Employee Benefits
Services Group.

DIXIE DISTRICT SCHOOLS
DIXIE COUNTY FLORIDA

Open Enrollment 2019

TO: Dixie District Schools Benefit Eligible Employees

FROM: J. Brad Hoard

Re: 2019 Renewal and Open Enrollment

Thank you for the opportunity to continue working together.

We have completed the renewal for your 2020 benefits. There will not be a change to the current basic life, voluntary life, long term disability, accidental death & dismemberment and TASC Voluntary FSA and 1800MD.

Changes for 2020 include

1. Medical insurance will have an 8.7% increase, new payroll deduction grid attached
2. Replace Florida Blue dental with Standard dental for a 20% savings.

Open enrollment schedule is enclosed. All employees will have to opportunity for a one-on-one private meeting to discuss benefit options.

Should you have any questions or need to discuss options prior to the enrollment please contact our office directly by either phone or email.

Respectfully yours,

J. Brad Hoard

Us Employee Benefits Services Group P O Box 13566 Tallahassee, Florida 32317
1-800-599-5552 Fax 850-906-9098 jbhoard@usebsg.com www.usebsg.com

To: Dixie District School Employees

Re: Annual Open Enrollment

US Employee Benefit Services Group will be conducting your open enrollment starting Tuesday, October 15th, 2019 through Wednesday October 30th, 2019. All employees will have the opportunity to meet privately with an enrollment representative.

15-oct	Anderson	7:30
16-Oct	Anderson	7:30
17-Oct	Ruth Rains	7:30
18-Oct	Ruth Rains	7:30
21-Oct	Transportation	7:30
21-Oct	District Office	10:00
21-Oct	Finance Office	2:00
22-Oct	DCHS	7:30
23-Oct	DCHS	7:30
28-Oct	OTE	7:30
29-Oct	OTE	7:30

If you would like to meet after hours at the Cross City Nature Coast Insurance you are welcome to contact Andrew Rains to schedule. If you have any questions prior to the enrollment, contact Brad Hoard at 1-800-599-5552. I look forward seeing you during the open enrollment.

Thank you,

J. Brad Hoard, Managing Partner

Us Employee Benefits Services Group 2852 Remington Green Circle Suite 204 Tallahassee, Florida 32308
1-800-599-5552 Fax 850-906-9098 jbhoard@usebsg.com www.usebsg.com

2020 Dixie County School Board Rate Sheet				
Benefits	**Blue Options PPO Plan 5180/5181 H S A**	**Blue Care HMO Plan 130/131 HSA**	**Blue Care HMO Plan 54**	**Blue Care HMO Plan 70**
	Out of Network Benefits			
OFFICE SERVICES				
PCP/Specialist In-Network	DED + Coinsurance	DED + Coinsurance	$40/$65 copay	$50/$75
PCP/Specialist Out of Network	DED + Coinsurance	N/A	N/A	N/A
Preventive Care In Network	DED + Coinsurance	100% covered	100% covered	100% covered
HOSPITAL SERVICES				
Inpatient In-Network	DED + Coinsurance	DED + Coinsurance	DED + Coinsurance	DED + 30%
Inpatient Out-of-Network	DED +INN Coinsurance	N/A	N/A	N/A
ER Services	DED + Coinsurance	DED + Coinsurance	$300 copay	$500 copay
OUTPATIENT SERVICES				
Surgery In-Network	DED + Coinsurance	DED + Coinsurance	DED + Coinsurance	DED + 30%
Surgery Out-of-Network	DED + Coinsurance	N/A	N/A	N/A
Simple Diagnostic Services In-Network	DED + Coinsurance	DED + Coinsurance	$65	$75
Simple Diagnostic Services Out-of-Network	DED + Coinsurance	N/A	N/A	N/A
Complex Diagnostic Services In-Network	DED + Coinsurance	DED + Coinsurance	$200	DED + 30%
Complex Diagnostic Services Out-of-Network	DED + Coinsurance	N/A	N/A	N/A
Urgent Care Services	DED + 10%	DED + Coinsurance	$85	$80
Rx				
Rx	$10/$50/$80 after Ded	$10/$50/$80 After Ded	$10/$50/$80 Retail Only	$10/$50/$80 Retail Only
CY DEDUCTIBLE (CYD)				
Individual/Family In-Network	$1,500 / NA	$1,500 / NA(130) $3,000/$3,000 (131)	$5,000/$10,000	$5,500/$11,000
Individual/Family Out-of-Network	$3,000 / NA	N/A (130 +131)	N/A	N/A
OUT-OF-POCKET MAXIMUM				
Individual/Family In-Network	$3,000 / NA	$4,500 / NA (130) $6,850 / $9,000 (131)	$6,350 / $12,700	$7,350 / $14,500
Individual/Family Out-of-Network	$6,000 / NA	N/A	N/A	N/A
COINSURANCE				
In Network	90% / 10%	80% / 20%	70% / 30%	70% / 30%
Out-of-Network	60%/40%	N/A	N/A	N/A
Employee Only 18 Pay	$ 145.20	$ 0.00	$ 15.63	$ 0.00
Employee & Spouse 18 Pay	$ 855.39	$ 572.90	$ 589.19	$ 545.39
Employee & Children 18 Pay	$ 570.56	$ 352.15	$ 364.76	$ 330.89
Family 18 Pay	$ 1245.72	$ 875.39	$ 896.75	$ 839.33

Florida Blue

BlueOptions 05180

HSA Compatible with Rx $10/$50/$80 after In-network Deductible

Coverage Period: 01/01/2019 - 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. Out-of-Network: **$3,000** Per Person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$3,000** Per Person. Out-Of-Network: **$6,000** Per Person.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 1701033

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Specialist visit	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		by mail		
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 10% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 10% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
	Inpatient services	Deductible + 10% Coinsurance	Physician Services: In-Network Deductible + 10% Coinsurance/ Hospital: Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional	Deductible + 10%	In-Network Deductible +	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services	Coinsurance	10% Coinsurance	
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care - Limited to 35 visits	• Most coverage provided outside the United States. See www.floridablue.com.	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other No Charge	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,590**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$1,400
Coinsurance	$50
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,010**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,540**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

Florida Blue

BlueOptions 05181

HSA Compatible with Rx $10/$50/$80 after In-network Deductible

Coverage Period: 01/01/2019 - 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,000** Per Person/**$3,000** Family. Out-of-Network: **$6,000** Per Person/**$6,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,000** Per Person/**$6,000** Family. Out-Of-Network: **$12,000** Per Person/**$12,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 1701035

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Specialist visit	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		by mail		
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 10% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 10% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
	Inpatient services	Deductible + 10% Coinsurance	Physician Services: In-Network Deductible + 10% Coinsurance/ Hospital: Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional	Deductible + 10%	In-Network Deductible +	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services	Coinsurance	10% Coinsurance	
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care - Limited to 35 visits	• Most coverage provided outside the United States. See www.floridablue.com.	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other No Charge	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$30
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,990**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$1,300
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

Florida Blue HMO

BlueCare 130

HSA Compatible with Rx $10/$50/$80 after In-network Deductible

Coverage Period: 01/01/2019 - 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$4,500** Per Person. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 1701031

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 20% Coinsurance	Not Covered	Physician administered drugs may have higher cost shares.
	Specialist visit	Deductible + 20% Coinsurance	Not Covered	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible + 20% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Deductible + 20% Coinsurance	Not Covered	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Inpatient services	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health	Home health care	Deductible + 20% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 20%	Not Covered	Coverage limited to 30 visits, including 30

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs		Coinsurance		manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 20% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$30
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,790**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$1,800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,460**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,590**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

Florida Blue HMO

BlueCare 131

HSA Compatible with Rx $10/$50/$80 after In-network Deductible

Coverage Period: 01/01/2019 - 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,000** Per Person/**$3,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,850** Per Person/**$9,000** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 1701029

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 20% Coinsurance	Not Covered	Physician administered drugs may have higher cost shares.
	Specialist visit	Deductible + 20% Coinsurance	Not Covered	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible + 20% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Deductible + 20% Coinsurance	Not Covered	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 20% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Inpatient services	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 20% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health	Home health care	Deductible + 20% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 20%	Not Covered	Coverage limited to 30 visits, including 30

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
needs		Coinsurance		manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 20% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 20% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,000**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$30
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,990**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,000**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$1,300
Coinsurance	$90
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,450**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,000**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

Florida Blue HMO

BlueCare 54
with Rx $10/$50/$80

Coverage Period: 01/01/2019 - 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual and/or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,350** Per Person/**$12,700** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 1701030

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copay per Visit	Not Covered	Physician administered drugs may have higher cost shares.
	Specialist visit	$65 Copay per Visit	Not Covered	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $65 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Physician Office: $300 Copay per Visit/ Independent Diagnostic Testing Center: $200 Copay per Visit	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$50 Copay per Prescription at retail, $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$80 Copay per Prescription at retail, $200 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	$300 Copay per Visit	$300 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	$85 Copay per Visit	Not Covered	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Inpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$65 Copay on initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	$65 Copay per Visit	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Motorized Wheelchairs: $500 Copay per Visit/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$5,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**30%**
Other No Charge	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,460**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$5,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**30%**
Other No Charge	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$2,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$5,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**30%**
Other Copayment	**$300**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

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PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

Florida Blue HMO

BlueCare 70
with Rx $10/$50/$80

Coverage Period: 01/01/2019 - 12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual and/or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,500** Per Person/**$11,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$7,350** Per Person/**$14,700** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 1701032

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 Copay per Visit	Not Covered	Physician administered drugs may have higher cost shares.
	Specialist visit	$75 Copay per Visit	Not Covered	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $75 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$50 Copay per Prescription at retail, $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$80 Copay per Prescription at retail, $200 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are	Not Covered	Not covered through Mail Order. Up to 30 day

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		subject to the cost share based on applicable drug tier.		supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	$500 Copay per Visit	$500 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	$80 Copay per Visit	Not Covered	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Inpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$75 Copay on initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	$75 Copay per Visit	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Motorized Wheelchairs: $500 Copay per Visit/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$5,500**
Specialist Copayment	**$75**
Hospital (facility) Coinsurance	**30%**
Other No Charge	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,500
Copayments	$30
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,390**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$5,500**
Specialist Copayment	**$75**
Hospital (facility) Coinsurance	**30%**
Other No Charge	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$2,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,860**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$5,500**
Specialist Copayment	**$75**
Hospital (facility) Coinsurance	**30%**
Other Copayment	**$500**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

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You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

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ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

Standard Insurance Company
Dixie District Schools
Group Policy #147568
Effective Date July 1, 2009

Group Basic Life and Accidental Death and Dismemberment Insurance

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

The cost of this insurance is paid by Dixie District Schools.

Eligibility

Definition of a Member	You are a member if you are an active employee of Dixie District Schools and regularly working at least 20 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 1 - Active Members
Eligibility Waiting Period	You are eligible on the first of the month that follows 60 consecutive days as a member.

Benefits

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

Other Basic Life Features and Services

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

Other Basic AD&D Features

- Air Bag Benefit
- Family Benefits Package
- Seat Belt Benefit

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

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279-D-FL-147568-C1 (10/17)
5391884-116239

Dixie District Schools - #758583
Dental Highlight Sheet

Low Plan: Dental Plan Summary **Effective Date: 1/1/2020**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	$150/family
Maximum *(per person)*	$1,000 per calendar year
Allowance	Discounted Fee
Max Builder[SM]	Included
Waiting Period	None
Annual Eye Exam	None
Annual Open Enrollment	Included

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

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

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 26,167 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

We make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Dixie District Schools - #758583
Dental Highlight Sheet

Max Builder℠

This dental plan includes a valuable feature that allows qualifying plan participants to carryover part of their unused annual maximum. A participant earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. In addition, a person earning dental rewards who submits a claim for services received through the dental network earns an extra reward, called the PPO Bonus. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

Groups with a program similar to Max Builder on their previous plan are eligible for Max Builder Credits. To qualify for Max Builder Credits, the employer must request a list of carryover amounts from the previous carrier, to be sent to The Standard.

The Standard will credit each account based on amounts identified by the previous carrier. The credit is available only to initial insureds. The credit, and any amounts earned under our plan, will not exceed the maximum carryover proposed for the plan selected.

Enrollment data must include information for all dependents enrolling in the plan.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: **http://www.standard.com/dental** and click on "Find a Dentist."

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1.

Dixie District Schools - #758583
Dental Highlight Sheet

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

Dixie District Schools - #758583
Dental Highlight Sheet

High Plan: Dental Plan Summary **Effective Date: 1/1/2020**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3 Waived Type 1 $150/family
Maximum *(per person)*	$1,500 per calendar year
Allowance	90th U&C
Max Builder[SM]	Included
Waiting Period	None
Annual Eye Exam	None
Annual Open Enrollment	Included

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,500
Waiting Period	None

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

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Open Enrollment

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Dixie District Schools - #758583
Dental Highlight Sheet

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OPEN ENROLLMENT Summary of Benefits

Your Vision Benefits

Dixie District Schools

Humana®

Humana.com

GN14136IIII 0713

Humana Vision 130

FLORIDA

Dixie District Schools

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary	$10	Up to $30
• Retinal imaging[1]	Up to $39	Not covered
Contact lens exam options[2]		
• Standard contact lens fit and follow-up	Up to $55	Not covered
• Premium contact lens fit and follow-up	10% off retail	Not covered
Frames[3]	Up to $130 20% off balance over $130	Up to $65
Standard plastic lenses[4]		
• Single vision	$15	Up to $25
• Bifocal	$15	Up to $40
• Trifocal	$15	Up to $60
• Lenticular	$15	Up to $100
Covered lens options[4]		
• 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-reflective coating	Premium anti-reflective coatings as follows:	Premium anti-reflective coatings as follows:
- 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	Premium progressives as follows:	Premium progressives as follows:
- Tier 1	$110	Not covered
- Tier 2	$120	Not covered
- Tier 3	$135	Not covered
- Tier 4	$90, 80% of charge, then up to $120	Not covered
• Photochromatic / plastic transitions	$75	Not covered
• Polarized	20% off retail	Not covered
Contact lenses[5] (applies to materials only)		
• Conventional	Up to $130, 15% off balance over $130	Up to $104
• Disposable	Up to $130	Up to $104
• Medically necessary	$0	Up to $200

Humana Vision 130

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 24 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• 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

[1] Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
[2] Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
[3] Discounts available on all frames except when prohibited by the manufacturer.
[4] Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
[5] Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

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.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
   - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
   - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
   - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
   - War or any act of war, whether declared or not;
   - Any act of international armed conflict; or
   - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
   - Is not a visual necessity;
   - Does not offer a favorable prognosis;
   - Does not have uniform professional endorsement; or
   - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts 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 [1].

[1] Thompson Media Inc.

Questions

Check out Humana.com

Call 1-866-995-9316 seven days a week: 8 a.m. to 6 p.m. Eastern Time Monday through Saturday, and 11 a.m. to 8 p.m. Sunday.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana®

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

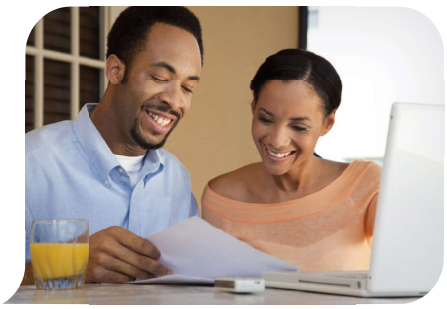
If you need these services, call **1-877-320-1235**, or if you use a TTY, call **711**.

If you believe that Humana Inc. and its subsidiaries have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512-4618

If you need help filing a grievance, call **1-877-320-1235** or if you use a TTY, call **711**.

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

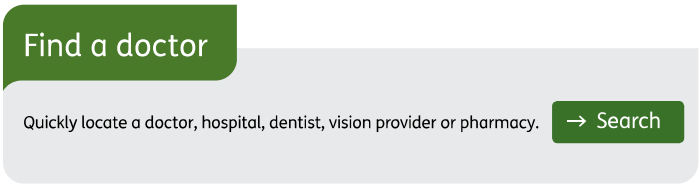
Provider Directory
Humana.com



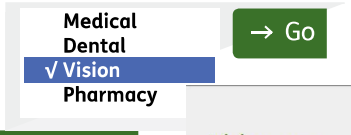
Get the most up-to-date information.

Follow these simple steps to find a Humana Vision provider:

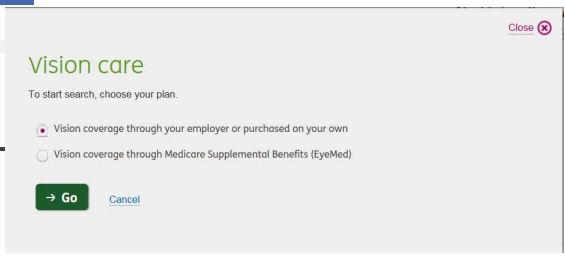
1. Under “Find a doctor” on the home page, click on **“Search.”**



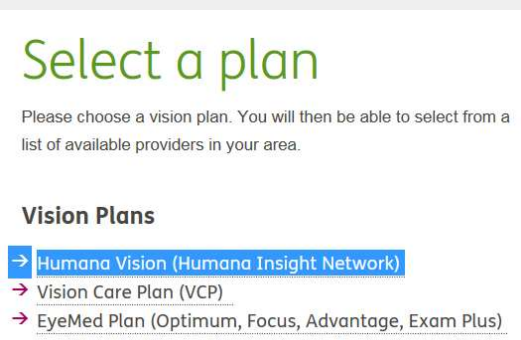
2. Under **“Search Type,”** select “Vision” and click on “Go.”



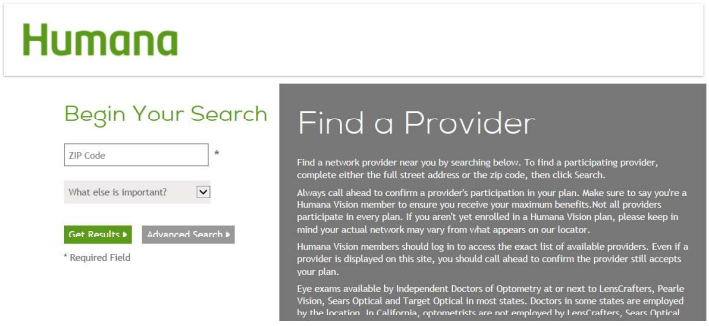
Select “Vision coverage through your employer” and click on “Go.”



Select Humana Vision (Humana Insight Network)



Enter Zip code and select Get Results



Humana®

Your search results will display.

DINNEEDED 0415

Choosing Humana Vision is good for your health

Besides checking for changes in your vision, your eye doctor can check for common eye conditions like glaucoma.

An eye exam can also uncover other health issues, such as high blood pressure and diabetes. If you have diabetes, most Humana Vision plans have additional coverage for the care and testing you need to help manage your condition.

Humana Vision makes good eye health easy and budget friendly

- Get an annual eye exam for $10
- Choose from more than 70,000 eye doctors in more than 24,000 locations including LensCrafters®, Pearle Vision®, Target Optical®, Sears® Optical, JCPenney Optical and many other private practioners

How you can save with Humana Vision

	Retail cost	Cost with Humana Vision	Potential savings
Exam	$70	$10	$60
Frames	$150	$16	$134
Single-vision lenses	$70–120	$15	$55–105
Standard scratch-resistant coating	$40	$15	$25
Standard UV coating	$40	$15	$25
Total	$370–420	$71	**$299–349**

More than **80% off** the total retail cost

Data is based on the Humana Vision 130 plan. Example is for illustration purposes only, and individual results may vary.

Humana®

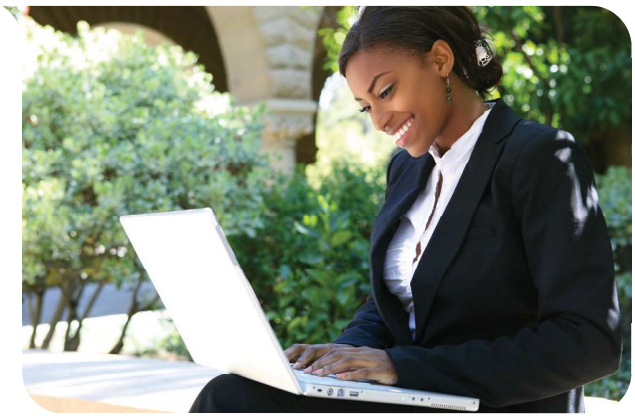
Humana.com

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

GCHJPWZEN 0816

MyHumana - Vision

Register now at Humana.com



Find your personalized vision benefit information in one place – MyHumana.com

As a Humana member, you have a secure website on Humana.com called MyHumana. With MyHumana, you have fast, easy access to your personalized benefits information, planning tools, and wellness resources.

Some of what you can do on MyHumana:

- Claims – Check vision benefit eligibility.
- Coverage details – Review co-pays and coverage levels.
- Provider search – Use Physician Finder Plus to find in-network vision providers near you.
- Health and Wellness – Access health and wellness information.
- Year-to-Date Summary – See an at-a-glance view of utilization
- Manage access
- Update your communications preferences – Select which communications you want to receive from Humana and how you want to receive them – via paper or e-mail

Registering is easy:

- Have your Humana ID card or Social Security number ready to register.
- Go to Humana.com
- Select “Register” at the top of the page or in the log-in box on the left.
- Choose “Member all other plan types”
- Fill in some basic information – like your member ID number, date of birth, ZIP code, and e-mail address, and click “next”
- Create a User ID, password, and security prompt and click “next” to finish

Now, how easy was that? You’re all set – jump in and start exploring!

You don’t have to wait for health and benefits guidance – you can get it right away with MyHumana.

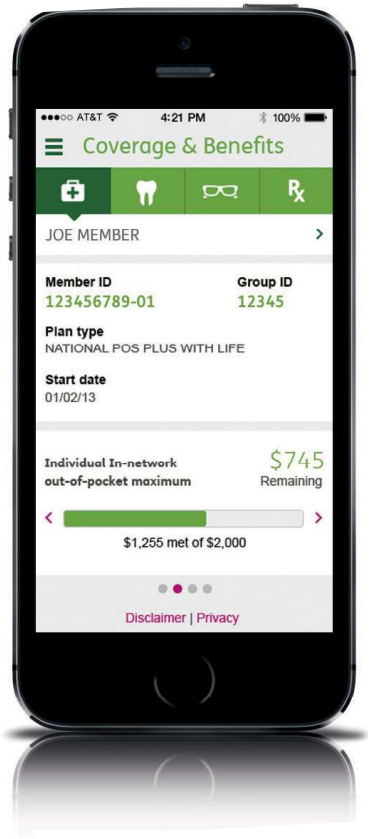
Please note, all features may not be available to all members.

Humana®

Humana.com

GN67582HH 0312

MyHumana Mobile app
"Now we go where you go"



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 medical, dental, vision, and pharmacy claims
- View your plans and coverage details
- View your Go365® Dashboard†
- Receive medication reminders
- Research drug prices
- Locate providers in your network
- Refill your RightSource® prescriptions

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

ANDROID APP ON Google play

From your mobile device's browser:

You can visit MyHumana from your mobile device's browser. To get started, go to **Humana.com** and sign-in.

Text message alerts*

On the MyHumana Mobile app:

1. Register or Sign in
2. Click on the Menu icon
3. Select Text Alerts
4. Register and verify your Mobile #
5. Select the alerts you want to receive

On Humana.com:

1. Register or Sign in
2. Click on Account settings & preferences
3. Select Edit your preferences
4. Select Mobile from the tab
5. Register and verify your Mobile #
6. Select the alerts you want to receive

†Available to Go365 members only.
*Message and data rates may apply.

Humana®

Humana.com

GCA07BNHH 0614

Relationships are built on trust. Respect for an individual's privacy goes a long way toward building trust. Humana values our relationship with you, and we take your personal privacy seriously. Humana's Notice of Privacy Practices outlines how Humana may use or disclose your personal and health information. It also tells how we protect this information. The notice provides an explanation of your rights concerning your information, including how you can access this information and how to limit access to your information. In addition, it provides instructions on how to file a privacy complaint with Humana or to exercise any of your rights regarding your information.

If you'd like a copy of Humana's Notice of Privacy Practices, you can request a copy by:

- Visiting **Humana.com** and clicking the Privacy Practices link at the bottom of the home page
- E-mailing us at privacyoffice@humana.com
- Sending a written request to:
  Humana Privacy Office
  P.O. Box 1438
  Louisville, KY 40202

Humana Large Group Employee Enrollment Form — FLORIDA

The offering company(ies) listed on the signature page, severally or collectively, as the content may require, are referred to in this application as "Humana". Print clearly and completely fill in each applicable circle.

PPO, EPO and Indemnity plans insured by Humana Health Insurance Company of Florida, Inc. POS and HMO plans offered by Humana Medical Plan, Inc. Humana National POS plan insured by Humana Health Insurance Company of Florida, Inc. and offered by Humana Medical Plan, Inc. Life and Short-Term Income Protection plans insured or administered by Humana Insurance Company.
Prepaid, Basic, Intermediate and High Dental plans underwritten by The Dental Concern, Inc. Prepaid and AdvantagePlus Dental plans offered and administered by CompBenefits Company. All other Dental plans insured or administered by HumanaDental Insurance Company or Humana Insurance Company.
Vision plans insured or administered by Humana Insurance Company, CompBenefits Insurance Company or CompBenefits Company.

Company name: DIXIE DISTRICT SCHOOLS | Company city: CROSS CITY | State: FL

Office use only
Qualifying event:
❍ Open Enrollment ❍ Re-hire
❍ New hire ❍ Changed to full time status
Qualifying event date (MM/DD/YYYY) / /
Benefit effective date (MM/DD/YYYY) / /

Employee information

Last name | First name | MI

Social security number – – | Date of birth (MM/DD/YYYY) / / | Area code ( ) | Phone number –

Street address

Apt / Suite / PO box number

Gender ❍ Female ❍ Male | Language of choice ❍ English ❍ Spanish

City | State | Zip code | County / Parish

E-mail address

Employment state ❍ Full-time employee ❍ Retiree | Date of full-time hire (MM/DD/YYYY) / /

Are you disabled or unable to perform normal work activities? ❍ No ❍ Yes If yes, indicate reason: _____

For Medical plans only: Do you wish to extend coverage for your dependent adult child(ren) up to age 30? ❍ N ❍ Y

FL-72001-GN 1/2009 | Reorder# FL-80124-GN 6/2009

Dependent information — FLORIDA

Enter information for each covered dependent, including spouse.

1 Dependent last name | First name | MI | Gender ❍ Female ❍ Male
Social security number – – | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____
Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

2 Dependent last name | First name | MI | Gender ❍ Female ❍ Male
Social security number – – | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____
Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

Last name: | First name:

3 Dependent last name | First name | MI | Gender ❍ Female ❍ Male

Social security number – – | Date of birth (MM/DD/YYYY) / / | Relationship ❍ Spouse ❍ Child ❍ Other:_____

Dependent status (if applicable): ❍ Full-time student (18 or older) ❍ Disabled If disabled, indicate reason: _____

Use the following alternate address for these dependents: ❍ 1 ❍ 2 ❍ 3

Street address

Apt / Suite / PO box number

City | State | Zip code | County / Parish

FL-72001-DP 1/2008 Reorder# FL-80124-DP 6/2009

Vision

Coverage type:
- ❍ Employee only $6.96
- ❍ Employee & spouse $13.92
- ❍ Family $20.79
- ❍ Employee & child(ren) $13.23
- ❍ Other: _____

Office use only

Group # 735341 | Benefit # HV130 VISION | Class/Div #

Plan name Humana Insight HV130

GN-72001-VS1 1/2008 Reorder# GN-80124-VS1 3/2008

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer. I proclaim that I was not pressured or forced by my employer, the writing agent, or Humana into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply):

Vision for: ❍ Myself ❍ My spouse ❍ My dependent child(ren)

I decline to apply for group coverage because of:
- ❍ Spousal coverage
- ❍ Medicare supplement
- ❍ Individual coverage
- ❍ Coverage under another carrier's plan provided by my employer
- ❍ Other: _____ _____

GN-72001-WV1 1/2008 Reorder# GN-80124-WV1 3/2008

Last name: | First name:

True and complete acknowledgement — FLORIDA

I understand, agree and represent:

- I have read this document or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of Humana's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the certificate of coverage/ certificate of insurance. If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my dependents provided I request enrollment with in 31 days after the qualifying event.
- In the event that I should decide to apply for coverage hereafter, that subsequent application shall be subject to the applicable terms and conditions of the master group contract(s) or plan provisions which may require additional limitations and waiting periods.
- If I am declining coverage for myself or my dependents (including my spouse) because of other coverage, I may in the future be able to enroll myself or my dependents provided that I request enrollment within 31 days after my other coverage ends.
- If any deductions are required for this coverage, I authorize those deductions from my earnings. If selecting the Health Savings Account (HSA), I authorize Humana or its banking partners to provide my account number to my employer for the purposes of depositing any contributions.
- Any misrepresentation contained herein relied on by Humana may be used to reduce or deny a claims or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

Signature - Please sign below if enrolling or waiving any group coverage

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee or legal representative signature

Date ☐☐ / ☐☐ / ☐☐☐☐

Name and relationship of legal representative _____

Dixie School District

Voluntary Accidental Death & Dismemberment Insurance • GTU 5091143

The following is a brief description of the Voluntary Accidental Death and Dismemberment Plan. The benefits described are subject to certain limitations and exclusions as described in the policy. For specific definitions of terms used below as well as further details and information about this plan, please see the policy.

Eligibility

Class I: All active full-time employees of the policyholder domiciled in the United States.

You may elect to include coverage for your eligible dependents under the Family Plan. Eligible dependents include your legally married spouse under age 70 and your unmarried dependent children from birth to 19 years of age, or to age 25 if attending an accredited school or college on a full-time basis, and are primarily dependent upon you for their support and maintenance.

No individual may be covered more than once under this plan. You cannot be covered as a spouse or dependent child of another employee.

Benefit Amount

Class I: You may purchase a benefit from a minimum of $10,000 to a maximum of $250,000 in increments of $10,000. [However, amounts applied for in excess of $150,000 must not exceed ten (10) times your base annual pay excluding overtime, bonuses, commissions and special compensation.

The benefit amount for your covered dependents will be a percentage of your benefit amount, as follows:

Plan Selected	% Spouse	% Child(ren)
Spouse only:	50%	0
Dependent Child(ren) only:	0	15%
Spouse and Dependent Child(ren)	40%	10%

Maximum benefit amount of $25,000 for dependent child(ren).

At age 70, for the insured employee only, your benefit amount will be reduced based on your previous benefit amount per the following schedule:

Age at Date of Loss	Percent of Principal Sum
70-74	65%
75-79	45%
80-84	30%
85 & Over	15%

Description of Coverage

This plan offers protection on a worldwide basis, 24 hours a day, 365 days a year against certain injuries resulting from a covered accident in the course of business or pleasure, including accidents on or off the job, in or away from the home, commuting, traveling by train, airplane, automobile, or other public and private conveyances, subject to certain limitations (see exclusions/limitations). The benefits provided are payable in addition to any other insurance which may be in effect at the time of the accident.

Exposure and Disappearance Coverage

If the conveyance in which you are riding disappears, is wrecked, or sinks, and you are not found within 365 days of the event, we will presume that you lost your life as a result of injury. If travel in such conveyance was covered under the terms of the policy, we will pay your benefit amount, subject to all policy terms.

If you are exposed to weather because of an accident and this results in a loss of life, we will pay your benefit amount, subject to all policy terms and conditions.

Benefits Provided

If you have an accident that results in any of the following losses, we will pay the benefit shown within 365 days of the date of the accident, Zurich American Insurance Company, may pay certain benefit amounts to you or your designated beneficiary. If the accident results in more than one of these losses, only the loss with the largest benefit will be payable. The amounts are based on the benefit amount shown in the schedule.

Loss of:		Benefit Amount
(1)	Life	100% of benefit amount
(2)	Both hands or both feet	100% of benefit amount
(3)	One hand and one foot	100% of benefit amount
(4)	One hand or one foot plus the sight of one eye	100% of benefit amount
(5)	Sight of both eyes	100% of benefit amount
(6)	Speech and Hearing	100% of benefit amount
(7)	Speech or Hearing	50% of benefit amount
(8)	One hand, one foot, or sight of one eye	50% of benefit amount
(9)	Thumb and index finger of the same hand	25% of benefit amount

Plegia		Benefit Amount
(1)	Quadriplegia (total paralysis of all four Limbs)	100% of benefit amount
(2)	Paraplegia (total paralysis of both lower Limbs)	75% of benefit amount
(3)	Hemiplegia (total paralysis of upper and lower Limbs on one side of the body)	50% of benefit amount

Additional Benefits

Higher Education Benefit

If you elect Family Plan coverage and suffer a covered loss of life, and have an eligible covered child(ren), who on the date of the accident, is enrolled as a full-time student in an institution of higher learning or is at the 12th grade level and enrolls in an institution of higher learning within one year from the date of the accident, an additional benefit of 5% of your benefit amount to $5,000 per year may be paid for each such covered child for up to four (4) consecutive years. If at the time of accident you have no dependent children who qualify for this benefit, we will pay an additional benefit of $2,000 to the designated beneficiary..

Seat Belt Benefit

If you suffer a loss of life in a covered automobile accident while wearing a factory installed or manufactured authorized seat belt, an additional benefit equal to 10% of your principal sum to a maximum of $10,000 may be paid.

Spouse Retraining Benefit

If you elect Family Plan coverage and suffer a covered loss of life, your covered spouse may receive the lesser of $3,000 or the actual cost incurred within 30 months of any professional or trade-training program in which your covered spouse enrolls to obtain an independent source of support and maintenance.

Beneficiary Designation

Benefits for your loss of life will be payable to the beneficiary or beneficiaries designated in writing by you and on file with the policyholder; otherwise, we will pay the benefit to the insured's survivors in the following order:

Your spouse;

Your children, equally;

Your parents, equally or to the survivor;

Your brothers or sisters equally or to the survivor or survivors;

Your estate.

Loss of Life of a Covered Person other than You:

Covered losses for the death of a covered person other than you will be paid to you. If you pre-decease or die at the same time as the covered person other than you, the benefit will be paid to your beneficiary unless your beneficiary designation has not been made or your beneficiary is no longer living at the time of death. In such case, the benefits will be paid to your estate.

All other indemnities shall be payable to you.

Exclusions

This plan does not cover any loss caused by, contributed to or resulting from: suicide or attempted suicide; a purposefully self-inflicted wound; war or any, act of war, declared or undeclared; a covered person's involvement in any type of active military service; illness, disease or infection; pregnancy, including childbirth, but not complications thereof; travel or flight in any aircraft except to the extent stated in the Hazards; skydiving, parasailing, hang gliding, bungee-jumping, or any similar activity; or the insured's participation in the commission or attempted commission of any felony or assault; being intoxicated; being under the influence of any controlled substance, unless such controlled substance was prescribed by a physician and taken in accordance with the prescribed dosage; flying as a pilot or crew member of any aircraft; any aircraft being used for aerial photography, test or experimental purposes; any aircraft that requires a special permit or waiver even if granted; any aircraft owned or controlled by, or under lease to the policyholder, an insured, or a member of a covered person's family or household; any aircraft which is operated by the policyholder, or one of its employees including members of an employee's family or household; any conveyance used in a race or speed test or being used for tests or experimental purposes.

Cost and Method of Payment

The monthly cost for **Employee Only** coverage is $.024 for each $1,000 of benefit amount. The monthly cost for the **Family Plan** is $.043 for each $1,000 of benefit amount. Premium payments will be deducted automatically from your pay. For example, if you had selected one of the benefit amounts below, your monthly cost would be:

	PLAN I	PLAN II
Benefit Amount*	Monthly Cost Employee Only	Monthly Cost Family Plan
$10,000	$0.24	$0.43
20,000	0.48	0.86
30,000	0.72	1.29
40,000	0.96	1.72
50,000	1.20	2.15
60,000	1.44	2.58
70,000	1.68	3.01
80,000	1.92	3.44
90,000	2.16	3.87
100,000	2.40	4.30
110,000	2.64	4.73
120,000	2.88	5.16
130,000	3.12	5.59
140,000	3.36	6.02
150,000	3.60	6.45
160,000*	3.84	6.88
170,000*	4.08	7.31
180,000*	4.32	7.74
190,000*	4.56	8.17
200,000*	4.80	8.60
210,000*	5.04	9.03
220,000*	5.28	9.46
230,000*	5.52	9.89
240,000*	5.76	10.32
250,000*	6.00	10.75

* Benefit amounts in excess of $150,000 may not exceed ten (10) times your base annual pay excluding overtime, bonuses, commissions and special compensation.

Premium payments will be deducted automatically from your pay.

To File a Claim

Contact Zurich American Insurance Company at 1-866-841-4771 for a claim form. Complete the form and send it to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041 within 90 days of the loss. Refer to Plan Number GTU 5091143.

Important

This is a brief description of the coverage provided through the Voluntary Accidental Death & Dismemberment plan. If any conflict should arise between the contents of this handout and the Master Policy or if any point is not covered herein, the terms of the Master Policy shall govern in all cases.

Zurich

1400 American Lane, Schaumburg, Illinois 60196-1056
800-382-2150 www.zurichna.com

The terms and conditions of the Plan described in this brief summary are governed by the individual Plan document that contains the complete terms. In the event of any discrepancy between the information in this brief summary and the Plan document, the Plan document shall govern.

Insurance coverages underwritten by member companies of Zurich in North America, including Zurich American Insurance Company. Certain coverages not available in all states. Some coverages may be written on a nonadmitted basis through licensed surplus lines brokers.

Zurich HelpPoint
Here to help your world.

ZURICH®

OVERVIEW

CONVENIENT CARE ANYWHERE™

1.800MD™

America's Most Reliable Telemedicine Network™

QUALITY CARE WHEN YOU NEED IT MOST

Looking for care that fits your schedule? 1.800MD offers reliable, quality health care at your fingertips with a remarkable reputation.

1.800MD is a fast, convenient alternative to waiting days for an appointment or spending hours sitting in the doctor's office, urgent care or ER. Whether it is 2 a.m. from your toddler's room or 7 p.m. from your business trip destination, our telehealth solutions save you time and money while providing peace of mind.

WHY CHOOSE 1.800MD?

SAVES MONEY

Visits to the emergency room or urgent care are costly prices to pay when many visits can be handled by calling 1.800MD. As a low-cost alternative 1.800MD physicians treat many common conditions via phone or video consultations, reducing un-necessary doctor's visits and saving you money.

CONVENIENCE AND QUALITY CARE

With more than a decade of experience, 1.800MD provides individuals, families, employers and groups with best of class medical care 24/7/365. Available any time day or night, our board-certified physicians are equipped to diagnose, recommend treatment and prescribe medications while in the comfort of your home, office or business trip destination.

SUPPORT

Independently owned, 1.800MD focuses on customer satisfaction. Our member service representatives are available any time to assist you or answer any questions you may have.

CUTTING EDGE TECHNOLOGY

1.800MD's website and mobile app are extensions of our customer service commitment. They provide consumers with access to fast, convenient access to health care. Individual secure member portals contain information and tools to help make informed health care decisions.

HOW DOES IT WORK?

1. ACTIVATE ACCOUNT

Activate your account online at **www.1800md.com** or by calling **1.800.530.8666**. Once activated, you will need to setup your member profile and complete your electronic health record.

2. REQUEST A CONSULT

Login to your account online or call member services at **1.800.530.8666** to request a consult anytime 24/7.

3. RECEIVE CARE

Receive diagnosis and treatment, giving you quality care and peace of mind where ever you are.

Call 1.800.530.8666 or visit www.1800MD.com to secure convenient care anywhere.

1.800.**530.8666**

www.**1800MD**.com

CONVENIENT CARE ANYWHERE™

1.800MD™

America's Most Reliable Telemedicine Network™

How To: Activate Your Account

To ensure that you receive the best and quickest care possible, call and activate you and your dependent's accounts today. It's as easy as 1, 2, 3!

Translation service is available for this process.

STEP 1 Call

Activate your account by calling member services at 1.800.530.8666.

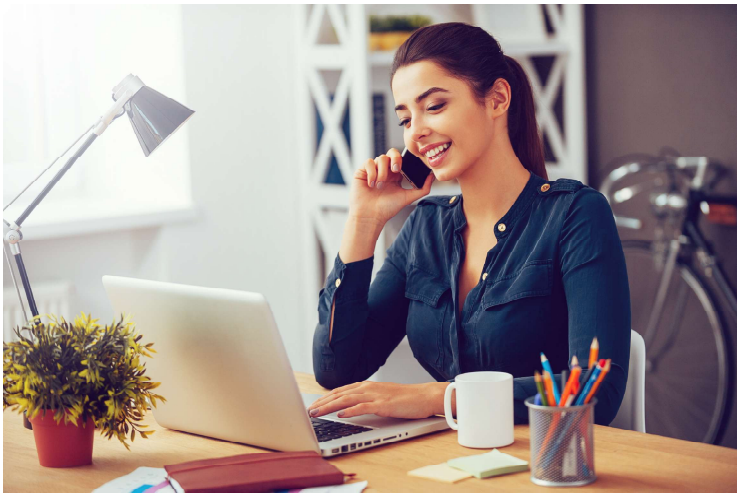
STEP 2 Verify Account

In order to verify your account, please provide the member service representative with either your **member number** OR **name, DOB and address information**.

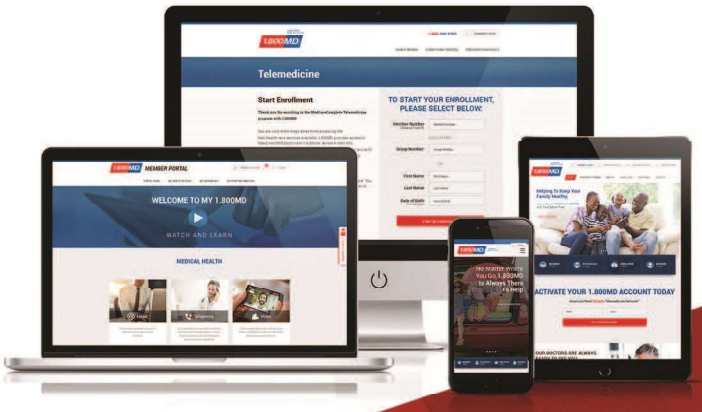
STEP 3 Complete Health History

Our representative will then ask a few questions to complete a brief **Health History**. This information helps our doctors give you the best care possible.

Activating your account gives you access to board certified physicians **anywhere, at anytime**!



If you need to activate a dependent's account please follow the same 3 simple steps!



What makes 1.800MD even better... it's absolutely FREE!*

*You may have a cost at the pharmacy for the prescription.

1.800.**530.8666**

www.**1800MD**.com

FlexSystem®
Flexible Spending Accounts (FSA)

Dependent Care Qualifications

FSA eligibility criteria for Dependent Care expenses

A Section 125 Cafeteria Plan (FlexSystem FSA) allows for the inclusion of Dependent Care (Section 129 of the Internal Revenue Code) benefits. Eligibility for the dependent care benefit requires that certain criteria be met with respect to the expense, the provider, etc.

FlexSystem FSA Dependent Care

A) **The dependent care expenses must be work related.** The care must be necessary for the employee and the employee's spouse to work, to look for work, or to attend school full-time, or if they are physically unable to care for their children.

B) **The dependent care expenses provided during a calendar year cannot exceed $5,000.** In the case of a separate return by a married individual, the limit is $2,500. This amount may be less if the employee's earned income or spouse's earned income is less than $5,000.

The dependent care expenses must be for the care of one or more qualifying persons. A qualifying person is one of the following:

A) A dependent who was under age 13 when the care was provided and for whom an exemption can be claimed.

B) A spouse who was physically or mentally not able to care for himself or herself, and lived with you for more than half the year.

C) A dependent who was physically or mentally not able to care for himself or herself and for whom an exemption can be claimed, and lived with you for more than half the year.

To receive the dependent care benefit, one must follow these procedures:

A) All persons and organizations that provide dependent care for a qualified person must be identified. This information is requested on Form 2441. The name, address, and taxpayer identification number of the provider must be included. Under certain circumstances, the taxpayer identification number will be a social security number.

B) If the care is being provided by a center that cares for more than six persons, the center must comply with all state and local regulations.

C) Payments made to relatives who are not dependents can be included. However, do not include amounts paid to a dependent for whom you can claim an exemption or for your child who is under age 19 at the end of the year, regardless of whether he or she is your dependent.

D) Use Form W-10 to request the required information from the care provider.

Continued on back...

Special rules apply to children of divorced or separated parents:

Even if you cannot claim your child as a dependent, he or she is treated as your qualifying person if all of the following are true:

- The child was under age 13 or was not physically or mentally able to care for himself or herself.
- One or both parents provided more than half of the child's support for the year and are divorced, legally separated, or lived apart at all times during the last 6 months of the calendar year.
- One or both parents had custody of the child for more than half of the year.
- You were the child's custodial parent. The custodial parent is the parent having custody for the greater portion of the calendar year. If the child was with both parents for an equal number of nights the parent with the higher adjusted gross income is the custodial parent.

A non-custodial parent that is entitled to claim the child as a dependent on their tax return may not treat the child as a qualifying individual for the dependent care benefit even when that parent is financially responsible for providing the care. Only one parent (the custodial parent) may qualify for the dependent care benefit for a taxable year. The regulations do not provide any relief for a non-custodial parent that incurs dependent care expenses for the portion of the year in which they have custody of the child to enable the non-custodial parent to work.

Eligible and Ineligible Expenses for FSA Dependent Care (partial list):

Eligible Expenses (must be employment related)

- FICA/FUTA taxes of dependent care provider.
- Nanny expenses attributed to dependent care.
- Nursery school (preschool).
- Late pick up fees.
- Day Camp – primary purpose must be custodial care and not educational in nature.
- Day care when one parent is working and the other is sleeping during daytime hours.

Ineligible Expenses

- Kindergarten.
- Activity fees/supplies.
- Late payment charges.
- Overnight camp.
- Transportation.
- Fees paid to a provider not reporting the income to the IRS.

For more information regarding dependent care expenses, please review IRS Publication 503.

FlexSystem®

Advantages of a Flexible Spending Account (FSA)

A valuable pre-tax benefit with innovative services!

FlexSystem Healthcare FSA
FlexSystem Dependent Care FSA

FlexSystem FSA increases your take-home pay by reducing your taxable income. A Flexible Spending Account (FSA) allows you to **save up to 30%** on your eligible healthcare and/or dependent care expenses every year by using **pre-tax dollars**.

Consider how much you spend on healthcare and/or dependent care expenses for you and your qualified dependents in one year:

- prescription drugs/medications
- medical/dental office visit co-pays
- eye exams and prescription glasses/lenses
- vaccinations
- daycare tuition

Why not reduce these expenses by using pre-tax dollars instead of after-tax dollars? With rising healthcare costs, ***every penny counts!*** By using pre-tax dollars, you are taxed on a lower gross salary, thereby saving money that would otherwise be spent on federal, state and FICA taxes, and thereby you ***increase your take home pay!***

Beginning in January 2013, employee salary reductions to a medical Flexible Spending Account (FSA) are limited to $2,500 per Plan Year, indexed for inflation. Check with your employer for your Plan's maximum annual election amount.

Pre-Tax Savings Example

	Without FSA	*With FSA*
Gross Monthly Pay:	$3,500	$3,500
Pre-Tax Contributions		
Medical/Dental Premiums	$0	-$125
Medical Expenses	$0	-$75
Dependent Care Expenses	$0	-$400
TOTAL:	$0	-$600
Taxable Monthly Income	**$3,500**	**$2,900**
Taxes (federal, state, FICA):	-$968	-$802
Out-of-pocket Expenses:	-$600	$0
Monthly Take-home Pay:	**$1,932**	**$2,098**

Net Increase in Take-Home Pay = $166/mo!

For illustration only. Actual dollar amounts may vary.

How FlexSystem Works

FlexSystem FSA is offered through your employer and is adminstered by TASC. When you choose to enroll in a FlexSystem FSA Healthcare and/or Dependent Care, you choose the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming Plan Year. Your contributions will be deducted in equal amounts from each paycheck, **pre-tax**, throughout the Plan Year. ***The more you contribute to these accounts, the more you save by paying less in taxes!*** Your total Healthcare FSA annual contribution amount is available immediately at the start of the Plan Year; Dependent Care FSA funds are available up to the current account balance only.

Reimbursements and the TASC Card

As you incur eligible expenses, simply submit a request for reimbursement to TASC to receive reimbursement from FlexSystem, up to the amount of your annual contribution. FlexSystem offers multiple methods for requesting a reimbursement: MyTASC Mobile App, text message, online, fax, or mail.

For additional convenience, you will be issued a **TASC Card** to directly access your FlexSystem funds when paying for eligible expenses at the point of purchase, which eliminates the need for requesting a reimbursement. On the rare occasion when you don't use your TASC Card to pay for an eligible expense, simply submit a request for reimbursement. Your reimbursement is deposited into your MyCash account. You can access your MyCash funds in three ways: (1) swipe your TASC Card at any merchant that accepts Visa, (2) withdraw at an ATM, or (3) transfer to a personal bank account from MyCash Manager within MyTASC.

FSA Eligible Expenses

FlexSystem FSA funds may only be used for eligible expenses under your healthcare FSA and/or dependent care FSA. Some eligible expenses include:

- Medical care services
- Dental care services
- Vision care expenses
- Prescriptions
- Certain over-the-counter medications
- Daycare tuition

More detailed lists can be found at www.irs.gov in IRS Publications 502 & 503.
Please note insurance premiums are NOT eligible for reimbursement.

33 million Americans
save up to 30%
every year
by participating
in an FSA.

2009 Nielson Consumer Research

Multiple Methods for Account Management

You may use any of the following self-service options to access your FlexSystem accounts and TASC Card transactions:

- **MyTASC Online**: www.tasconline.com
- **MyCash Manager:** within MyTASC at www.tasconline.com
- **MyTASC Mobile App:** free download at www.tasconline.com/mobile
- **MyTASC Text Messaging:** elect through your MyTASC account online

Online enrollment and account management.

Online tax-savings calculator to help determine how much to contribute.

Convenient pre-tax payroll deductions.

Benefits debit card for eligible purchases.

Mobile app for account access on the go.

Multiple self-service tools.

Fast reimbursements.

Important Considerations

FSA Funds do not Rollover:

It is important to be conservative in making elections because any unused funds left in your FSA at the close of the Plan Year are not refundable to you. You are urged to take precautionary steps, such as tracking account balances on the FlexSystem website and/or using the Interactive Voice Response System, to avoid having funds remaining in your account at year-end.

Using the Grace Period, or purchasing eligible over-the-counter items are ways to utilize leftover FSA funds.

Changing Elections During the Plan Year:

You may change your FSA elections during the Plan year only if you experience a change of status such as:

- a marriage or divorce
- birth or adoption of a child, or
- a change in employment status

Refer to the Change of Election Form (available from your employer) for a complete list of circumstances acceptable for changing elections mid-year.

Sign up for FlexSystem and keep more money in your pocket!

TASC®

FlexSystem®

Standard Insurance Company
Dixie District Schools
Group Policy #147568

Group Long Term Disability Insurance

Protect your income when you're coping with a long-lasting disability.

This coverage is designed to replace a portion of your income when you're disabled for an extended period of time due to a qualifying disability and help you get back to work when you're ready. Long Term Disability insurance benefits can help you pay your bills and safeguard your savings when you're unable to work. 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.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits for a qualifying disability that occurs on or off the job

About This Coverage

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

What Your Benefit Provides This is the amount per month you would receive if you were to suffer a qualifying disability. Eligible earnings are your monthly insured predisability earnings, as defined by the group policy. Your monthly benefit will be reduced by deductible income. Please see the Important Details section for a list of deductible income sources.	**60%** of your eligible earnings, up to a maximum benefit of **$5,000** per month. Plan minimum per month: **$100.**
Benefit Waiting Period If you suffer a qualifying disability, your benefit waiting period is the length of time you must be continuously disabled before you can begin receiving your monthly benefit.	180 days
How Long Your Benefits Last This is the maximum length of time you could be eligible to receive disability benefits for a continuous disability.	Until age 65 Depending on your age at the time of disability, your benefits may be subject to a different schedule. Refer to the table in the Important Details section for specifics.

Additional Features

Your coverage comes with some added features:

Help with Returning to Work	This plan provides incentives to help you get back to work. For instance, you'll get help paying for some of the expenses associated with participating in an approved rehabilitation plan. If a worksite modification would enable you to return to work, the coverage can help your employer make approved modifications.
Survivors Benefit	If you die while receiving benefits, your survivor may be eligible to receive a one-time additional payment.
Support When You Need It	You'll have access to an Employee Assistance Program, a valuable confidential counseling resource if you're experiencing personal or work-related issues. This service is provided through an arrangement with a service provider who is not affiliated with The Standard.
Lifetime Security Benefit	Additional benefits may be payable to you if your Long Term Disability benefits end due to the maximum benefit period, you remain disabled and you are unable to perform two or more activities of daily living or are suffering severe cognitive impairment.
Assisted Living Benefit	Your benefit will be increased by 20 percent of your predisability earnings when you are unable to perform two or more activities of daily living or suffering severe cognitive impairment. The maximum benefit amount cannot exceed $5,000 in addition to the Long Term Disability benefit.

How Much Your Coverage Costs

Because this insurance is offered through Dixie District Schools, you'll have access to competitive group rates that may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and benefit amount.

Use this formula to calculate your premium payment:

_____	x	_____	÷ 100 =	_____	→	_____
Enter your monthly earnings (cannot be more than $8,333).		Enter your rate from the rate table.		This amount is an estimate of how much you'd pay each month.		To get a sense of your 18thly premium, multiply your monthly premium amount by 12 and then divide by 18.

Your Age (as of last July 1)	Rate %
<25	0.08
25–29	0.10
30–34	0.14
35–39	0.17
40–44	0.27
45–49	0.42
50–54	0.62
55+	0.82

As you consider Long Term Disability insurance, evaluate what makes sense for you.

Getting by without a paycheck isn't easy, especially for an extended period of time. Make sure you have enough financial protection to help you cover your housing costs, utilities and other bills.

To estimate your insurance needs, you'll need to consider your unique circumstances.
Use our online calculator at **www.standard.com/disability/needs.**

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

To be eligible for coverage, you must be:

- A regular employee of Dixie District Schools
- Actively working at least 20 hours per week
- A citizen or resident of the United States or Canada

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

Employee Coverage Effective Date

To become insured, you must:

- Meet the eligibility requirements listed above
- Serve an eligibility waiting period*
- Apply for coverage and agree to pay premiums
- Receive medical underwriting approval (if applicable)
- Be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior long term disability insurance plan are also subject to medical underwriting approval. Please contact your human resources representative or plan administrator for more information regarding the requirements that must be satisfied for your insurance to become effective.

*Defined as first of the month that follows 60 consecutive days as a member

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, or
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

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:

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

Exclusions

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- A preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date you become disabled, you have been continuously insured under the group policy for the exclusion period and you have been actively at work for at least one full day after the end of the exclusion period

Preexisting Condition Provision

A preexisting condition is a mental or physical condition whether or not diagnosed or misdiagnosed during the 90-day period just before your insurance becomes effective:

- For which you would have consulted a physician or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures, including self-administered procedures; or

taken prescribed drugs or medications

- Which, as a result of any medical examination, including routine examination, was discovered or suspected

Exclusion Period: 12 months

Limitations

Long Term Disability benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty, as determined by The Standard
- Confined for any reason in a penal or correctional institution

In addition, the length of time you can receive Long Term Disability payments will be limited if:

- You reside outside of the United States or Canada
- Your disability is caused or contributed to by mental disorders or substance abuse.

When Your Benefits End

Your Long Term Disability benefits end automatically on the date any of the following occur:

- You are no longer disabled
- Your maximum benefit period ends
- Benefits become payable under any other disability insurance plan under which you become insured through employment during a period of temporary recovery
- You fail to provide proof of continued disability and entitlement to benefits
- You pass away

Deductible Income

Your benefits will be reduced if you have deductible income, which is income you receive or are eligible to receive while receiving Long Term Disability benefits. Deductible income includes:

- Sick pay, annual or personal leave pay, severance pay or other forms of salary continuation (including donated amounts) paid
- Benefits under any workers' compensation law or similar law
- Amounts under unemployment compensation law
- Social Security disability or retirement benefits, including benefits for your spouse and children
- Amounts because of your disability from any other group insurance
- Any disability or retirement benefits you received or are eligible to receive from your employer's retirement plan.
- Benefits under any state disability income benefit law or similar law
- Earnings from work activity while you are disabled, plus the earnings you could receive if you work as much as your disability allows
- Earnings or compensation included in your predisability earnings which you receive or are eligible to receive while Long Term Disability benefits are payable
- Amounts due from or on behalf of a third party because of your disability, whether by judgment, settlement or other method
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date the group policy terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date Dixie District Schools ends participation in the group policy

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com.**

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP190-LTD/S399, GP399-LTD/TRUST, GP899-LTD, GP209-LTD, GP608-LTD, GP190-LTD/ASSOC/S399, GP190-LTD/TRUST/S399, GP491-LTD/TRUST/S399

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 12501-D-FL-147568 (10/17)
5391884-116244

Standard Insurance Company
Dixie District Schools
Group Policy #147568

Group Additional Life Insurance

Help protect your loved ones from financial hardship.

This coverage is designed to help provide financial support and stability to your family should you pass away. You can also cover your eligible spouse and child(ren). Life insurance is an easy, responsible way to help protect your family from financial hardship during a difficult time — and into the future.

This plan offers:

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

About This Coverage

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

How Much Can I Apply For? Your Additional Life amount cannot exceed a maximum of 5 times your annual earnings. The coverage amount for your spouse cannot exceed 50 percent of your Additional Life coverage. The coverage amount for your child(ren) cannot exceed 50 percent of your Additional Life coverage.	For You:	**$10,000 – $300,000** in increments of **$10,000**
	For Your Spouse:	**$5,000** – **$150,000** in increments of **$5,000**
	For Your Child(ren):	**$5,000** or **$10,000**
What is the Guarantee Issue Maximum? Depending on your eligibility, this is the maximum amount of coverage you may apply for during initial enrollment without answering health questions.	For You:	Up to **$100,000**
	For Your Spouse:	Up to **$25,000**

See the Important Details section for more information, including requirements, exclusions, age reductions and definitions.

Additional Feature

Accelerated Benefit	If you become terminally ill, you may be eligible to receive up to 75 percent of your combined Basic and Additional Life benefit to a maximum of $500,000.

How much Life insurance do you need?
After a death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs.**

How Much Your Coverage Costs

Your Basic Life insurance is paid for by Dixie District Schools. If you choose to purchase Additional Life coverage, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck. How much your premium costs depends on a number of factors, such as your age and the benefit amount.

Use this formula to calculate your premium payment:

_____ ÷ 1000 = _____ x _____ = _____ → _____

Enter the amount of coverage you are requesting (see benefit amounts in the About This Coverage section).

Enter your rate from the rate table.

This amount is an estimate of how much you would pay each month.

To get a sense of your 18thly premium, multiply your monthly premium amount by 12 and then divide by 18.

If you buy coverage for your spouse, your monthly rate is shown in the table below. Use the same formula to calculate the premium that you used for yourself, but use your age and your spouse's rate.

If you buy Dependents Life coverage for your child(ren), your monthly rate is $0.10 per $1,000, no matter how many children you're covering.

Age (as of last July 1)	Your Rate (Per $1,000 of Total Coverage)	Your Spouse's Rate (Per $1,000 of Total Coverage)
<30	$0.050	$0.050
30–34	$0.060	$0.060
35–39	$0.080	$0.080
40–44	$0.120	$0.120
45–49	$0.200	$0.200
50–54	$0.320	$0.320
55–59	$0.550	$0.550
60–64	$0.800	$0.800
65+	$0.865	$0.865

Employee Life Premiums for 18 Pay Periods per Year

Coverage Amount	Employee's Age as of last July 1									
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+*
$10,000	0.33	0.40	0.53	0.80	1.33	2.13	3.67	5.33	5.77	2.88
$20,000	0.67	0.80	1.07	1.60	2.67	4.27	7.33	10.67	11.53	5.77
$30,000	1.00	1.20	1.60	2.40	4.00	6.40	11.00	16.00	17.30	8.65
$40,000	1.33	1.60	2.13	3.20	5.33	8.53	14.67	21.33	23.07	11.53
$50,000	1.67	2.00	2.67	4.00	6.67	10.67	18.33	26.67	28.83	14.42
$60,000	2.00	2.40	3.20	4.80	8.00	12.80	22.00	32.00	34.60	17.30
$70,000	2.33	2.80	3.73	5.60	9.33	14.93	25.67	37.33	40.37	20.18
$80,000	2.67	3.20	4.27	6.40	10.67	17.07	29.33	42.67	46.13	23.07
$90,000	3.00	3.60	4.80	7.20	12.00	19.20	33.00	48.00	51.90	25.95
$100,000**	**3.33**	**4.00**	**5.33**	**8.00**	**13.33**	**21.33**	**36.67**	**53.33**	**57.67**	**28.83**
$110,000	3.67	4.40	5.87	8.80	14.67	23.47	40.33	58.67	63.43	31.72
$120,000	4.00	4.80	6.40	9.60	16.00	25.60	44.00	64.00	69.20	34.60
$130,000	4.33	5.20	6.93	10.40	17.33	27.73	47.67	69.33	74.97	37.48
$140,000	4.67	5.60	7.47	11.20	18.67	29.87	51.33	74.67	80.73	40.37
$150,000	5.00	6.00	8.00	12.00	20.00	32.00	55.00	80.00	86.50	43.25
$160,000	5.33	6.40	8.53	12.80	21.33	34.13	58.67	85.33	92.27	46.13
$170,000	5.67	6.80	9.07	13.60	22.67	36.27	62.33	90.67	98.03	49.02
$180,000	6.00	7.20	9.60	14.40	24.00	38.40	66.00	96.00	103.80	51.90
$190,000	6.33	7.60	10.13	15.20	25.33	40.53	69.67	101.33	109.57	54.78
$200,000	6.67	8.00	10.67	16.00	26.67	42.67	73.33	106.67	115.33	57.67
$210,000	7.00	8.40	11.20	16.80	28.00	44.80	77.00	112.00	121.10	60.55
$220,000	7.33	8.80	11.73	17.60	29.33	46.93	80.67	117.33	126.87	63.43
$230,000	7.67	9.20	12.27	18.40	30.67	49.07	84.33	122.67	132.63	66.32
$240,000	8.00	9.60	12.80	19.20	32.00	51.20	88.00	128.00	138.40	69.20
$250,000	8.33	10.00	13.33	20.00	33.33	53.33	91.67	133.33	144.17	72.08
$260,000	8.67	10.40	13.87	20.80	34.67	55.47	95.33	138.67	149.93	74.97
$270,000	9.00	10.80	14.40	21.60	36.00	57.60	99.00	144.00	155.70	77.85
$280,000	9.33	11.20	14.93	22.40	37.33	59.73	102.67	149.33	161.47	80.73
$290,000	9.67	11.60	15.47	23.20	38.67	61.87	106.33	154.67	167.23	83.62
$300,000	10.00	12.00	16.00	24.00	40.00	64.00	110.00	160.00	173.00	86.50

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).
** Elected amounts over the Guarantee Issue amount of $100,000 are subject to Evidence of Insurability.

Spouse Life Premiums for 18 Pay Periods per Year

Coverage Amount	Employee's Age as of last July 1									
	< 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+*
$5,000	0.17	0.20	0.27	0.40	0.67	1.07	1.83	2.67	2.88	1.44
$10,000	0.33	0.40	0.53	0.80	1.33	2.13	3.67	5.33	5.77	2.88
$15,000	0.50	0.60	0.80	1.20	2.00	3.20	5.50	8.00	8.65	4.33
$20,000	0.67	0.80	1.07	1.60	2.67	4.27	7.33	10.67	11.53	5.77
$25,000**	**0.83**	**1.00**	**1.33**	**2.00**	**3.33**	**5.33**	**9.17**	**13.33**	**14.42**	**7.21**
$30,000	1.00	1.20	1.60	2.40	4.00	6.40	11.00	16.00	17.30	8.65
$35,000	1.17	1.40	1.87	2.80	4.67	7.47	12.83	18.67	20.18	10.09
$40,000	1.33	1.60	2.13	3.20	5.33	8.53	14.67	21.33	23.07	11.53
$45,000	1.50	1.80	2.40	3.60	6.00	9.60	16.50	24.00	25.95	12.98
$50,000	1.67	2.00	2.67	4.00	6.67	10.67	18.33	26.67	28.83	14.42
$55,000	1.83	2.20	2.93	4.40	7.33	11.73	20.17	29.33	31.72	15.86
$60,000	2.00	2.40	3.20	4.80	8.00	12.80	22.00	32.00	34.60	17.30
$65,000	2.17	2.60	3.47	5.20	8.67	13.87	23.83	34.67	37.48	18.74
$70,000	2.33	2.80	3.73	5.60	9.33	14.93	25.67	37.33	40.37	20.18
$75,000	2.50	3.00	4.00	6.00	10.00	16.00	27.50	40.00	43.25	21.63
$80,000	2.67	3.20	4.27	6.40	10.67	17.07	29.33	42.67	46.13	23.07
$85,000	2.83	3.40	4.53	6.80	11.33	18.13	31.17	45.33	49.02	24.51
$90,000	3.00	3.60	4.80	7.20	12.00	19.20	33.00	48.00	51.90	25.95
$95,000	3.17	3.80	5.07	7.60	12.67	20.27	34.83	50.67	54.78	27.39
$100,000	3.33	4.00	5.33	8.00	13.33	21.33	36.67	53.33	57.67	28.83
$105,000	3.50	4.20	5.60	8.40	14.00	22.40	38.50	56.00	60.55	30.28
$110,000	3.67	4.40	5.87	8.80	14.67	23.47	40.33	58.67	63.43	31.72
$115,000	3.83	4.60	6.13	9.20	15.33	24.53	42.17	61.33	66.32	33.16
$120,000	4.00	4.80	6.40	9.60	16.00	25.60	44.00	64.00	69.20	34.60
$125,000	4.17	5.00	6.67	10.00	16.67	26.67	45.83	66.67	72.08	36.04
$130,000	4.33	5.20	6.93	10.40	17.33	27.73	47.67	69.33	74.97	37.48
$135,000	4.50	5.40	7.20	10.80	18.00	28.80	49.50	72.00	77.85	38.93
$140,000	4.67	5.60	7.47	11.20	18.67	29.87	51.33	74.67	80.73	40.37
$145,000	4.83	5.80	7.73	11.60	19.33	30.93	53.17	77.33	83.62	41.81
$150,000	5.00	6.00	8.00	12.00	20.00	32.00	55.00	80.00	86.50	43.25

* Coverage amounts for ages 70 and over reduce due to age reduction (see Life Insurance Age Reductions section).
** Elected amounts over the Guarantee Issue amount of $25,000 are subject to Evidence of Insurability.

Child Life Premiums for 18 Pay Periods per Year

Coverage Amount	Premium
$5,000	0.33
$10,000	0.67

Important Details

Here's where you'll find the nitty-gritty details about the plan.

Eligibility Requirements

To be eligible for basic and additional coverage, you must be:

- An active employee of Dixie District Schools
- Regularly working at least 20 hours per week
- Insured for Basic Life insurance through The Standard to qualify for Additional Life insurance

Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible.

If you buy Additional Life insurance for yourself, you may also buy additional coverage for your eligible children and/or spouse. This is called Dependents Life insurance. You can choose to cover your spouse, meaning a person to whom you are legally married. Child means your child from live birth through age 20 (through age 24 if a registered student in full-time attendance at an accredited educational institution). Your child cannot be insured by more than one employee. Your spouse or child(ren) must not be full-time member(s) of the armed forces. You cannot be insured as both an individual and a dependent.

Medical Underwriting Approval

Required for:

- Coverage amounts higher than the guarantee issue maximum amount
- All late applications (applying 31 days after becoming eligible)
- Requests for coverage increases
- Reinstatements
- Eligible but not insured under the prior life insurance plan

Visit **www.standard.com/mhs** to submit a medical history statement online.

Coverage Effective Date

To become insured, you must

- Meet the eligibility requirements listed in the previous sections,
- Serve an eligibility waiting period*,
- Receive medical underwriting approval (if applicable),
- Apply for coverage and agree to pay premium, and
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective.

If you are not actively at work on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee. Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your coverage.

*Defined as first of the month that follows 60 consecutive days as a member

Life Insurance Age Reductions

Under this plan, your coverage amount reduces to 50 percent at age 70. Your spouse's coverage amount reduces by your age as follows: to 50 percent at age 70. If you are age or over, ask your human resources representative or plan administrator for the amount of coverage available.

Waiver of Premium

Your premiums may be waived if you:

- Become totally disabled while insured under this plan,
- Are under age 60, and
- Complete a waiting period of 180 days.

If these conditions are met, your Life insurance coverage may continue without cost until age 65, provided you give us satisfactory proof that you remain totally disabled.

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Exclusions

Subject to state variations, you and your dependents are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy

In addition to the above requirements, your Dependents Life coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com.**

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

GP190-LIFE/S399, GP399-LIFE/TRUST, GP899-LIFE, GP190-LIFE/A997/S399, GP411-LIFE

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 12506-D-AL-FL-147568 (10/17)
5391884-116243

DIXIE COUNTY SCHOOL BOARD
NOTICE OF USE OF SOCIAL SECURITY NUMBERS

In compliance with Florida Statute 119.071 (5), this document serves to notify you of the purpose for the collection and usage of your social security number.

Purpose	Federal and State Regulations
Employees:	
Payroll Processing, Employee Benefit Forms and Human Resource	Required by F.S. 119.071(5)(a)6
Bank Signature Cards, Direct Deposit, Bank Deductions and Deduction Remittances	Required by Fla. Admin. Code 6A-1.0012 and F.S. 119.071(5)(a)6
Social Security Contributions	Required by Fla. Admin. Code 60S-3.010 and F.S. 119.071(5)(a)2&6
Garnishments, Compliance with Court Requests, Child Support	Required by F.S. 61.1301(2)(e) and F.S. 119.071(5)(a), and required by 45 C.F.R. 307.11 and F.S. 61.13, 742.10 or 409.256.3 or 742.031 and required by Fla. Admin. Code 12E-1.028m
Worker's Compensation	Required and/or authorized by F.S. 440.185 and Fla. Admin. Code 69L-3.003 et seq., Fla. Admin. Code 60Q-6.103 and F.S. 119.071(5)(a)6
Unemployment Reports	Required by F.S. Ch. 443, including 443.16, and F.S. 119.071 (5)(a)6 and Fla. Admin. Code 60BB-2.2023
Federal Forms W-2, W-4, and W-9	Required by F.S. and regulation 26 U.S.C. 6051 and U.S.C. 3402, and 26 C.F.R. 31.601(b)-2, and 26 C.F.R. 31.6051-1, and 26 C.F.R. 301.6109-1 and 31.3402(f)(2)-1, and F.S. 119.071(5)(a)6,
Florida Retirement System and Retirement Programs	Required by Fla. Admin. Code 19-11.010, 19-11.006 and 19-11.007 and F.S. 119.071(5)(a)2&6 or required by F.S. 121.051 and 121.071 and Fla. Admin. Code 19-13.003, required by 26 C.F.R. 301.6057-1, and authorized by F.S. 238.01et seq., including 238.07
Teacher Certification	Required by F.S. 1012.56, and 119.071 (5)(a)6, and/or authorized by F.S. 1012.21 and 119.071 (5)(a)6
State Directory of New Hires	Required by federal law 42 U.S.C. 653a and F.S. 409.2576 and F.S. 119.071(5)(a)
Fingerprinting Identification/Criminal History/Sexual Predator Registration	Required by Fla. Admin. Code 11C-6.003 and F.S. 119.071(5)(a)2&6 and Authorized by F.S. 943.04351
Initial Employment Identification including I-9's	Authorized by 8 U.S.C. 1324 a(b) and 8 C.F.R. 274a.2
Vendors/Consultants with no Tax ID number for 1099's	Required by 26 C.F.R. 31.2306-0, 26 C.F.R. 301.6109-1 and F.S. 119.071 (5)(a)2&6

Students:

Student Enrollment,Student Demographic Record, Student ID Student Assessment Accountability Measures State Reporting of Student Data Student Athletic Forms Student Insurance and Student Health Records Student Activities and Clubs FACTS.org Scholarships National Lunch Program: Free/Reduced Lunch processing	Student-related uses are authorized by F.S. 1008.386

This is intended to be a general listing of uses of social security number by the Dixie County School Board. Any individual having specific questions or concerns regarding the disclosure of their social security number should contact the Personnel, Finance, or Student Service Department, dependent upon the area of their concern.

Social Security numbers are confidential and may only be released as authorized by Florida Statutes.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact TERRI JENKINS AT 352-469-3023 EXT 4.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name DIXIE COUNTY DISTRICT SCHOOLS	4. Employer Identification Number (EIN) 59-6000586
5. Employer address 823 SE 349 Highway	6. Employer phone number 352-469-3023

7. City Old Town	8. State Florida	9. ZIP code 32680

10. Who can we contact about employee health coverage at this job? TERRI JENKINS	
11. Phone number (if different fromabove) 352-469-3023 EXT 4	12. Email address terrijenkins@dixie.k12.fl.us

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Employees working full time

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Legal dependents defined by the insurance carrier contract.

☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

ACA Eligibility

Your Eligibility: You are eligible for health care benefits under the Plan if you are a full-time employee. For purposes of the Plan's health care benefits, a full-time employee is an employee who is employed, on average, for at least 30 hours of service per week.

Unless otherwise communicated to you by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, contract employees, part-time employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Company's payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Look-back Measurement Method for Determining Full-time Employee Status:

The Company uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- ❑ X All employees;
- ❑ Salaried employees;
- ❑ Hourly employees;
- ❑ Employees in the following state(s):
- ❑ _____;
- ❑ • All collectively bargained employees;
- ❑ • All non-collectively bargained employees;
- ❑ All collectively bargained employees covered by the following bargaining agreement(s): _____.

The **look-back measurement method** involves ***three different periods***:

1. A ***measurement period*** is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

    a. If you are an **ongoing employee**, this measurement period is called the "***standard measurement period***." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care

benefits for the stability period that follows the standard measurement period and any administrative period.

b. If you are a **new variable hour, seasonal or part-time employee**, this measurement period is called the "***initial measurement period*.**" Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

c. if you are a new non-seasonal employee who is expected to work full time, the Company will determine your status as a **full-time employee** who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

2. The ***stability period*** is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the Company. There are exceptions to this general rule for employees who experience certain changes in employment status.

3. An ***administrative period*** is a short period between the measurement period and the stability period when the Company performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the Company or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation. The Company intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

Patient's Bill of Rights

The Affordable Care Act puts consumers back in charge of their health care. Under the law, a new "Patient's Bill of Rights" gives the American people the stability and flexibility they need to make informed choices about their health.
View **Key Features of the Affordable Care Act** or read a **year-by-year overview of features**.

Coverage

- **Ends Pre-Existing Condition Exclusions for Children**: Health plans can no longer limit or deny benefits to children under 19 due to a pre-existing condition.
- **Keeps Young Adults Covered:** If you are under 26, you may be eligible to be covered under your parent's health plan.
- **Ends Arbitrary Withdrawals of Insurance Coverage**: Insurers can no longer cancel your coverage just because you made an honest mistake.
- **Guarantees Your Right to Appeal**: You now have the right to ask that your plan reconsider its denial of payment.

Costs

- **Ends Lifetime Limits on Coverage:** Lifetime limits on most benefits are banned for all new health insurance plans.
- **Reviews Premium Increases**: Insurance companies must now publicly justify any unreasonable rate hikes.
- **Helps You Get the Most from Your Premium Dollars**: Your premium dollars must be spent primarily on health care – not administrative costs.

Care

- **Covers Preventive Care at No Cost to You**: You may be eligible for recommended preventive health services. No copayment.
- **Protects Your Choice of Doctors:** Choose the primary care doctor you want from your plan's network.
- **Removes Insurance Company Barriers to Emergency Services**: You can seek emergency care at a hospital outside of your health plan's network.

For More Information

- Read the Full Law
- Find detailed technical and regulatory information on the Patient's Bill of Rights.

CHIPRA

The Children's Health Insurance Program Reauthorization Act (CHIPRA) extends and expands the state Children's Health Insurance Program (CHIP). The following key provisions affect group health plans. Employers and group health plan administrators should note that some obligations were required to be complied with by April 1, 2009.

Premium Assistance Subsidy for Employer Coverage

States may elect to offer a premium assistance subsidy to help CHIP and Medicaid eligible children obtain "qualified employer-sponsored coverage". The subsidy may be provided as a reimbursement directly to the employee or as a direct payment to the employer. Employers can opt-out of direct payments.

Notice to Employees of Premium Assistance

Special Update: The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) has released an updated model notice for employers to provide information on eligibility for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP). Employers that provide coverage in states with premium assistance through Medicaid or CHIP must inform employees of potential opportunities for assistance in obtaining health coverage. The updated model notice includes information on how employees can contact their state for additional information and how to apply for premium assistance.

The employer CHIP notice must be provided annually before the start of each plan year. An employer may provide the notice applicable to the state in which an employee resides concurrent with the furnishing of:

- Materials notifying the employee of health plan eligibility;
- Materials provided to the employee in connection with an open season or election process conducted under the plan; or
- The summary plan description.

To download the updated CHIP model notice, please click on the link below.

- Model Employer CHIP Notice

Disclosure to States

Plan administrators of group health plans are required to disclose information about the plan to State Medicaid and CHIP programs upon request. The Departments of Labor and Health and Human Services are required to develop a model disclosure form for plan administrators.
Before enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), employees and their dependents who became eligible for employment-based group health plan coverage, but did not enroll when first given the opportunity, had no guaranteed right under Federal law to join the group health plan if their circumstances changed at a later time. Even if the plan offered an annual open enrollment period, the individual would not only have to wait until that period, but enrollment during that period could be considered a “late enrollment” subject to a higher premium or restricted benefits.

Special Enrollment

CHIPRA provides that group health plans and health insurance issuers must permit employees and their dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

1. Losing eligibility for coverage under a State Medicaid or CHIP program, or
2. Becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage, or within 60 days of being determined to be eligible for premium assistance.
For more information and guidance regarding CHIPRA, click here.

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, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
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	Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	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
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Declaración de la Ley de Reducción de Trámites

Según la Ley de Reducción de Trámites de 1995 (Ley Pública 104-13) (PRA, por sus siglas en inglés), no es obligatorio que ninguna persona responda a una recopilación de información, a menos que dicha recopilación tenga un número de control válido de la Oficina de Administración y Presupuesto (OMB, por sus siglas en inglés). El Departamento advierte que una agencia federal no puede llevar a cabo ni patrocinar una recopilación de información, a menos que la OMB la apruebe en virtud de la ley PRA y esta tenga un número de control actualmente válido de la oficina mencionada. El público no tiene la obligación de responder a una recopilación de información, a menos que esta tenga un número de control actualmente válido de la OMB. Consulte la Sección 3507 del Título 44 del Código de Estados Unidos (USC). Además, sin perjuicio de ninguna otra disposición legal, ninguna persona quedará sujeta a sanciones por no cumplir con una recopilación de información, si dicha recopilación no tiene un número de control actualmente válido de la OMB. Consulte la Sección 3512 del Título 44 del Código de Estados Unidos (USC).

Se estima que el tiempo necesario para realizar esta recopilación de información es, en promedio, de aproximadamente siete minutos por persona. Se anima a los interesados a que envíen sus comentarios con respecto al tiempo estimado o a cualquier otro aspecto de esta recopilación de información, como sugerencias para reducir este tiempo, a la dependencia correspondiente del Ministerio de Trabajo de EE. UU., a la siguiente dirección: U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210. También pueden enviar un correo electrónico a ebsa.opr@dol.gov y hacer referencia al número de control de la OMB 1210-0137.

Número de Control de OMB 1210-0137 (caduca el 31/12/2016)

ERISA Special Enrollment

2590.701-6 Special enrollment periods.
(a) *Special enrollment for certain individuals who lose coverage—*
(1) *In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 2590.701-2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.
(2) *Individuals eligible for special enrollment—*
(i) *When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—
(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;
(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and
(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.
(ii) *When dependent loses coverage—*
(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—
(*1*) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(*2*) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(*3*) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

Special Enrollment under HIPAA

Under HIPAA, certain events that happen to employees or their dependents trigger a right to "special enroll" in your employer-sponsored group health plan. Special enrollment generally means that the employee or dependent will have 30 days from the date of the event to request coverage in your group health plan, **regardless of your open enrollment period**. Special enrollment rights under HIPAA arise out of:

- The loss of **other** health coverage; or an employer terminating contributions toward health coverage; and
- A person becoming a new dependent through
    - Marriage;
    - Birth;
    - Adoption; or
    - Placement for adoption

Loss of Other Health Coverage

When one of your employees, or a dependent of an employee, loses **other** health coverage, a special enrollment opportunity in your group health plan may be triggered.
To have a special enrollment opportunity as a result of losing other health coverage:

- The employee or dependent must have had other health coverage when he or she previously declined coverage under your group health plan.
- If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted.
- If the other coverage was not COBRA continuation coverage, special enrollment can be requested when the individual **loses eligibility** for the other coverage.

Events Related to Losing Health Coverage

Some examples of events that cause an individual to lose eligibility for health coverage include:

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan because of age, work, or school status;
- Death of the employee covered by the plan;
- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals;
- An individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

Termination of Employer Contributions

If an employer terminates all contributions to a group health plan, but individuals have the option to continue coverage and pay 100% of the cost themselves, these individuals have a special enrollment right because the employer has terminated contributions. Thus, if all employer contributions have ended, individuals covered under the plan would have a special enrollment right, regardless of their option to continue coverage under the plan by paying the full cost of coverage.

30 Days to Request Special Enrollment

If a plan must offer special enrollment due to a loss of eligibility or termination of employer contributions, the plan must provide at least 30 days for the employee or dependent to request coverage after the loss of other coverage or termination of employer contributions.
In addition, the resulting coverage must be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

New Dependent

A special enrollment opportunity may also be triggered when a person becomes a new dependent through marriage, birth, adoption or placement for adoption.
For each triggering event, a special enrollee may not be treated as a late enrollee. Therefore, the maximum pre-existing condition exclusion period that may be applied to a special enrollee is 12 months, and the 12 months are reduced by the special enrollee's prior creditable coverage.

Person Becoming a New Dependent- 30 Days to Request Special Enrollment

If a special enrollment opportunity is available, the individual must request special enrollment within 30 days of the marriage, birth, adoption or placement for adoption that triggered the special enrollment opportunity.

- In the case of marriage, enrollment is required to be effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan.
- In the case of birth, adoption or placement for adoption, enrollment is required to be effective not later than the date of such birth, adoption or placement for adoption.

No Pre-Existing Conditions for Children Acquiring Coverage Through Special Enrollment

A newborn, adopted child under 18 or child under 18 placed for adoption cannot be subjected to a pre-existing condition exclusion period if the child is enrolled within 30 days of birth, adoption or placement for adoption and has no subsequent significant break in coverage.

Requirement to Disclose Individuals' Special Enrollment Rights

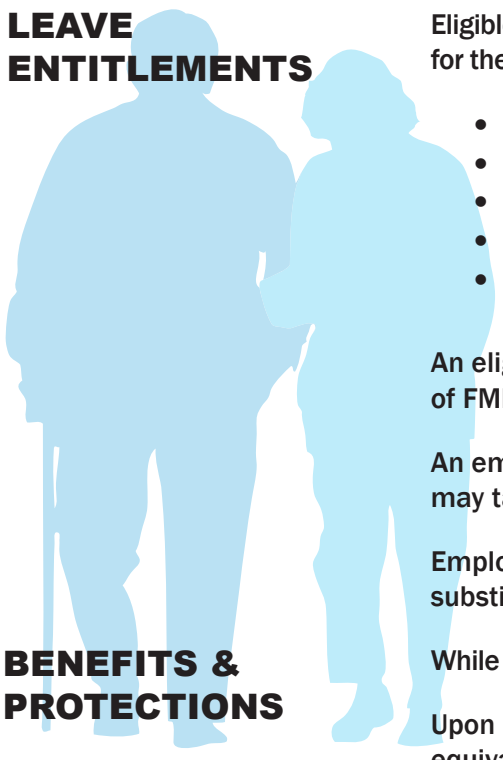
A description of special enrollment rights must be provided to employees at the time or before they are offered the opportunity to enroll in the group health plan. **Special enrollment notice may be provided in the summary plan description (SPD)** if the SPD is provided to the employee at the time or before the employee is initially offered the opportunity to enroll in the plan. If the SPD is provided at a later time, the special enrollment notice should be provided separately (for example, as part of the application for coverage).

Plans that qualify as "excepted benefits" do not have to offer special enrollment.

Please note that employees or dependents must be given 60 days to request enrollment if they lose Medicaid or Children's Health Insurance Program (CHIP, formerly known as the State Children's Health Insurance Program or SCHIP) coverage by losing eligibility or becoming eligible for Medicaid or CHIP assistance with group health plan premiums. See the CHIPRA compliance activity for more information.

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

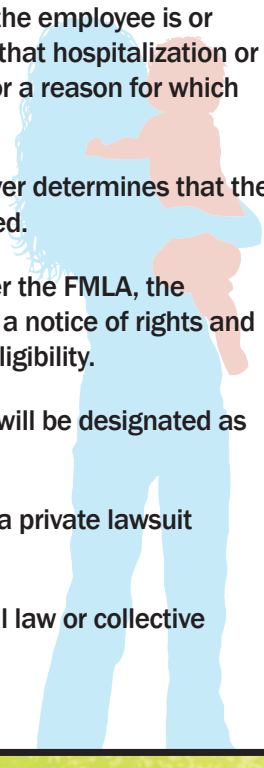
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

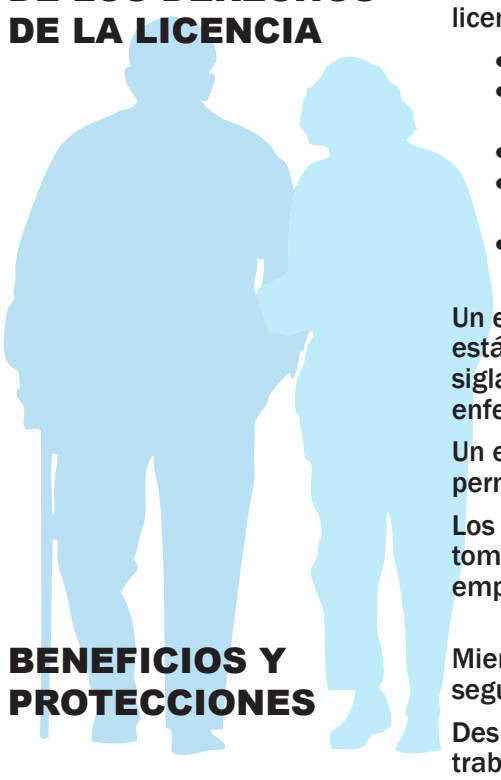
www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

DERECHOS DEL EMPLEADO
SEGÚN LA LEY DE AUSENCIA FAMILIAR Y MÉDICA

DIVISIÓN DE HORAS Y SALARIOS DEL DEPARTAMENTO DE EE. UU.



DE LOS DERECHOS DE LA LICENCIA

Los empleados elegibles que trabajan para un empleador sujeto a esta ley pueden tomarse hasta 12 semanas de licencia sin sueldo sin perder su empleo por las siguientes razones:

- El nacimiento de un hijo o la colocación de un hijo en adopción o en hogar de crianza;
- Para establecer lazos afectivos con un niño (la licencia debe ser tomada dentro del primer año del nacimiento o la colocación del niño);
- Para cuidar al cónyuge del empleado, al hijo, o al padre que tenga un problema de salud serio que califique;
- Debido a un problema de salud serio del mismo empleado que califique y que resulte en que el empleado no pueda realizar su trabajo;
- Por exigencias que califiquen relacionadas con el despliegue de un miembro de las fuerzas armadas que sea cónyuge del empleado, hijo o padre.

Un empleado elegible que es cónyuge, hijo, padre o familiar más cercano del miembro de las fuerzas armadas que está cubierto, puede tomarse hasta 26 semanas de licencia bajo la Ley de Ausencia Familiar y Médica (FMLA, por sus siglas en inglés) en un periodo de 12 meses para cuidar al miembro de las fuerzas armadas que tenga una lesión o enfermedad seria.

Un empleado no tiene que tomarse la licencia de una sola vez. Cuando es medicamente necesario o de otra manera permitido, los empleados pueden tomarse la licencia de forma intermitente o en una jornada reducida.

Los empleados pueden elegir, o un empleador puede exigir, el uso de licencias pagadas acumuladas mientras se toman la licencia bajo la FMLA. Si un empleado sustituye la licencia pagada acumulada por la licencia bajo la FMLA, el empleado tiene que respetar las políticas de pago de licencias normales del empleador.

BENEFICIOS Y PROTECCIONES

Mientras los empleados estén de licencia bajo la FMLA, los empleadores tienen que continuar con la cobertura del seguro de salud como si los empleados no estuvieran de licencia.

Después de regresar de la licencia bajo la FMLA, a la mayoría de los empleados se les tiene que restablecer el mismo trabajo o uno casi idéntico, con el pago, los beneficios y otros términos y otras condiciones de empleo equivalentes.

Un empleador no puede interferir con los derechos de la FMLA de un individuo o tomar represalias contra alguien por usar o tratar de usar la licencia bajo la FMLA, oponerse a cualquier práctica ilegal hecha por la FMLA, o estar involucrado en un procedimiento según o relacionado con la FMLA.

REQUISITOS DE ELEGIBILIDAD

Un empleado que trabaja para un empleador cubierto tiene que cumplir con tres criterios para poder ser elegible para una licencia bajo la FMLA. El empleado tiene que:

- Haber trabajado para el empleador por lo menos 12 meses;
- Tener por lo menos 1,250 horas de servicio en los 12 meses previos a tomar la licencia*; y
- Trabajar en el lugar donde el empleador tiene al menos 50 empleados dentro de 75 millas del lugar de trabajo del empleado.

*Requisitos especiales de “horas de servicio” se aplican a empleados de una tripulación de una aerolínea.

PEDIDO DE LA LICENCIA

En general, los empleados tienen que pedir la licencia necesaria bajo la FMLA con 30 días de anticipación. Si no es posible avisar con 30 días de anticipación, un empleado tiene que notificar al empleador lo más pronto posible y, generalmente, seguir los procedimientos usuales del empleador.

Los empleados no tienen que informar un diagnóstico médico, pero tienen que proporcionar información suficiente para que el empleador pueda determinar si la ausencia califica bajo la protección de la FMLA. La información suficiente podría incluir informarle al empleador que el empleado está o estará incapacitado para realizar sus funciones laborales, que un miembro de la familia no puede realizar las actividades diarias, o que una hospitalización o un tratamiento médico es necesario. Los empleados tienen que informar al empleador si la necesidad de la ausencia es por una razón por la cual la licencia bajo la FMLA fue previamente tomada o certificada.

Los empleadores pueden exigir un certificado o una recertificación periódica que respalde la necesitad de la licencia. Si el empleado determina que la certificación está incompleta, tiene que proporcionar un aviso por escrito indicando qué información adicional se requiere.

RESPONSABILIDADES DEL EMPLEADOR

Una vez que el empleador tome conocimiento que la necesidad de la ausencia del empleado es por una razón que puede calificar bajo la FMLA, el empleador tiene que notificar al empleado si él o ella es elegible para una licencia bajo FMLA y, si es elegible, también tiene que proporcionar un aviso de los derechos y las responsabilidades según la FMLA. Si el empleado no es elegible, el empleador tiene que brindar una razón por la cual no es elegible.

Los empleadores tienen que notificar a sus empleados si la ausencia será designada como licencia bajo la FMLA, y de ser así, cuánta ausencia será designada como licencia bajo la FMLA.

CUMPLIMIENTO

Los empleados pueden presentar un reclamo ante el Departamento de Los empleados Los Los empleados pueden presentar un reclamo ante el Departamento de Trabajo de EE. UU., la División de Horas y Salarios, o pueden presentar una demanda privada contra un empleador.

La FMLA no afecta a ninguna ley federal o estatal que prohíba la discriminación ni sustituye a ninguna ley estatal o local o convenio colectivo de negociación que proporcione mayores derechos de ausencias familiares o médicas.

Para información adicional o para presentar un reclamo:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

Departamento de Trabajo de los EE.UU. | División de Horas y Salarios

WHD DIVISIÓN DE HORAS Y SALARIOS

WH1420 SPA REV 04/16

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a Summary Plan Description or other similar description of benefits under the plan or health insurance coverage. The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

DIXIE DISTRICT SCHOOLS benefit plan does not require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Carrier Florida Blue 1-800-352-2583

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from Florida Blue or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the TERRI JENKINS at 352-469-3023.

Patient Protection Model Disclosure

Divulgación de modelo de protección de pacientes

Cuando corresponda, es importante que las personas inscritas en un plan o cobertura de seguro médico conozcan sus derechos a (1) elegir un proveedor de cuidados primarios o un pediatra cuando un plan o emisor exijan la designación de un médico de cuidados primarios; o (2) obtener atención obstétrica o ginecológica sin autorización previa. Asimismo, las normas finales interinas con respecto a protecciones para el paciente bajo la sección 2719A de la Ley de Cuidado de Salud de Bajo Precio exige que los planes y emisores notifiquen a los participantes acerca de estos derechos, cuando corresponda. El aviso debe ser proporcionado siempre que el plan o el emisor provean al participante una descripción resumida del plan u otra descripción similar de beneficios bajo el plan o la cobertura de seguro médico. Este aviso debe proveerse, a más tardar, el primer día del primer año del plan comenzando el 23 de septiembre de 2010 o en fecha posterior.

Se puede utilizar el siguiente texto modelo para cumplir con la exigencia de provisión de aviso:

Para planes y emisores que exijan o permitan la designación de proveedores de cuidados primarios por participantes o beneficiarios, insertar:

DIXIE DISTRICT SCHOOLS , en general, la designación de un proveedor de cuidados primarios. Usted tiene derecho a designar a cualquier proveedor de cuidados primarios que participe en nuestra red y esté disponible para aceptarlo(a) a usted o a sus familiares. Florida Blue 1-800-352-2583 Para obtener información sobre cómo seleccionar un proveedor de cuidados primarios, y para una lista de los proveedores de cuidado primarios participantes, comuníquese con el

Para planes y emisores que exijan o permitan la designación de un proveedor de cuidados primarios para un menor, añada:

Para los menores, usted podrá designar un pediatra como el proveedor de cuidados primarios.

Para planes y emisores que provean cobertura para atención obstétrica o ginecológica y exijan que el participante o el beneficiario designe un proveedor de cuidados primarios, añada:

Usted no necesita autorización previa de [nombre del plan de salud grupal o emisor] o de cualquier otra persona (incluido un proveedor de cuidados primarios) a fin de obtener acceso a atención obstétrica o ginecológica de un profesional de salud en nuestra red que se especialice en obstetricia o ginecología. Sin embargo, el profesional de salud puede ser requerido conformarse con ciertos procedimientos, inclusive obtener autorización previa para ciertos servicios, siguiendo un plan de tratamiento previamente aprobado, o

procedimientos de hacer referidos. Para obtener una lista de profesionales de salud participantes especializados en obstetricia o ginecología, comuníquese con el TERRI JENKINS AT 952-469-3023 EXT 3

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: If you would like more information on WHCRA benefits, call your plan administrator 850-701-0725

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 850-701-0725for more information.

Newborns' Act Disclosure

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

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

REEMPLOYMENT RIGHTS

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

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

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

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

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

then an employer may not deny you:

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

because of this status.

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

HEALTH INSURANCE PROTECTION

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

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

ENFORCEMENT

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

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

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

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

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

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

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—October 2008

MICHELLE'S LAW NOTICE

Plan Administrator Note: This notice must be provided with any notice regarding a requirement for certification of student status for coverage under the plan.

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the DIXIE DISTRICT SCHOOLS health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of DIXIE DISTRICT SCHOOLS t group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the DIXIE DISTRICT SCHOOLS group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the DIXIE DISTRICT SCHOOLS group health plan, whichever is earlier. In order to be eligible to continue coverage as a dependent during such leave of absence:

- The DIXIE DISTRICT SCHOOLS group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

To obtain additional information, please contact: TERRI JENKINS 352-469-3023 EXT 4

Important Notice from DIXIE 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 DIXIE 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. 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.

Medicare's

There are two important things you need to know about your current coverage and 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. DIXIE DISTRICT SCHOOLS has determined that the prescription drug coverage offered by the DIXIE DISTRICT SCHOOLS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore 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.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Franklin County School District coverage will not be affected. See pages 7- 9 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 DIXIE DISTRICT SCHOOLS coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with DIXIE DISTRICT SCHOOLS If you don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information [or call TERRI JENKINS AT 352-469-3023. 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 DIXIE 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your "" copy of the Medicare & You handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	01/01/2020
Name of Entity/Sender:	DIXIE DISTRICT SCHOOLS
Contact--Position/Office:	TERRI JENKINS
Address:	823 SE 349 Highway, Old Town 32680
Phone Number:	352-469-3023