you use an in-network dentist. Check for in-network providers at www.floridabluedental.com. Click "*Blue Dental Choice Plus*" to find a doctor. **You must create an account to view claims.**

	BlueDental Choice Plus Low 196L12		BlueDental Choice Plus High 196L12	
Benefits	**In Network**	**Out of Network**	**In Network**	**Out of Network ***
Annual Deductible - Individual	$50	$50	$50	$50
Annual Deductible - Family	$150	$150	$150	$150
Benefits Subject to Deductible	Preventive, Basic and Major		Preventive, Basic and Major	
Annual Benefit Maximum	$1,000	$1,000	$1,000	$1,000
OON Reimbursement	N/A	Percentage of Fee Schedule plus balance of charges	90th U&C	
Dental Rollover	Yes		Yes	
Coinsurance by Service Type *(member paid)*				
Preventive & Diagnostic	0%	0%	0%	0%
Basic	40% after deductible	40% after deductible	20% after deductible	20% after deductible
Major	60% after deductible	60% after deductible	50% after deductible	50% after deductible
Orthodontia	Not Covered		Not Covered	
Lifetime Orthodontia Plan Max	Not Covered		Not Covered	
Orthodontia for Adults (Yes/No)	Not Covered		Not Covered	

* If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount

Once you have enrolled in the dental plan, be sure to register at: www.floridabluedental.com

From here you will have access to:

- Claims information
- Provider searches
- Much more!

Vision Benefits ▪ VSP Vision Care

If you or your family members wear glasses or contacts, you know that vision care expenses only begin with an eye exam and can range in the hundreds of dollars. The School District of Madison County offers a Vision plan to all benefits-eligible employees. You and your dependents may enroll in the Vision plan even if you are not enrolled in the Medical plan. Visit the VSP network at www.vsp.com and enter your zip code to find a provider near you.

Benefits	In Network	Out of Network Reimbursement
Allowable Frequency of Exams / Lenses / Frames	12/12/2024	
Exam Copay	$10	Up to $45
Lenses - Standard Plastic		
Single	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $65
Lenses - Enhancement		
Standard Progressives	$0	N/A
Premium Progressive	$95 - $105	N/A
Customer Progressive	$150-$175	N/A
Frames		
Frames Benefit	$25 copay, $130 frame allowance $150 featured brands allowance 20% discount over allowance	Reimbursed up to $70
Contact Lenses *(in lieu of glasses)*		
Contact Lens Exam, Fitting and Evaluation	Up to $60 copay	
Elective	$130 allowance	Reimbursed up to $105
Medically Necessary	Covered in full after copay	Reimbursed up to $210

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

VSP VISION COVERAGE

SEE HEALTHY AND LIVE HAPPY WITH HELP FROM MADISON COUNTY SCHOOLS AND VSP

Enroll in VSP Vision Care to get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings

PROVIDER CHOICES YOU WANT

It's easy to find a nearby –in network doctor. Maximize your coverage with bonus offers and savings that are exclusive.

QUALITY VISION CARE YOU NEED

You'll get great care from a VP Network doctor, including a WellVision Exam™ - a comprehensive exam designed to detect eye and health conditions.

More Choices In-Network

Staying in-network has never been easier. With thousands of locations, getting the most out of your benefits is easy with VSP Premier Edge™ – including private practice doctors and Visionworks retail locations nationwide.

USING YOUR BENEFITS IS EASY!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

Retail Chains
(In-Network)

COSTCO OPTICAL
sam's club
Walmart
myeyedr.
PEARLE VISION
Henry Ford Health System
SVS VISION
Visionworks

Life and AD&D Insurance

Life Insurance provides your named beneficiary/beneficiaries with a benefit in the event of your death.

Accidental Death and Dismemberment (AD&D) Insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event your death occurs due to a covered accident, both the life and the AD&D benefit would be payable.

Life / AD&D

This benefit is provided at NO COST to you through Florida Combined Life
if not taking the Medical coverage:

Benefit Amount $25,000
If taking the Medical coverage:
Benefit Amount $1,000

Basic Life / AD&D

This benefit is provided to all employees at NO COST to you through The Standard
Benefit Amount $10,000

Supplemental Life / AD&D *(Employee paid)*

If you determine you need more than the basic coverage, you may purchase additional coverage through The Standard for yourself and your eligible family members.

	Benefit Option	Guaranteed Issue*
Employee	Max of $300,000 in $5,000 increments	$125,000
Spouse	Max of $150,000 in increments of $2,500-coverage amount for yourspouse cannot exceed 50% of employee's coverage	$25,000
Child(ren)	$10,000	none

*During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier

Disability Insurance

Disability insurance provides benefits that replace part of your lost income when you become unable to work due to accident or illness

Voluntary Short-Term Disability

YOU pay the cost for this benefit provided through The Standard for partial loss of income with the benefits reflected below.

Benefit Percentage	60% of eligible earnings
Weekly Benefit Maximum	$1,000
When Benefits Begin	After 14th day of disability
Maximum Benefit Duration	90 days

Long-Term Disability

YOU pay the cost provided through Florida Combined Life for those employees not on the HIP plan nor a Late Entrant and enrolled in Medical Coverage. For all other employees, provided at NO COST to you.

Benefit Percentage	60%
Monthly Benefit Maximum	$5,000
When Benefits Begin	After 90th day of disability
Maximum Benefit Duration	Social Security Retirement Age (SSRA)

Group Basic Life and Accident Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an event of an eligible member's covered death. Basic Accidental and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by the District School Board of Madison County.

Eligibility

Definition of a Member	You are a member if you are an active employer of District Board of Madison County and regularly working at least 20 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed force, a leased employee or an independent contractor.
Class Definition	Class 1 – Active Members
Eligibility Waiting Period	You are eligible on the first day of the month that follows or coincides with 30 consecutive days as a member.

Benefits

Basic Life Coverage	Your Basic Life coverage amount is $10,000.
Basic AD&D Coverage	For a covered accident loss of life , your Basic AD&D coverage amount is equal to your Basic Life coverage amount . For other covered losses, a percentage of this benefit will be payable.
Life & AD&D Age Reduction	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 65, to 50 percent at age 70 and to 25 percent at age 75.

Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Rights to Convert Provision
- Repatriation Benefit
- Portability of Insurance Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Standard Insurance Company
District School Board of Madison County
Group Policy #145705
Effective Date: October 1, 2023

Group Additional Life and AD&D Insurance

Help protect your loved one from financial hardship

Life insurance coverage is designed to help provide financial support and stability to your family should you pass away. Accidental Death and Dismemberment (AD&D) insurance provides an extra layer of protection if you die or become dismembered in an accident. You can also cover your eligible spouse and child(ren).

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits if you are dismembered, become terminally ill or die

Questions About This Coverage

If you take no action, you'll be covered under Basic Life insurance provided you meet eligibility requirements. Consider whether that would be enough to help your family meet daily expenses, maintain their standard of living, pay off debt and fund you children's education. If not, you may want to apply for additional coverage now.

Life Insurance

How Much Can I Apply For?

The coverage amount for your spouse cannot exceed 50 percent of your Additional Life coverage. The coverage amount for your child(ren) cannot exceed 50 percent of your Additional Life coverage.

For You:	**$5,000 - $300,000** in increments of **$5,000.**
For Your Spouse:	**$2,500 - $150,000** in increments of **$2,500**
For Your Children:	**$10,000** no evidence

What is the Guaranteed Issue Maximum?

Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.

For You:	Up to **$125,000**
For Your Spouse:	**Up to $25,000**

Standard Insurance Company
District School Board of Madison County
Group Policy #145705
Effective Date: October 1, 2023

Group Short Term Disability Insurance

Protect your income and those who depend on it.

This coverage replaces a portion of your income when you can't work because of a qualifying disability. Even if you're healthy now, it's important to protect yourself and the people who count on your income. This insurance can help you pay the bills when you're unable to work.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits for qualifying disability that is not work-related

Questions About This Coverage

See the important Details section for more information, including requirements, exclusions and definitions.

Short-Term Disability

What Your Benefit Provides This is a benefit you'd receive if you were to suffer a qualifying disability. Eligible earnings are your weekly insured predisability earnings, as defined by the group policy. Your benefit amount will be reduced by deductible income; see the important Details section for a list of deductible income sources.	**60%** of your eligible earnings, up to a maximum benefit of **$1,000** per week. Plan minimum **$15** per week.
Benefit Waiting Period If you suffer a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you can begin receiving your weekly benefit	14 days for accidental injury 14 days for physical disease, pregnancy or mental disorder.
How Long Your Benefits Last This is the maximum length of time you could be eligible to receive a weekly disability benefit.	90 days

This information is only a brief description of the group STD insurance policy sponsored by the School District of Madison County. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and the School District of Madison County may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that described the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
District School Board of Madison County
Group Policy #145705
Effective Date: October 1, 2023

Travel Assistance

Things can happen on the road. Passports get stole or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night. [1]

You and your spouse are covered with Travel Assistance – and so are kids through age 25 – with your group insurance from Standard Insurance Company (The Standard). [2]

Security That Travels With You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. If offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission.
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains. [3]
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond.
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization.
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded.
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability.

Contact Travel Assistance

800.872.1414

United States, Canada, Puerto Rico, U.S. Virgin Islands & Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Proceed to the Apple Store or Google Play to download the app. . Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

assist america®

Standard Insurance Company | 110 SW Sixth Avenue, Portland, OR 97204 | standard.com

[1] Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy

[2] Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

[3] Must be arranged by Assist America, Inc.

Aflac Accident Advantage (Policy Series A36000)

Aflac Accident Advantage insurance policy helps with the unexpected out-of-pocket costs that can hurt the family budget when accidents happen like ER visits and hospitalizations. In addition, the plan offers multiple coverage options to accommodate almost any budget and provide new and enhanced benefits not previously available with Aflac Accident Insurance.

Aflac Life Solutions (Whole Life Policy Series A68000)

Life Insurance. People know they should have it but it's a difficult conversation to have with your loved ones. Aflac Whole Life insurance policies are designed to help families get through the difficult times. Our policy provides protection with cash value that grows over time.

Cancer Protection Assurance (Policy Series B70000)

Cancer treatment is changing – and Aflac is proud to be changing with it. That's why we now offer Cancer Insurance. Our newest policy provides benefits for the new advances in treatment protocol and our robust benefits provide for the whole person. Because we believe in living life to the fullest, no matter what your diagnosis

Aflac Juvenile Life (Policy Series A65000)

Many insurance professionals think of life insurance for children as a tough sell. It shouldn't be. Unlike life insurance for adults, juvenile life insurance is not designed to protect against loss of income. With youth and health statistically on your side children are much easier to insure at competitive rates.

Aflac Choice (Policy Series B40000)

We know that not all hospital expenses are caused by something catastrophic. Even a quick trip to the hospital can be costly and have undesirable impacts on everyday life. Aflac Choice allows you to customize benefits based on your unique needs. With a simplified base plan and 3 available riders, policyholders can get the benefits they need and leave the ones they don't. No one should have to stress about the impact hospital-related visits have on everyday life, so make sure you aren't forced to choose between paying for your medical bills or paying for everyday needs.

Aflac Short-Term Disability Accident Advantage (Policy Series A57600)

For many employees, a temporary loss of income could have long-term financial consequences. Aflac's flexible, portable Short-Term Disability policies help you avoid the hardship of medical bills. An Aflac Short-Term Disability insurance policy provides a monthly benefit amount when the employee is disabled and unable to work due to a covered accident or illness. With features like a guaranteed-issue option and our unique Aflac Value and Aflac Plus riders and Aflac Short-Term Disability policy shows employees how easy and sensible it can be to protect their income.

Florida Combined Life Enhanced: Online Employee Assistance Program

USAble Life

Welcome to balanced care for a better life.

EAP can give you the support you need.
Whether you sense that a life challenge is just ahead, or you're already knee-deep in it, the EAP is here to help with top-notch providers, experts and offerings in these areas near you:

- Relationship and family challenges
- Life-changing events
- Legal or financial challenges
- Stress
- Excessive worry
- Feeling sad/blue
- Substance dependence or addiction
- Workplace challenges

Resources to help you find your best self. We're here for you around the clock:
Start a Chat
Go online for quick and easy access to experts who can immediately point you to the right resources.

Visit ndbh.com
View more than 10,000 resources to assist you in your improvement journey. Some available resources include:

- Videos
- Will Prep Toolkit
- Calculators
- Provider Directories
- Elder & Child Care Resources
- Stress Management Tools
- Self-Assessments
- Budgeting Worksheets
- Legal Documents

Visit ndbh.com to begin improving your health.

Florida Combined Life Enhanced: Online Employee Assistance Program *(Continued)*

Our expansive list of EAP resources includes:

Relationship Support
Visit ndbh.com to help you find resources to work through parental, personal or work related relationship challenges.

Health Resource Library
Search a comprehensive collection of articles, videos, self-assessments, Calculators and planners for information on thousands of topics designed to help improve your health.

Stress Toolkit
Understand the impact of stress on your happiness and productivity with this online toolkit. Take steps to improving your health with assessments, apps, tools and

Legal Resource Center
Resources designed to reduce stress. Explore a large database of free, customizable legal documents for wills, budgeting, retirement planning, big purchases and more. Store documents in one place for easy updates and secure saving.

Weekly Tips
Sign up for weekly tips and advice on how to work through stress, parenting, being your best at work and other helpful material — delivered right to your inbox.

For any additional questions or concerns, visit **ndbh.com.**

Our EAP representatives are available **24 /7/365.**

Your ndbh.com login: **USAL903**

Visit ndbh.com to begin improving your health.

Important Legal Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

1. You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
2. Generally, your health plan must: o
3. Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
4. Cover emergency services by out-of-network providers.
5. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
6. Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059 for information and complaints.
Visit as www.cms.gov/nosurprises/consumersfor more information about your rights under federal law.

Important Legal Notices

Important Notice from Madison County School Board 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 Madison County School Board 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. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two 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. **The School District of Madison County has determined that the prescription drug coverage offered through plans 5781 and 5907, is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage and considered creditable coverage; however, the plans 5196/5197 are NOT considered Creditable Coverage. Because your existing coverage is and is not considered Creditable Coverage, you need to take care in making a thoughtful decision about keeping plans 5196/5197 coverage as you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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 of Madison County coverage will be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not still be eligible to receive all of your current health and prescription drug benefits. If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may not enroll back into the School District of School District of Madison County benefit plan during an open enrollment period under the School District of Madison County benefit plan.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information or call Rose Raynak at 850-973-1541. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through School District of Madison County changes. You also may request a copy of this notice at any time.

Important Legal Notices

Important Notice from Madison County School Board About your Prescription Drug Coverage and Medicare – Continued

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).

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

Date: 10/01/2023
Name of Entity/Sender: School District of Madison County
Contact-Position/Office: Montrell Hawkins
Address: 210 NE Duval Avenue, Madison, Fl 32340
Phone Number: 850-973-1536

Important Legal Notices

HIPAA Special Enrollment Opportunity

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.

Also, if you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, contact Florida Blue at 800-545-6565.

A federal law called HIPAA requires that we notify your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Special Enrollment Provision

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

All enrollment changes due to special enrollment rights are subject to the approval of the Plan Administrator.

HIPAA Privacy Notice Reminder

The health plans offered by School District of Madison County are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to maintain the privacy of your health information. The Notices of Privacy Practices for our Health plans are available from the insurance carriers; in addition, you may also request a copy of a Notice by calling your insurance provider. **Be assured School District of Madison County and our insurance carriers fully comply with this requirement.**

Note: Because this reminder is required by law, you will receive separate reminders from each of the insurance plans in which you enroll as well as other providers describing the availability of their HIPAA notice of privacy practices and how to obtain a copy.

Woman's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the group medical plan. If you would like more information on WHCRA benefits, call your plan administrator.

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 850-973-1536 for more information.

Newborns and Mothers' Health Protection Act of 1996

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).

Important Legal Notices

Family Medical Leave Act (FMLA) Notice

What does the Family and Medical leave act provide?
The Family and Medical Leave Act (FMLA) provides eligible employees up to 12 work weeks of unpaid leave a year and requires group health benefits to be maintained during the leave as if employees continued to work instead of taking leave. Employees are also entitled to return to their same or an equivalent job at the end of their FMLA leave.

Who can take FMLA leave?
To be eligible to take leave under FMLA an employee must:
•Have worked 1,250 hours during the 12 months prior to the start of the leave (Note: Full-time teachers and other exempt employees are assumed to have worked 1,250 hours unless proven otherwise), and
•Have worked for the employer for 12 months (in total, not consecutive) within the last 7 years.

When can an eligible employee use FMLA leave?
A covered employer must grant an eligible employee up to a total of 12 work weeks of unpaid, job-protected leave (26 weeks in the case of military caregiver leave described below) in a 12-month period for one or more of the following reasons:
•For the birth of a child:
•For the placement with the employee of a child for adoption or foster care;
•To take medical leave when the employee is unable to work due to a serious health condition;
•To care for an immediate family member (spouse, child or parent-but **not** parent "in-law") with a serious health condition;
•To care for a spouse, son, daughter, parent or next-of-kin on covered active-duty service with a service-related serious health condition or injury;
•To deal with a qualifying emergency arising from a son's, daughter's, spouse's or parent's (but **not** parent "in-laws") active-duty service or call to active-duty service for deployment to a foreign country.

Responsibilities to the Madison County School Board Employees Requesting Leave.
It is the responsibility of the employee to notify their supervisor and provide at least thirty (30) days notice before the date the FMLA leave is to begin if the need for the leave is foreseeable. If the need for the leave is not foreseeable, you must give notice that you need to take a leave of absence as soon as practicable, but in no circumstances later than the next business day after you become aware of the need for the leave,. If you fail to adhere to these timeframes for notice, your request for leave may be delayed or denied. The required forms will be provided to you by the administrative office at your work location or the Human Resources Department.

Procedures on what you should do when taking a leave under FMLA:
•Inform your immediate supervisor at your work location.
•Request FMLA forms (4-part packet) from your work location or Human Resources.
•Submit a request for leave (normal form submitted when taking time off) it can be signed by your administrator to confirm notification, but final approval is received from the Human Resources department.
•Contact Payroll to discuss how this leave will impact your pay.
•Complete and submit all required forms to Human Resources for processing.
•Contact Benefits to discuss premium payment while on unpaid leave OR if leave will be unpaid, contact the Benefits Team to discuss premium payments

Contact:	Montrell Hawkins, Human Resource Specialist
Address:	210 NE Duval Ave, Madison, FL 32340
Phone:	850-973-1536
Email:	Montrell.Hawkins@mcsbfl.us

Important Legal Notices

Summary of Benefits and Coverage (SBC) Availability Notice
As required under the Patient Protection and Affordable Care Act, insurance companies and group health plans are providing consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. The purpose of the summary of benefits and coverage document is to help you better understand the coverage you have while allowing you to easily compare different coverage options. It summarizes the key features of the plan, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

As a result of the Patient Protection and Affordable Care Act (i.e. health care reform), School District of Madison County is required to make available a Summary of Benefits and Coverage (SBC), which summarizes important health plan information such as plan limits, coinsurance, and copays. The SBC is intended to provide this information in a standard format to help you compare across health plan options.

Please note that an SBC is not intended to be a complete listing of all of the plan provisions. For more detailed information, please refer to the SPD and the plan document, collectively known as the plan documents. If there are any discrepancies between the SBC and the plan documents, the plan documents prevail. Plan Documents are also available by contacting the Employee Benefits Department.

Discrimination is Against the Law
The School District of Madison County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. School District of Madison County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
School District of Madison County
Provides free aids and services to people with disabilities to communicate effectively with us, such as:
Qualified sign language interpreters
•Written information in other formats (large print, audio, accessible electronic formats, other formats)
•Provides free language services to people whose primary language is not English, such as:
♦Qualified interpreters
♦Information written in other languages
If you need these services, contact Equity & Compliance Officer. If you believe that School District of Madison County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Name & Title—Montrell Hawkins, Human Resource Specialist
Address—210 NE Duval Ave, Madison, FL 32340
Phone—850-973-1536
Email - Montrell.Hawkins@mcsbfl.us

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Stacy Haas is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at
https ://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697(TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Social Security Numbers Generally Required for Enrollment
Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare and Medicaid Services (CMS) generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, School District of Indian River will require that you provide Social Security numbers at the time of enrollment, so that School District of Madison County can assist its health plan administrator(s) to comply with this requirement.
For a newborn or newly adopted child, the newborn may be enrolled, provided that School District of Madison County is notified within 30 days of the birth, adoption, or placement for adoption. However, if a Social Security number is not provided by the later of (1) the end of the plan year, or (2) 90 days following the birth, adoption, or placement for adoption, the child will be disenrolled from the plan and will no longer be considered eligible for coverage. The child cannot be re-enrolled until the Social Security number is provided, and the child meets one of the mid-year enrollment or change in status coverage events.

Important Legal Notices

****Coverage Rights Under COBRA****

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

Important Legal Notices

Continuation Coverage Rights Under COBRA

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 *Madison County School Board*, 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.

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 *Madison County School Board*.

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.

Important Legal Notices

****Continuation Coverage Rights Under COBRA****

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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

Name & Title—Montrell Hawkins, Human Resource Specialist
Address—210 NE Duval Ave, Madison, FL 32340
Phone—850-973-1536
Email - Montrell.Hawkins@mcsbfl.us

https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Important Legal Notices

Your Group Benefits Under Section 125 – Qualifying Events

Your employee benefit program is a Premium Conversion Plan ("Plan") that is administered under the provisions of Section 125 of the Internal Revenue Code ("Code"). These provisions permit your contributions for various employee benefit plans to be deducted from your gross pay before calculation of withholding taxes. The result is that you have fewer taxes deducted from your paycheck, which increases your take home pay.

Plan elections you make during your initial enrollment and annual enrollment periods are binding for the applicable Plan year. In addition to the HIPAA Special Enrollment Right certain permitted mid-year Plan election changes are permitted. These permitted election changes are discussed below.

All enrollment changes due to a permitted election change are subject to the approval of the Plan Administrator. The Plan Administrator will have the discretionary authority to make a determination as to whether an election change has occurred in accordance with the rules and regulations of the Internal Revenue Service

Change in Status

Please see the Notice of HIPAA Special Enrollment Rights for election change during the Plan Year if you experience a Change in Status event. You must notify the Plan Administrator within 31 days of the event. Any election change due to a Change in Status event must be on account of and consistent with your Change in Status as determined by the Plan Administrator.

Generally, an election change will be considered consistent with your Change in Status only if it is on account of and corresponds with a Change in Status that affects an individual's eligibility for coverage under the Plan or a plan maintained by the employer of your Dependent. A Change in Status that affects eligibility under an employer's health plan includes a Change in Status that results in an increase or decrease in the number of your Dependents who may benefit from coverage under the Plan.

Permitted Change in Status events under the Plan include the following:

- Change in your legal marital status due to marriage, divorce, legal separation, annulment, or death of your spouse, or you enter into a domestic partnership, dissolve a domestic partnership or your Domestic Partner dies.
- Change in the number of your Dependents due to birth, death, adoption, or placement for adoption.
- Change in employment status of you, your covered Dependents including a termination or commencement of employment, commencement of or return from an unpaid leave of absence, a change in worksite, or any other change in employment status, if such change in employment status affects eligibility under a plan.
- Change in eligibility status of your Dependent Child(ren) on account of age, or any other circumstance affecting eligibility.
- Change in residence of you or your covered Dependent.

Qualified Medical Child Support Orders. If required by a Qualified Medical Child Support Order ("QMCSO"), you and/or an eligible dependent will be enrolled in the Plan in accordance with the terms of the order. Any required premiums will be deducted from your compensation. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Medical Plan's procedures governing QMCSO determinations.

You may make an election change to cancel coverage for your child if a QMCSO requires your spouse, former spouse, or other individual to provide coverage for the child; and that coverage is actually provided.

Entitlement To or Loss of Entitlement To Medicare or Medicaid. If you or your Covered Dependent becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), you may make a prospective election change to cancel or reduce coverage under the Plan for you or your applicable covered Dependent. In addition, if you or an eligible Dependent has been entitled to coverage under Medicare or Medicaid and loses eligibility for such coverage, you may make a prospective election to commence or increase your or your eligible Dependent's coverage, as appropriate, under the Plan.

Significant Change in Cost or Coverage Changes. You may also change your election mid-year due to a significant change in Plan cost or coverage, as provided below.

Significant cost changes. If the cost you are charged for a coverage option significantly increases or decreases during the Plan Year, you may make a corresponding change to your Plan election. Changes that may be made include commencing participation in the Plan for an option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under a Plan option providing similar coverage or dropping coverage if no option providing similar coverage is available.

Significant coverage changes curtailment with or without loss of coverage.

Significant Curtailment without loss of coverage. If you or your covered Dependent has a curtailment of coverage under the Plan that is significant but does not represent a total loss of coverage (for example, there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit), you may revoke your Plan election and elect to receive on a prospective basis coverage under another Plan option providing similar coverage. Coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

Significant curtailment with loss of coverage. If you or your covered Dependent has a curtailment of coverage under the Plan that constitutes a total loss of coverage, you may revoke your Plan election and elect either to receive on a prospective basis coverage under another Plan option providing similar coverage or to drop coverage if no similar option is available. A loss of coverage means a complete loss of coverage under the Plan option or other coverage option.

Addition or improvement of a benefit package option. If the Plan adds a new coverage option, or if coverage under an existing coverage option is significantly improved during the Plan Year, the Plan may permit eligible employees (whether or not they have previously made an election under the Plan or have previously elected a coverage option) to revoke their election under the Plan and to make an election on a prospective basis for coverage under the new or improved coverage option.

Important Legal Notices

Your Group Benefits Under Section 125 – Qualifying Events - Continued

Change in coverage under another employer plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer plan if (i) the other plan permits participants to change an election as described in this section, and (ii) the other plan permits participants to make an election for a period of coverage that is other than the Plan Year. For example, if you elect coverage through your spouse's employer's plan and that plan has a different annual enrollment period from this Plan, you may make a corresponding election change

Family and Medical Leave Act. If you take leave under the Family and Medical Leave Act (FMLA) you may revoke an existing Plan election and make another election for the remaining portion of the Plan year as may be provided for under the FMLA and regulations of the Internal Revenue Service.

Exchange Enrollment. Two mid-year election changes will be available to participants who meet the requirements of these election changes.

Reduction of Hours. If your hours are reduced to an expected average of less than 30 hours per week, you may revoke your election for coverage under the Plan if you intend to enroll in coverage offered in a government-sponsored Exchange (Marketplace) or in another group health plan that offers minimal essential coverage. This election change may be made even if the reduction in your hours would not cause you to lose coverage under the Plan. You will be required to provide the Plan Administrator with evidence that you intend to enroll in another plan with coverage effective no later than the first day of the second month following the revocation (i.e., if your coverage is revoked in May, coverage under the new plan must begin on July 1).

Obtaining Cover Through the Health Insurance Marketplace. If you are enrolled in the Plan and are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of Plan coverage.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

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

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration **www.dol.gov/agencies/ebsa** 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.**1**
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Madison County Schools, Montrell Hawkins, montrell.hawkins@mcsbfl.us.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.
[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Required Notices *(Continued)*

1. **Employer name** Madison County Schools	1. **Employer Identification Number (EIN)**
1. **Employer address** 210 NE Duval Avenue	1. **Employer phone number** **850-973-1536**
1. **City** Madison	1. **State** FL
1. **Who can we contact about employee health coverage at this job?** Montrell Hawkins	
1. **Phone number** *(if different from above)*	12. **Email address** Montrell.Hawkins@mcsbfl.us

Here are some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  [x] All employees. Eligible employees are:

  active, full-time employee of School District of Madison County who works at least 20 hours per week.

  With respect to dependents:

  [x] We do offer coverage. Eligible dependents are:

  your legally married spouse and eligible children who reside in your household and depend primarily on you for support. This includes: your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse to provide coverage. Age restrictions apply for the various benefits. Disabled children aged 26 or older who meet certain criteria may continue on your health coverage.

  [ ] We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee, or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you vis it **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Required Notices *(Continued)*

Patient Protection Provider Choice

Florida Blue generally requires the designation of a primary care provider for members of the HMO plan. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Florida Blue designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Florida Blue at **1-877-352-2583**.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Florida Blue or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Florida Blue at **1-877-352-2583**.

Special Enrollment Opportunity

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.

Also, if you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, contact Florida Blue at **1-877-352-2583**.

References and Resources

Benefit	Provider	Phone Number	Website
Medical	Florida Blue	1-877-352-2583	www.floridablue.com
Dental	Florida Combined Life	1-888-223-4892	www.floridabluedental.com
Vision	VSP	1-800-877-7195	www.vsp.com
Life, AD&D, LTD, and STD	The Standard	1-800-348-3226	www.standard.com
	Florida Combined Life	1-800-696-8562	www.floridablue.com
HSAs	Health Equity through Florida Blue	1-866-735-8195	www.answers.healthequity.com
Human Resources Department	School District of Madison County	1-352-742-6211	

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan documents, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

Rates – 2023 - 2024 Employee Contributions

Monthly Employee Medical Contributions:

Tier	Plan 5781	Plan 5907	HSA Plans 5196 / 5197
Employee	$391.49	$196.58	$0.00
Employee + Spouse	$1,501.70	$1,037.85	$569.96
Employee + Child(ren)	$1,131.65	$757.43	$379.98
Employee + Family	$2,161.40	$1,537.72	$908.62

Monthly Employee Dental Contributions: *(No Increase)*

Tiers	Low Plan	High Plan
Employee	$24.45	$31.77
Employee + Spouse/RDP	$46.94	$60.95
Employee + Child(ren)	$53.90	$70.00
Employee + Family	$76.36	$99.17

Monthly Employee Vision Contributions: *(No Increase)*

Tiers	VSP Choice Plan
Employee	$5.84
Employee + One	$11.92
Employee + Child(ren)	$12.76
Employee + Family	$20.37

Monthly Employee Voluntary Life and AD&D Contributions: *(No Increase)*

Coverage	Group Additional Life and AD&D
Employee Only	Aged based rates
Employee + Spouse/RDP	See Human Resources for rates
Child(ren)	$1.00

Your contributions toward the cost of medical, dental and vision are automatically deducted from your paycheck **before** taxes.

Rates – 2023 - 2024 Employee Contributions

Monthly Employee Long-Term Disability Contributions:

Coverage	Benefit
Monthly Benefit	60% of salary
Benefit Waiting Period	90 days
Monthly Rate	$0.73 per $100 Monthly Covered Payroll

Monthly Employee Short-Term Disability Contributions:

Coverage	Benefit
Monthly Benefit	60% of salary
Benefit Waiting Period	90 days
Monthly Rate	Age based rates

Monthly Employee Gap Plan Contributions: *(No Increase)*

TransConnect (Employees enrolled in Medical Plans 5196 / 5197 are enrolled in TransConnect at no additional cost)	
Tier	**Cost**
Employee	$18.93
Employee + One	$21.75
Employee + Child(ren)	$13.47
Employee + Family	$38.85

Note: Your contributions toward the cost of medical, dental and vision are automatically deducted from your paycheck **before** taxes.

Rates – 2023 - 2024 Employee Contributions

Monthly Employee & Spouse Additional Life:

Age Band *	Rate Per $1,000
0 – 29	$0.06
30 – 34	$0.07
35 – 39	$0.08
40 – 44	$0.12
45 – 49	$0.21
50 – 54	$0.34
55 – 59	$0.53
60- 64	$0.83
65 – 69	$1.49
70 – 74	$2.39
75 – 79	$3.78
80 and over	$5.90

School District of
Madison County
210 NE Duval Avenue
Madison, FL 32340

www.Madison.k12.fl.us
Phone: 850-973-5022