School District of Indian River County

2023—2024 Retiree Benefit Guide

Source: Risk/Benefits Dept/ Updated 11292023/SL

Table of Contents

Our Commitment to You

The School District of Indian River County is committed to providing our retirees with a benefits program that is both comprehensive and competitive. This guide provides a general overview of the coverages that may have available to retirees. Our benefits program offers healthcare, dental and vision coverage.

What's in this Guide?

Who is Eligible for Retiree Benefits?

All retirees who were eligible for active employee benefits, during employment with the District, are considered eligible for retiree benefits. Retirees must enroll within 30 days of retirement.

There are different options for pre- and post-65 retirees. Please carefully consider the differences. If you did not elect to continue health, dental and/or vision coverages with the District at retirement, you will not be eligible to enroll in these coverages after retirement. Please note that Medicare is primary coverage for Medicare eligible retirees. District coverage is secondary to Medicare coverage.

How to Enroll in Retiree Benefits

Please contact the Employee Benefits Department for enrollment information by calling 772-564-3175 or emailing sdircbenefits@indianriverschools.org.

Paying for Benefits

- Retirees pay the cost of their benefits.
- The District offers two different payment options:
    1. Florida Retirement System (FRS) withdraw from your monthly pension benefit check.
    2. ACH withdraw from a checking or savings account.
- Both options require you to complete the applicable form. Forms will be provided by the Benefits Department with the enrollment application, at the time of retirement or upon request. Retirees must enroll within 30 days of retirement.
- **Failure to pay insurance premiums within 60 days will result in immediate cancellation of coverage and you will receive an offer of COBRA coverage**.
- For specific information about your FRS account please contact FRS directly by calling 866-446-9377.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

If you, your spouse, or eligible dependent loses coverage under any District medical, dental or vision plan because of a COBRA-qualifying event, you may have the right to continue coverage under COBRA.

If your coverage ends due to a COBRA-qualifying event, you will receive a notice of your continuation rights. At that time, you will have up to 60 days—from the date of your event or the date you received your notice—to decide whether you want to continue your health coverage.

If you, your spouse, and/or dependent have a COBRA qualifying event, you must notify the Employee Benefits Department immediately.

For any specific questions about COBRA coverage contact Chard Snyder at 888-993-4646.

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 Retirees enrolled in the District's Florida Blue 0117, 05770, 05772, or 05774 health plans. The District Health Center also provides NO COST wellness programs and health coaches.

- Services that are available at no cost:
  - 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 you will be charged for each missed appointment after the third "No Show".

NOTE: The District Health Center is not available for Retirees enrolled in a Florida Blue Medicare Advantage Plan.

Medical - Florida Blue (Pre-65 Retirees)

School District of Indian River County Group Health Plan

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.

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
Annual Calendar Year Deductible						
Single	$1,000	$3,000	$2,000	$6,000	$3,000	$6,000
Family	$3,000	$6,000	$6,000	$18,000	$9,000	$18,000
Out-of-Pocket Maximum						
Single	$3,500	$7,000	$5,500	$11,000	$6,350	$15,000
Family	$7,000	$14,000	$11,000	$22,000	$12,700	$30,000
Coinsurance (% member pays of bill)	20%	50%	20%	50%	20%	50%
Physician Services						
Doctor's Office Visit	$25	50% after ded.	$35	50% after ded.	$40	50% after ded.
Specialist Office Visit	$25	50% after ded.	$65	50% after ded.	$100	50% after ded.
Preventive Care	No Charge	50%	No Charge	50%	No Charge	50%
Imaging Facility	$100	50% after ded.	20% after ded.	50% after ded.	$400.	50% after ded.
Hospital Facility Fees						
Inpatient	20% after ded.	$3,500	$100 + 20% after ded.	$500 + 50% after ded.	$500 + 20% after ded.	$500 + 50% after ded.
Outpatient	Ambulatory Surgical Center: $150 Hospital Option 1: 20% after ded.	50% after ded.	Ambulatory Surgical Center: $250 Hospital Option 1: $100 + 20% .	50% after ded.	Ambulatory Surgical Center: $350 Hospital Option 1: $500 + 20%	50% after ded.
Imaging Center	$100	50% after ded.	$300	50% after ded.	$400	50% after ded.
Emergency Care	$200		$300		$400	

Please see the next page for Prescription Drug information and Monthly Premiums

Note: 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.

Questions? Contact Florida Blue at 800-664-5295

Prescription Drugs - Express Scripts (Pre-65 Retirees)

School District of Indian River County Group Health Plan

With the election of a medical plan, employees are automatically enrolled in the corresponding prescription drug plan administered by Express Scripts. 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 Premiums (Pre-65 Retirees)

Benefit	Blue Options 05770	Blue Options 05772	Blue Options 05774
Total Monthly Premium			
Retiree Only	**$944.00**	**$832.00**	**$731.00**
Retiree + Spouse	**$1,521.00**	**$1,336.00**	**$1,176.00**
Retiree + Child(ren)	**$1,492.00**	**$1,310.00**	**$1,156.00**
Retiree + Family	**$1,690.00**	**$1,483.00**	**$1,307.00**

Medical - Florida Blue (Post-65 Retirees)

Medicare Advantage Program

In addition to the School District of Indian River County Group Health Plan (BlueChoice 0117), the District offers three Medicare Advantage Plans with Prescription Drug coverage, also known as Part C, through Florida Blue. .

For a more detailed Summary Plan Description of these plans, please visit our website at: www.indianriverschools.org/departments/employee_benefits

For additional questions about the Medicare Advantage Program please contact Florida Blue's Medicare Services by calling 1-844-258-3363 or emailing egwpinfo@bcbsfl.com.

Benefit	School District of Indian River County Group Health Plan Plan Year 10/1 /2023—9/30/2024		Medicare Advantage Program Plan Year 1/1/2024—12/31/20234		
	BlueChoice 0117		Elite PPO	Advanced PPO	Essential PPO
	In-Network	Out-of-Network	In-Network	In-Network	In-Network
Annual Calendar Year Deductible					
Per Person/Per Family	$0	$800/$1,600	$0	$0	$0
Out-of-Pocket Maximum					
Per Person/Per Family	$2,500/$5,000		$1,000	$1,000	$4,500
Coinsurance (% member pays of bill)	N/A	40%	N/A*	N/A*	N/A*
Physician Services					
Doctor Office Visit	$0	40% after Ded.	$10	$25	$35
Specialist Office Visit	$0	40% after Ded.	$25	$45	$50
Preventive Care	$0	40%	$0	$0	$0
Major Diagnostics (CT/PET scans/MRI)					
Physician's Office	$0	40% after Ded.	$50	$75	$75
Diagnostic Testing Facility	$0	40% after Ded.	$75	$100	$150
Outpatient Hospital	$0	40% after Ded.	$100	$150	$200
Hospital Services					
Inpatient *Copays are per day	$0	0%	$200 day(s) 1-5 $0 after day 5	$200 day(s) 1-7 $0 after day 7	$325 day(s) 1-6 $0 after day 6
Outpatient					
Medicare covered Services	$0	40% after Ded.	$75 per visit	$75 per visit	$90 per visit
All other Services	$0	Hosp: 20% after Ded.; Surg Cntr: 40% after Ded.	$200	$250	$250
Emergency Care					
Copay	$0	$0	$75	$75	$90
Worldwide max.	N/A	N/A	$25,000	$25,000	$25,000

Please see next page for Prescription Drug information and Monthly Premiums

Note: 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.

Questions? Contact Florida Blue at 1-844-258-3363

Prescription Drugs - Florida Blue (Post-65 Retirees)

Benefit	School District of Indian River County Group Health Plan Plan Year 10/1/2023—9/30/2024		Medicare Advantage Program Plan Year 1/1/2024—12/31/2024		
	BlueChoice 0117 & AmWins		Elite PPO	Advanced PPO	Essential PPO
	In-Network	Out-of-Network	In-Network	In-Network	In-Network
Prescription Drugs					
Deductible	$0		$0	$100 (Tier 3, 4, 5)	$250 (Tier 3, 4, 5)
Medicare Advantage (Initial Phase)					
Tier 1	$15		$0	$8	$10
Tier 2	$30		$3	$10	$20
Tier 3	$60		$30	$35	$40
Tier 4	$30		$60	$78	$93
Tier 5	n/a		$80	31% coinsurance	28% coinsurance
Medicare Advantage (Coverage Gap/Donut Hole Phase)					
	Once Retiree reaches an out-of-pocket spend of $5,030 then pay:				
Tier 1	$15		$0	25% coinsurance	25% coinsurance
Tier 2	$30		$3	25% coinsurance	25% coinsurance
Tier 3	$60		$30	25% coinsurance	25% coinsurance
Tier 4	$30		$60	25% coinsurance	25% coinsurance
Tier 5	n/a		$80	31% coinsurance	28% coinsurance
Medicare Advantage (Catastrophic Phase)					
	Once Retiree reaches an out-of-pocket spend of $8,000 then pay:				
Generic	Greater of $4.15 or 5%		$0	$0	$0
Brand Drugs	Greater of $10.35 or 5%		$0	$0	$0

*20% on certain services (example: Radiation Therapy and Part B drugs)

Monthly/Annual Premiums				
Single Coverage	**$703.00**	**$322.85**	**$230.74**	**$127.91**
Retiree + Spouse	**$1,318.00**	**N/A**	**N/A**	**N/A**

AmWins Prescription Drug Plan

With the election of a School District of Indian River County Group Health Plan (0117 Medical Retirement plan), Retirees are automatically enrolled in the corresponding AmWins Prescription Drug Plan. The information above is a summary of prescription drug coverage only. Please contact AmWins at 855-693-3921 or a summary of benefits can be found on the district web site at: https://www.indianriverschools.org/

Medicare Advantage Program Additional Benefits:

Telehealth	$10 copay for Primary Care Services $25 copay for urgently needed services
HealthyBlue Rewards	Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.
SilverSneakers Fitness Program	Gym membership and classes available at fitness locations across the country, including national chains and local gyms. Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.

For a more detailed Summary Plan Description of the above plans, please visit our website at: www.indianriverschools.org/departments/employee_benefits

Voluntary Dental - Aetna

The District is committed to a dental program that is 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 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
Annual Calendar Year Maximum (Per Enrollee)	$1,000	$1,000	N/A
Calendar Year Deductible (Per Enrollee)	$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
Monthly Premium			
Retiree Only	$36.35	$31.19	$19.66
Retiree + Spouse	$77.87	$66.82	$33.74
Retiree + Child(ren)	$72.87	$62.54	$33.98
Family	$114.62	$98.39	$48.95

Voluntary 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 **1-800-638-3120** 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 **1-800-638-3120.**

Benefit	Option 1	Option 2
Exam	$10 copay (Once every 12 months)	$10 copay (Once every 12 months)
Frames*	$130 allowance (Once every **24** months)	$130 allowance (Once every **12** months)
Contact Lenses (in lieu of eyeglasses)		
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 (up to 4 boxes) (Once every 12 months)	$25 (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)
Monthly Premium		
Retiree Only	$5.55	$6.18
Retiree + Spouse	$9.35	$10.39
Retiree + Child(ren)	$9.53	$10.65
Family	$15.08	$16.78

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

Questions? Contact UnitedHealthcare at 1-800-638-3120

The Standard—Life Insurance

The Standard is the Group Life and AD&D partner for the District and its retirees.

- All retirees that were covered by the Employer Paid Basic Life at the time of retirement, are eligible to enroll in Basic Life insurance for a coverage amount of $5,000 for a cost of $7.50 per month.
- All retirees that were enrolled in Voluntary Life at the time of retirement, are eligible to elect additional $5,000 of coverage for an additional cost of $17.50.
- The total cost for both options is $25.00

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 Senior Specialist, Benefits and Risk Management	https://www.indianriverschools.org/directory/benefits	772-564-3175 sdircbenefits@indianriverschools.org	N/A
Joan Martin Employee Benefit Specialist	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 (Pre-65 and Post-65) Florida Blue	www.floridablue.com	800-664-5295	#59016
Medicare Advantage (Post-65) Florida Blue	www.floridablue.com/Medicare	844-258-3363	#59106
Prescription Drug (Pre-65) Express Scripts, Inc. (ESI)	www.express-scripts.com	866-262-6427	#SDIRC01
Prescription Drug (Post-65) AmWins Retiree Rx Care	retireerxcare.amwins.com	855-693-3921	#AWS45200001
District Health Center Premise	www.mypremisehealth.com	844-422-7343	N/A
Dental Aetna	https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchPlanList&site_id=dse&language=en	877-238-6200	#181193
Vision United Healthcare Group	www.myuhcvision.com	800-638-3120	#914786
Life The Standard	www.standard.com	800-628-8600	#638521-B
403(b)/457(b) 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

Important Legal Notices

Important Notice 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 through our medical plans, is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is considered 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 15 to December 7. 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 will not be affected. 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 may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with 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. 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 800-MEDICARE (800.633.4227). TTY users should call 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 800.772.1213 (TTY 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 Benefits 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.

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

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/oc r/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

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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

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 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 copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

You're protected from balance billing for:

Emergency services

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

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

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

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

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

- 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: o
- 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 $2,850 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.

Glossary

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

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

Coinsurance:
A percentage of costs you pay "out of pocket" for covered expenses after you meet the deductible.

Copay (Copayment):
A fee you have to pay "out of pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible:
The amount you pay "out of pocket" before the health plan will start to pay its share of covered expenses.

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.

Out-of-pocket maximum:
The most you pay each year "out of pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

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 care:
Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Notes

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 retiree benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan 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.