2025 Employee Benefits Guide

Benefits to Support Your Life Journey

We offer a comprehensive health care program to meet the needs of you and your family. This guide provides information to help you make your enrollment decisions. During benefits enrollment, you have the opportunity to review your coverage needs, consider the benefits plans available to you and select those that will provide the most value to you and your family.

This guide also provides assistance in identifying ways you can save money. Be sure to review the plans in this guide to ensure you select the plans that will best meet your needs and financial goals.

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2025 Highlights

MEDICAL

- This year there are plan design changes to the 0317 and 03900 medical plans.
- Additionally, due to federal compliance concerns, those individuals on the 05912/3 plans will no longer have access to the BDS Wellness Center or Teladoc.

PRESCRIPTION DRUG COVERAGE

- We are moving our prescription drug coverage to Express Scripts (ESI). This means that you will receive an additional ID card in conjunction with your medical ID card. You will show this card instead of your medical insurance ID card at participating pharmacies.

DENTAL

- This year the allowance for orthodontia on the high plan increased from $500 to $1,500 at no additional cost to you.

VISION

- This year we moved our vision coverage to VSP. Additionally, we increased frame allowance in-network from $130 to $150 at no additional cost to you.

Enrollment Basics

WHO YOU CAN COVER

In order to be eligible to enroll in the benefits we provide, you or your dependents must meet the following eligibility criteria:

- **Employees** – Must be a regular, full-time employee currently working an average 30 hours or more per week.
- **Spouse** – Your legal spouse.
- **Dependents under age 26** – Your natural, step, adopted, or foster child, as well as a child you have legal guardianship for, who is dependent upon you for support.
    - Medical and Dental coverage only allows coverage until the end of the calendar year in which dependents turn 26.
    - Vision coverage only allows coverage until the end of the calendar year in which dependents turn 25.
- **Dependents over age 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.
- **Grandchildren** – Eligible for coverage up to 18 months of age. Dependent parent must have been covered at the time of birth for the covered employee's grandchild to be covered from the time of birth.

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 documents from the following list:

- **Spouse** – Marriage Certificate
- **Dependents under age 26** – Birth Certificate, court documentation awarding custody or requiring coverage
- **Dependents over age 26** – Same verifications as child, plus a physician's letter verifying the child's dependency status due to being incapable of self-sustaining employment
- **Grandchildren** – Birth Certificate reflecting a current dependent as the parent of the grandchild.

WHEN YOU CAN ENROLL

After you are hired

New full-time employees' benefits for all lines of coverage are retroactively effective as of their date of hire. You must submit your benefits elections and upload all required documentation prior to your coverage effective date.

During Open Enrollment

Open Enrollment is your opportunity to evaluate your benefit options and make changes for the following year. This year's Open Enrollment runs from November 1, 2024 – November 18, 2024. Benefits selected during Open Enrollment are effective January 1, 2025 – December 31, 2025.

Mid-year changes

You may make changes to your benefits elections if you experience a qualified life event. The changes you make must be the result of and consistent with the qualified life event that occurred.

EXAMPLES OF QUALIFIED LIFE EVENTS:

- Birth, adoption, legal guardianship or placement for adoption
- Marriage, divorce or annulment
- Death of a dependent
- Gain or loss of other creditable coverage

IMPORTANT TO KNOW

How to make mid-year changes to your benefits if you've experienced a qualified life event

- To determine if any of these apply to you, please complete the Qualifying Event Change Request form at www.bay.k12.fl.us/bds-benefits.
- If you do not request the change and provide the necessary documentation within 30 days, you will have to wait until the next Open Enrollment to make the change

Instructions For Using On-Line with Benefit Connector™

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.

Start Enrollment

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.

My Info

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.

My Family

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.

My Current Benefits

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.

Registering on the Benefit Connector Enrollment Site

Step 1

Log on to: **https://baycountyschools.benefitconnector.com**

Step 2

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

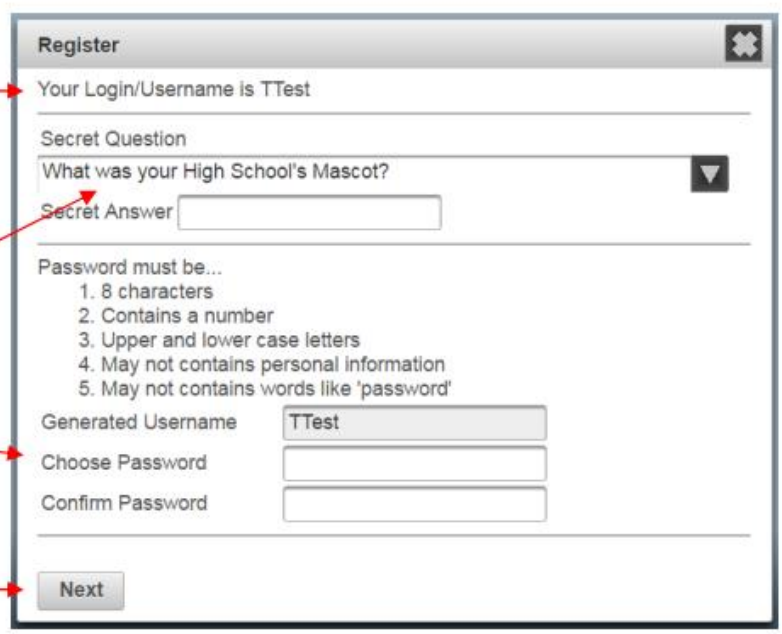
- From the log in screen, click '**register**' to begin registration process.

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 and Prescription Drugs

Your medical coverage is administered through FloridaBlue. You'll have access to a broad network of doctors and hospitals, providing you with quality care and significant savings in comparison to receiving services out-of-network.

Your pharmacy benefits are provided through Express Scripts. You may purchase up to a 30-day supply of covered drugs when you fill your prescription at a participating retail pharmacy. You can use the mail order pharmacy program if you use a maintenance medication, such as those for blood pressure or cholesterol. The mail order pharmacy program offers up to a 90-day supply.

You will receive 2 separate ID cards; one for your medical and one for your pharmacy coverages.

PLAN HIGHLIGHTS

- Three medical plans are offered: BlueChoice 0317, BlueOptions 03900, and BlueOptions 05192 / 05193 (HSA compatible).
- These plans all cover some items and services even if you haven't yet met the deductible amount. But a co-payment or coinsurance may apply. For example, some plans may 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/. Key point 3
- If you enroll in the BlueChoice 0317 or the BlueOptions 03900 plans – you may enroll in a Healthcare Flexible Spending Account.
- If you enroll in the BlueOptions 05192 / 05193 plan – you will have access to a Health Savings Account (HSA).

MEDICAL AND PRESCRIPTION DRUG PLANS

See the summary of your medical and prescription benefits below. For complete details, exclusions and limitations, and out-of-network benefits, see the Certificates of Coverage which are available from Human Resources or your benefits website.

	BLUECHOICE 0317	BLUEOPTIONS 03900	BLUEOPTIONS 05912 – HSA EE ONLY	BLUEOPTIONS 05913 – HSA EE + DEP
MEDICAL BENEFITS	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Calendar Year Deductible Per Individual Family	 $1,000 $3,000	 $2,000 $6,000	 $2,500 N/A	 $5,000 $5,000
Out-of-Pocket Maximum Per Individual Family Aggregate	 $3,000 $9,000	 $6,350 $12,700	 $5,800 N/A	 $6,850 $11,600
Coinsurance (% the member pays)	20%	30%	20%	20%
Preventive Services	$0	$0	$0	$0
Office Visits Primary Care Physician Specialist	 $20 copay $50 copay	 $20 copay $50 copay	 Ded + Coinsurance Ded + Coinsurance	 Ded + Coinsurance Ded + Coinsurance
Urgent Care	$20 copay	$60 copay	Ded + Coinsurance	Ded + Coinsurance
Emergency Room	$250 + Ded + Coinsurance	$250 + Ded + Coinsurance	Ded + Coinsurance	Ded + Coinsurance
Inpatient Hospital	Ded + Coinsurance	Ded + Coinsurance	Ded + Coinsurance	Ded + Coinsurance
Outpatient Procedures Hospital Ambulatory Surgery Center	 Ded + Coinsurance Ded + Coinsurance	 $300 copay Ded + Coinsurance	 Ded + Coinsurance Ded + Coinsurance	 Ded + Coinsurance Ded + Coinsurance
Outpatient Diagnostic Tests Independent Clinical Lab Out-Patient Diagnostic Testing (Freestanding)	 Coinsurance Ded + Coinsurance	 $0 Ded + Coinsurance	 Deductible Ded + Coinsurance	 Deductible Ded + Coinsurance
Advanced Imaging MRI, CT, PET, etc.	Ded + Coinsurance	$200 copay	Ded + Coinsurance	Ded + Coinsurance
Access to PanCare Wellness Clinic? (see details on page 13)	Yes	Yes	No	No
PRESCRIPTION BENEFITS				
Retail Pharmacy Generic / Preferred Brand / Non-Preferred Brand / Specialty	$10 / $30 / $50 / $100	$10 / $50 / $100 / 20% of cost of Rx up to max of $2,000	Ded, then $10 / $30 / $50 / N/A	Ded, then $10 / $30 / $50 / N/A
Mail Order (90-day supply) Generic / Preferred Brand / Non-Preferred Brand / Specialty	$14 / $28 / $28	$25 / 20% or $150 whichever is greater	$25 / $75 / $125	$25 / $75 / $125

MEDICAL PLAN PREMIUMS

Your employee contributions for this plan year are based on your choice of plan and coverage tier. Listed below are per-pay-period costs for you and your dependents effective January 1, 2025 – December 31, 2025:

	BLUECHOICE 0317	BLUEOPTIONS 03900	BLUEOPTIONS 05192 / 05193 - HSA
EMPLOYEE PREMIUMS PER PAYCHECK			
Administrative (12x per year)			
Employee	$187.14	$0	$0
Employee + Spouse	$1,072.90	$590.24	$650.88
Employee + Child(ren)	$576.90	$233.15	$355.62
Employee + Family	$1,727.34	$1,061.34	$1,055.46
Instructional & Licensed (24x per year)			
Employee	$93.57	$0	$0
Employee + Spouse	$536.45	$295.12	$325.44
Employee + Child(ren)	$288.45	$116.58	$177.81
Employee + Family	$863.67	$530.67	$527.73
Support & Confidential (24x per year)			
Employee	$78.99	$0	$0
Employee + Spouse	$521.87	$280.54	$310.86
Employee + Child(ren)	$273.87	$102.00	$163.23
Employee + Family	$849.09	$516.09	$513.15

	BLUECHOICE 0317	BLUEOPTIONS 03900	BLUEOPTIONS 05913 -HSA
EMPLOYER CONTRIBUTIONS PER MONTH			
Administrative (12x per year)			
Employee	$650.35	$602.90	$584.98 (to HSA $65.37)
Employee + Spouse	$650.35	$650.35	$650.35
Employee + Child(ren)	$650.35	$650.35	$650.35
Employee + Family	$650.35	$650.35	$650.35
Instructional & Licensed (24x per year)			
Employee	$650.35	$602.90	$584.98 (to HSA $65.37)
Employee + Spouse	$650.35	$650.35	$650.35
Employee + Child(ren)	$650.35	$650.35	$650.35
Employee + Family	$650.35	$650.35	$650.35
Support & Confidential (24 per year)			
Employee	$679.51	$602.90	$584.98 (to HSA $94.53)
Employee + Spouse	$679.51	$679.51	$679.51
Employee + Child(ren)	$679.51	$679.51	$679.51
Employee + Family	$679.51	$679.51	$679.51

Health Savings Account (HSA)

If you enroll in the BlueOptions 05192 / 05193 plan, you should consider contributing to the Health Savings Account administered by HSA Bank. With an HSA, you can gain more control over your health care expenses because contributions, interest and withdrawals for qualified health care expenses are all tax-advantaged.

The 2025 plan year contribution limit is $4,300 for single and $8,550 for family.

HSA owners age 55 and older can make additional contributions to their HSA called "catch-up contributions." For 2025, the allowed catch-up contribution is $1,000.

If you choose Employee Only coverage, then the district contributes money into your HSA account. The contribution amount is $65.37 for Administrative, Instructional and Licensed and $94.53 for Support and Confidential.

WHY HAVE AN HSA?

- Contributions are tax deductible
- Withdrawals to pay for eligible expenses are never taxed
- Accumulated interest earnings are tax deferred, and if used to pay eligible expenses, are tax free
- Money not used at year end 'rolls over' for use the next year
- Once you have a minimum balance of $1,000, the funds can be invested with TD Ameritrade Self-Directed Brokerage Option or Devenir Self-Directed Mutual Fund Program.

ELIGIBILITY REQUIREMENTS

- Must be enrolled in the BlueOptions 05192 / 05193 plan
- Must not be enrolled in Medicare (Parts A or B)
- Must not be covered by other medical insurance(s) such as a Health Care FSA, HRA and other 'first dollar' coverage
- Must not have received VA medical benefits at any time in the past three months
- May not be claimed as a dependent on another individual's tax return
- Spouse not contributing to/participating in a Health Care FSA through his/her employer

DEBIT CARD

All HSA participants will receive an HSA debit card from HSA Bank. Your HSA card can be used to pay for qualified medical expenses billed from an insurance company, a physician's office and pharmacies. Transactions with your HSA debit card are secure and will only work to purchase eligible and authorized items.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf .

Flexible Spending Accounts (FSAs)

We offer the choice of two Flexible Spending Accounts (FSAs) administered by Optum Financial, which allow you to pay for eligible expenses with pre-tax dollars.

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 the end of May next year.

If you are enrolled in the BlueOptions 05192 / 05193 plan, you are not eligible to participate in the Health Care FSA but can enroll in the Dependent Care FSA.

HEALTH CARE FSA

Health Care FSAs may be used to pay for eligible medical, prescription, dental and vision expenses not fully covered by your insurance plans for you and your tax eligible dependents. This account is only available to those enrolled in the BlueChoice 0317 or the BlueOptions 03900 plans.

Participants are currently allowed to carry over up to $640 in unused money at the end of the plan year to be used to reimburse expenses incurred in the next year. Any amount in excess of $640 will be forfeited, so plan accordingly.

DEPENDENT CARE FSA

Dependent Care FSAs may be used to pay for eligible expenses related to the care and supervision of your child (to age 13) or adult dependent on your tax return. You must accumulate the funds in your Dependent Care FSA before you can be reimbursed.

Eligible expenses include child or adult daycare, after school care, nursery school, nanny or babysitter. A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

	2024 ANNUAL IRS CONTRIBUTION LIMITS	
	MINIMUM	MAXIMUM
Health Care FSA	$100	$3,050
Dependent Care FSA	$100	$5,000 (or $2,500 if married and filing separately)

TELADOC

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 or 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 nonemergency issue
- On vacation, on a business trip, or away from home

Meet the Doctors

All Teladoc doctors:.

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

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!

Visit www.Teladoc.com or call 1-800-TELADOC.

However, if you are enrolled in the BlueOptions 05912/3 medical plans you will not have access to Teladoc.

WELLNESS CLINIC - PANCARE

PanCare of Florida has partnered with Bay District Schools to provide quality healthcare services to the Bay Education Wellness Center.

However, if you are enrolled in the BlueOptions 05912/3 medical plans you will not have access to the Wellness Clinic.

Services

- Primary Care
- Urgent Care
- On-Site Medications
- Off-Site Full Service Pharmacy
- Labs
- Additional Services

Location Information

Bay Educators Wellness Center
1515 June Avenue
Panama City, FL 32405
1-850-818-0025

Full Service Pharmacy (8am – 9pm)
2309 15th Street
Panama City, FL 32405
1-850-818-0455

Clinic Hours

Monday 6 am – 6 pm

Tuesday 8 am – 6 pm

Wednesday 6 am – 6 pm

Thursday 12 pm – 6 pm

Friday 10 am – 6 pm

Get started with Teladoc Health

It's quick and easy to set up your account online. Simply visit the Teladoc Health website, click "Get started" or "Sign up," and then follow the instructions below.

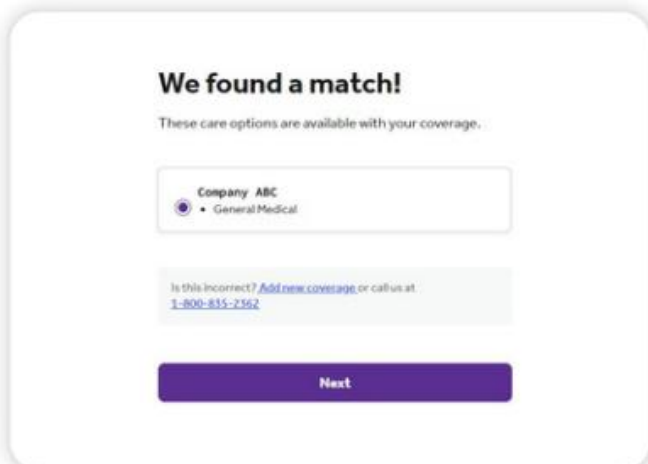
1 Confirm benefits

Provide some information about yourself to confirm your eligibility.

Do not check the "I received a Teladoc code from my employer or insurance company".

2 Find your coverage

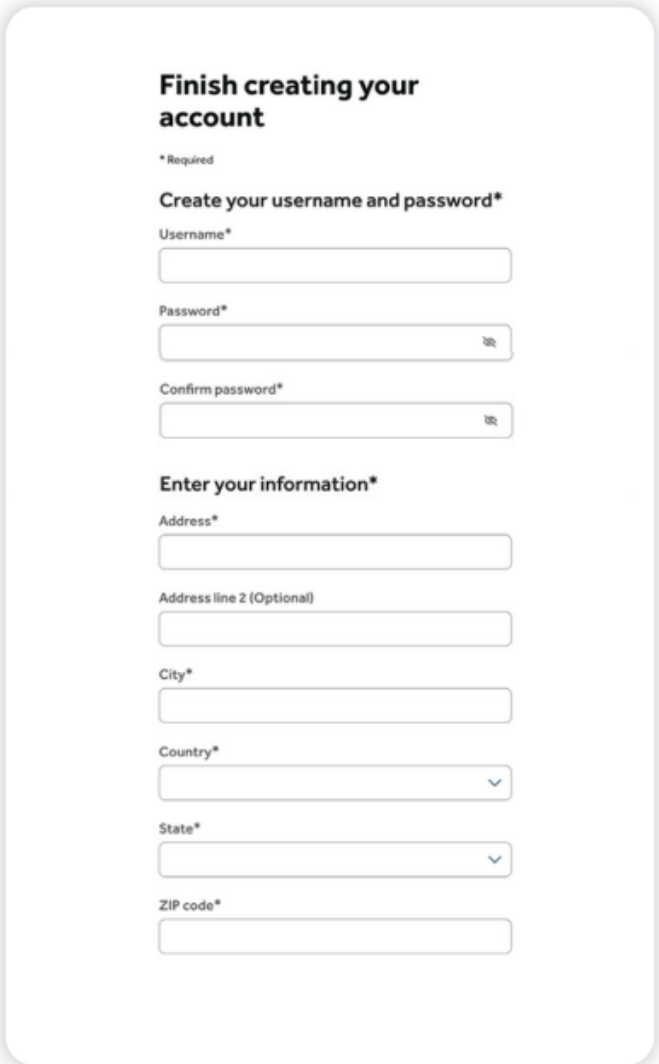
Confirm the coverage that has been matched to you. Please note your care option through your employer group will pop up here if a match is found, like the example below. Click "Next" to proceed with account set up.

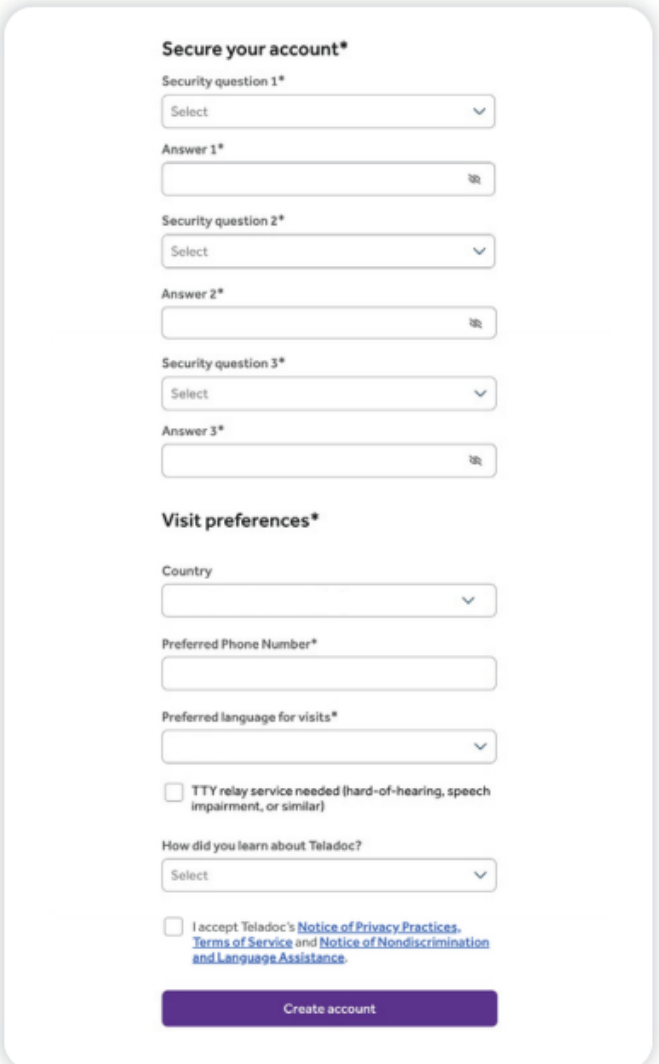


Teladoc HEALTH

3 Create account

Enter your contact information, username, password and security questions.



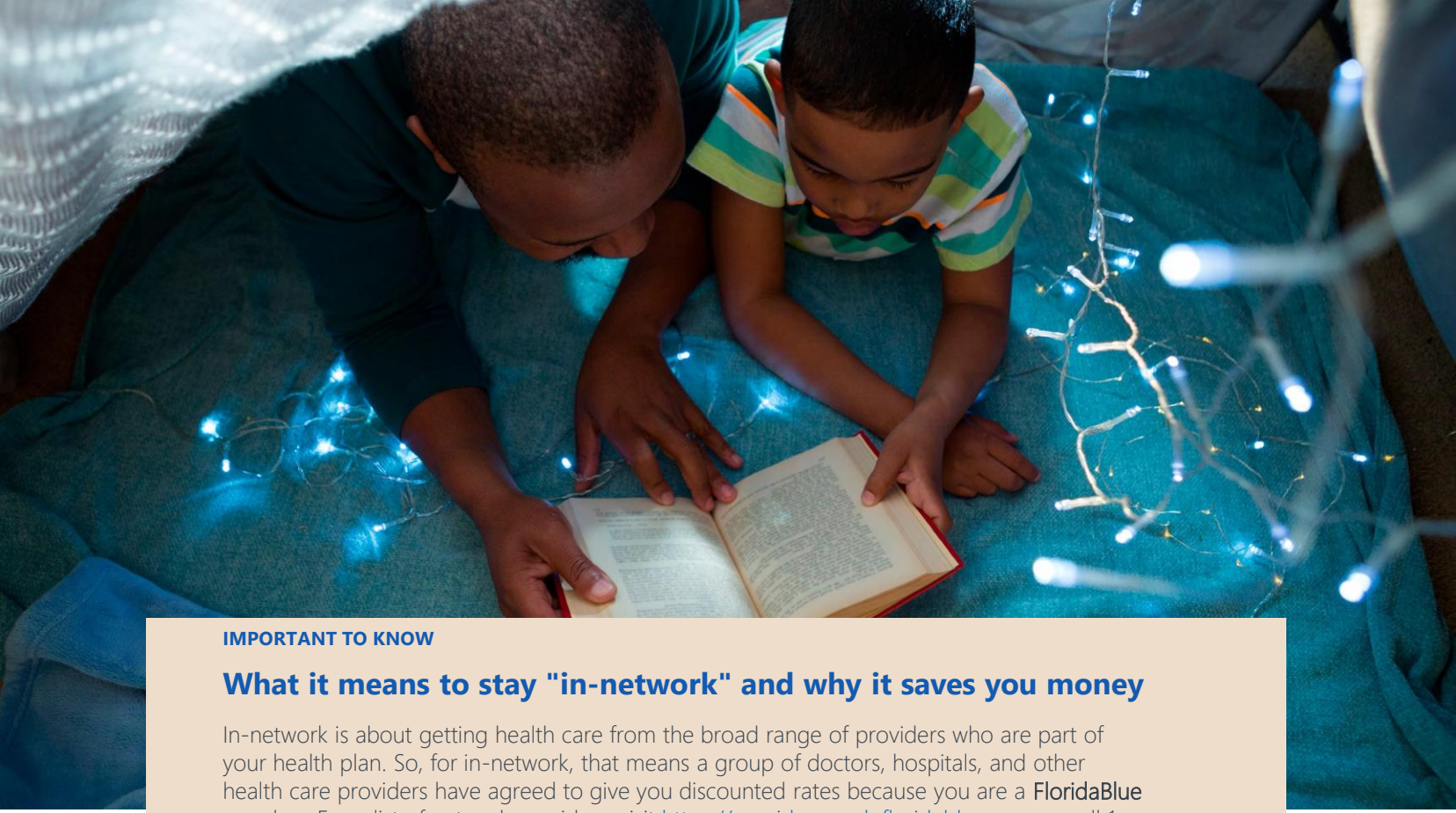


Once your account is created, eligible dependents under 18 years of age can be added in your account settings under the primary member. Dependents older than 18 should follow the steps above to create their own account.

Set up your Teladoc Health account today

Visit Teladoc.com | Call 1-800-TELADOC (800-835-2362) | Download the app

*Teladoc Health is not available internationally.



IMPORTANT TO KNOW

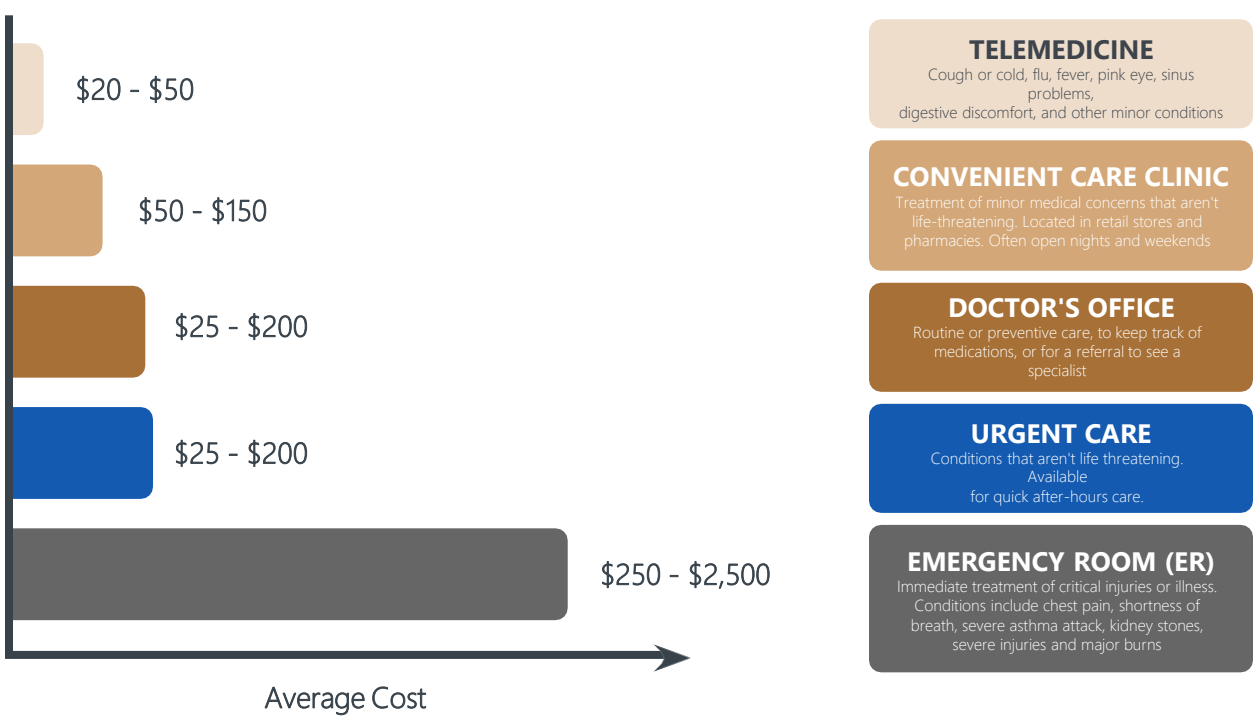
What it means to stay "in-network" and why it saves you money

In-network is about getting health care from the broad range of providers who are part of your health plan. So, for in-network, that means a group of doctors, hospitals, and other health care providers have agreed to give you discounted rates because you are a FloridaBlue member. For a list of network providers, visit https://providersearch.floridablue.com or call 1-800-352-2583.

They negotiate for you, so, you'll have less out-of-pocket costs when you get care. And they can't send you a bill for more than what has been agreed to - this is called balance billing and you're safe from it, as long as you stay in-network.

WHERE TO GO WHEN YOU NEED CARE

It can be hard to know where to go for medical care – especially in the heat of the moment. But, not every situation calls for a trip to the emergency room.



Dental Benefits

Your dental coverage is provided through Delta Dental.

You may view your benefits, print an ID card and locate in-network dental providers by visiting www.deltadentalins.com or call 1-800-521-2651.

KEY FEATURES AND DETAILS

- Group 17951
- The High Plan has no waiting period for Basic Benefits, Major Benefits, Prosthodontics, and Orthodontics.

	LOW PLAN	HIGH PLAN
IN-NETWORK		
Calendar Year Deductible Individual Family	$50 $150	$50 $150
Diagnostic & Preventive Cleanings, exams, x-rays, sealants, space maintainers and fluoride treatments	Covered 80%	Covered 100%
Major Services Fillings, Oral Surgery Endodontics (Root Canals) Periodontics (Gum Treatment)	Covered 60% N/A N/A	Covered 80% Covered 80% Covered 80%
Major Services Inlays, onlays, crowns, cast restorations	N/A	Covered 50%
Prosthodontics Bridges, dentures, implants	N/A	Covered 50%
Orthodontic Services	N/A	Covered 50%
Lifetime Orthodontia Max	N/A	$1,500
Annual Benefit Maximum	$1,000	$1,500
EMPLOYEE COST PER-PAY-PERIOD		
Employee Only	$7.42	$17.20
Employee + Spouse	$12.86	$29.81
Employee + Child(ren)	$12.81	$29.69
Employee + Family	$19.83	$45.91

IMPORTANT TO KNOW

Reimbursement schedule for your out-of-network benefits

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.

Vision Benefits

Your vision coverage is provided through VSP. When you utilize a provider that participates in the network, discounts will be greater and there are no claim forms necessary. Plan participants also have access to discounted lens upgrade options and lasik eye surgery.

You may view benefits, print an ID card and search for in-network vision providers at www.VSP.com or call 1.800.877.7195 (TTY: 711).

KEY FEATURES AND DETAILS

- Exams, lenses, contact lenses and frames can be purchased once every 12 months.
- Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, Custom PRK, LASIK, Custom LASIK, SMILE, and Contoura
    - Discounts are only available from VSP-contracted facilities. Also, custom LASIK coverage only available using wavefront technology, other LASIK procedures may be performed at an additional cost to the member

	IN-NETWORK	OUT-OF-NETWORK
Exams		
Including Dilation	$10 copay	Up to $30
Retinal Imaging	Up to $39 copay	N/A
Standard Contact Lens	Up to $40	N/A
Premium Contact Lens	10% off retail	N/A
Frames	$150 Allowance + 20% off balance	$65 Allowance
Lens		
Single Vision	$15 copay	$25 Allowance
Bifocal	$15 copay	$40 Allowance
Trifocal	$15 copay	$60 Allowance
Lenticular	$15 copay	$100 Allowance
Standard Progressive	$15 copay	$40 Allowance
Contact Lenses		
Conventional	$30 Allowance + 15% off balance	$104 Allowance
Disposable	$130 Allowance	$104 Allowance
Medically Necessary	Covered 100%	$200 Allowance
Diabetic Eye Care (up to 2 services per year)		
Exam	$0	$77 Allowance
Retinal Imaging	$0	$50 Allowance
Extended Ophthalmoscopy	$0	$15 Allowance
Gonioscopy	$0	$15 Allowance
Scanning Laser	$0	$33 Allowance

EMPLOYEE COST PER-PAY-PERIOD	
Employee Only	$2.58
Employee + Spouse	$5.17
Employee + Child(ren)	$6.45
Employee + Family	$9.04

IMPORTANT TO KNOW

Frequently asked questions

What is a benefit allowance?

A benefit allowance gives you a certain dollar amount to use towards contacts and glasses (lenses and frames). When you choose materials that are within that dollar amount or allowance, they are covered at 100%. If you choose a frame exceeding your plan allowance, you'll be responsible for paying the overage, in addition to any applicable copays at the time of your visit.

Can I get contacts AND glasses in the same calendar year?

No. You can only get contacts OR glasses in the same calendar year, not both.

Life and AD&D

We provide Basic Life and Accidental Death and Dismemberment (AD&D) coverage at no cost to you. Employees receive a generous benefit of $50,000 through The Standard.

Completion of enrollment documents must be performed to receive this benefit.

OPTIONAL EMPLOYEE LIFE AND AD&D

Employees have the option to purchase additional life insurance coverage through The Standard.

You may elect to purchase $10,000 coverage increments, up to $500,000.

The guarantee issue amount is $250,000.

OPTIONAL SPOUSE COVERAGE

THIS BENEFIT IS ONLY AVAILABLE IF ENROLLED IN EMPLOYEE OPTIONAL LIFE COVERAGE

Your spouse may elect to purchase $10,000 coverage increments, up to $500,000 or 100% of the Employee election.

The guarantee issue amount is $50,000.

OPTIONAL CHILD COVERAGE

THIS BENEFIT IS ONLY AVAILABLE IF ENROLLED IN EMPLOYEE OPTIONAL LIFE COVERAGE

Those enrolling in employee optional life coverage may also elect to purchase $10,000 of coverage for eligible children through age 25.

All child life amounts are guarantee issue and no evidence of insurability is required.

IMPORTANT TO KNOW

Frequently asked questions

Does the coverage amount change based on my age?

Benefit will be reduced by 50% if actively working and age 75.

Can I continue this coverage if my employment ends?

Coverage may be continued through Portability or Conversion if certain criteria is met.

Do I have to fill out a medical questionnaire?

During open enrollment, Employees may enroll in or increase coverage by up to $20,000 (not to exceed the guarantee issue amount) and Spouses may enroll in or increase coverage by up to $10,000 (not to exceed the guarantee issue amount) without completing an Evidence of Insurability (EOI).

An EOI form is required for any amount above $20,000 for employees and $10,000 for spouses if you are electing coverage outside of your initial enrollment period.

Coverage will be effective on the first day of the month following the date your medical questionnaire is approved by the insurance company.

Disability

SHORT-TERM DISABILITY INCOME BENEFITS

STD is offered through The Standard. This coverage is to protect you and your family in the event that a short-term disability prevents you from performing the duties of your occupation. .

SHORT-TERM DISABILITY INCOME	
Elimination Period The amount of time you must wait between an injury or illness begins and when you can start receiving benefits.	Option 1: 7 days Option 2: 14 days
Benefits Payable Duration	180 days while disabled
% of Income Replaced	60% of Earnings
Maximum Benefit Amount	$2,000 weekly benefit

IMPORTANT TO KNOW

Why disability coverage is important

We understand that for most of us our income is the most important financial resource. To be without income for an extended period of time would most likely be devastating for you and your family. We recognize the importance of protecting your income in the event you are unable to work due to an injury or illness.

LONG-TERM DISABILITY INCOME BENEFITS

LTD is offered through The Standard. LTD is an income replacement program that protects you and your family in the event you become disabled and are unable to perform the duties of your job.

LONG-TERM DISABILITY INCOME	
Elimination Period The amount of time you must wait between an illness or disability begins and when you can start receiving benefits.	Option 1: 90 days Option 2: 180 days
Benefits Payable Duration	To Normal Social Security Retirement Age (if 61 or older when disabled, please see the schedule)
% of Income Replaced	60% of Earnings
Maximum Benefit Amount	$7,500 monthly benefit

PRE-EXISTING CONDITION LIMITATION

You are not required to complete an Evidence of Insurability (EOI) form to enroll in the long-term disability plans. Instead, you will be required to satisfy a pre-existing condition limitation. This means The Standard will look back three months prior to your effective date, and anything you for which you were taking medication, in treatment, or under the care of a physician will not be covered for the first 12 months of enrollment.

Any new condition will be covered as soon as the elimination period has been satisfied.

ADDITIONAL BENEFITS THROUGH THE STANDARD

The Standard Insurance Company 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 if only part-time.

Employee Assistance Program (EAP)

At some point in our lives, each of us faces a problem or situation that is difficult to resolve.

Our Employee Assistance Programs are no cost, confidential resources that are available to you and your family to help you deal with life's challenges, and the demands that come with balancing home and work.

Staffed by licensed counselors, these benefits provide support, guidance and referrals to local resources 24 hours a day, 365 days a year.

THE STANDARD

By Phone

1-888-293-6948

Online

www.healthadvocate.com/standard3

EMPLOYEE ASSISTANCE GROUP

By Phone

1-800-252-4555

Online

www.theEAP.com

EAP SERVICES

Your program includes up to three counseling sessions per issue. Sessions can be done in person, on the phone or through video.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

WORK LIFE SERVICES

WorkLife Services are included with the Employee Assistance Program.

Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

ONLINE RESOURCES

Explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

Voluntary Benefits

Supplemental plans are offered through Allstate and provide benefits which pay directly to you regardless of any other insurance you may have. These plans help with the medical and personal expenses incurred when a person is undergoing treatment. Costs of the plans will vary by employee.

ACCIDENT

- 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 member (unless otherwise assigned), regardless of any other coverage members have.
- High benefit and Low benefit plans are available. Your coverage is guaranteed, regardless of your current health.

Sample Covered Incidents – Low Plan:

- Fracture: $210 - $9,000
- Ambulance: $300 - $900
- Hospital Admission: $400 (non-ICU) - $800 (ICU) per accident
- Inpatient Rehab (per accident): $200

Sample Covered Incidents – High Plan:

- Fracture: $280 - $12,000
- Ambulance: $400 - $1,200
- Hospital Admission: $400 (non-ICU) - $800 (ICU) per accident
- Inpatient Rehab (per accident): $300

CRITICAL ILLNESS

- Critical Illness Insurance pays you cash benefits to cover critical illness costs as you see fit. Access added financial resources to help with medical costs, such as procedures, specialized treatment costs, transportation needs, child care, or anything in-between.
- Elect $10,000 or $20,000 employee coverage.
- Spouse/domestic partner and dependent child(ren) can elect 50% of the employee coverage.
- Some critical illnesses covered by the plan include but are not limited to: Heart attack, Stroke, Major organ failure, Endstage renal failure, Coma, Paralysis, and Cancer screening services.
- Receive a $50 health screening benefit for taking one of the eligible screening/ prevention measures.

CRITICAL ILLNESS – CANCER ONLY

- Critical Illness – Cancer coverage provides financial support if you are diagnosed with cancer. Your medical coverage may only cover some of the costs associated with treatment. You're still responsible for deductibles and coinsurance.
- Elect $10,000 or $20,000 employee coverage.
- Spouse/domestic partner and dependent child(ren) can elect 50% of the employee coverage.
- Receive a $50 health screening benefit for taking one of the eligible screening/ prevention measures.

Benefit Premium Adjustments

NEW HIRES: CATCH-UP PREMIUMS

As a benefit to you, Bay District Schools allows 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.

IMPORTANT TO KNOW

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.

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 on the last working days of the weeks nearest to the middle and end of the month.

- Benefit premiums will be deducted from each paycheck automatically. You are paid twice a month, so normally half 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 January 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 February 4.
- The benefits you enrolled in on February 4 are made effective as of your hire date, January 10. The next pay day will be February 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, 1/2 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

Benefit Premium Adjustments

AN EXAMPLE SCENARIO (CONTINUED)

Here are some sample contributions from the previously described example scenario, using 20245 rates from the instructional Classification

BENEFIT	COVERAGE	SEMI-MONTHLY
Medical Plan	Employee Only	$93.57
Dental Plan	Employee Only, High	$17.20
Vision Plan	Employee Only	$2.58
Optional Life	$100,000	$14.50
TOTAL REGULAR DEDUCTION		$127.85

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, half 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. For example, we could expect the following:

MONTH	PREMIUMS	DEDUCTIONS
June Regular	$127.85 x 2	$255.70
July Regular	$127.85 x 2	$255.70
Total Deductions Owed		$511.40
December – May Increase	$511.40 / 12	$42.62

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.

2024 – 2025 INSURANCE ENDING DATES

	START DATE	END DATE	ENDING DATE
Instructional, 196 Days (Full Contract)	7/30/2024	5/30/2025	7/31/2025
Instructional, 195 Days or Less (Late Start)	ANY	5/30/2025	5/31/2025*
Licensed	ANY	5/30/2025	5/31/2025
10-Month Support	8/12/2024	5/28/2025	5/31/2025
Administrative	7/1/2024	6/30/2025	6/30/2025

*** Pending ratification and Board approval. Ending date will change to 7/31/2025.**

Florida Retirement System

Comparing the Plans: Investment Plan and Pension Plan

For complete plan details, refer to the Summary Plan Descriptions on MyFRS.com.

	Investment Plan	Pension Plan
This is a …	**401(k)-type investment plan.** It is designed primarily for employees who want greater control over their retirement plan and who want flexibility in how their benefit is paid at retirement.	**Traditional retirement pension plan.** It is designed for employees who are not comfortable with choosing investments and managing their own portfolio, and who want a guaranteed monthly retirement benefit.
You qualify for a benefit after …	**1 year of service.** Once you complete 1 year of service, you own all contributions and earnings in your account. If you leave FRS employment sooner, you own your employee contributions and any earnings on your contributions.	**8 years of service.** Once you complete 8 years of service, you qualify for a benefit which is payable when you reach retirement age as defined by the plan. If you leave FRS employment sooner, you own your employee contributions.
Plan investment choices are made by …	**You.** You are responsible for choosing investments from a diversified set of funds and for managing your account.	**The State.** The State is responsible for managing the Pension Plan Trust Fund.
Your benefit is …	**Based on your account balance.** Your account balance is based on your and your employer's contributions, the performance of your investments, and account fees and expenses.	**Based on a formula.** Your benefit is guaranteed and is based on a formula using your salary, years of service, FRS membership class, and age.
When you retire, your benefit can be paid to you as …	**A lump sum, a rollover, an annuity, a customized payment schedule,** or any combination of these.	**Monthly payments for your lifetime.** You will have options that provide continuing payments to your qualified beneficiary after your death.
Who contributes to the plan?	Both plans require you to contribute 3% of your salary, beginning with your first paycheck. You cannot change the amount you contribute. Your employer also contributes a fixed percentage of your gross salary to the plan you choose. Contribution rates are set by the Florida Legislature.	

The following services are available to you as a Florida Retirement System member. They are completely confidential, unbiased, and *FREE*.

MyFRS Financial Guidance Line

1-866-446-9377 (TRS 711), toll-free
8:00 a.m. to 6:00 p.m. ET, Monday through Friday, except holidays
(Division of Retirement available 8:00 a.m. to 5:00 p.m. ET)

Option 1: Speak with experienced EY financial planners about making an initial or 2nd Election, or get assistance with your MyFRS.com PIN or with other information available on MyFRS.com.

Option 2: Speak with experienced EY financial planners about any issue you think is important to your financial future. These planners work for **you**.

Option 3: Speak with the Division of Retirement about your Pension Plan account.

Option 4: Speak with the Investment Plan Administrator about your Investment Plan account.

MyFRS.com

This is your gateway to tools and information about your FRS retirement plan. Log in with your MyFRS.com PIN to access valuable personal tools and services.

Workshop Webcasts

Attend as many of these free FRS financial planning workshops as you like. Sessions include "Using the FRS to Plan for Your Retirement," "Estate Planning," "Nearing Retirement," and more. For dates and times, visit www.MyFRS.com/Workshop.htm.

ADVISOR® SERVICE

This free online service can help you estimate your retirement needs, choose investments, and create a personal financial plan that includes FRS and non-FRS retirement accounts. To access the service, log in to MyFRS.com.

Election CHOICE SERVICE

As a new hire, you can elect to join the Investment Plan or the Pension Plan. You may also change retirement plans one time during your FRS career. The CHOICE SERVICE can help you with your initial election and with deciding whether changing plans by using your 2nd Election makes sense for you. Reemployed retirees enrolled July 1, 2017 or after are not eligible to use a 2nd Election. To access the service, log in to MyFRS.com or call the MyFRS Financial Guidance Line.

Voluntary Retirement Options

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 U.S. OMNI & TSACG Compliance Services. Visit the U.S. OMNI & TSACG Compliance Services' 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 are not eligible to participate in the 403(b) plan. Please verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans and participants are fully vested in their contributions and earnings at all times.

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.

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. U.S. OMNI & TSACG Compliance Services monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

The basic contribution limit for 2025 is $23,500.

Age-based Additional Amount – Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $7,500 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.

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 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 reach age 59½ or have a severance from employment. 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.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions
PO Box 4037
Fort Walton Beach, FL 32549

For Overnight Deliveries
73 Eglin Parkway NE, Suite 202
Fort Walton Beach, FL 32548

Toll-free: 1-888-796-3786
https://www.tsacg.com

Key Terms to Know

Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Maximum

Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Out-of-Pocket Maximum

The maximum amount of coinsurance a Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of-pocket maximum.

Coinsurance

A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible.

Copayment

A set dollar amount you pay for network doctors' office visits, emergency room services and prescription drugs.

Deductible

Total dollar amount, based on the allowed amount, you must pay out-of-pocket for covered medical expenses each calendar year before the plan pays for most services. The deductible does not apply to network preventive care if any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

Brand Formulary Drugs

The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Generic Drugs

These drugs are usually the most cost-effective. Generic drugs are chemically identical to their brand- name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non- formulary brand name drugs.

Maintenance Drugs

Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Non-Formulary Drugs

These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost.

Specialty Drugs

Prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions.

Portability

An employee carries or 'ports' his/ her current Group Life coverage after employment ends, without having to answer any medical questions. Portability is for an employee who is leaving his/her job and still wants to maintain the protection that life insurance provides.

Primary Care Physician (PCP)

The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Network

A group of health care providers, including dentists, physicians, hospitals and other health care providers that agree to accept pre- determined rates when servicing members.

Qualifying Event

An occurrence that qualifies the subscriber to make an insurance coverage change outside of Open Enrollment.

Federal Notices

IMPORTANT NOTICE FROM BAY DISTRICT SCHOOLS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

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

2. Bay District Schools has determined that the prescription drug coverage offered by all medical plans are on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Creditable Coverage.

When can you join a Medicare drug plan?

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

However, if you decide to drop your current coverage with , since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under (Insert Name of Plan.)

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current coverage with Bay District Schools will not be affected. Your current coverage pays for health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits. [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available 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 District Schools coverage, be aware that you and your dependents will be able to get this coverage back only during a qualified life event or during the annual enrollment period.

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Bay District Schools changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

HIPAA PRIVACY PRACTICES

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.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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:

Kelly Starling starlkd@bay.k12.fl.us 850-767-4213 1311 Balboa Ave., Ste. 228, Panama City, FL 32401

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.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MICHELLE'S LAW

Michelle's Law protects a postsecondary student from losing full-time student status under an employer's medical coverage if the student is (i) a dependent child of a participant or beneficiary under the terms of the plan; and (ii) enrolled in a plan on the basis of being a student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school. A dependent covered under the law is entitled to the same benefits as if the dependent continued to be enrolled as a full-time student. The law also recognizes that changes in coverage (whether due to plan design or a subsequent annual enrollment election) pass through to the dependent for the remainder of the medically necessary leave of absence.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

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

CHIPRA - PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a

"special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility..

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov/

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+:https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, 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

Key Contacts

CONTACT	PHONE	WEBSITE
Bay District Schools - Insurance Kelly Starling Fax Bay District Schools - Payroll Danielle Schultz Rhonda Taylor Candace Rentz	 850-767-4213 850-767-4225 850-767-4237 850-767-4277 850-767-4243	www.bay.k12.fl.us/bds-benefits
Medical FloridaBlue BlueChoice 0317, BlueOptions 03900, BlueOptions 05192/05193	1-800-352-2583	www.floridablue.com
Telehealth Teladoc	1-800-TELADOC	www.Teladoc.com
PanCare Bay Educators Wellness Center	1-850-818-0025	www.bay.k12.fl.us/bay-educators-wellness-center
HSA HSA Bank BlueOptions HSA 05192/05193 Only	1-855-731-5213	www.HSABank.com
FSA Optum Financial	1-888-339-3685	www.OptumFinancial.com
Dental Delta Dental Group #17951	1-800-521-2651	www.DeltaDentalIns.com
Vision VSP	1.800.877.7195 (TTY: 711)	www.vsp.com
Life and Disability The Standard		www.standard.com
Accident, Cancer & Critical Illness Allstate Group #		www.Allstate.com
The Bailey Group Benefits Consultants	Llewis@mbaileygroup.com Cholder@mbaileygroup.com	The Bailey Group – An NFP Company | Health Insurance & Corporate Benefits

Bay District Schools
2025 Benefits

The information in this Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. The benefit options selected during Open Enrollment will be binding. The terms and provisions will govern you and restrictions of the plans in which you enroll. Generally, unless you experience a qualifying life event, your elections will remain in effect for the entire plan year. By completing your enrollment, you authorize Bay District Schools to deduct contributions from your paycheck, now and in the future, as required under each of the plans. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources. Bay District Schools reserves the right to change, amend or cease these benefits at any time.