School District of Indian River County

2023—2024 Employee Benefit Guide

Revised: September 18, 2023

November 1st Medical Rate Change

Updated September 18 2023

Welcome to your District Benefit Enrollment Guide

Our Commitment to You

The School District of Indian River County is committed to providing our employees with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental and vision coverage, as well as many other products.

As a new hire and at Open Enrollment, we ask you to make benefit elections for you and your family so that you will be financially prepared for any health and life challenges you may face. Here are two easy steps you can follow to do just that:

1. Review the Benefit Guide. This guide provides highlights of your benefits, points out what is new and tells you where to get more information.

2. Consider your needs and those of your covered dependents. Life changes and so do your healthcare needs. Check to be sure your dependents are eligible for coverage and that their Social Security numbers and your beneficiary designations are up-to-date.

What's in the Guide?

Information on the Creditable Coverage status of the District's Prescription Drug (Rx) Plans can be found in this booklet on page 39

Open Enrollment

Please be sure to read this entire Benefit Guide thoroughly to ensure you understand the changes taking place this year.

This will be a MANDATORY Re-Enrollment

- NEW for the 2023-2024 Plan Year:
  - New EAP vendor see page 20.
- All benefit eligible employees must re-enroll every year.
- **You must** complete the enrollment process even if you choose to waive benefits.
- **Previous elections will expire on September 30, 2023** and new elections will begin on October 1, 2023.

New enrollment elections begin with the new plan year that starts October 1, 2023 and ends September 30, 2024. The Open Enrollment period begins August 1, 2023 and ends on August 22, 2023 at 5:00 pm ET.

- *Options to Enroll:*
  - **Self-Service** Enrollment can be completed via the Explain My Benefits (EMB) Enrollment system or the Mobile App beginning 8/1/2023 and ending 8/22/2023. This option is available 24 hours throughout Open Enrollment.
  - The **Call Center** will be available 8:00 am—5:00 pm Eastern Time, Monday through Friday, beginning 8/8/2023 and ending 8/22/2023.
  - **Benefit Counselor Assisted**—Self enroll via a provided computer with a counselor available for questions. This option is available in the TEC at the SDIRC Administration Building (6500 57th Street) 8/15 and 8/16 between 8:00 am and 4:30 pm **OR** via virtual meeting.

    *** Available by appointment only ***
  - Book your appointment by going to **www.sdirc-benefits.com** and choosing the "Click here to learn our options to enroll" button.

- Verification of eligibility must be provided for all dependents who are not currently enrolled. (See page 5 for additional information)
- Employees who decline medical coverage with the district must elect the Opt-Out Health Reimbursement Account (HRA) during open enrollment and will be required to provide proof of existing medical coverage. Documents can include a copy of a medical card, a letter from an employer, or a letter from an insurance company. Please see page 5 for additional information.

Open Enrollment

Open Enrollment begins on **August 1, 2023 and ends on August 22, 2023 at 5:00 pm EST**.
Re-Enrollment is MANDATORY!

How do I re-enroll?

To start the Open Enrollment process, go on-line to www.sdirc-benefits.com and select "Log Into Your Benefit System."
All previous passwords have been removed, therefore you will be required to create a new account:

1. Enter User Name: **IR** AND **your seven digit employee ID**
   Example: **IR1234567** If you don't recall your employee ID. Please refer to a recent paystub.
2. Enter Password: **Date of Birth (YYYYMMDD)** and click Login.
3. Select **"Get Started".**
4. Confirm your information along with dependents information.
5. Shop for your insurance benefits.

Important Steps:

- **Changes may not be made after Open Enrollment ends on August 22, 2023**
- **Be sure to click "checkout" at the end of the Open Enrollment process to complete. If you do not click "checkout" you will not be enrolled in benefits.**
- Be sure to check your "to-do" list for pending items such as dependent verification documents and any other requirements.
- Please **print** a hard copy of your new benefits summary to confirm that you have completed the process. You will want a copy of the new benefits summary to compare to your payroll deductions to ensure that the deduction amounts are correct. **Benefits cannot be changed after August 22nd except for qualifying events (see page 11).**
- Confirm your payroll deductions by the first pay period of the new plan year, October 15, 2023, to ensure they are correct. Payroll corrections must be requested in writing by sending an email to sdircbenefits@indianriverschools.org within 30 days of the first pay period (by November 15, 2023).

Newly Hired:

Or did you transfer positions and believe that you may now be benefits eligible? Eligibility criteria can be found on page 8 of this Guide. **Enrollment must be completed within 30 days of eligibility.**

Need Additional Open Enrollment Assistance? Contact the Service Center

- **Service Center**—Open Enrollment can be completed through the online self-enroll system. If you would like additional assistance or prefer to enroll over the phone, you can contact the Service Center by calling 772-202-9234 August 8th through August 22nd 8:00—6:00 pm ET, Monday through Friday.
- **Benefit Counselor Assisted**—Self enroll via a provided computer with a counselor available for questions. This option is available in the TEC at the SDIRC Administration Building (6500 57th Street) 8/16 and 8/17 between 8:00 am and 4:30 pm **OR** via virtual meeting. Available by appointment only.
- To view virtual meeting dates and times or to book your appointment by going to
- **www.sdirc-benefits.com** and "Click here to learn our options to enroll" button.

All benefit eligible employees MUST re-enroll

Adding Dependents to your Coverage?

If you are adding dependents to your coverage, you must provide documentation verifying the dependent's eligibility. Dependent eligibility criteria for health, dental, vision and/or life insurance can be found on page 8.

To enroll new dependents, the Benefits system will require you to enter their basic demographic information such as: full name, date of birth, social security number, and address. In addition to their basic demographic information you will be required to provide documentation as described below:

Dependent	Type of Documentation Needed
Spouse	Marriage Certificate and current tax return to show filing as married
Child (Under the age of 26)	Birth Certificate
Child (Age 26-30)	Proof of Drivers License, Proof of college admission, enrollment or current college schedule

How to Upload Documents

A. Documents must be uploaded by logging into the Explain My Benefits Mobile App. Photos can be taken using your smart phone and then uploaded.

B. You can also login to the benefit system by going to www.SDIRC-Benefits.com and clicking on the "Log Into Your Benefit System".

C. **Upload required documentation by clicking on the "To Do" list at the end of the of the enrollment process.** Documents can ***not*** be submitted through the Benefits Department.

Waiving Medical Insurance—Health Reimbursement Account

- Open Enrollment must be completed even if you are waiving benefits.
- The District offers an annual Health Reimbursement Account in the amount of $480 to any employee who **declines** medical coverage during open enrollment.
- Employees who decline their medical coverage during open enrollment and elect the Opt-Out HRA will be required to provide proof of existing medical coverage. Documents can include a copy of a medical card, a letter from employer, or a letter from insurance company.
- If you choose to waive the District's medical coverage and opt-out during Open Enrollment, the District will deposit $20.00 per pay period into your Health Reimbursement account, beginning October 1, 2023.
- If you are a late hire or leave the district early, the $480 credit will be prorated based on the time you are with the District during the plan year.

What does the Health Reimbursement Account Cover?

- Doctor Visits
- Over-the-counter medications
- Prescription drugs
- Dental and Orthodontia
- Vision expenses

How does a Health Reimbursement Account (HRA) Work?

- You can use your HRA dollars on eligible healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Simply swipe your debit card at the point of purchase.

Benefit Program Participation: Employee Responsibilities and Agreement

Please be aware that when an employee participates in the SDIRC's benefit programs, they agree to the following statements:

- Employees are responsible for participating in the Open Enrollment process annually.
- Employees are responsible for participating in and completing the online internet enrollment on their own as a new employee or during each Open Enrollment period.
- Employees are responsible for carefully reviewing their demographic information to confirm that the information in the system is correct.
- Employees are responsible for thoroughly reviewing their choices during their online enrollment and prior to submitting their elections.
- Employees are responsible for entering and reviewing all dependent data, including the dependents' dates of birth and their Social Security information within the established enrollment time frames.
- Employees are responsible for submitting applicable benefit changes within 30 days of qualifying events.
- Employees are responsible for maintaining their personal information, such as keeping their address and phone number current.
- Employees are responsible for providing required documentation within 30 days of coverage to satisfy the eligibility criteria for all enrolled dependents. Otherwise, dependent coverage will be canceled.
- Employees are responsible for identifying and updating their life insurance beneficiaries.
- Employees are responsible for reviewing their paycheck stub when their benefits become effective in order to verify their enrollment election deductions are correct for the benefits elected.
- Employees are responsible for notifying the Benefits Department immediately (within 30 calendar days of the effective date of benefits) if payroll deductions are incorrect and do not properly reflect the benefit elections made.
- Employees are responsible for notifying the Employee Benefits Department immediately (within 30 days) when a covered dependent no longer meets the eligibility requirements as defined under the Dependent Eligibility section.
- Employees are responsible for reviewing their Life/AD&D Beneficiary Information to confirm they are still accurate or add them if a new employee.

Benefit Program Participation: Affirmations

Please be aware that when an employee participates in SDIRC's benefit programs, the employee is automatically making the following affirmations:

- Employee authorizes SDIRC to deduct payroll premiums for employee benefit elections and employee authorizes the deduction of any missed premiums not deducted from payroll for any reason. Employee acknowledges that employee will be responsible for any and all premiums, deductibles and copays that may apply.
- Employee certifies that the information provided on the Explain My Benefits (EMB) enrollment portal is true and correct to the best of employee's knowledge.
- Employee acknowledges that employee cannot stop or change benefits paid on a pre-tax basis during the plan year unless employee experiences a Qualifying Event or during the Open Enrollment period.
- Employee agrees that SDIRC and its third party administrator are not responsible for employee's failure to read or understand all rules or regulations pertaining to benefits enrollment, nor employee's failure to enroll online accurately or to submit timely elections.
- Employee agrees for employee and covered members of employee's family under District insurance plan(s) to be bound by the benefits, deductibles, copayments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements or plan documents for the plan(s) in which employee enrolls.
- Employee agrees that they are exclusively responsible for and assume the risks associated with the choice of plan option(s) and covered dependents, selected by the employee, and agrees neither SDIRC or its representatives, employees, agents or insurers are responsible for choosing or providing advice on the plan options available for employee and employee's family.
- Employee agrees that employee is responsible for reading, understanding, and asking questions regarding benefits, exclusions and limitations for each plan. Failure to adequately review employee plan options will not be a valid reason for a coverage change once Open Enrollment or New Hire Enrollment concludes. Changes cannot be made once enrollment period closes.

Eligibility

All employees shall have the opportunity to enroll in medical care benefits if the employee works at least twenty-one (21) hours per week.

Eligibility is determined at the time of hire, or when you transfer into a benefits eligible position. If you are not sure of your eligibility status, please contact the benefits department by email at sdircbenefits@indianriverschools.org.

New Hire Enrollment must be completed within 30 days of the employee's start date. Please see the enrollment instructions found on pages 13 and 14 in this Guide.

If an employee transfers to a benefits eligible position, the enrollment process must be completed within 30 days, of the transfer.

Effective Dates

The Open Enrollment effective date of the benefits is based on the Plan Year which is October 1st through September 30th. However, the effective date of benefits for a newly hired employee is the first of the month following one full calendar month of continuous active employment. For example, if the hire date is January 9th, then benefits will become effective March 1st. This is also true if you transfer positions.

New Hire Enrollment must be completed within 30 days of the new hire date. Be sure you print a hard copy of your new benefits summary to compare to your payroll deductions to ensure accuracy of elections. **Please Note: Be sure to click "checkout" at the end of the enrollment process to complete the elections. If you do not click "checkout" you will not be enrolled in benefits.** Please see pages 13 and 14

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Eligible dependents are defined as your legal spouse and eligible children who reside in your household and depend primarily on you for support. This includes: your own children; legally adopted children; stepchildren, a child for whom you have been appointed legal guardian; and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse to provide coverage. Age limits vary depending on coverage, so be sure to check each benefit. In order to cover dependents under District benefits, you will be required to upload documentation proving their eligibility under each plan. Please see page 5 for a list of required documents and further information.

Medical Plan Dependent Coverage

Under the Affordable Care Act, you can cover your children under the District's medical plan until the end of the month in which they reach age 26 regardless of full-time student status, marital status or place of residency. Under Florida legislation, you may cover your eligible dependent children through the end of the calendar year in which they turn 30. To qualify, your adult child must meet all of the following eligibility criteria each year and documentation must be provided and verified:

- Be unmarried and have no dependent children of his/her own
- Be a resident of the State of Florida or a full or part-time student whose parents reside in Florida
- Have no medical insurance as a named subscriber, insured enrollee or covered person under any group or not entitled to benefits under the Title XVII of the Social Security Act.

Other Plans Offering Dependent Coverage (Dental, Vision and Life)

Dependent children under the dental plan are covered until the end of the year in which they turn **25**. Vision coverage for dependent children will cease at the end of the month in which an unmarried eligible dependent reaches **age 25**, regardless of student status. Voluntary child life insurance coverage is available for unmarried children through age 25.

Benefits and Leave

Paying for your Benefits

All benefits are paid through payroll deductions, unless you are placed on an "unpaid leave" status. Benefits are payroll deducted to pay for the current month of coverage. Many of the benefits are paid pre-tax. Some of the cost of the benefits are paid by the District, some by you, and some are shared by you and the District. Please refer to the following chart for specifications.

BENEFIT	WHO CONTRIBUTES?	TAX BASIS
Medical & Prescription	Employee & The District	Pre-Tax
Basic Life/AD&D, EAP	The District	Not Applicable
Dental, Vision, Health Spending Accounts, Retirement Plans	Employee	Pre-Tax
Additional Life/AD&D, Disability, Additional Elective Benefits	Employee	Post-Tax

Two-Credit Health Rate

Employees may elect the two-credit health rate if both spouses are employed in benefit eligible positions within the district. Each employee receives the board contribution toward the cost of coverage. One employee must choose a health plan for either Employee/Spouse coverage or Employee/Family coverage. Any cost difference is then shared evenly by both employees each month through payroll deductions.

For example:
One Employee chooses the 5770-health plan for Employee/Spouse coverage. The other spouse declines—covered under my spouses plan.
The cost per month is $1,502.00.
The board contribution is $604 per month per **employee** for a total contribution of $1,208.
The cost per month ($1,502) minus the board contributions ($1,208) is a difference of $294 per month.
The cost difference of $294 shared evenly by both employees is $147 per employee per month.
The $147 per employee per month is payroll deducted for each of the two pay periods in a month.
The payroll deduction per pay period is $73.50 for each employee.
If one employee leaves SDIRC during the year, the rates revert back to full Employee Only, Employee + Spouse, Employee + Child(ren) and Family premium at beginning of the next month post separation. If the remaining employee wishes to make a change, this would be considered a qualifying event if the change is made within 30 days.

Waiving Medical Insurance—Health Reimbursement Account

- Open Enrollment process must be completed even if you are waiving coverage.
- The District offers an annual Health Reimbursement Account in the amount of $480 to any employee who **declines** medical coverage during open enrollment.
- Employees who decline their medical coverage with the District and **elect** the Opt-Out HRA will be required to provide proof of existing medical coverage. Documents can include a copy of a medical card, a letter from employer, or a letter from insurance company.
- If you choose to waive the District's medical coverage and opt-out during Open Enrollment, the District will deposit $20.00 per pay period into your Health Reimbursement Account, beginning October 1, 2023.
- If you are a late hire or leave the District early, the $480 credit will be prorated based on the time you are with the District during the plan year.

What does the Health Reimbursement Account Cover?

- Doctor Visits
- Over-the-counter medications
- Prescription drugs
- Dental and Orthodontia
- Vision expenses

How does a Health Reimbursement Account (HRA) Work?

- You can use your HRA dollars on eligible healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreens and more. Simply swipe your debit card at the point of purchase.

Benefits and Leave

Family Medical Leave Act (FMLA) — Approved Leave with Benefits

The District will continue to pay the employer's contributions for your medical and employer paid basic life insurance coverages for up to 12 weeks while you are on approved FMLA leave; however, you are responsible for paying the employee cost for any insurance coverage you have elected for yourself, and, if applicable, your family. These payments will continue to be payroll deducted until such time you go into an "unpaid leave status." At that time, you will be required to make premium payments directly to the District for each pay period that premiums are no longer payroll deducted. **Failure to pay insurance invoiced premiums within 60 days will result in immediate cancellation of coverage.**

District Payment Instructions: Direct payment can be made by check or money order (cash payments are not accepted) to the address below. **Failure to pay insurance invoiced premiums within 60 days will result in immediate cancellation of coverage.** The amount owed is the amount normally deducted per pay as shown on your paystub in Focus.

Make payments to: School District of Indian River County (SDIRC)
Mailing Address: School District of Indian River County
Attention: Jim Higgins
6500 57th Street, Vero Beach, Fl 32967

NON-FMLA Leave

If you go out on an approved Non-FMLA leave, you will be responsible for paying 100% of your insurance premiums (for all plans). You will no longer receive the Board contribution towards the health premiums. **Failure to pay insurance invoiced premiums within 60 days will result in immediate cancellation of coverage.**

FMLA or Approved Leave of Absence— Frequently Asked Questions and Answers

1. **What happens to my benefits when I go out on Leave?** If you are on approved FMLA leave, the District will continue your benefits and pay the District cost of benefits. However, you will be required to pay for your share of the health insurance premiums, see above District payment instructions. If you are on Non -FMLA leave, you will be responsible for paying 100% of the cost of the your medical insurance along with your cost of any other benefits you have elected. You will no longer receive the Board contribution to the medical insurance.
2. **How do I know how much I will owe?** You may determine the cost of your benefits by reviewing your printed hard copy of the benefit confirmation sheet or your most recent pay stub.
3. **Can I add my newborn to my policy?** Yes, your newborn may be enrolled on your plan within one month of birth by going online to www.sdirc-benefits.com and processing a qualifying event.
4. **Can I add other family members to my policy at the same time I add my newborn?** Yes, you can add your spouse or other qualified dependent children at the time you add your newborn.
5. **What happens to my benefits if I don't come back from leave after my FMLA expires?** If you are on leave beyond the FMLA period, the Board contribution towards the District medical and life insurance coverages will stop. **Therefore, you will be responsible for paying the total cost, whether through payroll d eductions or direct payment. Failure to pay insurance invoiced premiums within 60 days will result in immediate cancellation of coverage.**
6. **What happens if I go out on Workers Comp?** If you are placed in an "out of work" status by the Worker's Compensation physician for longer than 21 days, you will receive your paycheck from the insurance carrier, NOT from SDIRC.
   The amount of the check will be different than your SDIRC payroll because taxes and BENEFITS are not deducted. Failure to pay insurance premiums within 60 days will result in immediate cancellation of coverage. Make payments to: School District of Indian River County (SDIRC). Send payments to:
   6500 57th Street, Vero Beach, Florida 32967 Attention: Jim Higgins

Qualifying Events

Making Changes During the Year

Choose your benefits carefully! **Benefits cannot be changed during the year unless you have a qualified life event.** Qualified Life Events include:

- ⇒ Marriage or divorce
- ⇒ Death of your spouse or dependent
- ⇒ Birth or adoption of a child
- ⇒ Gain of other coverage
- ⇒ Loss of other coverage
- ⇒ Change in your employment status —Employment termination or obtaining new employment
- ⇒ Change in spouse's employment status —Employment termination or obtaining new employment
- ⇒ Change in dependent eligibility status
- ⇒ Gaining coverage through Spouse's employer
- ⇒ Losing coverage through Spouse's employer

*****You have 30 days from the Qualifying Life Event Date to submit your benefit changes and you must provide required documentation to be approved. *****

Qualifying Events—Newborns

- **Newborns** will be covered under your medical plan if you have any of the District medical plans for the first month of life at no charge. YOU MUST enroll the newborn within 30 days of birth in order for them to be covered. If you wish to enroll the newborn and other eligible dependents to your health insurance, please read below.
- **If you do not have family coverage,** you may enroll the newborn, as well as other eligible dependents, within 30 days of birth. If you do not complete the enrollment for the newborn/other dependents within 30 days from the date of birth, you will not be able to add them until the next Open Enrollment period unless you have another qualifying event.
- **If you already have family coverage**, be sure to complete the Qualifying Event online within 30 days to add the newborn as a new dependent. There is no increase in your family premium when adding the newborn to your existing family coverage.

*** A copy of the birth certificate must be submitted to verify the life event.

Submitting Qualifying Life Events

1. To submit a qualifying life event to Employee Benefits please visit www.sdirc-benefits.com.
2. Follow the login instructions on page 13.
3. Select your applicable life event and enter the date of your life event.
4. Follow the instructions provided in the system on each life event to advise what date should be used.
5. Complete the process by following the system prompts.
6. Upload the required documentation by clicking on the "to do" list at the end of the of the enrollment process.
7. Print your confirmation page once completed and check your payroll deductions for accuracy.

Benefit Termination

Benefit Termination and Rehire Policy

Terminations:

Employees' benefit coverages continue through the end of the month in which they leave District employment, when employment ends (interim employees are in this category), by resignation, termination, or retirement, as long as premiums have been paid. If premiums are not current, coverage will be terminated retroactively back to the end of the month in which premiums were last paid. Benefits termination may also occur due t o a court order.
***Please note, Life and Disability coverage's end on date of termination.

For non-renewed employees, if the last day of the contract is 6/2, then benefits will end 6/30 and premium deductions from "summer checks" will be adjusted accordingly.

If an employee transfers to a new position and is no longer considered benefits eligible. (Working a total of 21 or more hours per week), coverages will terminate at the end of the month in which the transfer was made.

Instructional employees, who are non-renewed due to certification, will have their coverage continued/ reinstated if certification requirements are met and verified by Human Resources on or before 6/30.

Benefits termination may also occur in accordance with a court order.

Re-Hires:

If employment is terminated and the employee is re-hired within the same month, benefits will be reinstated with no lapse in coverage from the original date of termination. However, employee is required to make payment for premiums that were not payroll deducted.

If an employee is rehired 30 days after termination, they will be required to re-elect coverages as a new hire and elections will not go into effect until the first of the month, following one full calendar month of employment.

COBRA:

If you, your spouse, or eligible dependent loses coverage under any School District of Indian River County group medical, dental or vision plan because of a COBRA-qualifying event, you may have the right to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For details about qualifying events, refer to page 10 of this guide.

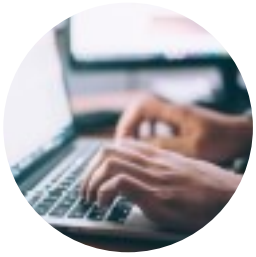
If your coverage ends due to a COBRA-qualifying event, you will receive a notice of your continuation rights from the District's COBRA, UnifyHR (sister company to Chard Snyder). If you, your spouse, and/or dependent have a COBRA qualifying event, you must notify the Employee Benefits Department immediately.

For specific questions about COBRA coverage contact Chard Snyder's Customer Service Benefit Continuation Services at 1-888-993-4646

Enrollment Process

Benefits Re-Enrollment
August 1st - August 22nd

WAYS TO ENROLL



Self-Service Enrollment – Complete your enrollment online using any computer or smartphone with internet access.

- www.SDIRC-Benefits.com
- Login instructions are on page 14
- Enrollment Available: **August 1st and ends on August 22nd at 5:00 pm EST**.

Call Center - Have Questions regarding the enrollment system or benefits covered? Contact the Explain My Benefits Enrollment Call Center!

- Call Center Available: **August 8th — August 22nd**
- 772-202-9234
- 8 am - 6 pm (Monday - Friday)

Mobile App - You can enroll through the Explain My Benefits Mobile App, review your benefits and see important documents as well as educational videos

- Sign in using the Company Code: **sdirc (*all lower case letters*)**
- Be sure to enable Push Notifications to receive messages about your benefits

Virtual or Benefit Counselor Assisted—
Self-enroll via a provided computer with a counselor available for questions at the South Transportation Training Center 8/15 and 8/16 between 8:00 am and 4:30 pm
OR via a virtual meeting. Available by appointment only.
Appointments may be scheduled online at www.sdirc-benefits.com and are by appointment only

For more information about enrollment, videos and other important information, please visit:

www.SDIRC-Benefits.com

Explain My Benefits

Login Instructions

ACCESSING EMB ENROLL

Access ***www.SDIRC-Benefits.com*** and select ***"Log Into Your Benefit System"***

Account Access Steps

1. Enter Username
   IR AND **Your seven digit employee ID**
   Example: IR1234567
   If you don't recall your employee ID. Please refer to a recent paystub

2. Enter Password and click Login

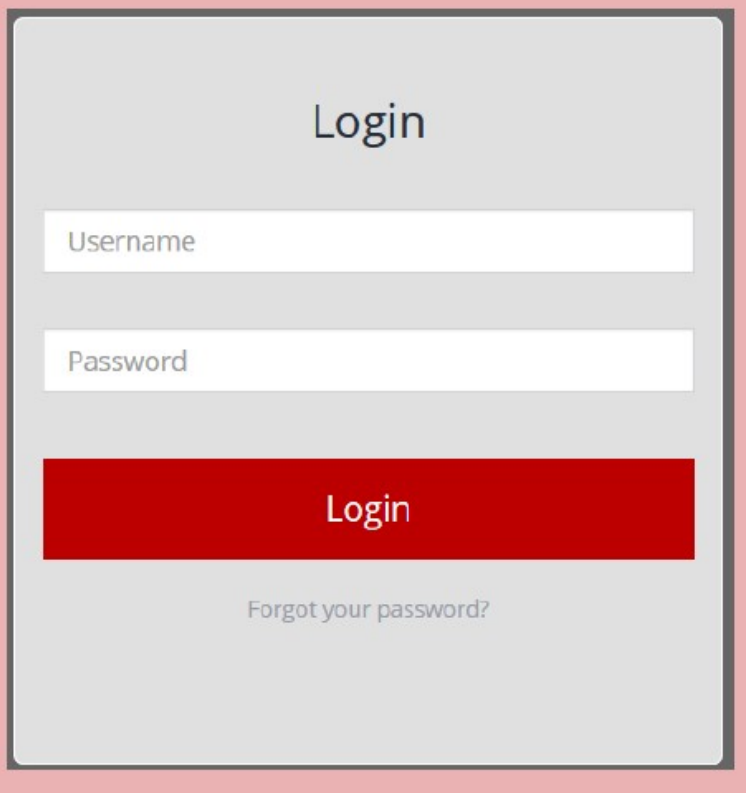
   If you already created an account and can't remember your password, click **"Need Help?"** Follow the prompts to have a password sent to your email on file with us

Once You Have Access

1. Select **"Get Started"** from the middle section of the screen

2. Confirm your information along with Dependents

3. Shop for your insurance benefits



BENEFITS ENROLLMENT APP

School District of Indian River County has provided you a benefits app to manage your benefits that allows you to:

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

Please be sure to Enable Push Notifications

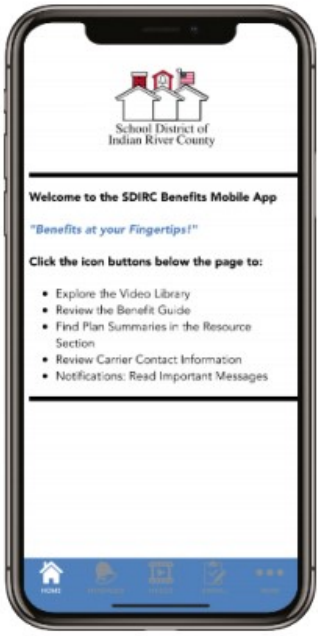
TO DOWNLOAD:

1. Scan the QR Code
2. Download by clicking the link for iOS or android
3. Enter company code: **sdirc (all lower case letters)**

Download on the App Store

GET IT ON Google Play

GET THE APP



Medical - Florida Blue

The District seeks to provide the best possible medical benefits at a reasonable cost to you. The information below is a summary of medical coverage only. For more information about your medical plan with Florida Blue, visit www.floridablue.com or call 1-800-664-5295. Plan summaries may be found on the district web site at: https://www.indianriverschools.org/directory/benefits

Plan Name	BlueOptions	BlueOptions	BlueOptions
Plan Number	05770	05772	05774
Deductible	Single / Family	Single / Family	Single / Family
In-Network	$1,000 / $3,000	$2,000 / $6,000	$3,000 / $9,000
Out-of-Network	$3,000 / $6,000	$6,000 / $18,000	$6,000 / $18,000
Coinsurance (BCBSF pays / Member pays)			
In-Network	80% / 20%	80% / 20%	80% / 20%
Out-of-Network	50% / 50%	50% / 50%	50% / 50%
Out-of-Pocket Maximum			
In-Network	$3,500 / $7,000	$5,500 / $11,000	$6,350 / $12,700
Out-of-Network	$7,000 / $14,000	$11,000 / $22,000	$15,000 / $30,000
Virtual Visits			
In-Network Family Physician	$25 copayment	$35 Copayment	$40 Copayment
In-Network Specialist	$25 Copayment	$65 Copayment	$100 Copayment
Out-of-Network	Not Covered	Not Covered	Not Covered
Office Services			
In-Network Family Physician	$25 Copayment	$35 Copayment	$40 Copayment
In-Network Specialist	$25 Copayment	$65 Copayment	$100 Copayment
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Convenient Care Center			
In-Network	$25 Copayment	$35 Copayment	$50 Copayment
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Inpatient Hospital Facility (per admit)			
In-Network	DED + 20%	$100 PAD + DED + 20%	$500 PAD + DED + 20%
Out-of-Network	$3,500 Copayment per admission	$500 PAD + DED + 50%	$500 PAD + DED + 50%
Physician Services at Hospital			
In-Network	$100 Copayment	DED + 20%	DED + 20%
Out-of-Network	$100 Copayment	INN DED + 20%	INN DED + 20%
Outpatient Hospital Facility (per visit) (Surgical)			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%

NOTES: Any deductibles ("DED") and copays in the chart above are amounts for which you are responsible. Deductibles, copays and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary and Reasonable charges apply for all out-of-network benefits. Prior authorization may be required for imaging services.
The totals for Medical Deductibles and Out-of-Pocket maximums are based on a January 1 – December 31 Calendar Year.

Medical Continued - Florida Blue

The District seeks to provide the best possible medical benefits at a reasonable cost to you. The information below is a summary of medical coverage only. For more information about your medical plan with Florida Blue, visit www.floridablue.com or call 1-800-664-5295. Plan summaries may be found on the district web site at: https://www.indianriverschools.org/directory/benefits

Plan Name	BlueOptions	BlueOptions	BlueOptions
Plan Number	05770	05772	05774
Radiology, Pathology and Anesthesiology Provider Services at Hospital			
In-Network	$100 Copayment	DED + 20%	DED + 20%
Out-of-Network	$100 Copayment	INN DED + 20%	INN DED + 20%
Preventive Services-Adult Wellness Services-Office Services			
In-Network Family Physician	$0 Copayment	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment	$0 Copayment
Out-of-Network	50%	50%	50%
Independent Clinical Laboratory (Blood Work)			
In-Network	$0 Copayment	$0 Copayment	$0 Copayment
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Independent Diagnostic Testing Center (X-rays)			
In-Network	$50 Copayment	$50 Copayment	$50 Copayment
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Emergency and Urgent Care			
Emergency Room Facility (per visit) (ER Co-pay Waived if Admitted)			
In-Network	$200 Copayment	$300 Copayment	$400 Copayment
Out-of-Network	$200 Copayment	$300 Copayment	$400 Copayment
Urgent Care Centers			
In-Network	$50 Copayment	$70 Copayment	$100 Copayment
Out-of-Network	DED + $50 Copayment	DED + $70 Copayment	DED + $100 Copayment
Ambulance			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 20%
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)			
Physician Office			
In-Network Family Physician	$200 Copayment	$300 Copayment	$400 Copayment
In-Network Specialist	$200 Copayment	$300 Copayment	$400 Copayment
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Allergy Injections (Office)			
In-Network Family Physician	$10 Copayment	$10 Copayment	$10 Copayment
In-Network Specialist	$10 Copayment	$10 Copayment	$10 Copayment
Out-of-Network	DED + 50%	DED + 50%	DED + 50%

NOTE: Usual, Customary and Reasonable charges apply for all out-of-network benefits. Prior authorization may be required for imaging services.

Medical Continued - Florida Blue

The District seeks to provide the best possible medical benefits at a reasonable cost to you. The information below is a summary of medical coverage only. For more information about your medical plan with Florida Blue, visit www.floridablue.com or call 1-800-664-5295. Plan summaries may be found on the district web site at: https://www.indianriverschools.org/directory/benefits

Plan Name	BlueOptions	BlueOptions	BlueOptions
Plan Number	05770	05772	05774
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)			
Independent Diagnostic Testing Center			
In-Network	$100 Copay	$300 Copayment	$400 Copayment
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Outpatient Hospital Facility			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Mental Health Services			
Physician Office			
In-Network Family Physician	$0 Copayment	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment	$0 Copayment
Out-of-Network	50%	50%	50%
Inpatient / Outpatient Hospital Facility			
In-Network	$0 Copayment	$0 Copayment	$0 Copayment
Out-of-Network	$500 Copayment	50%	50%

NOTE: Usual, Customary and Reasonable charges apply for all out-of-network benefits.

Prescription Drugs - Express Scripts, Inc. (ESI)

With the election of a medical plan, employees are automatically enrolled in the corresponding prescription drug plan administered by ESI. For more information about your pharmacy plan and to find a pharmacy near you, visit www.express-scripts.com or call 1-866-262-6427. A summary of benefits can be found on the district web site at: https://www.indianriverschools.org/directory/benefits.
The copays shown are amounts for which you are responsible.

Benefit	Blue Options 05770		Blue Options 05772		Blue Options 05774	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (31 day supply)						
Generic	$10	$10	$10	$10	$10	$10
Preferred Brand	$30	$30	$50	$50	$50	$50
Non-preferred Brand	$60	$60	$80	$80	$80	$80
Mail Order (90 day supply)						
Generic	$20	$20	$20	$20	$20	$20
Preferred Brand	$60	$60	$100	$100	$100	$100
Non-preferred Brand	$120	$120	$160	$160	$160	$160

Medical and Prescription Drug Contribution Rates

Plan Name	BlueOptions	BlueOptions	BlueOptions
Plan Number	05770	05772	05774
Semi-Monthly Per Paycheck Deductions			
Employee Only	$122.50	$66.50	$16.00
Employee + Spouse	$411.00	$318.50	$238.50
Employee + Child(ren)	$396.50	$305.50	$228.50
Family	$495.50	$392.00	$304.00
2 Credit Employee + Spouse	$30.75 each	$0.00 each	$0.00 each
2 Credit Employee + Family	$73.00 each	$21.23 each	$0.00 each

Note: The District's Contribution for the 2023/2024 school year are $349.50 per pay or $699 per month.

The District Health Center

5245 41st Avenue

The District Health Center is a primary care facility treating both acute and chronic conditions at NO COST for both employees and dependents enrolled in a District health plan. The District Health Center also provides NO COST wellness programs and health coaches to guide you through the process of losing weight, quitting smoking, controlling your blood pressure and more. The District Health Center is a well-known and trusted healthcare organization provided by Premise, skilled at delivering innovative, high-quality, cost-effective primary care.

- NO COST for:
  - Visits
  - 200+ generic medications
  - Labs
  - Annual Health Risk Assessment
  - Wellness Programs and Health Coaching
  - Well-man, well-woman, sports and school physicals
  - Certain imaging services available when referred by a District Health Center provider to Indian River Radiology
  - Home Delivery Pharmacy program for many chronic medications
- Convenient schedule that includes early morning, late evening and Saturday hours
- 24/7 Scheduling and Nurse Advice Line by calling 844.422.7343

Members can go online to schedule, cancel or reschedule appointments 24/7 at

www.mypremisehealth.com

Or by calling 844.422.7343

Register with your access code **NRSE2**

IMPORTANT REMINDER

REGARDING MISSED APPOINTMENTS AT DISTRICT HEALTH CENTER

Missed appointments, without proper cancellation, are considered "No Show" appointments that prevent others from being served and add to the cost of our health care. Therefore, in an effort to reduce the number of "No Shows", a fee will be charged if an employee or dependent missed a scheduled appointment and failed to cancel more than three times in a calendar year. The "No Show" fee is $25.00 and is deducted from the employee's payroll for each missed appointment after the third "No Show".

Employee Assistance Program (EAP) - ComPsych

The District has partnered with **ComPsych GuidanceResources** to provide an employer sponsored Employee Assistance Program (EAP). **GuidanceResources** will help you resolve personal, wellness, and professional concerns that can adversely affect workplace productivity. This service is available for all employees, anyone living in your household, and dependent children living out of your home. Services are free and confidential and available 24 hours a day, 7 days a week.

Employee Assistance Program (EAP)
877-264-3399
Account #254602
www.guidanceresources.com
Go to "Register"
Enter Organization Web ID: COM589

Emotional well-being support

You can call 24 hours a day for in-the-moment emotional well-being support. You can also access up to six counseling sessions per issue per year.

Visit with a counselor face-to-face, online with tele-video or get in-the-moment support by phone. Services are free and confidential. The EAP is available to help with a wide range of issues including:

- Relationship Support
- Depression
- Stress Management
- Anxiety
- Work/Life Balance
- Substance misuse and more
- Family Issues
- Self-esteem
- Grief and loss
- Personal development

Online Resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars

You'll also find access to these helpful tools:

GuidanceNow App

Access online resources via the GuidanceNow mobile app available for download on mobile device.

Work and Lifestyle Support

- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25% discount.

*Services must be related to the employee and eligible household members. Work-related issues are not covered.

FinancialConnect

Unlimited telephonic access to financial information by speaking with ComPsych financial experts. Financial topics may include:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions and preparation

*Services must be for financial matters related to the employee and eligible household member.

Flexible Spending Accounts - Chard Snyder

Note: Services must be rendered or purchases made within the plan year of 10/1 - 9/30.
Employees MUST RE-ENROLL EVERY YEAR. FSA's do not roll over into the new plan year.

What is a Medical Flexible Spending Account (FSA)?

The District offers a medical FSA benefit that allows you to choose how much of your paycheck you would like to set aside for healthcare expenses before taxes are taken out, so the money deposited into the account is tax free, which saves you money. You choose the amount you want to elect up to $3,050 for plan year 2023-2024. The amount you choose will be deducted from your paycheck over the 24 pay periods.

Benefits of a Medical Flexible Spending Account (FSA)

Funds available on October 1, 2023
All of your FSA funds are available at the start of the plan year for you to use right away. Simply swipe your FSA debit card at your healthcare provider's office, pharmacy or on other eligible expenses.

What does it cover?

View the complete list of eligible expenses: Healthcare Eligible Expenses | Chard Snyder (chard-snyder.com)

How long do I have to use the money in my Flexible Spending Account (FSA)?

Funds in your FSA need to be used prior to September 30, 2023. However, SDIRC offers a grace period which extends the period of time you have to use your FSA funds on eligible expenses, such as going to the doctor or purchasing prescriptions or over-the-counter medications. Think of it as a safety net for your FSA. If you end up spending less than you anticipated when you made your elections during open enrollment, you can tap into those funds for up to an additional 2 ½ months.

- ✓ Copays
- ✓ Coinsurance
- ✓ Dental Expenses
- ✓ Prescription drugs
- ✓ Birthing Classes
- ✓ Orthodontia Expenses
- ✓ Frames, contacts, lenses
- ✓ Over-the-counter medications

Dependent Care FSA

A Dependent Care FSA allows you to put aside a portion of your paycheck before taxes for eligible dependent care expenses each year. You can choose the amount you want to elect up to $5,000. The funds are then deducted from your pay check on a pre tax basis and become available to you after each pay period. Once the funds become available you can submit reimbursement for eligible expenses such as Childcare, Summer Camps, Before—or—after school care, or Elder care.

View the complete list of eligible expenses: Dependent Daycare Eligible Expenses | Chard Snyder (chard-snyder.com)

Questions?

Contact Chard Snyder by calling 1-800-982-7715 or access your account by visiting www.chard-snyder.com

Dental - Aetna

The District is committed to a dental program that's easy to use. This means better overall health and cost savings. The District offers employees three dental plan options through Aetna. The below chart is a an overview of the plans offered. Please visit https://www.indianriverschools.org/directory/benefits to see the complete benefit summaries.

Please keep in mind that some network providers' status may change. Please confirm with your provider if they are in-network or speak to an Aetna representative at **1-877-238-6200**.

Your dental plan covers four main types of expenses:

- Preventive and diagnostic services like exams and cleanings, fluoride treatments, and sealants
- Basic services such a simple fillings, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontia (DHMO Only)*

Provider Search: To search for in-network providers please visit www.DocFind.com or call 1-877-238-6200 to confirm your providers are in-network.

DHMO Providers: If you choose to enroll in the DHMO plan you MUST choose a provider prior to seeking services. Once you receive your ID card you can contact Aetna to choose your designated provider, by calling the number on the back of your id card.

For additional information please contact Aetna directly at 1-877-238-6200

Benefit	PPO High Plan	PPO Low Plan	DHMO
Network Name	***Dental PPO/PDN***	***Dental PPO/PDN***	***DMO/DNO***
Annual Calendar Year Maximum (Per Enrollee)	$1,000	$1,000	N/A
Calendar Year Deductible (up to 3x per family)	$50	$50	N/A
Preventive Services	No Charge	No Charge	No Charge
Basic Services	No Charge	20%	Copays Vary
Major Services	40%	50%	Copays Vary
Orthodontia Coverage	Not Offered	Not Offered	Adults & Children $2,000 copay
Semi-Monthly Per Paycheck Deductions	**PPO High Plan**	**PPO Low Plan**	**DHMO**
Employee Only	$18.18	$15.60	$9.83
Employee + Spouse	$38.94	$33.41	$16.87
Employee + Child(ren)	$36.44	$31.27	$16.99
Family	$57.31	$49.20	$24.48

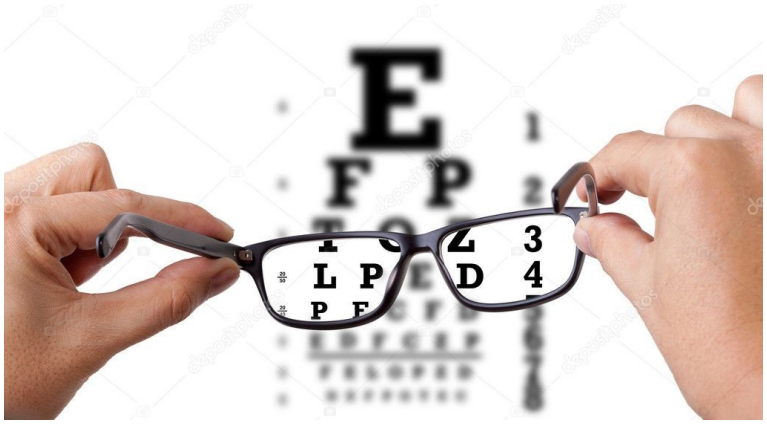
Coinsurance's listed for PPO plans reflects what member would be responsible for with In-Network providers. Members can see dentists that are in the PPO 2 + Extend network which would reflect the coinsurance coverages listed above. Non-contracted providers can include balance billing, benefits may be lower and members might have to file your own claims when visiting a provider outside of the PPO network.
*Maximum benefit of 24 months of interceptive orthodontics and/or comprehensive treatment. Atypical treatment plans beyond a 24 month plan may require additional payment by the patient.
Note: The totals for Dental Deductibles and Maximums are based on a January 1 – December 31 Calendar Year.

Questions? Contact Aetna at 1-877-238-6200

Vision - UnitedHealthcare

The District offers employees two vision plans through **UnitedHealthcare** that includes coverage for eye exams and eyeglasses or contact lenses. Please access www.myuhcvision.com and utilize the "Provider Quick Search" feature, or you can call **800-638-3120** to get the names and addresses of the network providers nearest you.

Please keep in mind that some providers' network status may have changed. Please confirm with your provider if they are in-network or speak to a UnitedHealthcare representative at **800-638-3120.**



Benefit	Option 1	Option 2
Exam	$10 copay (Once every 12 months)	$10 copay (Once every 12 months)
Frames* (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)	$130 allowance (Once every 24 months)	$130 allowance (Once every 12 months)
Contact Lenses (in lieu of eyeglasses)	**Option 1**	**Option 2**
Contact Lenses (Non-Collection)	$125 allowance (copay waived) (Once every 12 months)	$125 allowance (copay waived) (Once every 12 months)
Selection Contact Lenses (Conventional/Disposable)	$25 copay (up to 4 boxes) (Once every 12 months)	$25 copay (up to 4 boxes) (Once every 12 months)
Medically Necessary (with prior approval)	$25 copay (Once every 12 months)	$25 copay (Once every 12 months)
Semi-Monthly Per Paycheck Deductions	**Option 1**	**Option 2**
Employee Only	$2.78	$3.09
Employee + Spouse	$4.68	$5.20
Employee + Child(ren)	$4.77	$5.33
Family	$7.54	$8.39

Please Note: Additional charges may apply for Out-of-Network services. Please refer to the plan summary

Questions? Contact UnitedHealthcare at 800-638-3120

Life Insurance-The Standard

Basic Life:

The District provides employees with basic life insurance and accidental death and dismemberment (AD&D) coverage in the amount of $25,000 at no cost to you. Board-paid basic life and AD&D insurance protects your family's financial future if you die or if you experience a loss of limb, eyesight, or other dismemberment.

* Age reductions after age 65 apply to life and AD&D insurance amounts.

Additional Voluntary Life and AD&D:

- As an active full-time employee, you may purchase additional voluntary life and AD&D coverage for yourself and dependent life coverage for your family. The amount and cost of additional coverage that you may elect can be found on the next page. New Hires may purchase up to the Guaranteed Issue amount during their initial eligibility period of $200,000 for employees and $50,000 for spouses without completing a Statement of Health application.
- To purchase coverage for either your spouse or child(ren), you must enroll yourself for voluntary life coverage. You pay 100% of the cost for this coverage. Statement of Health application will be required if you elect coverage for you or your spouse over the Guaranteed Issue amount or are outside of your initial eligibility period. The enrollment platform will automatically redirect you to the site for the necessary forms. Age reductions after age 65 apply to employee life and AD&D insurance amounts.
- Increases in coverage and new enrollments will be subject to proof of good health (EOI) unless you are a new hire applying during your initial period of eligibility.

Guaranteed coverage is for New Hires only. Any election outside of initial eligibility requires an EOI submittal to the Standard for review/approval of coverage.

AD&D Features:

These benefits are included at no additional cost to District employees and the insured:

- **Career Adjustment Benefit:** Pays for qualifying tuition expenses incurred by an employee's eligible spouse for training aimed at obtaining employment or increased earnings within 36 months of the insured's death.
- **Child Care Benefit:** Pays for qualifying child care expenses for all children under age 13 incurred by an employee's eligible spouse within 36 months of the insured's death.
- **Higher Education Benefit:** Covers tuition expenses for up to four consecutive years for children attending or who will be attending college within 12 months after the insured's death.
- **Seat Belt Benefit:** Paid if you die as a result of a car accident and is found to be wearing a seat belt.
- **Occupational Assault Benefit:** Pays for qualifying loss resulting from an act of physical violence against the employee while at work; assault must involve a police report and be punishable by law.
- **Public Transportation Benefit:** Pays for qualifying loss of life while riding as a fare-paying passenger on public transportation.
- The Standard also offers an expanded AD&D Living Needs Package at no additional cost to District employees.

Other information:

- For New Hires the employee Guaranteed Issue amount is **$200,000**. Spouse Guaranteed Issue amount is **$50,000**. All other changes require EOI.
- The beneficiary(ies) you elect for your basic life and AD&D insurance will be the same for your employee voluntary term life insurance.
- Employees cannot elect life coverage for a spouse who is also a District employee.
- Voluntary spouse life premiums are calculated based on the employee's age.
- You can elect a child life benefit of either $5,000 or $10,000. ***If both parents work for the District, only one can purchase dependent coverage for the same child(ren).***
- ***Confirm your Beneficiary information is accurate or add information if you are a new employee.***

Questions? Contact The Standard at 800-628-8600

Voluntary Additional Life & AD&D Rates

Employee (Life/AD&D)	Up to $300,000 in increments of $25,000
Spouse (Life only)	Increments of $12,500 to a maximum of $75,000. Cannot exceed 100% of employee's Voluntary Additional Life Insurance
Child(ren) (Life only)	$5,000 or $10,000

Employee Age	Employee Additional Life and AD&D Per Semi-Monthly Pay Premiums											
	$25,000	$50,000	$75,000	$100,000	$125,000	$150,000	$175,000	$200,000	$225,000	$250,000	$275,000	$300,000
<30	$0.88	$1.75	$2.63	$3.50	$4.38	$5.25	$6.13	$7.00	$7.88	$8.75	$9.63	$10.50
30-34	$1.25	$2.50	$3.75	$5.00	$6.25	$7.50	$8.75	$10.00	$11.25	$12.50	$13.75	$15.00
35-39	$1.38	$2.75	$4.13	$5.50	$6.88	$8.25	$9.63	$11.00	$12.38	$13.75	$15.13	$16.50
40-44	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50	$15.00	$16.50	$18.00
45-49	$2.13	$4.25	$6.38	$8.50	$10.63	$12.75	$14.88	$17.00	$19.13	$21.25	$23.38	$25.50
50-54	$3.13	$6.25	$9.38	$12.50	$15.63	$18.75	$21.88	$25.00	$28.13	$31.25	$34.38	$37.50
55-59	$5.25	$10.50	$15.75	$21.00	$26.25	$31.50	$36.75	$42.00	$47.25	$52.50	$57.75	$63.00
60-64	$7.75	$15.50	$23.25	$31.00	$38.75	$46.50	$54.25	$62.00	$69.75	$77.50	$85.25	$93.00
65-69*	$9.91	$19.83	$29.74	$39.65	$49.56	$59.48	$69.39	$79.30	$89.21	$99.13	$109.04	$118.95
70-74*	$11.38	$22.75	$34.13	$45.50	$56.88	$68.25	$79.63	$91.00	$102.38	$113.75	$125.13	$136.50
75+*	$7.96	$15.93	$23.89	$31.85	$39.81	$47.78	$55.74	$63.70	$71.66	$79.63	$87.59	$95.55

*Coverage amounts for ages 65 and over reduce due to age.

Employee Age	Spouse Life Per Semi-Monthly Pay Premiums					
	$12,500	$25,000	$37,500	$50,000	$62,500	$75,000
<30	$0.31	$0.63	$0.94	$1.25	$1.56	$1.88
30-34	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00
35-39	$0.56	$1.13	$1.69	$2.25	$2.81	$3.38
40-44	$0.63	$1.25	$1.88	$2.50	$3.13	$3.75
45-49	$0.94	$1.88	$2.81	$3.75	$4.69	$5.63
50-54	$1.44	$2.88	$4.31	$5.75	$7.19	$8.63
55-59	$2.50	$5.00	$7.50	$10.00	$12.50	$15.00
60-64	$3.75	$7.50	$11.25	$15.00	$18.75	$22.50
65-69*	$4.88	$9.75	$14.63	$19.50	$24.38	$29.25
70-74*	$5.63	$11.25	$16.88	$22.50	$28.13	$33.75
75+*	$3.94	$7.88	$11.81	$15.75	$19.69	$23.63

*Coverage amounts for ages 65 and over reduce due to age reduction.

Age	Child(ren) Life Per Semi-Monthly Pay Premiums	
	$5,000	$10,000
Child	$0.25	$0.50

Short Term Disability - The Standard

What is Short Term Disability Insurance?

Short Term Disability Insurance helps protect your income for a short duration. If you become disabled and are unable to work, disability insurance can help replace some of your lost income, help you pay bills and protect your long-term savings.

Employees are eligible to receive short-term disability (STD) benefits for a qualified non-work illness or injury after being continuously disabled through your elected waiting period. **SDIRC offers three plan options each with a different waiting period. Each option allows you to choose a coverage amount of either 50% for your weekly salary to $1,000, 60% of your weekly salary up to $1,500 or 66.67% of your weekly salary up to $2,500.**

If you are not in active employment due to injury or sickness, or if you are on a covered layoff or leave of absence, any increased or additional coverage will begin on the date you return to active employment.

Guaranteed coverage is for New Hires only. Any election outside of initial eligibility requires an EOI submittal to Standard for review/approval of coverage.

OPTION 1:
7 day waiting period

Benefit Waiting Period:
0 Days for Accident
7 days for Sickness
Maximum Benefit Period:
13 weeks for Accident
12 weeks for Sickness

Age	Semi-Monthly Rate Per $10 of Weekly Salary
<24	$0.221
25-29	$0.237
30-34	$0.209
35-39	$0.166
40-44	$0.163
45-49	$0.157
50-54	$0.187
55-59	$0.265
60-64	$0.322
65-99	$0.350

OPTION 2:
14 day waiting period

Benefit Waiting Period:
14 Days for Accident
14 days for Sickness
Maximum Benefit Period:
11 weeks for Accident
11 weeks for Sickness

Age	Semi-Monthly Rate Per $10 of Weekly Salary
<24	$0.201
25-29	$0.223
30-34	$0.185
35-39	$0.149
40-44	$0.135
45-49	$0.135
50-54	$0.163
55-59	$0.209
60-64	$0.253
65-99	$0.290

OPTION 3:
30 day waiting period

Benefit Waiting Period:
30 Days for Accident
30 days for Sickness
Maximum Benefit Period:
9 weeks for Accident
9 weeks for Sickness

Age	Semi-Monthly Rate Per $10 of Weekly Salary
<24	$0.132
25-29	$0.163
30-34	$0.132
35-39	$0.113
40-44	$0.105
45-49	$0.113
50-54	$0.146
55-59	$0.182
60-64	$0.209
65-99	$0.219

Questions? Contact The Standard at 800-628-8600

Long Term Disability - The Standard

What is Long Term Disability Insurance?

Long Term Disability Insurance helps safeguard your financial security by replacing a portion of your income while you are unable to work. LTD benefits are intended to protect your income for a long duration after you have depleted short-term disability or available paid time off.

Employees are eligible to purchase long-term disability (LTD) insurance which pays a monthly benefit in the event you cannot work because of a long-term illness or injury. You must be continuously disabled through your elimination period of **90 days** to be eligible for LTD benefits.

This plan will pay 66.67% of your monthly salary but no more than $8,000 (in $100 increments) per month. Benefit and maximum period of payment are based on age when disability occurs.

Guaranteed coverage is for New Hires only. Any election outside of initial eligibility requires an EOI submittal to Standard for review/approval of coverage.

Age	Semi-Monthly Pay Rate Per $100
<24	$0.066
25-29	$0.085
30-34	$0.163
35-39	$0.255
40-44	$0.381
45-49	$0.512
50-54	$0.706
55-59	$0.752
60-64	$0.794
65-69	$0.825
70+	$0.626

Questions? Contact The Standard at 800-628-8600

Accident Insurance - MetLife

Accident Plan

Accident insurance provides a financial cushion for life's unexpected events. You can use it to help pay costs that aren't covered by your medical plan. It provides you with a lump-sum payment - one convenient payment all at once - when you or your family need it most. The extra cash can help you focus on getting back on track, without worrying about finding the money to help cover the cost of treatment.

The plan provides a lump sum payment for over 150 different covered events, such as:

- Fractures
- Dislocations
- Second and third degree burns
- Skin grafts
- Torn knee cartilage
- Ruptured disc
- Concussions
- Cuts or lacerations
- Eye injuries
- Coma
- Broken teeth

You'll receive a lump sum payment when you have these covered medical services:

- Ambulance
- Emergency Care
- Inpatient Surgery
- Outpatient Surgery
- Medical Testing Benefits (including X-rays, MRIs, CT scans)
- Physician follow-up visits
- Transportation
- Home modifications
- Therapy services (including physical and occupational therapy)

These additional benefits are offered to strengthen your overall benefits package. You customize the benefit based on need and affordability.

- Ownership - Policies are fully portable and belong to you if you leave your employer; same price and same plan
- Benefits are payroll deducted
- ***Cash benefits are paid directly to you, <u>not</u> to a hospital or a doctor***
- ***Benefits are paid regardless of any other coverage you may have***
- Guaranteed Renewable
- Designed to provide additional cash flow to assist with out-of-pocket medical costs and other bills

Per Pay Period	Employee	Employee & Spouse	Employee & Child(ren)	Family
High Plan	$6.25	$13.29	$12.67	$15.89
Low Plan	$3.38	$7.23	$6.77	$8.67

Key Coverage Notes:

- No Age reduction.
- This plan provides protection for covered events experienced 24 Hours a day.
- Organized Sports Activity Injury benefit Rider is included

Questions? Contact MetLife at 800-438-6388

MetLife Critical Illness and Cancer Insurance - MetLife

Critical Illness

Critical illness insurance provides you with a lump-sum payment of your choice of either $10,000, $20,000, $30,000, $40,000 or $50,000 when your family needs it most. The payment you receive is yours to spend as you see fit and in addition to any other insurance you may have.

MetLife Critical Illness Insurance provides a lump-sum payment if you or a covered family member are diagnosed with one of the following medical conditions: **Full Benefit Cancer, Stroke, Partial Benefit Cancer, Coronary Artery Bypass Graft, All Other Cancer, Kidney Failure, Heart Attack, Alzheimer's Disease, Major Organ Transplant and 22 additional conditions.**

A Recurrence Benefit is paid after 90 days for the following covered conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. See Plan Summary for a full explanation of Recurrence Benefit limitations.

$50 Health Screening Benefit included: A benefit is paid for each covered person for health screening tests, such as: **Annual Physical Exam; HPV Vaccination; Colonoscopy; Pap Smear; Mammogram; Endoscopy.** See the Plan Summary for a full list.

* No Pre-Existing limitation
* COVID-19 covered at 25%
* No Age Reduction
* Total Benefit Amount is unlimited

Critical Illness Per Pay Rate Per $1,000 of Coverage (Non-Tobacco)											
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
EE	$0.30	$0.32	$0.41	$0.51	$0.71	$0.94	$1.22	$1.52	$1.82	$2.07	$2.50
EE & SP	$0.54	$0.58	$0.72	$0.91	$1.24	$1.62	$2.09	$2.57	$3.03	$3.43	$4.12
EE & CH	$0.52	$0.54	$0.63	$0.74	$0.93	$1.16	$1.45	$1.75	$2.05	$2.30	$2.72
Family	$0.76	$0.81	$0.95	$1.14	$1.46	$1.85	$2.31	$2.80	$3.26	$3.66	$4.34
Critical Illness Per Pay Rate Per $1,000 of Coverage (Tobacco)											
EE	$0.38	$0.41	$0.56	$0.74	$1.08	$1.47	$1.94	$2.45	$2.97	$3.43	$4.21
EE & SP	$0.66	$0.74	$0.97	$1.29	$1.84	$2.50	$3.28	$4.12	$4.93	$5.66	$6.92
EE & CH	$0.60	$0.64	$0.79	$0.97	$1.30	$1.70	$2.17	$2.68	$3.20	$3.65	$4.43
Family	$0.89	$0.96	$1.20	$1.51	$2.07	$2.72	$3.51	$4.35	$5.15	$5.89	$7.14

Cancer Insurance

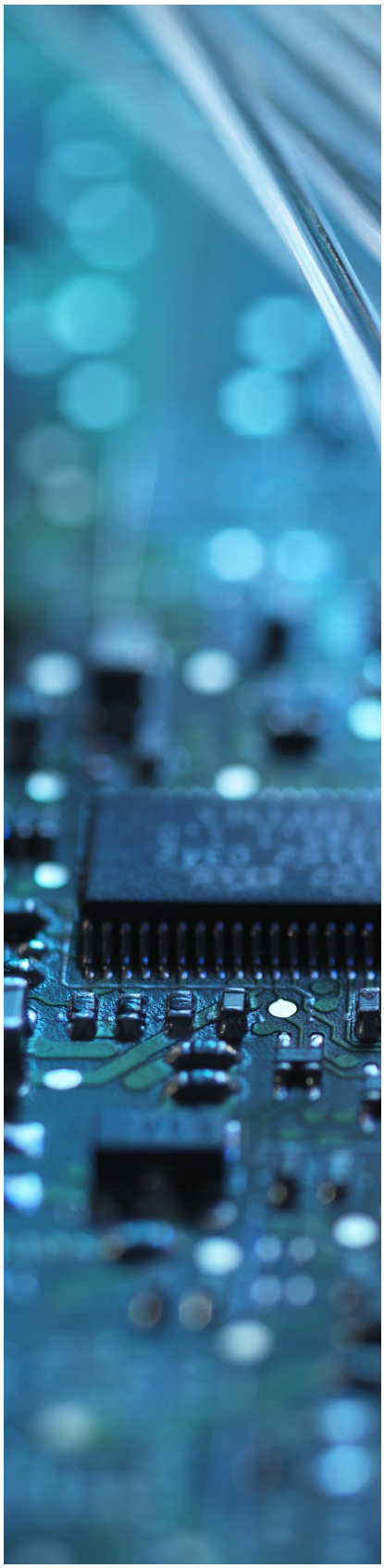
Cancer insurance works to compliment your medical coverage - and pays a lump sum in addition to what our medical plan may or may not cover. It's coverage that provides financial support when you or a loved one become seriously ill. Preventive measures, early detection, and quality care and treatment are all important in the fight against cancer. While you can't always prevent it, cancer insurance is there to make life a little easier.

Upon initial verified diagnosis of a covered cancer condition, it provides you with a lump-sum payment of up to $15,000 or $30,000. If a Full Cancer Benefit was received and there is a recurrence, you will receive 50% of the Full Cancer Benefit. If a Partial Cancer Benefit was received, you will receive 12.5% of the Partial Cancer Benefit.

$50 Health Screening Benefit included: A benefit is paid for each covered person from health screening tests, such as: **Annual Physical Exam; HPV Vaccination; Colonoscopy; Pap Smear; Mammogram; Endoscopy.** See Plan Summary for a full list.

Cancer Per Pay Rate Per $1,000 of Coverage (Non-Tobacco)											
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
EE	$0.14	$0.15	$0.19	$0.23	$0.32	$0.42	$0.52	$0.63	$0.71	$0.72	$0.71
EE & SP	$0.24	$0.26	$0.32	$0.39	$0.53	$0.69	$0.88	$1.06	$1.20	$1.23	$1.24
EE & CH	$0.27	$0.28	$0.32	$0.36	$0.45	$0.54	$0.65	$0.76	$0.84	$0.85	$0.84
Family	$0.37	$0.39	$0.45	$0.52	$0.65	$0.82	$1.01	$1.19	$1.33	$1.36	$1.37
Cancer Per Pay Rate Per $1,000 of Coverage (Tobacco)											
EE	$0.20	$0.21	$0.29	$0.38	$0.54	$0.73	$0.94	$1.15	$1.31	$1.35	$1.34
EE & SP	$0.32	$0.36	$0.46	$0.61	$0.87	$1.18	$1.55	$1.91	$2.19	$2.27	$2.30
EE & CH	$0.32	$0.34	$0.42	$0.51	$0.67	$0.86	$1.07	$1.28	$1.44	$1.48	$1.47
Family	$0.45	$0.49	$0.59	$0.74	$1.00	$1.31	$1.68	$2.04	$2.32	$2.40	$2.43

Legal and Identity Theft Protection
LegalShield & IDShield



Affordable Legal and Identity Theft Protection

Legal Protection - LegalShield

Every year millions of people have legal issues and do not receive the legal counsel they need and deserve. Protect Your Legal Rights with LegalShield

LegalShield Plan Benefits Include*:

- Legal Consultation and Advice
- Court Representation
- Dedicated Law Firm
- Legal Document Preparation and Review
- Letters and Phone calls Made on Your Behalf
- Speeding Ticket Assistance
- 24/7 Emergency Legal Access

*Restrictions may apply. See your summary plan description for details.

Identity Theft Protection - IDShield

Millions of people have their identity stolen each year. IDShield provides the identity theft protection and identity restoration services you not only need but deserve.

IDShield Plan Benefits Include*:

- Identity Consultation and Advice
- Identity and Credit Monitoring
- Identity and Credit Threat Alerts
- Complete Identity Restoration
- Direct Access to Licensed Private Investigators
- Monthly Credit Score Tracker
- Social Media Monitoring
- Mobile App

*Restrictions may apply. See your summary plan description for details.

	LegalShield Only Per Pay	IDShield Only Per Pay	Combo Plan Per Pay
Employee Only	$7.63	$3.00	$10.13
Employee + Spouse	$7.63	$5.50	$12.63
Employee + Child(ren)	$7.63	$5.50	$12.63
Employee + Family	$7.63	$5.50	$12.63

Questions? Contact LegalShield at 888-807-0407

Semi-Monthly Per Paycheck Deductions

Florida Blue	BlueOptions 05770	BlueOptions 05772	BlueOptions 05774
Employee Only	$122.50	$66.50	$16.00
Employee + Spouse	$411.00	$318.50	$238.50
Employee + Child(ren)	$396.50	$305.50	$228.50
Family	$495.50	$392.00	$304.00
2 Credit (Employee + Spouse)	$30.75 each	$0.00 each	$0.00 each
2 Credit (Employee + Family)	$73.00 each	$21.25 each	$0.00 each

Note: The District's Contribution for the 2023/2024 school year are $349.50 per pay or $699 per month.

Aetna Dental	PPO High Plan	PPO Low Plan	DHMO
Employee Only	$18.18	$15.60	$9.83
Employee + Spouse	$38.94	$33.41	$16.87
Employee + Child(ren)	$36.44	$31.27	$16.99
Family	$57.31	$49.20	$24.48

UnitedHealthcare Vision	Option 1	Option 2
Employee Only	$2.78	$3.09
Employee + Spouse	$4.68	$5.20
Employee + Child(ren)	$4.77	$5.33
Family	$7.54	$8.39

Legal and Identity Theft Protection - LegalShield & IDShield

	LegalShield Only Per Pay	IDShield Only Per Pay	Combo Plan Per Pay
Employee Only	$7.63	$3.00	$10.13
Employee + Spouse	$7.63	$5.50	$12.63
Employee + Child(ren)	$7.63	$5.50	$12.63
Employee + Family	$7.63	$5.50	$12.63

Retirement Savings

The District understands that saving for retirement is an important priority for our employees. We a offer 401(a) Plan and 403 (b)/457(b) Plans, so you can make sure that more of your money is working for your future. The plans allow you to save money for retirement through convenient pre-tax payroll deduction. These are plans available to you in addition to the Florida Retirement System (FRS) pension plan, so there is no set contribution and no district contribution.

For additional information regarding any of the plan provisions, please reach out to the vendors below.

Our 403(b)/457(b) Plan Administrator is TSA Consulting Group and may be reached at: **888-796-3786** or visit www.tsacg.com.

The 401(a) Plan Administrator is Bencor. Please visit www.bencorplans.com for more information.

For more information regarding the FRS plan please visit www.myfrs.com or call **866-446-9377.**

Contribution forms for TSA products are available on the Payroll Page of the District website.

Important Contacts

Vendor	Website	Phone Number / E-mail	Group Numbers
The School District of Indian River County (the "District")	www.indianriverschools.org	sdircbenefits@indianriverschools.org	N/A
Amy Yeitter Employee Benefits Specialist	https://www.indianriverschools.org/directory/benefits	772-564-3175 sdircbenefits@indianriverschools.org	N/A
Joan Martin Employee Benefit Admin Assistant	https://www.indianriverschools.org/directory/benefits	772-564-3011 sdircbenefits@indianriverschools.org	N/A
Stacy Haas Retirement/FMLA Coordinator	www.indianriverschools.org/human-resources	772-564-3001 Stacy.Haas@indianriverschools.org	N/A
Medical Florida Blue	www.floridablue.com	800-664-5295	#59106
Prescription Drug Express Scripts, Inc. (ESI)	www.express-scripts.com	866-262-6427	#SDIRC01
District Health Center Premise	www.mypremisehealth.com	844-422-7343	N/A
Employee Assistance Program (EAP) ComPsych	www.guidanceresources.com Go to "Register" Enter Organization Web ID: COM589	877-264-3399	#254602
Flexible Spending Accounts Chard Snyder	www.chard-snyder.com	800-982-7715	N/A
Dental Aetna	https://www.aetna.com/dsepublic/#/contentPage?	877-238-6200	#181193
Vision United Healthcare Group	www.myuhcvision.com	800-638-3120	#914786
Life Insurance and Disability The Standard	www.standard.com	800-628-8600	#638521-B
Accident/Critical Illness/Cancer MetLife	www.metlife.com/MyBenefits	800-438-6388	#215349
Legal & ID Theft Protection LegalShield	membersupport@legalshield.com https://benefits.legalshield.com/indianriver	888-807-0407	#203750/ #302074
403b/457b Retirement Plan TSA Consulting Group	www.tsacg.com	888-796-3786	N/A
401(a) Retirement Plan Bencor	www.bencorplans.com	888-258-3422	N/A
Florida Retirement System MyFRS Financial Guidance	www.myfrs.com	866-446-9377	N/A
Explain My Benefits Enrollment Assistance	www.sdirc-benefits.com	New Hire enrollment assistance is available for newly enrolled eligible employees by appointment only through www.sdirc-benefits.com,	

Understanding Your Health Statement (Explanation of Benefits/EOB) from Florida Blue

What is a Health Statement?

- A Health statement is also known as an Explanation of Benefits or EOB for short.
- An EOB is a health care financial statement.
- It is prepared by your health insurance company, Florida Blue, after your health care provider has billed the insurance company for services rendered.
- The EOB is NOT A BILL. It is a financial statement indicating how muchthe provider charged for the services they provided you, how much the insurance company paid and how much you owe.
- It will also tell you how much was applied to your deductible amount/copayment amount.
- The statement is available monthly on-line at: www.floridablue.com

Why should I review the health statement?

- The information on the EOB should match what you have already paid your health care provider.
- It is important to be sure that the amount the health care provider charged you is the same amount billed to the insurance company.
- It helps to be sure that the amount that the health care provider bills you is correct.
- Be sure that the items match
    - Services provided
    - Dates of Services
    - The amount charged for your copay or deductible.
    - The amount you paid.
- It is important to check your statement as you may be owed a refund from your provider.

How to get a copy of the health statement or EOB?

The EOB is available online within 24 hours and can be obtained at www.floridablue.com

- Log in to your online member account at www.floridablue.com
- Click *Claims & Payments* then choose *Claims & Statements*
- Click *My Health Statements* (towards the top middle of thescreen)
- Chose the most recent monthly or annual statement.

Florida Blue notifies members that Health Statements are available monthly, through email. If there is no email assigned to your account, a Health Statement will be sent via postal mail.

If you have questions, please call the Customer Service number on the back of your Member ID card.

Florida Blue
In the pursuit of health

EXAMPLE

Your Health Statement

THIS IS NOT A BILL

Member: First and Last Name
Member Number: H000000000
Your Plan: Group BlueOptions
Statement Period: 00/00/0000 - 00/00/0000

Deductible and Out-of-Pocket Status By Member

Name	In-Network		Out-of-Network	
	Amount Applied Toward Deductible	Amount Applied Toward Out-Of-Pocket Max.	Amount Applied Toward Deductible	Amount Applied Toward Out-Of-Pocket Max.
Employee	$0.00	$1,000.00	$0.00	$0.00
Spouse	$0.00	$25.00	$0.00	$0.00
Dependent Child	$125.00	$125.00	$0.00	$0.00

Tip: Amounts add up separately for in and out-of-network covered medical services. Using doctors, hospitals in your plan's network will save you the most money.

Claim Activity for Employee Name

MEDICAL SERVICES Member Number: H00000000
CLAIM NUMBER: H0000000000000000
PLAN: Group BlueOptions
PROVIDER: Provider of your choosing

DIAGNOSIS CODE: X12345
DESCRIPTION: Medical Condition

Description of Service shows the health services you received, like a medical visit, lab test, or screening.

Amount Billed is the amount your provider bills for your visit.

Amount Allowed is the amount your provider will be paid; this may not be the same as the Amount Billed by your health plan.

Amount Paid is the amount your health plan will pay your provider.

From – To Date of Service	Procedure Code	1 Description of Service	2 Amount Billed	3 Amount Allowed	4 Amount Paid	Member Responsibility: Deductible Amount 5	Copayment Amount 6	Coinsurance Amount 7	You Owe 8
10/1/2022 - 10/1/2022	12345	Office Visit	($100.00)	($25.00)	($25.00)	$0.00	$0.00	$0.00	$0.00
10/4/2022 - 10/4/2022	23456	X-Ray	($100.00)	($25.00)	($25.00)	$0.00	$25.00	$0.00	$25.00
10/9/2022 - 10/9/2022	34567	Lab	($100.00)	($50.00)	($50.00)	$0.00	$0.00	$0.00	$0.00

Deductible Amount shows the amount of the member responsibility that would apply to the deductible.

Copayment Amount shows the amount of the member responsibility that would apply as a copayment.

Coinsurance Amount shows the amount of the member responsibility that would apply as a coinsurance.

You owe shows the amount of the member owes after the health plan has paid their portion. You may be billed by your provider or paid this amount prior to the service.

Pay your bills
Pay your bills and keep all paperwork in a safe place. Some providers will not see you if you have unpaid bills. You may be able to pay your bills online or over the phone. This can vary depending on your health plan and coverage.

Appeals
If you disagree with a coverage or payment decision by your health plan, you may be able to appeal. If you think you were charged for tests or services your coverage should pay for, keep the bill. Call your health plan right away. Health plans have call and support centers to help.

Please note this is an example designed for educational purposes only. For specific questions regarding your Health Statement, it is suggested you contact the number listed on your member id card.

Medical Terms Glossary

Important Terms

Insurance can sometimes sound like a foreign language. Take a moment to review the meaning of these common terms to best understand your benefit plans.

ACA (Patient Protection and Affordable Care Act)

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

Annual Deductible

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. Some services, such as office visits, require copays and do not apply to the deductible. This is an annual calendar year deductible.

After you meet your deductible, the plan pays for a percentage of eligible expenses (coinsurance) until you meet your out-of-pocket maximum. If you receive services from an out-of-network provider, the plan pays a lower percentage of coinsurance. Refer to your health care plan summaries for more information.

Brand Name Drug

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

Care Coordination

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

Copayment and Coinsurance

A copayment (copay) is the fixed dollar amount you pay for certain in network services. In some cases, you may be responsible for coinsurance after a copay is made.

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

Employer Contribution

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

Generic drug

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

Medical Terms Glossary—Continued

Important Terms

Insurance can sometimes sound like a foreign language. Take a moment to review the meaning of these common terms to best understand your benefit plans.

In-Network Advantage

Within some of the medical, dental and vision plans, you have the freedom to use any provider. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible to pay for the difference of the Usual, Customary and Reasonable (UCR) charges and what the provider bills. You also may need to submit claim forms.

NURSES ON CALL 24/7:

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

Out-of-Pocket Maximum

Some plans feature an out-of-pocket maximum, which limits the amount of coinsurance you will pay for eligible health care expenses within a calendar year. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in and out-of-network annual out-of-pocket maximums. Copays, deductible and coinsurance accumulate towards your out-of-pocket maximum.

Plan year

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

Preventive and Non-Preventive Services

Preventive care services are those that are generally linked to routine wellness exams. Non-preventive services are those that are considered treatment or diagnosis for an illness, injury, or other medical condition. There are limits on how often you can receive preventive care treatments and services. You should ask your health care provider whether your visit is considered preventive or non-preventive care. Examples of preventive care include:

- Annual routine physicals
- Bone-density tests, cholesterol screening
- Immunizations, mammograms, Pap smears, pelvic exams, PSA exams
- Sigmoidoscopies, colonoscopies

Important Legal Notices

Important Notice from School District of Indian River County 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 School District of Indian River County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

***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.**

***School District of Indian River County has determined that the prescription drug coverage offered by the medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is there fore 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 School District of Indian River County coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you drop your current prescription drug coverage and enroll in Medicare prescription drug coverage, you may not enroll back into the School District of Indian River County benefit plan during an open enrollment period under the School District of Indian River County benefit plan.

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact employee benefits for further information or call Employee Benefits Department at 772-564-3175. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through School District of Indian River County 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: October 2023
Name of Entity/Sender: School District of Indian River County
Contact-Position/Office: Employee Benefit Department
Address:6500 57th Street, Vero Beach, FL 32967
Phone Number:772-564-3175

Important Legal Notices

HIPAA Special Enrollment Opportunity

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

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

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

To request special enrollment or obtain more information, contact Florida Blue at 800-545-6565 ext. 25305.

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

Special Enrollment Provision

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

HIPAA Privacy Notice Reminder

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

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

Woman's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the group medical plan. If you would like more information on WHCRA benefits, call your plan administrator 772-564-3175.

Newborns' and Mothers' Health Protection Act of 1996

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

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

Important Legal Notices

Family Medical Leave Act (FMLA)

What does the Family and Medical leave act provide?

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

Who can take FMLA leave?

To be eligible to take leave under FMLA an employee must:

- Have worked 1,250 hours during the 12 months prior to the start of the leave (Note: Full-time teachers and other exempt employees are assumed to have worked 1,250 hours unless proven otherwise), and
- Have worked for the employer for 12 months (in total, not consecutive) within the last 7 years.

When can an eligible employee use FMLA leave?

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid, job-protected leave (26 weeks in the case of military caregiver leave described below) in a 12 month period for one or more of the following reasons:

- For the birth of a child:
- For the placement with the employee of a child for adoption or foster care;
- To take medical leave when the employee is unable to work due to a serious health condition;
- To care for an immediate family member (spouse, child or parent-but **not** parent "in-law") with a serious health condition;
- To care for a spouse, son, daughter, parent or next-of-kin on covered active duty service with a service-related serious health condition or injury;
- To deal with a qualifying emergency arising from a son's, daughter's, spouse's or parent's (but **not** parent "in-laws") active duty service or call to active duty service for deployment to a foreign country.

Responsibilities to the District Employees Requesting Leave.

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

Procedures on what you should do when taking a leave under FMLA:

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

Contact:	Stacy Haas, Human Resources FMLA
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3001
Email:	stacy.haas@indianriverschools.org

Important Legal Notices

Summary of Benefits and Coverage (SBC) Availability Notice

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

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

The SBC is available on the School District of Indian River County's Benefit Landing Page:
http://www.explainmybenefits.com/sdirc/

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

Discrimination is Against the Law

School District of Indian River County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. School District of Indian River County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

School District of Indian River County

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters

- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Equity & Compliance Officer. If you believe that School District of Indian River County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Name & Title—Stacy Haas
Office—Human Resources, FMLA
Address—6500 57th Street, Vero Beach, FL 32967
Phone—772-564-3001
Email - stacy.haas@indianriverschools.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Stacy Haas is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https ://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Social Security Numbers Generally Required for Enrollment

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare and Medicaid Services (CMS) generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, School District of Indian River will require that you provide Social Security numbers at the time of enrollment, so that School District of Indian River County can assist its health plan administrator(s) to comply with this requirement.

For a newborn or newly adopted child, the newborn may be enrolled, provided that School District of Indian River County is notified within 30 days of the birth, adoption, or placement for adoption. However, if a Social Security number is not provided by the later of (1) the end of the plan year, or (2) 90 days following the birth, adoption, or placement for adoption, the child will be disenrolled from the plan and will no longer be considered eligible for coverage. The child cannot be re-enrolled until the Social Security number is provided, and the child meets one of the mid-year enrollment or change in status coverage events.

Important Legal Notices

Model COBRA Continuation Coverage General Notice

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

- Your hours of employment are reduced, or

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

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

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

You become divorced or legally separated from your spouse.

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

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

Important Legal Notices

Model COBRA Continuation Coverage General Notice—Continued

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to School District of Indian River County and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin retroactively back to date of termination.
Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

Important Legal Notices

Model COBRA Continuation Coverage General Notice—Continued

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [*enter name of party responsible for COBRA administration*] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/an-employees-guide-to-health-benefits-under-cobra.pdf.

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

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

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

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

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

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

If you have questions

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

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

Keep your Plan informed of address changes

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

Plan contact information

Name of Entity/Sender: School District of Indian River County
Contact-Position/Office: Employee Benefit Department
Address:6500 57th Street, Vero Beach, FL 32967
Phone Number:772-564-3175

Important Legal Notices

Your Group Benefits Under Section 125

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

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

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

Change in Status

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

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

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

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

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

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

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

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

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

Significant coverage changes curtailment with or without loss of coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA—Medicaid	IOWA—Medicaid and CHIP (Hawki)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
ALASKA—Medicaid	**KANSAS - Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
ARKANSAS—Medicaid	**KENTUCKY - Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 / Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
CALIFORNIA - Medical	**LOUISIANA - Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 / Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE - 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 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003, TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740, TTY: Main relay 711
FLORIDA - Medicaid	**MASSACHUSETTS - Medicaid and CHIP**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 1-617-886-8102
GEORGIA - Medicaid	**MINNESOTA - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
INDIANA—Medicaid	**MISSOURI - Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

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

MONTANA - Medicaid	RHODE ISLAND—Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEBRASKA - Medicaid	**SOUTH CAROLINA- Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA - Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE - Medicaid	**TEXAS - Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY—Medicaid and CHIP	**UTAH - Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIPWebsite: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK—Medicaid	**VERMONT - Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA—Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
NORTH DAKOTA—Medicaid	**WASHINGTON - Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OKLAHOMA—Medicaid and CHIP	**WEST VIRGINIA - Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
OREGON—Medicaid	**WISCONSIN - Medicaid and CHIP**
Website: http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
PENNSYLVANIA—Medicaid	**WYOMING - Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

New Health Insurance Marketplace Coverage Options and Your Health

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact The Benefits Department.

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 School District of Indian River County	**4. Employer Identification Number (EIN)** 59-6000884	
5. Employer address 6500 57th Street	**6. Employer phone number** 772-564-3175	
7. City Vero Beach	**8. State** Florida	**9. ZIP code** 32967
10. Who can we contact about employee health coverage at this job? Employee Benefits, Amy Yeitter		
11. Phone number (if different from above) n/a	**12. Email address** sdircbenefits@indianriverschools.org	

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

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

☒ All employees. Eligible employees are:

All regular employees working at least 21 hours per week.

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse—Legally married; Children—up to age 26 under Health Care Reform. Up to age 30, Florida Statute if child is: 1)Unmarried without dependents of their own AND 2) A Florida resident of a full-time student AND 3) Not covered under any health plan or policy AND 4) Not entitled to coverage under Medicare

☐ 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.

Important Legal Notices

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

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

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

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

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

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

Important Legal Notices

Patient Protection Provider Choice

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

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

Patient Protection and Affordable Care Act (PPACA, or Health Care Reform)

The Affordable Care Act (ACA) has brought sweeping changes to the U.S. health insurance system. Its goal is to make health insurance available to everyone, regardless of medical history or ability to pay. Many of the ACA changes have already affected our plans, such as covering adult children through age 26, free preventive care, reducing or removing annual or lifetime limits on essential health benefits, and the $2,750 cap on Medical Expense FSA contributions. Some of the biggest changes resulting from the law took effect January 1, 2014. These changes are explained below.

Medical Plan Enhancements

All of the medical plans offered by School District of Indian River comply with the required changes and result in the following changes: (1) The annual maximum includes the annual deductible. (2) The annual out-of-pocket maximum is capped, lowering the maximum that you could pay for eligible health care expenses in a year.

Social Security Numbers

Effective January 2016, the Affordable Care Act (ACA) will require employers and health insurance carriers to file reports under the Internal Revenue Code to establish compliance with the employer mandate. As part of this requirement, School District of Indian River County must provide Social Security numbers for all individuals covered by a School District of Indian River County sponsored medical plan. In compliance with the ACA requirements, you will be asked to provide Social Security numbers for yourself and all dependents enrolled in a School District of Indian River County sponsored medical plan. If you are unable to respond to this request our health insurance carrier may also request Social Security numbers for your enrolled dependents.

Important Legal Notices

EEOC NOTICE REGARDING WELLNESS PROGRAM

[Name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [be specific about the conditions for which blood will be tested.] You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of [indicate the incentive] for [specify criteria]. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive [the incentive].

Additional incentives of up to [indicate the additional incentives] may be available for employees who participate in certain health-related activities [specify activities, if any] or achieve certain health outcomes [specify particular health outcomes to be achieved, if any]. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [name] at [contact information].

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as [indicate services that may be offered]. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach"] in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. [Specify any other or additional confidentiality protections if applicable.] Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact [insert name of appropriate contact] at [contact information].

Enrollment Preparation Worksheet

	Current Election	New Election
Medical/Rx	**Florida Blue / Express Scripts** 5770 / 5772 / 5774	**Florida Blue / Express Scripts** 5770 / 5772 / 5774
Tier	EE ES ECH FAM $_____	EE ES ECH FAM $_____
Flex Spending	**Chard-Snyder** Medical $_____ Dependent Care $_____	**Chard-Snyder** Medical $_____ Dependent Care $_____
Dental	**Aetna Dental** High PPO / Low PPO / DHMO	**Aetna Dental** High PPO / Low PPO / DHMO
Tier	EE ES ECH FAM $_____	EE ES ECH FAM $_____
Vision	**UnitedHealthcare** Option 1 / Option 2	**UnitedHealthcare** Option 1 / Option 2
Tier	EE ES ECH FAM $_____	EE ES ECH FAM $_____
Life Insurance	**The Standard** Employee Coverage $_____ Deduction $_____ Spouse Coverage $_____ Deduction $_____ Child(ren) Coverage $_____ Deduction $_____	**The Standard** Employee Coverage $_____ Deduction $_____ Spouse Coverage $_____ Deduction $_____ Child(ren) Coverage $_____ Deduction $_____
Short Term Disability	**The Standard** Monthly Benefit $_____ Deduction $_____	**The Standard** Monthly Benefit $_____ Deduction $_____
Long Term Disability	**The Standard** Weekly Benefit $_____ Deduction $_____	**The Standard** Weekly Benefit $_____ Deduction $_____
Accident/Critical Illness/Cancer	**MetLife** Accident EE ES ECH FAM $_____ Critical Illness EE ES ECH FAM $_____ Cancer EE ES ECH FAM $_____	**MetLife** Accident EE ES ECH FAM $_____ Critical Illness EE ES ECH FAM $_____ Cancer EE ES ECH FAM $_____
Legal & Identity Theft Protection	**LegalShield Only** EE ES ECH FAM $_____ **IDShield Only** EE ES ECH FAM $_____ **Combo Plan** EE ES ECH FAM $_____	**LegalShield Only** EE ES ECH FAM $_____ **IDShield Only** EE ES ECH FAM $_____ **Combo Plan** EE ES ECH FAM $_____

EE = Employee **ES = Employee & Spouse** **ECH = Employee & Child(ren)** **FAM = Family**

Benefit Guide Description

Please Note: This guide provides information regarding the District's benefit program. More detailed information is available from the plan documents and administrative contacts. The plans and policies stated in this information are not a contract or a promise of benefits of any kind, and therefore, should not be interpreted as such.

About This Guide

This guide highlights all employee benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan description (SPDs), plan document or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. The School District of Indian River County reserves the right to make changes at any time to the benefits, costs and other provisions relative to benefits.