CHOOSE YOUR BENEFITS!

–– 2020 EMPLOYEE INFORMATION GUIDE ––

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 36 for more details.

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Important Information

Bay District Schools offer you and your eligible family members a comprehensive and valuable benefits program. We encourage you to educate yourself about your options and choose the best coverage for you and your family.

Enrollment & Eligibility

All full-time employees working an average of 30 hours per week are eligible to enroll in benefits. For specific details, please refer to the plan documents.

How to Enroll

Make your benefit elections online through Benefit Connector (see page 8). Once you have made elections, you will not be able to change them until the next open enrollment period, unless you have a qualifying life event.

When to Enroll

- **NEW HIRES:** During your **initial eligibility period for 30 calendar days starting from your date of hire.**
  - Elections you make during your eligibility period are effective **from your date of hire** through Dec. 31, 2020.
  - New full-time employee benefits are active immediately upon your first day of work no matter the line of coverage. No insurance premium payments are due until a line of coverage is chosen. **Catch-up premiums will be due at this time to pay for the insurance offered immediately upon hire (see page 5).**
- Within 30 days of a qualifying life event (see page 4).
- During the annual Open Enrollment period in the fall each year.
  - Benefits you elect during Open Enrollment will be effective from Jan. 1 – Dec. 31 of the following year.
  - **Plan Year 2021 Open Enrollment to be held in the fall of 2020, exact dates to be determined.**

Dependents

Eligible dependents[1] generally include:

- Your **legal spouse**
- Your natural, step, adopted, or foster **child**, as well as a child you have legal guardianship for, who is dependent upon you for support, may be covered on the medical and dental plans. Dependent children can be covered to the end of their birth month in which they turn 26.
- Dependents **26 years or older, who are incapable of self-sustaining employment** by reason of intellectual disability, developmental disability, mental illness, or physical disability. This dependent must be primarily dependent upon you for financial support and maintenance on a continuous basis.
- An adult child's spouse and children are not subject to coverage.

Dependent Verification of Eligibility

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you will be asked to provide the applicable verification documents from the following list:

- **Spouse**: Marriage Certificate
- **Child**: Birth Certificate, court documentation awarding custody or requiring coverage
- **Grandchild**: Photocopy of the child's Birth Certificate showing the name of the employee/retiree's dependent as a parent
- **Adult Child with Disability**: Same documentation as child, plus a physician's letter verifying the child's dependency status due to being incapable of self-sustaining employment

[1]To see the Dependent Eligibility and Verification Chart, visit **www.bay.k12.fl.us/benefits**.

96% of Americans don't understand basic insurance terminology.* See our Glossary of Terms on page 7!

* https://www.policygenius.com/health-insurance/learn/health-insurance-literacy-survey/

Important Information

Payroll Deductions

As a new employee, you will be enrolled in the Flexible Benefits Plan, which pays for benefit premiums on a pretax basis through automatic payroll deduction. The deadline for making your benefits enrollment elections is 30 days from your date of hire.

Understanding Pretax Deductions

Pretax deduction allows you to pay for your share of certain premiums before taxes. Enrollment is automatic. This feature enables your portion of insurance premiums (group health, dental & vision, and any other qualified insurance premiums) to be deducted before federal withholding or FICA taxes are calculated. Therefore, you lower your taxable income. This allows you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.

Because you do not pay Social Security taxes on your Flexible Benefits Plan redirection monies, your eventual Social Security benefits at retirement or disability may be reduced. For most employees, the advantages of using the money tax-free will probably outweigh any potential reduction in Social Security benefits in the future.

Qualifying Life Events

Individuals participating in pretax deductions must have a qualifying status change event in order to change insurance coverage. IF EMPLOYEES DO NOT MAKE CHANGES WITHIN 30 DAYS OF THE QUALIFYING EVENT, CHANGES CAN NOT BE MADE UNTIL THE BEGINNING OF THE NEW PLAN YEAR OF THE INSURANCE COVERAGE (OPEN ENROLLMENT). It is very important that you take appropriate action immediately upon the experience of a qualifying event.

Some common qualifying events may include:

- Marriage, legal separation, divorce, or death of spouse
- Birth, adoption, or the custody change of an eligible dependent
- Loss of other coverage
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

To determine if any of these apply to you, please complete the Qualifying Event Change Request form at **www.bay.k12.fl.us/benefits**.

NOTE: the IRS does not consider financial hardship a qualifying event to drop coverage.

Opting-Out of Pretax Deductions

You have the option to opt-out of the Flexible Benefits Plan and pay your premiums post-tax. You must sign a waiver of participation if you do not want to participate in pretax payroll deductions.

If you desire not to participate, a waiver form must be submitted. A waiver form is in effect for the **FISCAL YEAR OF JULY 1 THROUGH JUNE 30.** You must submit this waiver to the payroll office prior to **July 1st each year**.

The waiver is on the District's Intranet (secure internal network). Go to **www.bay.k12.fl.us/intranet**, click the "Intranet Portal Link" button, and log in. Select the "Insurance" folder in the left sidebar, then the "Insurance Premium Pre-Tax Waiver Document" file.

Tips to Help You Save Money

Prescription Drugs

- Find the complete list of covered medications on **flblue.com**
- Generics offer the best value
- Know what brand-name drugs are covered under your plan
- Consider a 90-day supply of prescription drugs you take on a regular basis so you're less likely to miss a dose

Know in Advance

- Know which providers are in your network by using the provider search tool on **flblue.com**
- Download the Teledoc app and configure it right away so that it's ready when you need it
- Know and locate care facilities in your area including a care clinic or urgent care center near you
- Make use of the Bay Educators Wellness Center

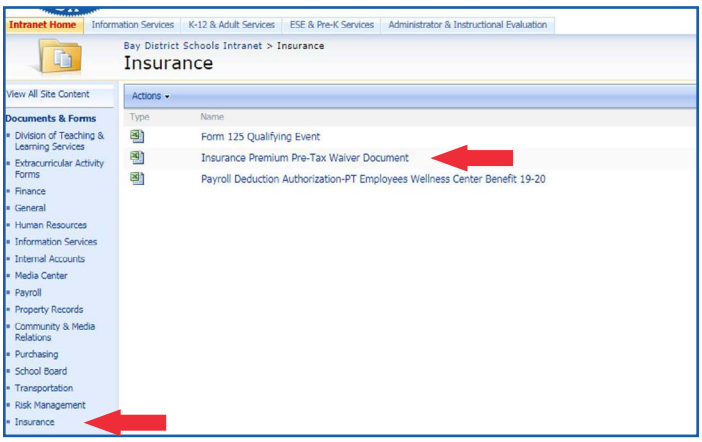
Be Proactive in Your Health

- Get information on the cost of medications and treatments to avoid surprises
- Use your preventative care benefits, learn your core health numbers and get more information at **flblue.com**

Use the Appropriate Care Facility

- Take advantage of all your preventative care benefits
- Visit the health care provider most appropriate for your care
- Use the Marathon Health onsite healthcare center near you! See page 16 for more information.
- Use Teladoc to speak with a board-certified doctor via video chat or phone, 24/7/365 (see page 15)
- Use in-network national labs to help save money
- Urgent Care centers can save thousands over emergency rooms. Use the ER only for true emergencies.

District Intranet screenshot showing documentation to Opt-Out of Pretax Deductions



Important Information

New Hires: Catch-Up Premiums

As a benefit to you, Bay District Schools allow the insurance for health, dental, vision, life, and group products to retroactively take effect from your date of hire. This way you're covered for any incidents and appointments that take place as soon as you are hired. The District is required to remit the premium payments for these insurance coverages at the beginning of the month.

This combination of factors requires a calculation and adjustment to recover the employee's contribution of the premium payments back to your date of hire.

After this catch-up period, just one premium as shown on the Benefit Confirmation Statement or Employee Contribution amount will be applied. Future payments will cover the premium cost of benefits effective for each month following the payment.

An Example Scenario

Let's say you were hired in January of a given year, and will be paid semi-monthly. Semi-monthly paid employees are paid twice a month. Pay dates fall on the last working day of the weeks of the 15th and the end of the month.

- Benefit premiums will be deducted from each paycheck automatically. You are paid twice a month, so normally ½ of the total premium is deducted from each paycheck. This pays for coverage for the next month. (For example, the two payments in April will pay for insurance coverage effective during May.)

The initial Catch-Up period, however, will be irregular.

- In this example, your first day of work (hire date) will be Jan. 10.
- All new hires have an Eligibility Period of 30 calendar days starting from their hire date to enroll in benefits.
- In this example, you put off enrolling in benefits until Feb. 4.
- The benefits you enrolled in on Feb. 4 are made effective as of your hire date, Jan. 10. The next pay day will be Feb. 14, which is the next opportunity to deduct accurate premium payments. This means you will owe:
  - 2 deductions to pay for January's coverage
  - 2 more deductions to pay for February's coverage
  - 1 normal, on schedule, ½ premium deduction to pay for the first half of March's coverage

Your real life situation will be unique. To predict your first paycheck's deductions, you need to consider all the variables:

- Your hire date
- The day you enroll in benefits
- Your next pay date after that
- The premium costs for the benefits you enroll in

Together these determine the total catch-up premium amounts, and how many payments you will need to make.

With these effects in mind, it is to your advantage to review your benefits options and enroll as soon as possible after your hire date, rather than wait until near the end of the eligibility period.

Here are some sample contributions from the previously described example scenario, using 2019 rates from the Instructional Classification.

BENEFIT	COVERAGE	SEMI-MONTHLY
Medical Plan	Employee Only	$42.16
Dental Plan	Employee Only, High	$16.45
Vision Plan	Employee Only	$2.81
Optional Life	$100,000	$17.50
TOTAL REGULAR DEDUCTION		$78.92

Again, in this example, the first pay date after enrolling will be Feb. 14. The deductions from this check will cover:

- 2 Catch-Up deductions to pay for January's coverage
- 2 more Catch-Up deductions to pay for February
- 1 regular semi-monthly deduction to pay the 1st half of March

MONTH	PREMIUMS	DEDUCTIONS
January Catch-Up	$78.92 x 2	$157.84
February Catch-Up	$78.92 x 2	$157.84
CATCH-UP DEDUCTIONS		$315.68
March Regular	$78.92	$78.92
TOTAL DEDUCTION		$394.60

Instructional Classification

In accordance with Article 17.5 of the ABCE Master Contract, if a newly hired teacher elects insurance coverage through the District, and election of that coverage requires more than $300.00 of catch-up payment (the amount beyond the normally deducted premium amount) in a single paycheck, then the District will prorate the catch-up payment amount due over three (3) paychecks. If fewer than three (3) pay periods remain then the amount will be prorated over the remaining number of paychecks to be received.

Important Information

Summer Premium Deductions

Employees in 10-month positions are paid on a 20 check payment cycle. To cover the two months of summer in which they do not work nor are paid, additional premium deductions will be collected. These begin on the first pay check in December, and will continue over the next 12 pay checks.

Normally, ½ a month's premium is deducted from each paycheck to cover 1 month of benefits. These deductions cover 2 months, divided over 12 pay checks. Using the previous example rates, we could expect the following deduction increase per pay check.

MONTH	PREMIUMS	DEDUCTIONS
June Regular	$78.92 x 2	$157.84
July Regular	$78.92 x 2	$157.84
TOTAL DEDUCTIONS OWED		$315.68
Dec-May Increase	$315.68 ÷ 12	+$26.31

If the employee retires, resigns, or does not have their contract renewed for the following school year, any summer premiums withheld will be returned to the employee. We cannot provide insurance to an individual who is no longer an employee of Bay District Schools.

Separation & Coverage

In the event of separation of service, it is understood that all elected coverages will cease at 12:01 a.m. on the last day of the first month that the individual fails to meet any of the applicable eligibility requirements, or ceases to be an employee of Bay District Schools if the employment contract has ended.

The individual will be offered the opportunity to continue with coverage and will have independent election rights through COBRA continuation coverage.

If your contract is non-renewed for the new fiscal year, the following insurance ending dates will apply.

2020-21 Insurance Ending Dates

START DATE	END DATE	ENDING DATE
INSTRUCTIONAL, 196 DAYS (FULL CONTRACT)		
07/29/20	05/28/21	07/31/21
INSTRUCTIONAL, 195 DAYS OR LESS (LATE START)		
ANY	05/28/21	05/31/21
LICENSED		
07/29/20	05/28/21	05/31/21
10-MONTH SUPPORT		
08/11/20	05/26/21	05/31/21
ADMINISTRATIVE		
07/01/20	06/30/21	06/30/21

Glossary Of Terms

ACA or AHCA: **Affordable (Health) Care Act**, sometimes referred to as "Obamacare."

AD&D: Accidental Death and Dismemberment insurance.

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage.

CARRIER: Refers to the insurance company.

CLAIM: The request for payment of benefits received in accordance with an insurance policy.

COPAY: A copayment is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

COINSURANCE: A payment for covered charges shared on a percentage basis between the covered person and the health plan. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan there is usually a separate higher deductible for using out of network providers.

DEPENDENT: A person or persons relying on the policyholder for support. May include the spouse and/or unmarried children (whether natural, adopted or step) of an insured policyholder.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipt of benefit payments.

EE: Enrolled Employee. This person is the policyholder.

EOB: **Explanation of Benefits**. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EOI: Evidence of Insurability. The medical information you must provide that requires review and approval by the insurance company before coverage becomes effective. This may include medical records and a physical exam.

GI: Guaranteed Issue. A person qualifies for a plan without the need to take a prior exam or produce an EOI.

HIPAA: **Health Insurance Portability and Accountability Act**. A law passed in 1996 that gives citizens both the right to privacy of their medical records, and a certain level of control over how, when, and with whom those records are shared. This also includes the right to be notified of how, when, and with whom sharing takes place.

HMO: **Health Maintenance Organization**. This type of medical plan is Network exclusive. A participant must receive services from in-network providers except in the case of a medical emergency.

IN-NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAIL ORDER PRESCRIPTIONS: Refers to maintenance drugs. members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure, and asthma. This also includes birth control.

MAXIMUM OUT-OF-POCKET: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out-of-pocket, depending on the plan.

OAD: **Overage Dependent**. Those over the age of 18 who are still on their parents' policy due to being a college student, disabled, or meeting other certain criteria.

OUT-OF-NETWORK: The use of healthcare providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point of Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

PARTICIPATING PROVIDER: Contracted individual physicians, hospitals, and professional healthcare providers that provide services to its members at a discounted rate.

PCP: **Primary Care Physician**. A doctor elected by the insurance plan member and is part of the plan network. They provide routine care and coordinate other specialized care. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist, or pediatrician.

PPO: Preferred Provider Organization. A network of healthcare providers that contract with a carrier to provide care at a discounted rate. Benefits can be paid for out-of-network doctors at a higher rate. Plans feature office visit copays, deductibles at a variety of levels, and coinsurance to a maximum out-of-pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

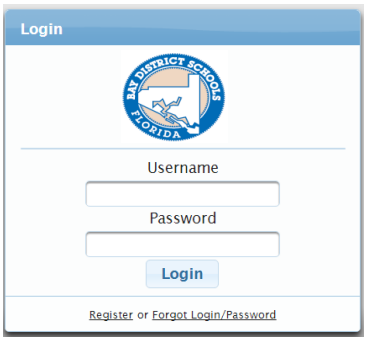
PREMIUM: The regular fee to pay for an insurance plan. Employees pay premiums deducted pretax from their paycheck.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides nonroutine care, such as a dermatologist or orthopedist.

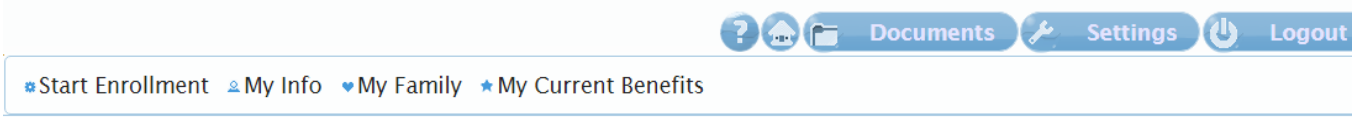
SPD: Summary Plan Description. This is the definitive document that outlines the complete terms of a policy.

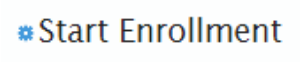
How To Enroll



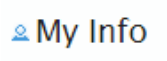
Your employer will provide you with the specific site address for the enrollment site. To access the site go to: https:// baycountyschools.benefitconnector.com

User Name and Password are required to enter the enrollment site. If you are a first time user you must go through the registration process. Click on '**Register**' and follow the simple registration instructions. A default User Name will be assigned. You will create your Password.



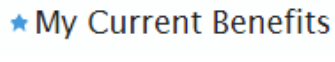


During an Open Enrollment period click **Start Enrollment** to begin the enrollment process. Depending on case settings you may or may not be asked to verify both employee and dependent information. Dependents who are currently listed in the system can be updated and verified at this point. Important: You'll be given the opportunity to add dependents during the actual enrollment process.



Your demographic information will be displayed in the **My Info** tab, some of which can be edited. If there is incorrect information in fields that you are not allowed to edit, please contact your HR Dept and provide them with the correct information. Suggestion: Depending on case settings you may or may not be asked to verify your employee information during the enrollment process. Complete your enrollment first. If you were not asked to verity your information during the enrollment process, you can view/update your information once you've completed enrollment.

Dependents who are currently listed in the system will be displayed in the **My Family** tab. Where allowed you can update and correct dependent information. Suggestion: Depending on case settings you may or may not be asked to verify your dependent information during the enrollment process. Complete your enrollment first. If you were not asked to verity your dependent information during the enrollment process, you can view/update your dependents once you've completed enrollment.



Select **My Current Benefits** to view a summary of the benefits you are currently enrolled in.

Selects **Documents** to view and print any Forms or Documents that have been posted by your employer.

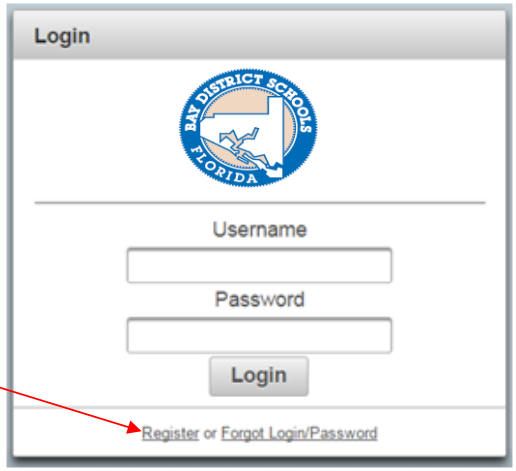
Selects **Settings** to change your Password or your Registration information.

Click for additional help information.

How To Enroll

Registering on the Benefit Connector Enrollment Site

Step 1
Log on to:
baycountyschools.benefitconnector.com



Step 2
If you have never accessed the site, you must register.

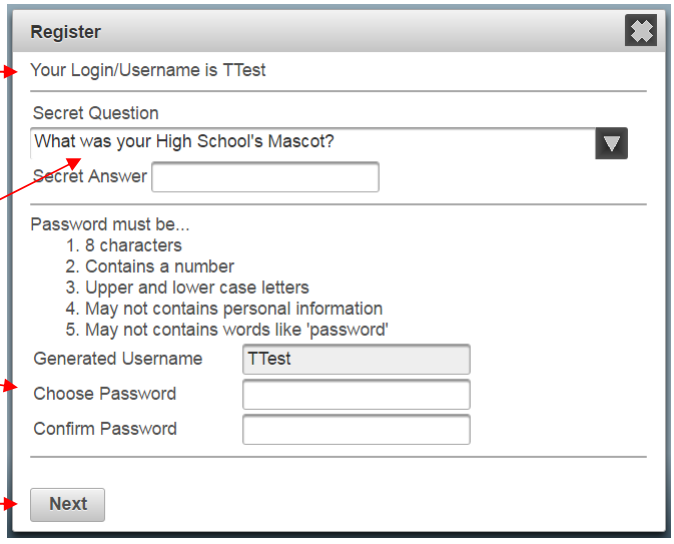
- From the log in screen, click '**register**' to begin registration process.

Step 3

- Enter the **Registration Information** - Last Name, Date of Birth, Last 4-Digits of SS#.
- Click 'Next' to continue.

Step 4

- Make note of your **Login/Username**
- Select and answer a **Secret Question**
- Create and verify a **Password**. Password strength is displayed as password is developed.
- Click 'Next' to continue.



Be sure to remember your Login/Username and Password for future access to Benefit Connector. If you forget your Password, it can be reset it by following the instructions for **'Forgot Login/Password'** in the log in box.

Triune Technologies

Medical Insurance

PLAN COMPARISONS**	BLUECHOICE 317	BLUE OPTIONS 03900	BLUE OPTIONS 05192 / 05193*
Deductible	In Network	In Network	In Network
• Per Individual	$500	$2000	$2500
• Family	$1500	Per Person Only	$5000
Coinsurance	20%	30%	20%
Out-of-Pocket Maximum			
• Per Individual	$2000	$6350	05192: $5800 / 05193: $6850
• Family	$6000	$12,700	$11,600
SERVICES			
Out-Patient Hospital (Surgery)	Deductible + Coinsurance	$300 Copay	Deductible + Coinsurance
In-Patient Hospital	Deductible + Coinsurance	$1500 Copay	Deductible + Coinsurance
Ambulatory Surgical Center	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Independent Clinical Lab	Coinsurance	$0	Deductible
Out-Patient Diagnostic Testing	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Advanced Imaging Facility Services	Deductible + Coinsurance	$200 Copay	Deductible + Coinsurance
Provider Services at Hospital/ER	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room	Deductible + Coinsurance	$200 Copay	Deductible + Coinsurance
Ambulance Ground and Air Travel	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Urgent Care	$20 Copay	$60 Copay	Deductible + Coinsurance
Office Visit - Family Physician	$20 Copay	$35 Copay	Deductible + Coinsurance
Office Visit - Specialist	Deductible + Coinsurance	$50 Copay	Deductible + Coinsurance
Adult Wellness Benefit Maximum	No max, same as Office Visit	Covered at 100%	Covered at 100%
PRESCRIPTION DRUGS (RETAIL)			
Generic	Deductible + Coinsurance	$10 Copay	$10 Copay after Deductible
Preferred Brand	Deductible + Coinsurance	20% for **Select Brand**, or $50 whichever is greater	$30 Copay after Deductible
Non-Preferred Brand	Deductible + Coinsurance	Not Covered	$50 Copay after Deductible

PREMIUMS PER PAYCHECK	BLUECHOICE 317	BLUE OPTIONS 03900	BLUE OPTIONS 05192 / 05193*
ADMINISTRATIVE (MONTHLY)			
Employee	$84.31	$0.00	$0.00
Employee/Spouse	$854.88	$381.03	$431.15
Employee/Child(ren)	$423.39	$85.91	$187.13
Employee/Family	$1,424.20	$770.37	$765.51
INSTRUCTIONAL & LICENSED (SEMI-MONTHLY)			
Employee	$42.16	$0.00	$0.00
Employee/Spouse	$427.44	$190.52	$215.58
Employee/Child(ren)	$211.70	$42.96	$93.57
Employee/Family	$712.10	$385.19	$382.76
SUPPORT & CONFIDENTIAL (SEMI-MONTHLY)			
Employee	$27.58	$0.00	$0.00
Employee/Spouse	$412.86	$175.94	$201.00
Employee/Child(ren)	$197.12	$28.38	$78.99
Employee/Family	$697.52	$370.61	$368.18

NOTE: Contribution rates for individuals in the non-bargaining classifications are pending Board approval.
* Includes access to a Health Savings Account (HSA), see Blue Options 05192 & 05193 details.
** This is a side-by-side summary of plan highlights. Individuals should review the Schedule of Benefits and the Plan Summary document posted on the District website **www.bay.k12.fl.us/benefits** for complete details.

Medical Insurance

Florida Blue will provide medical administrative services to Bay County District Schools for the new plan year (January – December 2020).

Three Medical Options Are Available*

- BlueChoice 317
- BlueOptions 03900
- BlueOptions 05192 / 05193 (HSA compatible)
  - These plans are the same, but cover different groups:
    - Plan 05192 covers at the individual level
    - Plan 05193 covers at the family level

BlueChoice 317, BlueOptions 03900, Blue Options 05192 each:

- allows you to choose the physician of your choice. However, to receive your maximum benefit, you should select an in-network doctor. For a list of network providers, visit **https://providersearch.floridablue.com** or call 1-800-352-2583.
- covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, these plans cover certain preventive services without cost sharing even before you meet your deductible. See a list of covered preventive services at **www.healthcare.gov/coverage/preventive-care-benefits/**.
- allows you to see a specialist without a referral

With BlueChoice 317 and BlueOptions 03900

- You may enroll in an Healthcare Flexible Spending Account (FSA) See page 13 for more on FSAs.

With BlueOptions 05192 and BlueOptions 05193

- You will have access to a Health Savings Account (HSA) through HSA Bank. See the District's benefits website at **www.bay.k12.fl.us/benefits** under Florida Blue: Blue Options 5192-93 HSA, and the HSA Bank (Health Savings Account) sections for more information.

More About HSAs

An HSA is an interest-bearing spending and savings account that you use to pay for eligible healthcare expenses using tax-free dollars. You must be enrolled in either BlueOptions 05912 or BlueOptions 05913 to contribute to the HSA.

Qualifying for an HSA

In order to open an HSA, you must be "HSA Eligible." IRS guidelines say that an HSA Eligible Individual is anyone who:

- Is covered by an HSA-qualified High Deductible Health Plan (HDHP).
- Cannot be claimed as a dependent by another person.
- Isn't covered by some sort of additional, non-HDHP insurance program.
- Is under age 65 and not entitled to Medicare.

Annual HSA Contributions

The IRS sets limits for how much you can contribute to an HSA in each calendar year. These limits, established by the federal government and subject to change, are tied to the rate of inflation. Over-contributing to your HSA leads to a tax penalty on excessive funds.

The 2020 plan year contribution limit is $3,550 for single and $7,100 for family.

Catch-up Contributions

HSA owners age 55 and older can make additional contributions to their HSA called "catch-up contributions." For 2020, the allowed catch-up contribution is $1,000.

Important Facts About High Deductible Health Plans (HDHP) with HSA

The law stipulates that in order to have a Health Savings Account (HSA) you must participate in a qualified High Deductible Health Plan (HDHP). However, if any of the following situations pertain to you, you can participate in the HDHP but NOT the HSA.

- If you enrolled in Medicare or Medicaid, you cannot open an HSA.
- If you have Tricare, you cannot have an HSA because Tricare does not offer an HDHP.
- If you are receiving medical care from the Veteran's Administration for a non-service related disability, you cannot have an HSA.
- Flexible Spending Accounts (FSA) which cover all medically necessary expenses make you ineligible for an HSA.
- Employees may not contribute to an HSA until their FSA account is empty.
- If a spouse participates in a private healthcare plan, Medicare, Medicaid, or Tricare, this will make you ineligible for a HSA if you are also covered.
- If you no longer have an HSA qualified HDHP, you cannot contribute to your HSA, but you can maintain and spend the already deposited funds as stipulated by law.

Use It or Save It

Your HSA is your personal account, and you can choose how you want to use it. You can choose to use the funds as you need them for medical care, or pay for medical expenses with other non-HSA funds. You may save the funds for upcoming expenses.

Manage Your HSA Account Online

Access real-time account balances, transaction history and statements, as well as track your expenses online. Sign up for online banking today.

- **Mobile App** – Use your iOS (iPhone, iPod Touch, iPad) or Android-powered device to check available balances in your account and view HSA transaction details, save and store receipts using your device's camera, receive account balances and configurable alerts via text message, and access customer service contact information.
- **myHealth Portfolio℠** – Use this tool to track your healthcare expenses, submit and retain receipts and claims from multiple insurance and financial account providers. Also view expenses by provider, description, and more.

* This is an Employer Benefits Highlights Summary and not a contract. The information in this guide does not include all terms and conditions of the benefits. Please refer to the policy and certificate of coverage online at **http://www.bay.k12.fl.us/benefits** for complete details.

Medical Insurance

How to Deposit Funds

To maximize HSA tax and savings benefits, begin funding your account as soon as you can. HSA Bank offers several convenient methods for making contributions to your HSA.

- **Payroll Deductions** – If your employer offers this option, HSA Bank will facilitate recurring pretax payroll deductions. Contact your employer to complete the appropriate paperwork.
- **Online Transfers** – On HSA Bank's member website, you can transfer funds from an external bank account, such as a personal checking or savings account, to your HSA.
- **Check** – Mail your personal check and completed Contribution Form to: HSA Bank, PO Box 939, Sheboygan, WI 53082

How to Pay for Healthcare Expenses from Your HSA*

- **Health Benefits Debit Card** – Your HSA Bank Health Benefits Debit Card provides access to your HSA funds at point-of-sale with signature or PIN and at ATMs for withdrawals. The daily debit card limit for the Health Benefits Debit Card is $5,000 at merchants dedicated to healthcare and $3,500 at merchants that are not healthcare specific, but offer eligible medical products and/or services (e.g. Walmart, Target, etc.). The number of debit card transactions is limited to five transactions per day. These limits exist as a safeguard against fraudulent activity. We offer multiple options to pay for an expense that exceeds the daily debit card limit. Transaction fees may apply when used with a PIN.†
- **Checks** – A book of 50 checks can be ordered upon request for an additional fee.† You can use these checks to pay providers or reimburse yourself for expenses already incurred. There is no daily limit on dollar amounts.
- **Online Transfers** – On HSA Bank's Member Website or mobile app, you can reimburse yourself for out-of-pocket expenses by making a one-time or reoccurring online transfer from your HSA to your personal checking or savings account. There is a daily limit of $2,500.
- **Online Bill Pay** – Use this feature to pay medical providers directly from your HSA. There is no daily limit.

HSA Bank's Health Benefits Debit Card can be used for point-of-sale transactions in two ways, signature or PIN. For signature, swipe card, press credit on the keypad, and sign the receipt. To pay using a PIN (fee per PIN transaction may apply†), swipe your card, select debit on the keypad, and enter your PIN. To withdraw HSA funds from an ATM (fee per ATM withdrawal may apply†), be sure to select the "checking" option (not savings) when asked the type of account you are withdrawing from. HSA Bank limits point-of-sale debit card transactions to medical merchants. As a mechanism for fraud protection, HSA Bank has set daily limits on debit card transactions. These limits are listed in your Deposit Account Agreement and Disclosures Booklet. Debit card transactions are also limited to your current balance.

* You can pay for a wide range of IRS-qualified medical expenses with your HSA, including many that aren't typically covered by health insurance plans. This includes deductibles, co-insurance, prescriptions, dental and vision care, and more. For a complete list of IRS-qualified medical expenses, visit irs.gov or hsabank.com/IRSQualifiedExpenses.

† For applicable fees, see your HSA Bank Interest and Fee Schedule or Explanation of HSA Bank Fee Changes document.

How to use your HSA Mobile App

At HSA Bank, our goal is to help you Own Your Health℠. HSA Bank Mobile is all about giving you the tools to take control and better manage your health accounts. Safe and secure, HSA Bank Mobile offers real-time access for all your account needs, 24 hours a day, seven days a week. It's simple, intuitive, and convenient.

How to Get Started

1. Create your username and password. Register on the Member Website.
2. Download HSA Bank Mobile at Google Play or the App Store.
3. Login to HSA Mobile and start managing your account on the go.

Note: While the HSA Mobile app is free to download, message and data rates may apply. Check with your mobile services provider for any charges that may apply for data usage on your mobile device. Please refer to the Online Services Agreement for further details regarding HSA Bank mobile banking services.

HSA Investment Opportunities

HSA Bank provides unique opportunities to invest Health Savings Account (HSA) funds in self-directed investment options. It's a great way to potentially grow HSA funds for healthcare expenses, or save funds as a nest egg for retirement. You must have a minimum of a $1,000 balance in order to invest funds.

- TD Ameritrade Self-Directed Brokerage Option
- Devenir Self-Directed Mutual Fund Program

For more information, please contact the Client Assistance Center at 800-357-6246 or **www.hsabank.com**.

HSA Bank does not provide brokerage/investment services; brokerage services are provided by TD Ameritrade, Inc., member FINRA/SIPC/NFA, and investment services are provided by Devenir. HSA Bank, TD Ameritrade, and Devenir are separate, unaffiliated companies and are not responsible for each other's services or policies. Self-directed investment accounts are the sole responsibility of the account owner. Carefully weigh the advantages and disadvantages of investing your HSA funds before doing so. HSA Bank and other business entities receive compensation for providing various services to the funds, including distribution (12b-1) and service fees. Your ability to replace losses in the investment account may be limited by the annual contribution limits of your HSA. HSA Bank does not offer investment advice.

Investment accounts are not FDIC insured and they are not bank guaranteed. Investment accounts are not a deposit account, or an obligation of HSA Bank, and they may lose value. They are not guaranteed by any federal government agency. Performance data and ratings represent past performance and are not a guarantee of future results. Investment returns and principal value will fluctuate and investors' shares, when sold, may be worth more or less than their original cost.

Contact Information

For more information, contact the Client Assistance Center at 800-357-6246 or **www.hsabank.com**.

605 N. 8th Street, Ste. 320, Sheboygan, WI 53081

Flexible Spending Accounts

NOTE: Flexible Spending Accounts (FSAs) **CANNOT** be enrolled in during the fall Open Enrollment period for existing employees. **These benefits have a Plan Year aligned with the District's fiscal year of July 1 - June 30**. A separate Open Enrollment period just for FSAs will be announced near May of the next year.

New hires may enroll in the currently effective FSA plan within their 30-day period of eligibility with other benefits.

NOTE: You cannot enroll in a Healthcare FSA if you participate in the BlueOptions HSA 05192 / 05193 health insurance plan. That plan instead offers an associated Health Savings Account, which functions similarly to a Healthcare FSA. It does not preclude you from enrolling in a Dependent Care FSA.

An FSA plan lets you pay for eligible expenses with contributions from your paycheck pretax. This may help lower your taxable income. There are two types of FSAs – Healthcare FSA and Dependent Care FSA. Enrolling in both or either of these FSA options carries a monthly premium of $3.10.

At the end of each plan year, you must reenroll in the plan to continue participating in it. Even if other benefits are passively preserved in a plan year, FSAs never are, and you will need to enroll again and declare your contribution each year.

Healthcare FSA

A Healthcare FSA is used to pay for eligible medical, dental, vision, and prescription expenses which are not covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

If you have any funds left in your Healthcare FSA at the end of the plan year, and you reenroll in the Healthcare FSA the following year, up to $500 of the previous balance will roll over into the next year's funds.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as before and after school care, day time babysitting fees, elder care services, nursery and preschool costs. Eligible dependents include your qualifying child up to age 13, spouse and/or relative.

You can request reimbursement from your Dependent Care FSA after your dependent receives a qualified expense. Unlike the Healthcare FSA, your full annual contribution is not available at the beginning of the plan year. You can only get reimbursed up to the amount that is available in your account at that time.

Remember when estimating your childcare expenses that IRS regulations will not allow reimbursement for expenses such as days you are not working – including sick leave, vacation days or breaks in service or days when you do not meet the eligibility requirements. Money put into the account but not reimbursed for Child Care expenses can not be reimbursed to the employee. It is important to plan ahead and not over-estimate your expenses.

NOTE: A Dependent Care FSA may or may not produce greater federal tax savings versus the Dependent Care Tax Credit. You may wish to consult a tax advisor to determine which is best for you.

Annual Contribution Limits

The IRS maximum annual contribution to FSA accounts is:

- For Healthcare FSA: $2,750
- For Dependent Care FSA: $5,000

How the Flexible Benefits Plan Affects You

This is an employee benefit that should result in monthly savings to all eligible employees. However, there are some risks that you need to consider. For details, see the "Flexible Spending Account Handbook" available from the District website at **http://www.bay.k12.fl.us/benefits**.

Flexible Spending Accounts

Frequently Asked Questions

How much can I contribute to my accounts?

Beginning January 1, 2020, Health FSA contributions are limited by the IRS to $2,750 each year. The limit may be adjusted annually to account for inflation increases.

For a Dependent Care Account, the IRS limits contributions to $5,000 per year if you are married and filing a joint return, or if you are a single parent. If you are married and filing separately, you may contribute up to $2,500 per year per parent.

How can I find out my account balance and review transactions?

Account Balance and Claims Status information is available 24 hours a day, seven days a week:

- Visit **www.ConnectYourCare.com** to log into your online account. If it is your first time visiting the site, click on the "Register" button to select your user name and password.
- Call the number on the back of your payment card for balance information.

How will I be able to access my funds?

You will receive a payment card to access your FSA funds. You can also pay for eligible expenses with any other form of payment and request a withdrawal from your account.

When can I request reimbursement from my FSA?

You will have access to the funds in your account on the first day of your plan effective date.

You are eligible to receive funds by check or direct deposit. For quicker reimbursements, sign up for direct deposit in your online account.

How do I set up direct deposit?

- Log into your online account and click Settings and Preferences under your name.
- Complete the short, secure form. Be sure to have your bank account and routing numbers on hand.
- Choose Direct Deposit as your preferred method of Claim Reimbursement and click the Confirm button.

Can I order a replacement or additional card for my spouse or dependent?

Yes. Simply log on to your online account or contact Customer Service to request an additional card.

What happens if I use my account for a non-eligible expense?

If you file a manual request for reimbursement, the request will be denied. If you used your payment card and the expense is deemed ineligible, you will be required to reimburse your account for that transaction.

Do I need to submit a receipt?

You can review if your claim requires receipts online by logging into your account. You need to submit receipts if you see a notice. If a receipt is needed, you will also be notified by email or letter within a week of your payment card swipe. You should always save your receipts even if you have not received such a notice. You must provide the receipts within the time requested, or the transaction will be deemed ineligible, and you will be required to refund the amount of the transaction. If you fail to submit required receipts within 45 days, your payment card will be deactivated. If you fail to reimburse the account, the amount of the ineligible expenses may be added to your W-2 or withheld from your pay.

Is the payment card a debit card?

No, your payment card is a prepaid card. It is provided to give you quick access to your account. The card knows if funds are available and whether your coverage is active. If asked at a merchant, select "credit," to use it without a personal identification number (PIN), or "debit" to use a PIN. Your card comes with a preset PIN, which is the last four digits of your card number.

Where can I use my payment card?

Your payment card can be used nationwide at qualified merchants. Examples of qualified merchants may include pharmacies, doctors' offices, vision centers, and hospitals. Visit **www.ConnectYourCare.com/stores** for a list of approved merchants. Your card should only be used to pay for medical expenses eligible under your plan, and you should always save your receipts.

Do I need to keep my receipts when I use my card?

YES! We may request documentation any time you use your payment card. Therefore, always hold on to your receipts in case further documentation is requested. Receipts must contain the date of service, name and address of service provider/merchant, description of the service or expense provided, amount charged, and name of person receiving care or service.

Non-itemized cash register tapes, credit card receipts and canceled checks alone do not provide proper substantiation.

Can I make changes to my FSA plan?

For Healthcare FSAs, changes in the election amount can only be revised during the plan year if experiencing a qualified status change and the revision must be consistent with the event.

For Dependent Care FSAs, changes in your election amount can be revised during the plan year with no qualified status change requirement.

For Additional Plan Information

Please refer to your summary plan description, contact the District Insurance Department, or contact ConnectYourCare Customer Service at 877-292-4040. You may access your account online at **www.ConnectYourCare.com**, or the ConnectYourCare smartphone app.

This guide does not constitute tax advice. For more assistance, please contact your tax advisor. You can also find more information in IRS Publication 969 at **http://www.irs.gov/pub/irs-pdf/p969.pdf**. Please keep in mind that your state might have different tax rules. Always refer to your state's tax guidance regarding FSA taxation.

Telehealth

Teladoc HEALTH

Talk to a  anytime

- This benefit is provided to all full- and part-time employees and their dependents at no cost to employees.

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults. It's an affordable alternative to costly urgent care and ER visits when you need care now.

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 15 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

With your consent, Teladoc is happy to provide information about your Teladoc consult to your primary care physician.

Talk to a doctor anytime for Free

Teladoc.com

Facebook.com/Teladoc

1-800-Teladoc

Teladoc.com/mobile

Wellness Clinic

This is *your* health center.

Bay Educators Wellness Center

Our services include:

Care
For common illnesses, flu, headaches, rashes, prescriptions, and labs

Coaching
For nutrition, tobacco, stress, exercise, and chronic conditions

Assessments
For cholesterol, glucose, blood pressure, height, and weight

Portal
A one-stop location for your personal health record, trackers, and health information.

To schedule an appointment, call your center or book online at **my.marathon-health.com.**

Eligibility and Cost

Full time employees, their spouse and dependents age six and older who are currently enrolled in the Bay District Schools health plan or full time employees with other health insurance coverage are eligible to use the Bay Educators Wellness Center at no cost.

Privacy

The care you receive by Marathon Health is confidential and protected by state and federal law.

Bay Educators Wellness Center
1515 June Ave
Panama City, FL 32405
850-215-2896
Mon/Wed 6am-6pm
Tue/Thu/Fri 12pm-6pm
Sat 7am-1pm

Bay District Schools Florida

Marathon health For life.

Dental Plan

Dental Care Works for You

Professional dental care is important. Unfortunately, fitting this expense into your budget isn't always easy. That's why we offer dental insurance through Delta Dental to make care more affordable.

If you are planning major dental work for you and/or your dependents during the upcoming plan year, enrolling in a dental care plan could dramatically reduce your out-of-pocket expenses.

Plan Provider

The dental plan is underwritten by Delta Dental. For an up-to-date listing of providers in your area, go to **deltadentalins.com**, or call 800-521-2651 and mention Group 17951.

Premiums Per Paycheck

COVERAGE LEVEL	MONTHLY	SEMI-MONTHLY
LOW OPTION		
Employee Only	$14.19	$7.10
Employee/Spouse	$24.59	$12.30
Employee/Child	$24.49	$12.25
Family	$37.91	$18.96
HIGH OPTION		
Employee Only	$32.90	$16.45
Employee/Spouse	$57.00	$28.50
Employee/Child	$56.79	$28.40
Family	$87.81	$43.91

Dental Plan

Plan Benefits

FEATURES	LOW PLAN	HIGH PLAN
Eligibility	Primary enrollee, spouse, and eligible dependent children to the end of the month that the dependent children turn age 26	
Deductibles	$50 per person / $150 per family each calendar year	
Waived for Diagnostic & Preventative (D&P) services?	YES	YES
Waived for Orthodontics?	N/A	YES
Out-of-Pocket Maximums	$1,000 per person each calendar year	$1,500 per person each calendar year
D&P counts toward maximum?	YES	NO
Waiting Periods	Basic Benefits, Major Benefits, Prosthodontics, Orthodontics (High Plan Only): NONE	
Networks	Benefits and Coverage apply to Delta Dental PPO Dentists, Premier Dentists, and Non-Delta Dental Dentists*	
BENEFITS AND COVERED SERVICES**		
Diagnostic & Preventative • Oral Exams, Cleanings, Routine X-rays, Sealants	80%	100%
Basic Benefits • Fillings	60%	80%
• Endodontics (Root Canals)	0%	80%
• Periodontics (Gum Treatment)	0%	80%
• Oral Surgery	60%	80%
Major Benefits • Crowns, Inlays, Onlays, Cast Restorations	0%	50%
Prosthodontics • Bridges, Dentures, Implants	0%	50%
Orthodontic Benefits • Adults & Dependent Children	0%	50%
• Out-of-Pocket Maximums	N/A	$500/Lifetime

* Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

Vision Plan

Vision Health Improves Your Overall Health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.

Our Humana Vision 130 plan offers a network of providers that services your eyecare needs. More details can be found in the Humana Vision brochure posted on the District website under benefits, at **www.bay.k12.fl.us/benefits**.

Access Your Health Information Anytime, Anywhere

Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your healthcare needs virtually anywhere, anytime.

Use the MyHumana Mobile app and website to...
- View dental or vision claims
- View your plans and coverage details

Download the Mobile App

Download the MyHumana Mobile app from your app store. Search "MyHumana" in the Google Play or App Store.

Download on the App Store

GET IT ON Google Play

Premiums Per Paycheck

COVERAGE LEVEL	MONTHLY	SEMI-MONTHLY
Employee Only	$5.62	$2.81
Employee/Spouse	$11.25	$5.63
Employee/Child	$14.06	$7.03
Family	$19.70	$9.85

Plan Provider

The vision plan is underwritten by Humana Vision. For the most up-to-date listing of providers in your area, go to **humana.com**, or call 1-877-398-2980.

Vision Plan

Plan Benefits

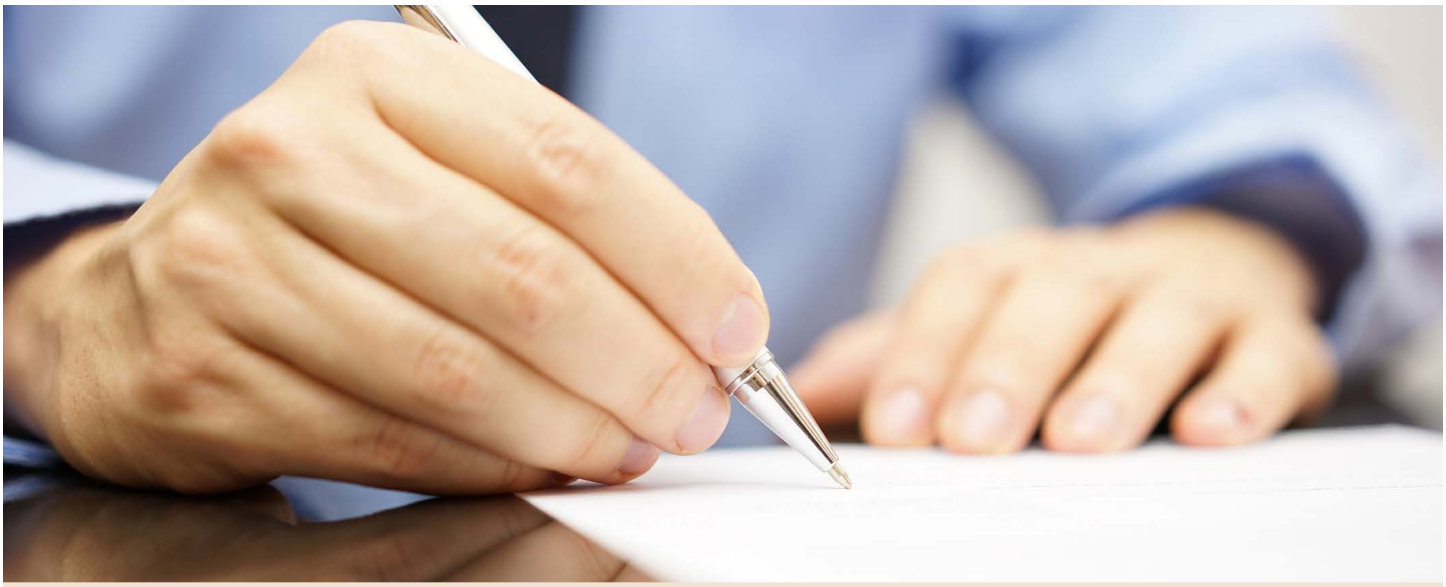
COVERAGE	IN-NETWORK BENEFIT	OUT-OF-NETWORK REIMBURSEMENT
Exams (includes Dilation)	$10	Up to $30
• Retinal Imaging	Up to $39	Not covered
Contact Lens Exam Options		
• Standard contacts lens fit and follow-up	Up to $55	Not covered
• Premium contacts lens fit and follow-up	10% off retail	Not covered
Frames	$130 allowance 20% off balance over $130	$65 Allowance
Standard Plastic Lenses		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered Lens Options		
• UV coating	$15	Not covered
• Tint (solid and gradient)	$15	Not covered
• Standard scratch-resistance	$15	Not covered
• Standard polycarbonate - adults	$40	Not covered
• Standard polycarbonate - children < 19	$40	Not covered
• Standard anti-reflective coating	$45	Not covered
• Premium anti-relfective coating		
• Tier 1	$57	Not covered
• Tier 2	$68	Not covered
• Tier 3	80% of charge	Not covered
• Standard progressive (add-on to bifocal)	$15	Up to $40
• Premium progressive		
• Tier 1	$110	Not covered
• Tier 2	$120	Not covered
• Tier 3	$135	Not covered
• Tier 4	$90 copay, 80% of charge -$120 allowance	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact Lenses* (applies to materials only)		
• Conventional	$130 allowance, 15% of balance over $130	$104 allowance
• Disposable	$130 allowance	$104 allowance
• Medically necessary	$0	$200 allowance
Contact Lenses, Medically Necessary	Covered 100% After $20 Copay	-
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frames	Once every 12 months	Once every 24 months
Diabetic Eye Testing and Care		
• Examination (up to 2 services per year)	$0	Up to $77
• Retinal Imaging (up to 2 services per year)	$0	Up to $50
• Extended Ophthalmoscopy (up to 2 services per year)	$0	Up to $15
• Gonioscopy (up to 2 services per year)	$0	Up to $15
• Scanning Laser (up to 2 services per year)	$0	Up to $33

ADDITIONAL PLAN DISCOUNTS

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

* Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

Life Insurance



Employer Paid Basic Life

The District offers Life and Accidental Death and Dismemberment (AD&D) Insurance coverage to you and your dependents.

All full-time employees are provided $50,000 of Basic Life and AD&D insurance coverage by the District. Completion of enrollment documents must be performed to receive this benefit. Benefit will be reduced by 50% if actively working and age 75.

Employees may purchase additional group life coverage at a cost of $0.34 per thousand. See calculated costs in the Premiums Per Paycheck table.

Optional Supplemental Term Life Insurance Coverage

Upon hire, each benefit eligible employee may elect additional Supplemental Life and AD&D Insurance coverage in $10,000 increments up to a maximum of $150,000 with no Evidence of Insurability (EOI, or a statement of health) required. Completion of enrollment documents must be performed within 30 days of hire to receive this optional coverage. Premiums for supplemental insurance will be paid via payroll deduction.

During the annual Open Enrollment Period, participating employees can increase their election of Supplemental Additional Life and AD&D coverage by one level of $10,000 each year without any statement of health up to the maximum amount available of $150,000.

EOI and insurance company approval will be required should you desire to increase your supplemental insurance by more than one level, or if you elect to participate in the supplemental life program after the initial enrollment period.

Additional Included Benefits

Once enrolled, you have access to MetLife Advantages℠ services to help navigate what life may bring. For details on all of these features, please ask your Human Resources contact for a full MetLife Life Insurance booklet.

www.bay.k12.fl.us/benefits

Premiums Per Paycheck

ADDITIONAL VALUE	MONTHLY	SEMI-MONTHLY
SUPPLEMENTAL TERM LIFE COVERAGE		
$10,000	$3.40	$1.70
$20,000	$6.80	$3.40
$30,000	$10.20	$5.10
$40,000	$13.60	$6.80
$50,000	$17.00	$8.50
$60,000	$20.40	$10.20
$70,000	$23.80	$11.90
$80,000	$27.20	$13.60
$90,000	$30.60	$15.30
$100,000	$34.00	$17.00
$110,000	$37.40	$18.70
$120,000	$40.80	$20.40
$130,000	$44.20	$22.10
$140,000	$47.60	$23.80
$150,000	$51.00	$25.50
SPOUSE SUPPLEMENTAL TERM LIFE COVERAGE		
$20,000	$5.48	$2.74
DEPENDENT CHILD SUPPLEMENTAL COVERAGE		
$10,000	$2.74	$1.37

Plan Provider

The life insurance and AD&D plan is underwritten by MetLife. For more information, see Life Insurance on the District benefits page at **www.bay.k12.fl.us/benefits**, or go to **www.MetLife.com**.

Short-Term Disability Insurance

How Does It Work?

A disability can put a lot of things in your life on hold. Unfortunately, expenses aren't one of those things, and they keep coming. If you become disabled, this insurance plan can help you keep up by providing a stable basic income. One of the most common short-term disability claims is for maternity leave. See your plan details for recognized conditions that qualify you as disabled under the plan. Any time you are injured enough that you cannot work, check your eligibility to claim disability insurance.

Short-term disability insurance comes in 7- or 14-Day Elimination Period (EP) plans. In both cases, an injury or illness event must first occur, then an EP must pass. The EP serves a similar purpose to a deductible as in other insurance plans. It also allows time for you, your healthcare providers, and the carrier to determine whether or not the injury or illness qualifies you for disability. After the EP, benefits begin being paid regularly for as long as you are disabled, to a maximum of the Benefit Duration Period.

7-Day EP Short-Term Disability

FEATURE	AMOUNT
Elimination Period (EP) for Injuries	7 Days
EP for Sickness	7 Days
Benefit Duration Period	26 Weeks while Disabled
Benefit Amount	60% of Earnings ($1500 maximum weekly)

7-Day EP Disability Premiums

Your coverage level is based on your annual earnings and your age. That coverage level then determines your monthly premiums. The payroll department will finally calculate your per paycheck deductions, based on your pay frequency. You can estimate your costs by using these tables.

AGE	MONTHLY	SEMI-MONTHLY
Under 25	$0.64	$0.32
25-29	$0.67	$0.34
30-34	$0.68	$0.34
35-39	$0.62	$0.31
40-44	$0.67	$0.34
45-49	$0.81	$0.41
50-54	$1.00	$0.50
55-59	$1.23	$0.62
60-64	$1.47	$0.74
65+	$1.76	$0.88

Example: 24-Year Old With $30,000 Annual Salary

CALCULATION	AMOUNT
Example Annual Earnings	$30,000
Weekly Earnings (divide by 52)	$576.92
Weekly Benefit (60% of earnings) *This is what the plan would pay if this person qualified for disability insurance*	$346.15
Value Per $10 (divide by 10)	$34.62
Estimated Monthly Contribution (multiply by $0.64 using the Age table above)	$22.16

Estimate Your Costs With Your Information

CALCULATION	AMOUNT
Your Annual Earnings	
Your Weekly Earnings (divide by 52)	
Your Weekly Benefit (60% of earnings) *This is the benefit for your plan*	
Value Per $10 (divide by 10)	
Estimated Monthly Contribution (use Age table)	
If you are paid semi-monthly, divide by 2	

Short-Term Disability Insurance

14-Day EP Short-Term Disability

FEATURE	AMOUNT
Elimination Period (EP) for Injuries	14 Days
EP for Sickness	14 Days
Benefit Duration Period	26 Weeks while Disabled
Benefit Amount	60% of Earnings ($1500 maximum weekly)

14-Day EP Disability Premiums

This plan works identically to the 7-Day EP plan, with a longer EP and a lower premium. Similarly, your coverage level is based on your annual earnings and your age. You can estimate your costs by using these tables.

AGE	MONTHLY	SEMI-MONTHLY
Under 25	$0.41	$0.21
25-29	$0.43	$0.22
30-34	$0.44	$0.22
35-39	$0.41	$0.21
40-44	$0.43	$0.22
45-49	$0.53	$0.27
50-54	$0.66	$0.33
55-59	$0.80	$0.40
60-64	$0.95	$0.48
65+	$1.14	$0.57

Example: 24-Year Old With $30,000 Annual Salary

CALCULATION	AMOUNT
Example Annual Earnings	$30,000
Weekly Earnings (divide by 52)	$576.92
Weekly Benefit (60% of earnings) *This is what the plan would pay if this person qualified for disability insurance*	$346.15
Value Per $10 (divide by 10)	$34.62
Estimated Monthly Contribution (multiply by $0.41 using the Age table above)	$14.19

Estimate Your Costs With Your Information

CALCULATION	AMOUNT
Your Annual Earnings	
Your Weekly Earnings (divide by 52)	
Your Weekly Benefit (60% of earnings) *This is the benefit for your plan*	
Value Per $10 (divide by 10)	
Estimated Monthly Contribution (use Age table)	
If you are paid semi-monthly, divide by 2	

Additional Benefits

MetLife also provides many forms of assistance to return to work. These include access to nurse consultants and case managers, vocational analysis with job modifications or accommodations. There are financial incentives to receive benefits while you attempt to return to work, even only part-time. Your Certificate of Insurance will provide full details.

Plan Provider

The Short-Term Disability insurance plans are underwritten by MetLife. For more information, see Short-Term Disability on the District benefits page at **www.bay.k12.fl.us/benefits**, or go to **www.MetLife.com**.

Long-Term Disability Insurance

Long-Term Disability insurance works similarly to Short-Term Disability insurance. Long-Term Disability insurance will have a longer Waiting or Elimination Period (EP) to allow any Short-Term Disability insurance you may have to be exhausted. Whether you're out for a few months or several years, this benefit can help you protect your income – and those who depend on it.

The District offers two Long-Term Disability plan Options. Option 1 offers a lower premium, while Option 2 comes with a shorter Waiting Period before benefits are paid out.

Long-Term Disability Terms

FEATURE	AMOUNT
Benefit Waiting Period (EP)	180 or 90 Days
Benefit Duration Period	Until Age 65*
Benefit Amount	60% of Earnings ($100 minimum monthly, $5000 maximum monthly)

* Your benefits may apply to a different schedule if your disability occurs near to age 65. See Maximum Benefit Period section.

Long-Term Disability Premiums

Your benefit amount is a percentage of your annual earnings. That coverage level, combined with your chosen Waiting Period (EP), then determines your monthly premiums. The payroll department will finally calculate your per paycheck deductions based on your pay frequency. You can estimate your costs by using these tables.

Example

CALCULATION	AMOUNT
Example Annual Earnings	$30,000
Monthly Earnings (divide by 12) *Cannot exceed maximum of $8333*	$2500
Multiply by your rate percentage *Example uses Option 1: 180-Day EP*	Option 1: 180-Day EP x 0.46 = $1150
Monthly Payment (divide by 100)	$11.50

Estimate Your Costs With Your Information

CALCULATION	AMOUNT	
Your Annual Earnings		
Monthly Earnings (divide by 12) *Cannot exceed maximum of $8333*		
Multiply by your rate percentage *Choose Option 1 or Option 2*	Option 1 180-Day EP x 0.46	Option 2 90-Day EP x 0.60
Your Monthly Payment (divide by 100)		
If you are paid semi-monthly, divide by 2		

Maximum Benefit Period

If you become disabled before age 62, Long-Term Disability benefits may continue during disability until you reach age 65. If you become disabled at age 62 or older, the benefit duration is determined by your age when disability begins, as per the table below.

AGE	MAXIMUM BENEFIT PERIOD
62	3 years, 6 months
63	3 years
64	2 years, 6 months
65	2 years
66	1 year, 9 months
67	1 year, 6 months
68	1 year, 3 months
69+	1 year

Guaranteed Issue At Hire

If you enroll in Long-Term Disability insurance during your initial enrollment period upon hiring, you will not need to produce Evidence of Insurability (EOI). During annual enrollment periods after that, EOI will be required to enroll. EOI is also required if you want to move from 180 days to 90 days.

Additional Benefits

Standard Insurance Company also provides many forms of assistance to return to work. These include an Employee Assistance Program, and payment assistance with rehabilitation plans or workplace accommodations. There are financial incentives to receive 10% of your predisability earnings for participating in an approved rehabilitation program. If you die while receiving benefits, your survivor may be eligible to receive a one-time additional payment. Your Certificate of Insurance will provide full details.

Plan Provider

The Long-Term Disability insurance plans are underwritten by Standard Insurance Company. This information is not intended to be a complete description of the insurance coverage available. The policies have exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, see Voluntary Long-Term Disability (LTD)Coverage on the District website at **www.bay.k12.fl.us/benefits**.

Accident Insurance

What is Accident Insurance?

Accident insurance helps cover out-of-pocket costs related to unexpected injuries like a broken arm or a severe burn. This type of insurance provides benefits for initial care, hospitalization, and follow-up care due to covered accidents. Benefits are paid directly to the employee (unless otherwise assigned), regardless of any other coverage employees have.

MetLife Accident Insurance pays you cash benefits for injuries relating to covered accidents for hospital and intensive care confinement. Your plan may also include coverage for a variety of occurrences, such as dismemberment, dislocation, fracture, ambulance services, physical therapy, and more. You can use the lump-sum cash payment as you wish for anything from deductibles to treatment copays to rent or other expenses you face. By using Accident Insurance you can:

- Continue protecting your savings, retirement plans, and 401(k) from depletion
- Help protect your home by paying for the mortgage, continue rental payments, or perform needed home repairs for your after care
- Keep up with your family's living expenses such as bills, electricity, and gas

High benefit and Low benefit plans are available. Your coverage is guaranteed, regardless of your current health. The plans are portable, so you can keep your coverage should you leave employment with the District, however you will need to continue making premium payments on your own directly to MetLife.

A list of covered incidents appears on the next page.

For more information on the plan, including limitations and exclusions, please see the documents under Accident at the District's benefits page at **www.bay.k12.fl.us/benefits**, or contact MetLife at 1-800-GET-MET8 (1-800-438-6388).

Premiums Per Month

Actual per paycheck deductions will be calculated by the Payroll department based on your frequency of pay.

	LOW PLAN		HIGH PLAN	
COVERAGE LEVEL	MONTHLY	SEMI-MONTHLY	MONTHLY	SEMI-MONTHLY
Employee Only	$6.73	$3.37	$10.26	$5.13
Employee/Spouse	$13.70	$6.85	$21.06	$10.53
Employee/Child	$14.04	$7.02	$21.46	$10.73
Family	$17.46	$8.73	$26.90	$13.45

Accident Insurance

Plan Benefits

BENEFIT TYPE[1]	LOW PLAN COVERAGE	HIGH PLAN COVERAGE
INJURIES		
Fractures[2]	$50 - $6000	$100 - $8000
Dislocations[2]	$100 - $6000	$100 - $8000
Second and Third Degree Burns	$200 - $5000	$300 - $10,000
Concussions	$300	$600
Cuts/Lacerations	$25 - $200	$50 - $400
Eye Injuries	$200	$300
MEDICAL SERVICES & TREATMENT		
Ambulance	$300 - $900	$400 - $1200
Emergency Care	$150 - $300	$200 - $400
Non-Emergency Care	$25	$50
Physician Follow-Up	$100	$150
Therapy Services (including Physical Therapy)	$60	$90
Medical Testing Benefit	$300	$400
Medical Appliances	$50 - $500	$100 - $1000
Inpatient Surgery	$100 - $2000	$200 - $3000
HOSPITAL[3] COVERAGE (ACCIDENT)		
Admission	$500 (non-ICU) - $1000 (ICU) per accident	$1000 (non-ICU) - $2000 (ICU) per accident
Confinement • Non-ICU • ICU	 $1500/day up to 31 days $2100/day up to 31 days	 $2000/day up to 31 days $2800/day up to 31 days
Inpatient Rehab (paid per accident)	$200/day up to 15 days	$300/day up to 15 days
ACCIDENTAL DEATH		
Employee receives 100% of amount shown Spouse receives 50% of amount shown Children receive 20% of amount shown.	$25,000 $75,000 for common carrier[4]	$50,000 $150,000 for common carrier[4]
DISMEMBERMENT, LOSS & PARALYSIS		
Dismemberment, Loss & Paralysis	$250 - $10,000 per injury	$500 - $50,000 per injury
OTHER BENEFITS		
Lodging[5] (pays for lodging for companion up to 30 nights per calendar year)	$100/night up to 31 nights Maximum $3100 total benefit/calendar year	$200/night up to 31 nights Maximum $6200 total benefit/calendar year

1 Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

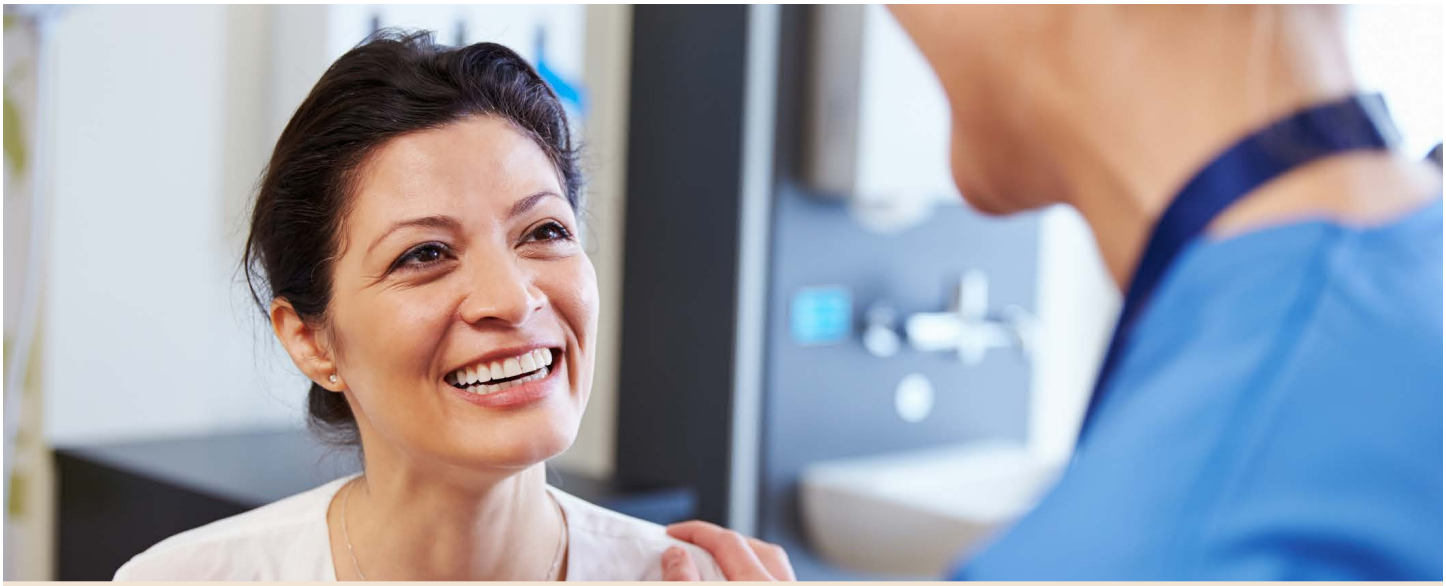
2 Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.

3 Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

4 Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details. Be sure to review other information contained in this booklet for more details about plan benefits, monthly rates and other terms and conditions.

5 The lodging benefit is not available in all states. It provides a benefit for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from insured's primary residence.

Cancer Insurance



Why Is It So Important?

When cancer affects your family, you'll have the support you need when it matters most. Many people underestimate the financial impact of a critical illness like cancer. And while experts recommend that families have three to nine months of living expenses set aside to help in an emergency, most families could use extra support to keep things moving forward.

Even if you have medical and disability insurance, there can be financial gaps in your coverage. Disability plans may only cover a portion of your income. Medical insurance may leave you covering extra expenses like deductibles, copays, out-of-network care, and alternative treatments. You would have to cover deductibles, copays, extra costs for out-of-network care and perhaps alternative treatments. Following a cancer diagnosis, your first priority is getting better, not worrying about lost income, or everyday living expenses. Rely on cancer insurance to help pay for things like:

- Mortgage or rent
- Credit card bills or other debts
- Utilities
- Groceries
- Car payments
- Child care expenses

How It Works

Cancer insurance is coverage that can help safeguard your finances. Upon initial verified diagnosis or recurrence of cancer, you'll receive a lump-sum payment — one convenient payment all at once — when you or your family need it most. The extra cash can help you focus on getting back on track, without worrying about finding the money to help pay for the costs of treatment.

And best of all, the payment is made directly to you, and is in addition to any other insurance you may have. It's yours to spend however you like, including for your or your family's everyday living expenses.

Preventive measures, early detection, and quality care and treatment are all important in the fight against cancer. While you can't always prevent it, cancer insurance is there to make life a little easier.

Your premium is based on your age at the time your coverage becomes effective (Issue Age), and your rates will not increase due to age. See the Premiums on the next page. Under certain circumstances, you can take your coverage with you if you leave employment with the District. You must make a request in writing after you leave the District, and continue to pay premiums to keep the coverage in force.

Plan Benefits

ELIGIBLE PERSON	INITIAL BENEFIT*
Employee	$10,000 or $20,000
Spouse/Domestic Partner	50% of the Employee's Initial Benefit
Dependent Child(ren)	50% of the Employee's Initial Benefit

* Limitations and exclusions may apply. The initial benefit coverage is guaranteed provided you are actively at work. For spouses, domestic partners, or dependent children, their coverage is likewise guaranteed while you are actively at work, and they must not be subject to a medical condition as set forth in the Certificate, See Human Resources or contact MetLife for details.

COVERED CANCERS	INITIAL BENEFIT	RECURRENCE BENEFIT
Full Benefit Cancer	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer	25% of initial Benefit	12.5% of Initial Benefit

Health Screening Benefit

MetLife will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year. A list of eligible screening/prevention measures are listed on the following page.

Cancer Insurance

Premiums - Monthly

ISSUE AGE	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILDREN	FAMILY
PER $1000 OF COVERAGE: NON-SMOKER				
<25	$0.25	$0.45	$0.49	$0.69
25-29	$0.27	$0.48	$0.52	$0.72
30-34	$0.34	$0.58	$0.59	$0.82
35-39	$0.43	$0.72	$0.67	$0.95
40-44	$0.59	$0.97	$0.82	$1.22
45-49	$0.77	$1.28	$1.02	$1.52
50-54	$0.97	$1.63	$1.22	$1.87
55-59	$1.17	$1.98	$1.41	$2.21
60-64	$1.33	$2.24	$1.58	$2.49
65-69	$1.36	$2.30	$1.60	$2.55
70+	$1.35	$2.34	$1.58	$2.57
PER $1000 OF COVERAGE: SMOKER				
<25	$0.36	$0.60	$0.60	$0.83
25-29	$0.39	$0.66	$0.63	$0.89
30-34	$0.53	$0.85	$0.77	$1.09
35-39	$0.69	$1.11	$0.93	$1.36
40-44	$1.01	$1.61	$1.24	$1.85
45-49	$1.37	$2.21	$1.60	$2.44
50-54	$1.75	$2.89	$2.00	$3.12
55-59	$2.14	$3.57	$2.38	$3.81
60-64	$2.47	$4.11	$2.71	$4.35
65-69	$2.54	$4.27	$2.78	$4.51
70+	$2.53	$4.35	$2.77	$4.59

(Semi-Monthly Rates on the following page)

Eligible Screening/Prevention Measures

- annual physical exam
- biopsies for cancer
- blood test to determine total cholesterol
- blood test to determine triglycerides
- bone marrow testing
- breast MRI
- breast sonogram
- breast ultrasound
- cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- cancer antigen 125 blood test for ovarian cancer (CA 125)
- carcinoembryonic antigen blood test for colon cancer (CEA)
- carotid doppler
- chest x-rays
- clinical testicular exam
- colonoscopy
- digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screening for peripheral vascular disease
- echocardiogram
- electrocardiogram (EKG)
- endoscopy
- fasting blood glucose test
- fasting plasma glucose test
- flexible sigmoidoscopy
- hemoccult stool specimen
- hemoglobin A1C
- human papillomavirus (HPV) vaccination
- lipid panel
- mammogram
- oral cancer screening
- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- serum protein electrophoresis
- skin cancer biopsy
- skin cancer screening
- skin exam
- stress test on bicycle or treadmill
- successful completion of smoking cessation program
- tests for sexually transmitted infections (STIs)
- thermography
- two hour post-load plasma glucose test
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- ultrasounds for cancer detection
- virtual colonoscopy

Cancer Insurance

Premiums - Semi-Monthly

ISSUE AGE	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILDREN	FAMILY
PER $1000 OF COVERAGE: NON-SMOKER				
<25	$0.13	$0.23	$0.25	$0.35
25-29	$0.14	$0.24	$0.26	$0.36
30-34	$0.17	$0.29	$0.30	$0.41
35-39	$0.22	$0.36	$0.34	$0.48
40-44	$0.30	$0.49	$0.41	$0.61
45-49	$0.39	$0.64	$0.51	$0.76
50-54	$0.49	$0.82	$0.61	$0.94
55-59	$0.59	$0.99	$0.71	$1.11
60-64	$0.67	$1.12	$0.79	$1.25
65-69	$0.68	$1.15	$0.80	$1.28
70+	$0.68	$1.17	$0.79	$1.29
PER $1000 OF COVERAGE: SMOKER				
<25	$0.18	$0.30	$0.30	$0.42
25-29	$0.20	$0.33	$0.32	$0.45
30-34	$0.27	$0.43	$0.39	$0.55
35-39	$0.35	$0.56	$0.47	$0.68
40-44	$0.51	$0.81	$0.62	$0.93
45-49	$0.69	$1.11	$0.80	$1.22
50-54	$0.88	$1.45	$1.00	$1.56
55-59	$1.07	$1.79	$1.19	$1.91
60-64	$1.24	$2.06	$1.36	$2.18
65-69	$1.27	$2.14	$1.39	$2.26
70+	$1.27	$2.18	$1.39	$2.30

Plan Provider

For more information on the plan, including limitations and exclusions, please see the documents under Cancer at the District's benefits page at **www.bay.k12.fl.us/benefits**, or contact MetLife at 1-800-GET-MET8 (1-800-438-6388).

Critical Illness Insurance

Ready For Anything

Critical Illness Insurance pays you cash benefits to cover critical illness costs as you see fit. MetLife's Critical Illness Insurance plan means that you will have added financial resources to help with medical costs or ongoing living expenses. You can use funds to help pay for procedures, specialized treatment costs, transportation needs, child care, or anything in-between. Some critical illnesses covered by the plan include but are not limited to:

- Heart attack
- Stroke
- Major human organ transplant
- End-stage renal failure
- Coma
- Paralysis
- Cancer (Internal or Invasive)

The covered conditions must be caused by underlying diseases as defined in the plan. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

Benefit Highlights

- Benefits are paid in addition to any other medical insurance coverage you may have
- Benefits are paid in a lump-sum upon initial diagnosis of a covered condition, or its recurrence
- Dependent coverage is 50% of employee amount, and is included in employee cost.
- The maximum , total lifetime benefit you can receive is $30,000
- Rates are based on attained age, as shown in Premiums Per Month on the next page.
- Coverage may be continued after employment with the District ceases (see certificate for details).
- Health Screening Benefit

Plan Benefits

ELIGIBLE PERSON	INITIAL BENEFIT*
Employee	$10,000
Spouse/Domestic Partner	50% of the Employee's Initial Benefit
Dependent Child(ren)	50% of the Employee's Initial Benefit

COVERED CONDITIONS*	INITIAL BENEFIT	RECURRENCE BENEFIT
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not Applicable
Alzheimer's Disease	100% of Initial Benefit	Not Applicable
Major Organ Transplant	100% of Initial Benefit	Not Applicable
22 Listed Other Conditions	25% of Initial Benefit	Not Applicable

* Limitations and exclusions may apply. The initial benefit coverage is guaranteed provided you are actively at work. For spouses, domestic partners, or dependent children, their coverage is likewise guaranteed while you are actively at work, and they must not be subject to a medical condition as set forth in the Certificate, See Human Resources or contact MetLife for details.

22 Listed Other Conditions

- Addison's disease (adrenal hypofunction)
- amyotrophic lateral sclerosis (Lou Gehrig's disease)
- cerebrospinal meningitis (bacterial)
- cerebral palsy
- cystic fibrosis
- diphtheria
- encephalitis
- Huntington's disease
- (Huntington's chorea)

Critical Illness Insurance

Premiums - Monthly

ISSUE AGE	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILDREN	FAMILY
PER $1000 OF COVERAGE: NON-SMOKER				
<25	$0.31	$0.58	$0.65	$0.92
25-29	$0.31	$0.60	$0.65	$0.94
30-34	$0.35	$0.67	$0.69	$1.01
35-39	$0.42	$0.79	$0.75	$1.13
40-44	$0.52	$0.98	$0.86	$1.32
45-49	$0.66	$1.25	$1.00	$1.58
50-54	$0.86	$1.59	$1.20	$1.93
55-59	$1.11	$2.03	$1.45	$2.37
60-64	$1.55	$2.78	$1.89	$3.12
65-69	$2.26	$4.06	$2.59	$4.39
70+	$3.99	$6.74	$4.33	$7.07
PER $1000 OF COVERAGE: SMOKER				
<25	$0.33	$0.61	$0.66	$0.94
25-29	$0.33	$0.63	$0.66	$0.97
30-34	$0.39	$0.75	$0.73	$1.09
35-39	$0.48	$0.93	$0.82	$1.26
40-44	$0.65	$1.22	$0.98	$1.56
45-49	$0.88	$1.65	$1.22	$1.98
50-54	$1.20	$2.21	$1.54	$2.54
55-59	$1.59	$2.91	$1.93	$3.25
60-64	$2.30	$4.12	$2.63	$4.46
65-69	$3.47	$6.23	$3.80	$6.57
70+	$6.50	$10.91	$6.84	$11.25

- Legionnaire's disease
- malaria
- multiple sclerosis (definitive diagnosis)
- muscular dystrophy
- myasthenia gravis
- necrotizing fasciitis
- osteomyelitis
- poliomyelitis
- rabies
- sickle cell anemia (excluding sickle cell trait)
- systemic lupus erythematosus (SLE)
- systemic sclerosis (scleroderma)
- tetanus
- tuberculosis

Health Screening Benefit

MetLife will provide an annual benefit of $50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year. See the list of eligible screening/prevention measures.

Eligible Screening/Prevention Measures Include

- annual physical exam
- biopsies for cancer
- blood test to determine total cholesterol
- blood test to determine triglycerides
- bone marrow testing
- breast MRI
- breast sonogram
- breast ultrasound
- cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- cancer antigen 125 blood test for ovarian cancer (CA 125)
- carcinoembryonic antigen blood test for colon cancer (CEA)
- carotid doppler
- chest x-rays
- clinical testicular exam
- mammogram
- oral cancer screening
- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- successful completion of smoking cessation program
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- virtual colonoscopy

Critical Illness Insurance

Premiums - Semi-Monthly

ISSUE AGE	EMPLOYEE ONLY	EMPLOYEE/SPOUSE	EMPLOYEE/CHILDREN	FAMILY
PER $1000 OF COVERAGE: NON-SMOKER				
<25	$0.16	$0.29	$0.33	$0.46
25-29	$0.16	$0.30	$0.33	$0.47
30-34	$0.18	$0.34	$0.35	$0.51
35-39	$0.21	$0.40	$0.38	$0.57
40-44	$0.26	$0.49	$0.43	$0.66
45-49	$0.33	$0.63	$0.50	$0.79
50-54	$0.43	$0.80	$0.60	$0.97
55-59	$0.56	$1.02	$0.73	$1.19
60-64	$0.78	$1.39	$0.95	$1.56
65-69	$1.13	$2.03	$1.30	$2.20
70+	$2.00	$3.37	$2.17	$3.54
PER $1000 OF COVERAGE: SMOKER				
<25	$0.17	$0.31	$0.33	$0.47
25-29	$0.17	$0.32	$0.33	$0.49
30-34	$0.20	$0.38	$0.37	$0.55
35-39	$0.24	$0.47	$0.41	$0.63
40-44	$0.33	$0.61	$0.49	$0.78
45-49	$0.44	$0.83	$0.61	$0.99
50-54	$0.60	$1.11	$0.77	$1.27
55-59	$0.80	$1.46	$0.97	$1.63
60-64	$1.15	$2.06	$1.32	$2.23
65-69	$1.74	$3.12	$1.90	$3.29
70+	$3.25	$5.46	$3.42	$5.63

Plan Provider

For more information on the plan, including limitations and exclusions, please see the documents under Critical Illness at the District benefits page at **www.bay.k12.fl.us/benefits**, or contact MetLife at 1-800-GET-MET8 (1-800-438-6388).

Voluntary Retirement Options

TSA CONSULTING GROUP

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION 2020

Bay District Schools, FL

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN

The 403(b) and 457(b) Plans are valuable retirement savings options. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) and 457(b) Plans offered.

Plan administration services for the 403(b) and 457(b) plans are provided by TSA Consulting Group, Inc. (TSACG). Visit the TSACG website *(https://www.tsacg.com*) for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfers, 403(b) and/or 457(b) loans, and rollovers.

ELIGIBILITY

Most employees are eligible to participate in the 403(b) and 457(b) plans immediately upon employment, however, private contractors, appointed/elected trustees and/or school board members and student workers are not eligible to participate in the 403(b) Plan. Employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Traditional 403(b) and 457(b)

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) or 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b)

Contributions made to a Roth 403(b) account are after-tax deductions from your paycheck. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth 403(b) accounts are tax-free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Distributions may be taken if you are 59½ (subject to plan document provisions) or at separation from service.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. TSACG monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2020 IS $19,500.
Additional provisions allowed:

AGE-BASED AMOUNT

Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $6,500 to the 403(b) and/or 457(b) accounts.

THE SERVICE-BASED CATCH UP AMOUNT

The 403(b) special catch-up provision allows participants to make additional contributions of up to $3,000 to the 403(b) account if, as of the preceding calendar year, the participant has completed 15 or more full years of employment with the current employer, not averaged over $5,000 per year in annual contributions, and has not utilized catch-up contributions in excess of the aggregate of $15,000. For a detailed explanation of this provision, please visit *https://www.tsacg.com.*

ENROLLMENT

Employees who wish to enroll in the 403(b) and/or 457(b) plan must first select the provider and investment product best suited for their account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and/or a deferred compensation enrollment form and any disclosure forms must be completed and submitted to the employer. These forms authorize the employer to withhold 403(b) and/or 457(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. A SRA form and/or a deferred compensation enrollment form must be completed to start, stop or modify contributions to 403(b) and/or 457(b) accounts. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.

Voluntary Retirement Options

INVESTMENT PROVIDER INFORMATION

A current list of authorized 403(b) and 457(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com.*

PLAN DISTRIBUTION TRANSACTIONS

Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, unforeseen financial emergency withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing.

PLAN-TO-PLAN TRANSFERS

A plan-to-plan transfer is defined as the movement of a 403(b) and/or 457(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

ROLLOVERS

Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS

Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations without penalty unless they have attained age 59½ or separated from service in the year in which they turn 55 or older. Generally, a distribution cannot be made from a 457(b) account until you have a severance from employment or reach age 70½. In most cases, any withdrawals made from a 403(b) or 457(b) account are taxable in full as ordinary income.

EXCHANGES

Within each plan, participants may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange. Exchanges can only be made from one 457(b) plan to another 457(b) plan, or from one 403(b) plan to another 403(b) plan.

403(b) and 457(b) PLAN LOANS

Participants may be eligible to borrow their 403(b) and/or 457(b) plan accumulations depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider. Prior to taking a loan, participants should consult a tax advisor.

HARDSHIP WITHDRAWALS

Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must verify and provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com.*

UNFORESEEN FINANCIAL EMERGENCY WITHDRAWAL

You may be able to take a withdrawal from your 457(b) account in the event of an unforeseen financial emergency. An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary. The eligibility requirements to receive a Unforeseen Financial Emergency Withdrawal are provided on the Unforeseen Financial Emergency Withdrawal Disclosure form at *https://www.tsacg.com.*

EMPLOYEE INFORMATION STATEMENT

Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) and 457(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

A current list of Authorized 403(b) and 457 Providers can be found on the District website's benefits section at **www.bay.k12.fl.us/benefits** under Employee Insurance, 403(b) and 457 Providers.

Legal Notices

FBMC Privacy Statement

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal, and sometimes sensitive, information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect.

Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. **Note: this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.**

FBMC's privacy statement is as follows:

I. **We collect only the customer information necessary to consistently deliver responsive services.**
FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

1. Information provided on enrollment and related forms, for example, name, age, address, Social Security number, email address, annual income, health history, marital status, and spousal and beneficiary information.
2. Responses from you and others, such as information relating to your employment and insurance coverage.
3. Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
4. Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. **Under federal law, you have certain rights with respect to your protected health information.**
You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

III. **We maintain safeguards to ensure information security.**
We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.

IV. **We limit how, and with whom, we share customer information.**
We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information as we otherwise would. The words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice Of Social Security Number Disclosure

Section 119.071(5)(a) - Florida Statutes requires agencies to notify individuals of the purpose(s) that require the collection of Social Security numbers.

Bay District Schools collects Social Security numbers (SSNs) for the following payroll/ benefit enrollment purposes:

1. The Internal Revenue Service and Social Security Administration require a Social Security number on a Form W-4, that is used to determine how much federal withholding tax is to be collected and Federal Insurance Contribution Act (FICA) tax on wages paid and later reported in a W-2 Wage and Tax Statement.

2, The TERMS Human Resources software program requires use of Social Security numbers as the primary personal identifier of employees for wages, leaves, payroll deductions and to generate the annual W-2 Wage and Tax Statement. This is a secondary identifier, as all employees have been issued an Employee Number to be utilized for day-to-day situations.

3. Social Security numbers for employees and dependents are required for enrollment in the group health insurance, life insurance, dental insurance and vision insurance. Other various miscellaneous voluntary payroll deductions may require the use of Social Security numbers.

4. Social Security numbers are utilized to report to the various voluntary payroll deduction providers the individuals and deduction amount for each payroll.

5. A Social Security number is required on the Direct Deposit Authorization Form to ensure that the banking information provided matches that of the individual.

6. Social Security numbers are required by the Florida Division of Retirement to report earnings used to document creditable years of service in the Florida Retirement System.

The Employee Identification Number assigned to each employee has been established to eliminate the use of your Social Security Number. Bay District Schools recommends that this be utilized whenever possible to protect your information.

The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. 1 of the State Constitution.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA Special Enrollment Notice

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 or any longer period that applies under the plan 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 or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Priya Hiraga
Human_Resources-Administration-Priya_Hiraga@tallahasseeprimarycare.com
850-702-5857
2260 Wednesday Street, Ste. 600, Tallahassee, FL 32308

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

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

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 lymphedemas? Call your Plan Administrator for more information.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.

Determination of when the hospital stay begins is based on the following:
- For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.
- Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:
- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

Legal Notices

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Capital Health Plan at 850-383-3311.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your carrier 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 your 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 Capital Health Plan at 850-383-3311

COBRA Q&A

What Benefits Am I Eligible For If I Terminate Employment?

During the plan year, except as otherwise provided by law and in accordance with your employer's plan(s), terminating employees are covered until the last day of the month following 31 days after termination, provided you make necessary contributions. If termination occurs in the month of December, then coverage will cease no later than Dec. 31, 2019. You can continue certain benefits by contacting the following within 30 days of your termination of employment:

- Human Resources Administration for benefits continuation and to obtain information on the Family Medical Leave Act (FMLA). Call 850-702-5857 to apply for continuation, on a post-tax basis, of your Medical, Dental, Vision and Dependent FSA coverage.

Overview

COBRA is a continuation of Plan coverage when it would otherwise end because of a life event, also called a "qualifying event." 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 for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA 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; 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 the Human Resources Administrator.

Options Besides COBRA

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

More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

Keep Address Updated

To protect your family's rights, let your 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.

Important Notice from Bay District Schools About Your Prescription Drug Coverage and Medicare

This notice applies ONLY to individuals who are **over age 65 and on Medicare** or **approaching age 65 and eligible for Medicare** or **receiving Medicare Disability benefits**. Please disregard this notice if you are not in one of these categories of individuals.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bay County School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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 four 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. Bay County School District has determined that the prescription drug coverage offered by the Florida Blue under the **BlueChoice 317 Plan** and the **HSA 5192/5193 Plan**, on average for all plan participants, are expected to pay out as much as standard Medicare prescription drug coverage pays and **is considered Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
3. Bay County School District has determined that the prescription drug coverage offered by the Florida Blue under the **BlueOptions 3900 PPO**, is on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Florida Blue BlueOptions 3900 PPO Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

   You can keep your current coverage from Bay County School District. However because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if an when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When Can You Join A Medicare Drug Plan?

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

Legal Notices

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

- **Florida Blue BlueChoice 317** and the **HSA 5192/5193 Plans**
  You should know that if you drop or lose your coverage with Bay County School District 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 enroll.
- **Florida Blue BlueOptions 3900**
  Since the coverage under the Florida Blue BlueOptions 3900 plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current Florida Blue coverage will be affected. You can keep this coverage if you elect to join a Medicare drug plan and your Florida Blue health plan will coordinate your benefits with Medicare for drug coverage. See pages 7-11 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance located at **http://www.cms.hhs.gov/CreditableCoverage/**, which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Bay County School District (Florida Blue) coverage, be aware that you and your dependents may not be able to get this coverage back. Also note, that it is not possible to drop your Bay County School District drug coverage without also dropping your health coverage.

For more information about this notice or your current prescription drug coverage...

Contact our office for further information or contact Florida Blue at 1-800-352-2583. **NOTE**: You will receive this notice each year. You will also get it before the next period you can enroll in a Medicare drug plan, or if this coverage through Bay County School District changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

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

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see 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 (SSA) 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 whether or not you are not required to pay a higher premium (a penalty).

Date: September 18, 2019
Name of Entity/Sender: Bay County School District
Contact--Position/Office: Insurance Department
Address: 1311 Balboa Avenue, Panama City, FL 32401
Phone Number: 850-767-4213

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.

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 the Monroe County School District offers coverage that doesn't meet certain standards. Your household income will determine the amount of available savings on your premium.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from the district that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in the employer health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if the district does not offer coverage that meets certain standards. If the cost of a plan from the District that would cover you (and not any other members of your family) is more than 9.5 percent 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.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by the District, then you may lose the employer contribution (if any) to the District-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, please check your summary plan description or contact the Human Resources Department at 850-767-4213, or see Elena Laidler.

The Health Insurance Marketplace can help you evaluate coverage options, 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.

Legal Notices

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 Florida, you may be eligible for assistance paying your employer health plan premiums.

If you reside outside of Florida, view the entire CHIP Model Notice online at **www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc**

Contact your state for more information on eligibility.

FLORIDA – MEDICAID

Website: **http://flmedicaidtplrecovery.com/hipp/**

Phone: 1-877-357-3268

To locate the list of states, current as of July 31, 2018, or to view states that have recently added a premium assistance program since July 31, 2018, 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

Benefits Provider Directory

Bay District Schools

Insurance

Elena Laidler: 850-767-4213
Rhonda Taylor: 850-767-5284
Fax: 850-767-4225

Payroll

Danielle Schultz: 850-767-4237
Rebecca Warren: 850-767-4277
Nora Klunk: 850-767-4232
Deborah Loosbrock: 850-767-4212

www.bay.k12.fl.us/benefits

Florida Blue

Medical Plan

BlueChoice 317
BlueOptions 3900
BlueOptions 05192/05193 HSA Compatible Plan

Customer Service: 1-800-352-2583

www.floridablue.com

Teladoc

Telehealth

Customer Service: 1-800-TELADOC

www.Teladoc.com

Delta Dental

Dental Plan

Customer Service: 1-800-521-2651

Group 17951

www.DeltaDentalIns.com

Humana Vision (Humana Insight)

Vision Plan

Member Services: 1-877-398-2980

Humana.com

ConnectYourCare

Flexible Spending Accounts

See Customer Service number on the back of your card

www.ConnectYourCare.com

HSA Bank

Healthcare Savings Accounts

BlueOptions HSA 05192/05193 Only

See Customer Service number on the back of your card

www.HSABank.com

Marathon Health

Wellness Clinic

850-215-2896

www.marathon-health.com

MetLife

Life and AD&D Insurance

Short-Term Disability Insurance

Accident Insurance

Cancer Insurance

Critical Illness Insurance

1-800-GET-MET8 (1-800-438-6388)

www.MetLife.com

The Standard

Long-Term Disability Insurance

www.standard.com

FBMC Benefits Management

Contract Administrator

P.O. Box 1878
Tallahassee, FL 32302-1878

Service Center: 1-855-5MYFBMC (569-3262)

www.fbmc.com

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