Indian River County Survey on Employee Health Clinics 2020	**Responding Agency: School District of Indian River County**
Contact: Sheila O'Sullivan - 772-226-1377 sosullivan@ircgov.com	**Contact: Amy Yeitter (amy.yeitter@indianriverschools.org**
Purpose: We are evaluating the different types of employee clinics that various agencies have implemented to evaluate whether implementing a clinic would be beneficial and cost effective.	**Please provide responses below and provide any details and comments that may assist us in evaluating clinic options.**

Your Health Plan Participant Count:	**Subscribers: 1807 Members: 3332**
HISTORY	
Are you self-insured for your health insurance?	Yes
Please provide the employer's monthly contribution towards the various health plan options.	$540.00 now, $590 effective 10/1/20
Please provide the employee's monthly contribution toward the various health plan options.	5770 E only High plan - $212.00, 5772 E only middle plan - $113.00, 5774 E only middle plan $24.00 Each plan increasing $5.00 effective 10/1/20
What motivated your agency's decision to pursue a clinic? What were the main drivers?	Lower health claims costs
Please list the goals you were hoping to accomplish when implementing a clinic. Employee benefit enhancement? Cost savings? Wellness program? Access to care?	Becuase SDIRC is self funded, our main goal was to lower claims cost. Both health and orescription. The second goal was to assist employees in identifying and treating underlying issues and conditions that increase those claims.
How did you determine your organization was ready to implement a clinic?	This, I cannot answer as I was not with the District yet.
IMPELEMENTATION PROCESS	
How long did it take from the decision to implement to go live?	Just over 1 year.
Describe the implementation process.	Once the plan was approved, and a vendor in place (Care Here) the District had a building already available to house the clinic, so it was just a matter of retrofitting it for this purpose and Care Her outfitting the spoce with equipment and staff. .
What resources did you need? Did you use an outside consultant to assist you?	No, Care Here has a basic implementation plan, includng requirements of space, equipment and staff
What were the start up costs?	$150,000 approximately
Which department oversees the clinic and how many staff are allocated in support of employee benefits and the employee clinic?	Employee Benefits oversees the clinic. We have a Benefits Specialist, a dedicated accountant and an admin assistant on our staff
Describe your communication plan to your members?	Again, not involved at the time of implementation, but currently we use site poster for infomration and updats, as well as e-mails. Care Here is very good about creatinf flyers and sending them out to patients as well
What challenges did you face and what would you do differently? Describe lessons learned related to implementation?	Once decided, the implementation was fairly easy, however we have since grown in number of patients, staff and services. We are currently adding pre-employment drug testing, physicals, randoms and w/c. We should have planned, space wise, better for future growth as we are typically at about 83% utilization.
CLINIC MODEL	
When was the clinic implemented?	September, 2014
Describe your clinic model. Number of clinic locations, number and type of clinic staff, days and hours of operations, and services provided.	
Who is/are your vendor partner(s)?	Care Here
Who is eligible to visit the clinic and what is the number of eligibles?	Benefits Eligible Employees & retirees - Approximately 2000
What is the member cost for a clinic visit?	$0.00
How is the clinic funded and what are the annual costs?	The clinic is funded through our health fund.
How are the clinic expenses verified and paid?	We have a dedicated senior accountant on the Benefit's staff who reconciles and pays the invoices received from care Here.
Describe any member incentives or well being strategies associated with the clinic.	Curerently, we have a wellness staff member available once a month through the clinic. We do have funding however for another full time employee, a wellness specialist. Just not hired yet.
Please describe any innovations or programs running in the clinic that are working well.	Our diabetes care management allows patients to get their meds and suoplies through the clinic. This has helped immensely with adhearance to medical plans. We have also been able to secure a contract with IR Radiologyfor reduced rates for our memebers who are referred to them therough the clinic. This enables the District to offer the employees $0 co-pay for these services. We are in the process of securing a contract with Quest, to pick up our lab work and run it through Florida Blue since it is a capitated cost, rather than paying the clinic fee for labs sent through their vendor, Lab Corp.
Please indicate if you have any plans to expand or reduce clinic services in the future.	In the last two years we have seen steady utilization rates of near 90%, so we have started the dicussion of opening a 2nd clinic with our Health Insurance Advisory Task Force.
OUTCOMES	

Indian River County Survey on Employee Health Clinics 2020	Responding Agency: School District of Indian River County
Contact: Sheila O'Sullivan - 772-226-1377 sosullivan@ircgov.com	Contact: Amy Yeitter (amy.yeitter@indianriverschools.org
How many of your members are participating in the clinic? Please express as both as a number and percent of total eligibles.	1291 eligible employees registered to use the clinic, 1804 employees are eligible. 85 retirees are registered, 101 are eligible
Please describe any metrics you have established to determine clinic outcomes.	We utilize a risk movement report that is a report of the same individuals year over year, we also conduct slope movement and biometrics reports. Metrics are also utilized to measure clinic utilization, where percentages, heat maps and unique patient counts are measured.
What reporting do you receive to demonstrate outcomes?	See above
Please describe success/outcomes that are noteworthy.	Our utilization is our biggest success. Our employees that utilize the clinic, love the convenience, the continuity of care and the staff. Staffing is a very important part of the whole. If your employees do not feel comfortable with the staff, they will not utilize the clinic. We have been able to add in more and more programs over the years in order to further assist employees with chronic conditions, such as our diabetes management program and our mail order option for prescriptions.
Describe employee satisfaction with the clinic. Have you conducted employee surveys related to the clinic, if so please summarize overall employee sentiments related to the clinic.	Care Here has sent out survey's to patients and most were very favoarable. Our employees love the access and convienence of the clinic. We do still have some employees who do not feel comfortable using the clinic, thinking that their PHI is shared with the District. This is something we are working to overcome. The main negative response to our surveys have been lack of appointments available due to our high utilization. This will be one of our focus ponts for the coming year, the possibility of expanding.
Describe how the clinic has met the initial clinic goals stated above. How have you quanitified success as it relates to your upfront goals.	Claims through Florida Blue are down, clinic utilization is up. Through our various reporting from Care Here, we see that many more employees with continuing medical issues such as diabetes, are maintaing a medical regamine, therefore major medical isues due to non-adherence are lowering. We keep a very close eye on our top recurring medical issues and work to find programs, changes that can be made too assist those employees specifically.
Is there anything you would change or do differently if you had it to do it over again?	Start with a building big enough for expansion, or have a plan for that early on.
Please share any additional information that you believe would be helpful to us as we evaluate the possibility of pursing an employee clinic.	Look more closely at vendors who can not only run a employee clinic, but who can eventually move towards other opportunities such as Pre-employment screening, drug testing, worker's comp. This is all a part of our initial contract and we are moving towards utilizing all of these services to save costs in those areas as well.

Medication

Does the clinic provide medications through the clinic? If so, what are the member copays? If you offer medications with no copays, how was the list of "free" medications determined?	We do offer every day/non-narcotic medications at no cost to the employees. Antibiotics, vitamin B shots, flu shots, etc. The list of medications was provided by Care Here based on their clinic history with other groups. The District did choose, however, to not include any over the counter medications. Based on reporting from Care Here regarding our top medical issues, we have recently made diabetic medicines to our available list, which is reviewed at least annually. Again based on our top diagnoses. So our available medication list is not stagnant, by any means.
How did you evaluate which medications to offer through the clinic? What was the main reason you offer medications through the clinic?	The main reason we chose to offer medications through the clinic was to promote adherence by the employees, to their treatment plans. Secondly, we review costs of these medications through the clinic versus through Express Scripts on a regular basis as well and have found that we do see significant savings through the clinic. Added to that, we also receive all discounts and rebates through the manufacturers.
Is the cost of medications to the employer's plan, less than the cost through the traditional pharmacy benefit? What data was used to make this determination?	See above
What is the annual cost to the employer's plan of offering the medications through the clinic?	Our 2020 medication costs were $304,736.00
Do your medications expire and have to be disposed of without being dispensed to members?	Care Here is very good at keeping tabs on the medications that we have in-house, and not allowing items to expire. This has been an issue with the annual flu shot in the past when we had less demand than expected. We were able to transfer doses to other clients in order to prevent waste.

2020—2021
Benefit Guide

MANDATORY OPEN ENROLLMENT

All Benefit Eligible Employees are Required to Participate

ENROLLMENT DATES:

8/17/2020—8/31/2020

School District of Indian River County

Welcome to your District Benefit Enrollment Guide

Our Commitment to You

The School District of Indian River County (the "District") 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 products that help to provide income protection in an emergency.

This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that's right for you.

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 make sure their Social Security numbers and your beneficiary designations are up-to-date.

What's in the Guide?

What's New This Year?

There are several important changes this year.

Please be sure to read this entire Benefit Guide thoroughly to ensure you understand these changes.

This will be a MANDATORY Open Enrollment.

- All employees must enroll this year.
- **You must** complete the enrollment process even if you choose not to elect benefits.
- Previous benefit choices for Medical, FSA, Dental, Vision and Legal will NOT automatically carry over.
- **Previous elections will expire on September 30, 2020** and new elections will begin on October 1, 2020.
- New enrollment elections begin with the new plan year that begins on October 1, 2020 and ends September 30, 2021.
- The Open Enrollment period begins August 17, 2020 and ends on August 31, 2020 at 5:00pm EST.
- Verification must be provided for all NEW dependents who will be covered. Please see page 5 for additional information.
- In order to receive the annual opt-out credit you must actively decline medical coverage and provide proof of coverage in the form of your current medical ID card or a letter from the employer confirming your active coverage. Please see page 5 for additional information.
- Voluntary Additional Life Insurance— The Standard Insurance Company is offering a one-time opportunity to purchase or increase coverage without a proof of health form , up to the new Guarantee Issue amount of $200,000 for employees and $50,000 for spouses. Please see pages 5, 22 and 23 for additional details.

Open Enrollment

Open Enrollment begins August 17, 2020 and ends on August 31, 2020 at 5:00pm EST.

How do I enroll?

Review this entire Enrollment Guide before beginning the enrollment process. A convenient Enrollment Preparation Worksheet can be found at the back of this guide. Complete the worksheet as you review the Guide to help prepare you for the open enrollment process.

To start the enrollment process, go on-line to register at www.sdirc-benefits.com. **If you have not logged into the online portal since last year, you will need to re-register.** To start the enrollment process, go to www.sdirc-benefits.com and click "Log into your benefits system." "Create New Log in" using your social security number and birth year (see page 12).

Open Enrollment begins on August 17, 2020 and ends on August 31, 2020 at 5:00pm EST. **No changes can be made after Open enrollment ends on August 31, 2020.**

Open Enrollment is not complete until you print a copy of the CONFIRMATION sheet.
Be sure to click "submit" at the end of the enrollment process and note your confirmation number. If you do not receive a confirmation number you have **not** completed your enrollment and you will not be enrolled in benefits.

Be sure you **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 31st except for qualifying events (see page 10).**

Confirm your payroll deductions with the first pay period of the new plan year, October 15, 2020, (or when newly hired) to ensure they are correct. Payroll corrections must be requested in writing by sending an email to sdircbenefits@indianriverschools.org. Payroll corrections must be made within 30 days of the first pay period (by November 15, 2020).

Newly hired? Or did you transfer positions or enter a job share position? Eligibility criteria can be found on page 8 of this Guidebook. **Enrollment must be completed within 30 days of eligibility.**

The on-line Open Enrollment platform is managed by "Explain My Benefit" (EMB).

Need Open Enrollment Assistance?

Open Enrollment can be completed through the online self-enroll system. If you would like additional assistance with the online self-enroll system or prefer to enroll over the phone you can contact The Open Enrollment Assistance Service Center by calling 1-800-505-8416 (see below for hours). Open Enrollment Assistance is available:

- August 17th through August 31st 9:00am—7:00pm Eastern Time, Monday through Friday

This will be a MANDATORY Open Enrollment

ALL employees must enroll this year.
You must complete the enrollment process even if you choose not to elect benefits.

Adding Dependents to your coverage?

If you are adding any NEW dependents to your coverage, effective October 1, 2020, you will be required to provide documentation proving the dependent's eligibility.

To enroll any new dependents the 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 college admission/enrollment or current college schedule

These documents must be uploaded to the EMB Enroll Document Management tool in the online enrollment system, prior to August 31, 2020 at 5:00pm EST.

Please Note: Documents can not be submitted through the Benefits Department, however documents can be uploaded by logging into the EMB Mobile APP— Photos can be taken using your smart phone and then uploaded, under enrollment (please see page 12).

Opting-Out of Medical Insurance?

- The District offers an annual flex spending amount of $480 to any employee who actively opts-out of medical coverage during open enrollment.
- If you choose to decline the District's medical coverage and opt-out during Open Enrollment, the District will deposit $20.00 per pay period into your flex spending account, beginning October 1, 2020.
- In order to be eligible you **MUST elect "OPT-OUT" during Open Enrollment and you MUST show proof of other coverage to receive this credit.**
- The system will require you to upload proof of other coverage, which could be a letter from the employer stating you have active coverage OR your current active insurance card.
- 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.

Interested in Adding or Increasing your Voluntary Additional Life Insurance?

- The Standard Life Insurance is offering an one time Opportunity to Increase Coverage without Proof of Health.
- During this year's Open Enrollment coverage, may be increased up the Guarantee Issue amount for employees and dependents. This offer applies to employees and dependents not currently enrolled. It also applies to employees and dependents who are enrolled for less than the Guarantee Issue amount.
- Guarantee Issue amounts have been enhanced this year to $200,000 for employees and $50,000 for spouses.
- Adding or increasing your Voluntary Additional Life Insurance is ONLY available during Open Enrollment from, August 17, 2020 through August 31, 2020. If you do not elect now, all future increases in coverage will be subject to proof of good health unless you are a new hire applying during your initial period of eligibility.

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 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 correctly reflect the benefit elections made.
- Employees are responsible for participating in the Open Enrollment process annually.
- 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.

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 of the School District of Indian River County are considered eligible for benefits if they work 30 hours or more per week.

Eligibility is determined at the time of hire, or when you transfer positions, or if you enter a job share 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 page 12 and 13 in this Guide.

Effective Dates

The Open Enrollment effective date of the benefits is based on the Plan Year which is October 1st through September 30th.

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 5th, then benefits will become effective March 1st. This is also true if you transfer positions or if you enter a job share position.

New Hire Enrollment must be completed within 30 days of new hire date. ***Enrollment is not completed until you click "submit" to confirm and print a copy of the CONFIRMATION sheet.*** Be sure you print a hard copy of your new benefits summary to compare to your payroll deductions to ensure that the deduction amounts are correct. Please Note: Printing your confirmation will not confirm your enrollment, you must click "submit" to confirm.

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.

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 to be 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 eligible dependent reaches **age 25**, regardless of student status, if the dependent is unmarried. Voluntary child life 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 (see below). 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 Savings Accounts, Retirement Plans	Employee	Pre-Tax
Additional Life/AD&D, Disability, Additional Elective Benefits	Employee	Post-Tax

Family Medical Leave Act — 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 as premiums are no longer payroll deducted. **Failure to pay insurance premiums by the 30th of the month 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. Please include your Employee ID on the check and a copy of your benefit confirmation page. **Failure to pay insurance premiums by the 30th of the month 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: Employee Benefit Department
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 paid contribution. **Failure to pay insurance premiums by the 30th of the month 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 your benefits by reviewing your printed hard copy of the benefit confirmation sheet and 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, you will stop receiving the Board contribution towards the District medical and life insurance coverages and will be responsible for paying the total cost, whether through payroll deductions or direct payment. If payments are not received by the end of each month, **benefits will be cancelled immediately.**

Qualifying Events

Making Changes During the Year

Choose your benefits carefully! **You cannot change your benefit options 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
- ⇒ 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

*****You have 30 days from the Qualifying Event Date to submit your benefit changes*****

Qualifying Events—Additional Information

- **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 contact the Employee Benefits Department within the initial 30 days for this coverage to be added to your health insurance deductions. 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. NOTE: You will be required to pay the Employee + Family premium from the date the insurance coverage is added (back to date of birth).
- **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 and any other dependent documentation will be required.

Submitting Qualifying Events

1. To submit a qualifying event to Employee Benefits please visit www.sdirc-benefits.com.

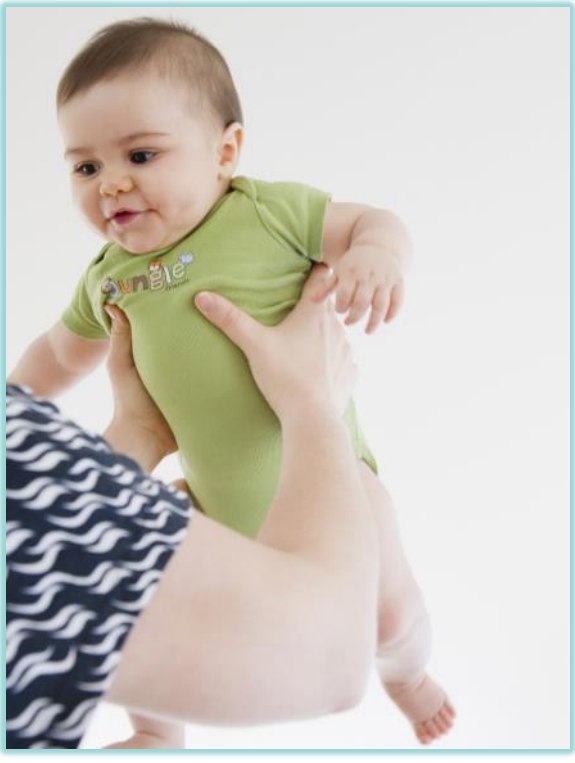
2. Follow the login instructions on page 13.

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 required documentation by clicking on the paper icon above the Florida Blue section.



Benefit Termination

Benefit Termination Policy

Terminated employees are covered until the last day of the month:

- In which employment ends (interim employees are in this category).
- In which you cease being in a benefit eligible position.
- In which you retire.
- In which payments are not received.

Family Medical Leave Act (FMLA)

FMLA — Approved Leave with Benefits

The District will continue to pay the employer's contributions for your medical insurance coverages and employer paid basic life for up to 12 weeks while you are on approved FMLA leave; however, you are responsible for paying the employee cost for any medical 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 as premiums are no longer payroll deducted. **Failure to pay insurance premiums by the 30th of the month 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. Please include your Employee ID on the check and a copy of your benefit confirmation page. **Failure to pay insurance premiums by the 30th of the month 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: Employee Benefit Department
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 paid contribution. **Failure to pay insurance premiums by the 30th of the month will result in immediate cancellation of coverage.**

- If you are an instructional employee and you work through the last day of your contract period and subsequently resign, "not retire," coverage will be in force **through the period already covered by paid premiums.**

When an employee leaves the District, either involuntary or voluntarily, benefits will end the last day of the month in which the last day was worked, for all paid benefits.

How to Enroll

Enrollment has never been easier. It is accessible 24 hours a day, and contains information about all of your options to help you make informed decisions.

The School District of Indian River County provides electronic enrollment through **Explain My Benefits (EMB)**. Explain My Benefits provides eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment, new hire orientation and qualifying events.

You can log into the Explain My Benefits, portal at any time or download the Mobile App to review your benefits, access carrier links, update your personal information for yourself and dependents, update your beneficiaries and process qualifying life events.

How to Enroll

Decide which of these two convenient enrollment options best meet your needs:

Self-Service

- Visit www.SDIRC-Benefits.com, click on the blue "Log into Your Benefit System" button and move through the enrollment system at your own pace.
- Please see login instructions on page 13.
- If choosing this option, be sure to click "submit" at the end of the process and make note of your confirmation number. **If you do not receive a confirmation number you have not completed your enrollment and you will not be enrolled in benefits**.
- Return to the system anytime and click your confirmation number to view your confirmation statement.

Mobile App

Log into the EMB mobile app

- Download from the APP Store—search "Explain My Benefits"
- Enter Company Code— "sdirc"
- Select enroll from the menu on the right.
- Go through the enrollment process and finalize by clicking "SUBMIT".

You may call the EMB Customer Service Center During Open Enrollment at 1-800-505-8416 for assistance with the enrollment portal.

Reminders

Be sure to review this Benefit Guide and plan summaries **prior** to going through your enrollment process.

Be prepared by gathering dependent and beneficiary information (i.e. Social Security Numbers and Dates of Birth). A convenient Enrollment Preparation Worksheet has been provided at the back of this guide to help you prepare for your enrollment.

Login Instructions

Explain My Benefits

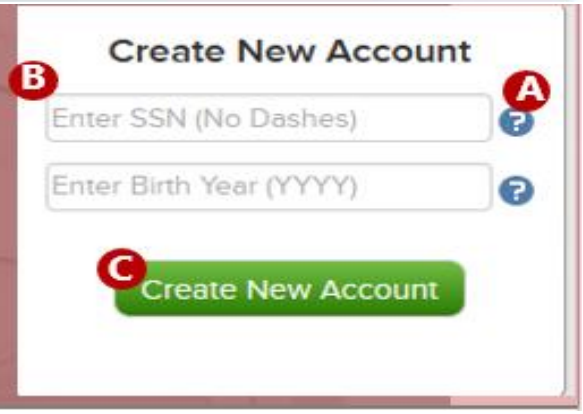
EMB ENROLL

ALL EMPLOYEES ARE REQUIRED TO CREATE A NEW ACCOUNT FOR OPEN ENROLLMENT

CREATE NEW ACCOUNT

- **A** • **Hover** over the question mark next to each field for specific instructions
- **B** • **Enter** the required SSN (No Dashes) and Birth Year (YYYY) as instructed.
- **C** • Click ***"Create New Account"***

*In the event the system advises that an account already exists, return to the **"Log In"** steps above.*



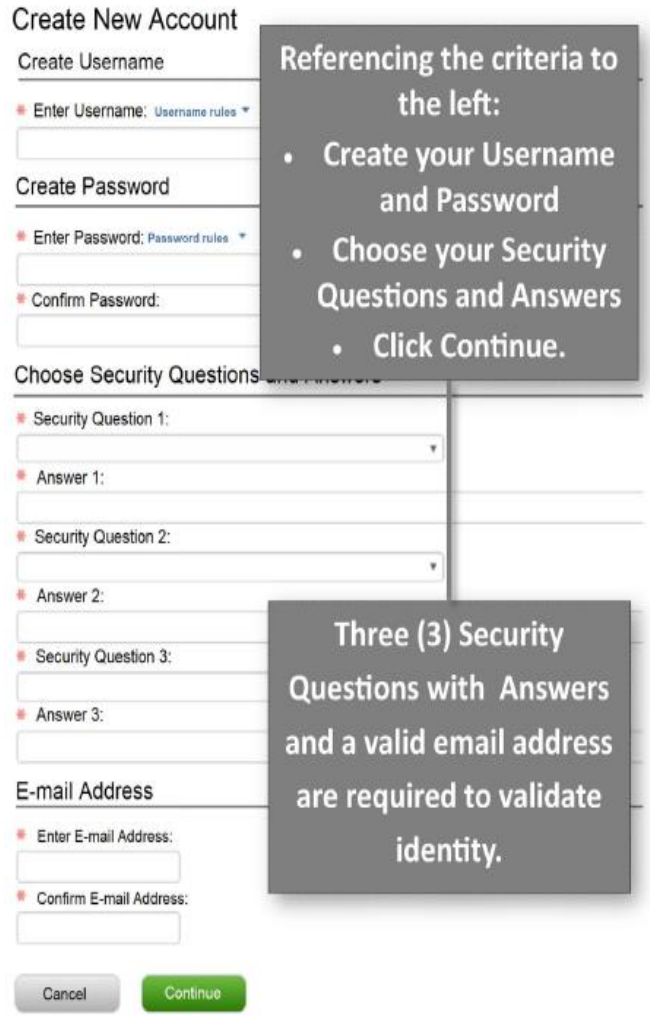
USERNAME AND PASSWORD CRITERIA

Username:

- At least one (1) letter and one (1) number
- Between 8 - 32 characters
- Not the same as your password
- No more than three sequential characters *(abc, cba, 123, 321)*
- No more than three repeating characters *(aaa, 111)*
- Permitted special characters: @ . - _ *
- Your username must be unique

Password:

- At least one (1) uppercase letter and one (1) lowercase letter
- At least one (1) number
- Between 8 - 20 characters
- Not the same as your username
- No more than three sequential characters *(abc, cba, 123, 321)*
- No more than three repeating characters *(aaa, 111)*
- Permitted special characters: @ . - _ *
- Password cannot be the same as your previous 10 passwords on this system



Referencing the criteria to the left:

- Create your Username and Password
- Choose your Security Questions and Answers
- Click Continue.

Three (3) Security Questions with Answers and a valid email address are required to validate identity.

Medical - Florida Blue

The District seeks to provide the best possible medical and prescription drug benefits at a reasonable cost to you. The information below is a summary of medical coverage only. Please contact Florida Blue, the Benefit Administrator, at www.floridablue.com, for plan summaries detailing coverage information and exclusions.

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.	20% after ded.	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: 20% after ded.	50% after ded.	Ambulatory Surgical Center: $350 Hospital Option 1: 20% after ded.	50% after ded.
Imaging Center	$100	50% after ded.	$300	50% after ded.	$400	50% after ded.
Emergency Care	$200		$300		$400	
Pregnancy and Maternity Care (prenatal and postnatal) Office Services	$25	50% after ded.	$65	50% after ded.	$100	50% after ded.
Semi Monthly Per Paycheck Deductions						
Employee Only	$108.50		$59.00		$14.50	
Employee + Spouse	$363.00		$281.00		$211.00	
Employee + Child(ren)	$350.00		$270.00		$201.50	
Family	$438.00		$346.50		$268.50	
2 Credit Employee + Spouse	$34.00 each		$0.00 each		$0.00 each	
2 Credit Employee + Family	$71.50 each		$25.75 each		$0.00 each	
Note: The District s Contribution for the 2020/2021 school year is $295.00 per pay or $590.00 per month.						

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.

Prescription Drugs - Express Scripts

With the election of a medical plan, employees are automatically enrolled in the corresponding Express Scripts' Prescription Drug Plan. The information below is a summary of prescription drug coverage only. Please contact Express Scripts, the Prescription Drug Benefits Administrator, at Express-Scripts.com for more information detailing coverage information, limitations and exclusions.

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

Opt-Out Medical Insurance Option

The District offers an annual flex spending amount of $480 to any employee who actively opts-out of medical coverage during open enrollment. If you choose to decline the District's medical coverage and opt out, the District will deposit $20.00 per pay period into your flex spending account, beginning October 1, 2020. In order to be eligible you **MUST elect the "OPT-OUT" flex during Open Enrollment and you MUST show proof of other coverage to receive this credit.** 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.

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.

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, Paps smears, pelvic exams, PSA exams
- Sigmoidoscopies, colonoscopies

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%.

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.**

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.**

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.

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.

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.

The Employee Health & Wellness Center

The Employee Health & Wellness 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. CareHere 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.

CareHere is a well-known and trusted healthcare organization skilled at delivering innovative, high-quality, cost-effective primary care.

- NO COST for visits or 200+ generic medications
- NO COST for labs
- Convenient schedule that includes early morning, late evening and Saturday hours
- 24/7 Scheduling and Nurse Advice Line
- Less than 5 minute average wait time
- NO COST for annual Health Risk Assessment
- NO COST for wellness programs and health coaching
- NO COST for well-man, well-woman, sports and school physicals
- Certain imaging services available at NO COST when referred by a CareHere provider to Indian River Radiology
- Home Delivery Pharmacy program for many chronic medications

SCHEDULE ANYWHERE

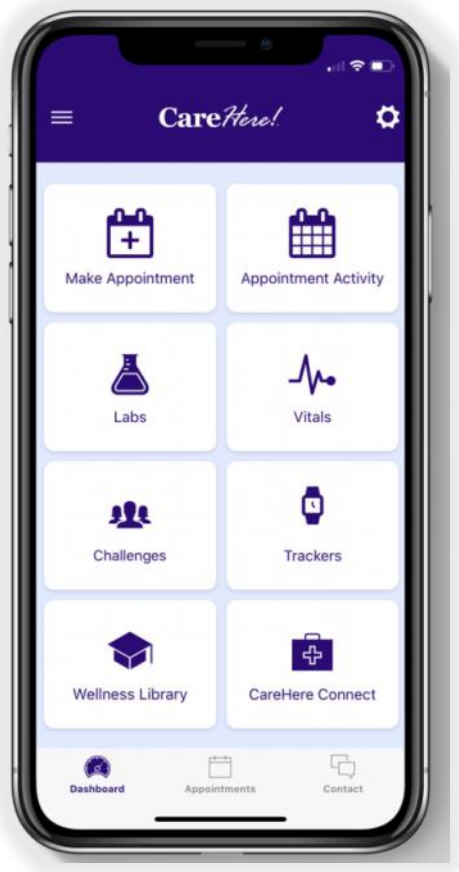
844.422.7343 | CareHere.com | CareHere App

Register with your access code **NRSE2**

CareHere abides by all federal HIPAA and confidentiality regulations.

Indian River Health & Wellness Center

5255 41st Street | Vero Beach



IMPORTANT NOTICE

REGARDING MISSED APPOINTMENTS AT WELLNESS CENTER

Effective immediately, we are implementing a new policy that is designed to reduce the number of "No Shows" at the Wellness Center. "No Show" appointments prevent others from being served and add to the cost of our health care. Therefore, after an employee or dependent has missed three appointments in a calendar year without cancelling, that member or dependent will be charged a $25.00 fee, deducted through payroll. The member will then be charged an additional $25.00 fee for any future missed appointments, without prior cancellation, for the remainder of that calendar year.

Employee Assistance Program (EAP)

Resources for Living

The District has partnered with Aetna's **Resources for Living** to provide an employer sponsored Employee Assistance Program (EAP). Aetna's Resources for Living, 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 up to the age of 26. Services are free and confidential and available 24 hours a day, 7 days a week.

Employee Assistance Program (EAP)
1-800-272-3626
www.resourcesforliving.com
Username: Indian River County School Board
Password: 8002723626

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 televideo 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
- Stress Management
- Work/Life Balance
- Family Issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse and more
- Self-esteem
- 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
- Mobile app

You'll also find access to these helpful tools:

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel and more.

Fitness Discounts

Save on gym memberships at over 9,000 locations nationwide and home fitness equipment. Participating gyms and programs include 24 Hour Fitness, LA Fitness, Anytime Fitness®, Zumba®, Nutrisystem® and more.

myStrength

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain.

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 percent discount.

*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial Services

Simply call for a free 30-minute consultation for each new financial topic related to:

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

You can also get a 25 percent discount on tax preparation services.

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

Other Services

Identity theft services - One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Flexible Spending Account
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.

Are you losing money on your family's health and wellness costs?

A Flexible Spending Account will give you significant savings on health and wellness costs not covered by insurance.

Pay 25-40% Less for Your Family's Health and Wellness Costs

Insurance probably doesn't cover all your family's health costs. You might have to pay a small copay when you see the doctor or maybe even some extra charges if your doctor or hospital is not covered by your plan. Maybe you need services your insurance just doesn't cover. These costs can add up quite a lot over the course of a year.

Wouldn't you like to save 25-40% on all those charges?

It's Simple

You choose how much to put into the account and pay for health and wellness expenses using tax-free dollars, up to a maximum of $2,750 yearly.

Without the FSA you pay for those expenses with what's left after taxes have been deducted. Instead of the $100 you earned, you actually have only $60 to $75 left to spend.

With tax-free dollars, $100 put into your account is $100 you can spend. Your savings will add up quickly.

Are There Rules?

A few, and they're easy to follow:

- You must decide how much you want to put in the plan for the year.
- You can't change your mind later (unless you experience specific work/life events).
- You must use the money for eligible expenses and keep the receipts.
- You must spend your money within the deadlines of your plan.
- You may not spend the money for anything cosmetic.

Use the Benny Card and Save Your Cash

Benny® helps you keep it all straight. It pays at locations that offer eligible merchandise and services...and usually knows exactly what is eligible. When you use the card your payment comes right out of your account.

Don't Think an FSA's for You?

You'll be surprised by some of the items eligible for savings:

Alternative medicine
Childbirth classes
Dental treatment
Learning disability services
Medical equipment
Prescriptions
Speech training
Vision
With a doctor's note:
- Herbal supplements
- Massage Therapy
- Weight loss programs
- Stop smoking aids

Does the cost of dependent daycare drain too much of your salary?

Save 25-40% off the cost of dependent daycare by using a Dependent Daycare Flexible Spending Account.

Pay Less for Dependent Daycare While You Work

Dependent daycare is a big drain on family income and we're all looking for ways to slow the flow. Paying for daycare through a dependent daycare flexible spending account can help you keep more of your money in your pocket.

How does it work?

You choose how much to put into the account, and pay dependent daycare expenses using tax-free dollars, up to a maximum of $5,000 per household.

Without the FSA you pay for your dependent daycare with what's left after taxes have been deducted. Instead of the $100 you earned, you actually have only $60 to $75 left to pay for care.

With tax-free dollars, $100 put into your account is $100 you can use to pay for daycare.

What is an Eligible Expense?

Any type of daycare you choose:

In-home babysitter
Nursery schools
After-school activities
Summer day camp
Elder custodial care
Outside babysitter
Daycare center
Latchkey program
Elder daycare

Dependent Daycare Isn't Just Kid Stuff

If your child is 12 or less, this program is for you. If your dependent of any age can't be left alone for mental or physical reasons, this program is for you.

Are There Rules?

Yes, but they're simple:

- Services you claim must be provided while you and your spouse are at work, looking for work or attending classes as a full-time student.
- You must decide how much you want to put in the plan for the year.
- You can't change your mind later (unless you experience specific work/life events).
- You must spend your money within the claims deadline for your plan
- You may only be reimbursed for the amount of money in your plan at the time of your claim.
- Your provider must report this as income.

Dental - Cigna

Dental coverage is key to your overall health. The District offers employees three dental plan options through Cigna. For more information about your plan and to find a Cigna dentist near your, visit www.cigna.com, or call **800-244-6224.**

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)*

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%	$0 - $345
Major Services	40%	50%	$20 - $415
Semi Monthly Per Paycheck Deductions			
Employee Only	$17.25	$14.80	$10.04
Employee + Spouse	$36.94	$31.70	$17.24
Employee + Child(ren)	$34.57	$29.67	$17.36
Family	$54.38	$46.67	$25.01

Note: Coinsurance shown is member paid for In-Network providers. Non-contracted providers would include balance billing. Members can see dentists that are part of the Advantage network; which is the highest tier providing coverage at the full in-network benefit level, DPPO network which still offers a discount on the services however benefits are paid based on the out of network benefit levels, and full Out of network, your benefits may be lower and you may have to file your own claims. DHMO plan members are encouraged to select a dentist.

*Maximum benefit of 24 months of interceptive orthodontics and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.

Vision - UnitedHealthcare

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.**

The District offers employees two vision plans through **UnitedHealthcare Group** 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.

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)		
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)
Semi Monthly Per Paycheck Deductions		
Employee Only	$2.70	$3.00
Employee + Spouse	$4.53	$5.05
Employee + Child(ren)	$4.63	$5.17
Family	$7.32	$8.15

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

Basic Life & AD&D Insurance - The Standard

The Standard is the Group Life and AD&D partner for the District and its employees. The Standard also has offered an expanded AD&D Living Needs Package at no additional cost to District employees.
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. Supplemental term life insurance is an option that gives you the opportunity to enhance the basic life insurance that the District provides for you. Age reductions after age 65 apply to life and AD&D insurance amounts.

Additional Voluntary Life and AD&D—ONE Time Opportunity to Increase Coverage without Proof of Good Health

- Active full-time employees 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. During this year's Open Enrollment The Standard is offering a one-time opportunity to purchase or increase coverage without a proof of health form (EOI), up to the new Guarantee Issue amount of $200,000 for employees and $50,000 for spouses.
- 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. The enrollment platform will automatically re-direct you to the site for the necessary forms. Age reductions after age 65 apply to life and AD&D insurance amounts.
- The Open Enrollment referenced above only applies to the Open Enrollment taking place from August 17, 2020 through August 31, 2020. If you do not elect now, all future increases in coverage will be subject to proof of good health (EOI) unless you are a new hire applying during your initial period of eligibility.

AD&D Living Needs 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 or your insured dependent dies 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.

Other information: Guaranteed Issue Amounts have been Enhanced

- Employee guaranteed issue amount is now **$200,000**. Spouse life guaranteed issue amount is now **$50,000**
- The beneficiary 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.
- The child life benefit will be a flat $5,000 or $10,000. ***If both parents work for the District, both cannot purchase dependent coverage for the same children.***

Voluntary 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 Life Insurance
Child(ren) (Life only)	$5,000 or $10,000

Employee Age	Employee Life and AD&D Semi Monthly 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 Semi Monthly 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 Semi Monthly Premiums	
	$5,000	**$10,000**
Child	$0.25	$0.50

Short Term Disability - Cigna

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 elimination period. **This plan will pay 66.67% of your weekly salary but no more than $2,000 (in $100 increments) per week.**

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.

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	**<24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**
Semi-Monthly Rate Per $100	$2.73	$2.94	$2.59	$2.05	$2.01	$1.95	$2.32
Age	**55-59**	**60-64**	**65-99**				
Semi-Monthly Rate Per $100	$3.28	$3.99	$4.33				

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	**<24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**
Semi-Monthly Rate Per $100	$2.49	$2.76	$2.29	$1.84	$1.67	$1.67	$2.01
Age	**55-59**	**60-64**	**65-99**				
Semi-Monthly Rate Per $100	$2.59	$3.14	$3.58				

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	**<24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**
Per Pay Rate Per $100	$1.64	$2.01	$1.64	$1.40	$1.30	$1.40	$1.81
Age	**55-59**	**60-64**	**65-99**				
Semi-Monthly Rate Per $100	$2.25	$2.59	$2.70				

How to Calculate Your Semi-Monthly Cost:

Step 1: Use the chart above to find your monthly rate based on age. Multiply this rate by your gross weekly benefit.

Step 2: Divide the total by 100. The result is your **semi-monthly** cost.

Calculate Your Cost

_____ x _____ / 100 = _____

Semi-Monthly Rate | Gross Weekly Benefit | Semi-Monthly Cost

Long Term Disability - Cigna

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.

Age	Semi Monthly Rate Per $100	Age	Semi Monthly Rate Per $100
<24	$0.082	**50-54**	$0.875
25-29	$0.106	**55-59**	$0.932
30-34	$0.202	**60-64**	$0.983
35-39	$0.315	**65-69**	$1.021
40-44	$0.471	**70+**	$0.775
45-49	$0.634		

How to Calculate Your Semi-Monthly Cost:

Step 1: Use the chart above to find your monthly rate based on age. Multiply this rate by your gross monthly benefit.

Step 2: Divide the total by 100. The result is your **semi-monthly** cost.

Calculate Your Cost

_____ x _____ / 100 = _____

Semi-Monthly Rate | Gross Monthly Benefit | Semi-Monthly Cost

Accident/Critical Illness/ Cancer - MetLife

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, not 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

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)

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

Guaranteed Issue

Benefits are paid directly to the employee based on a flat schedule (not reimbursement) and there is no coordination with other insurance coverage. An assignment of benefits to a hospital or healthcare facility will be available when required by applicable law.

This plan provides protection for covered events experienced while off the job only.

Accident/Critical Illness/Cancer - MetLife

Critical Illness

Critical illness insurance can help safeguard your finances by providing you with a lump-sum payment 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 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 health screening tests for each covered person, such as: **Annual Physical Exam, HPV Vaccination, Colonoscopy, Pap Smear, Mammogram, Endoscopy.** See the Plan Summary for a full list.

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 health screening tests for each covered person, 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

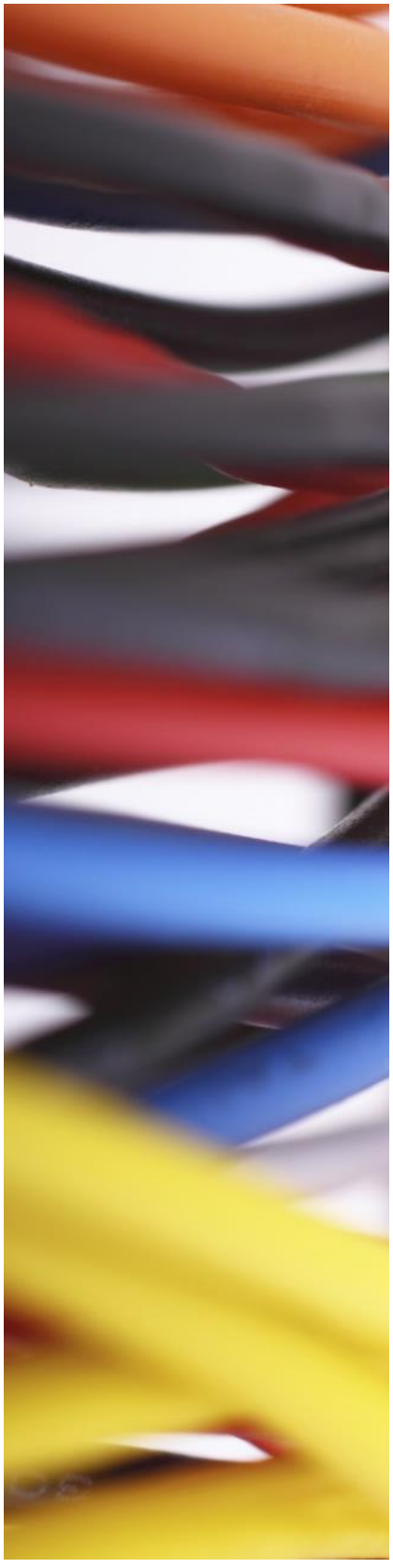
Millions of people have their identity stolen each year. IDShield provides the identity theft protection and identity restoration services you not only need but deserve.

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



Retirement Savings

The District understands that saving for retirement is an important priority for our employees. We 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.**

Important Contacts

Vendor	Website	Phone Number / E mail
The School District of Indian River County (the "District")	www.indianriverschools.org	sdircbenefits@indianriverschools.org
Amy Yeitter Employee Benefits Specialist	www.indianriverschools.org/employee-benefits	772-564-3175 sdircbenefits@indianriverschools.org
Joan Martin Employee Benefit Admin Assistant	www.indianriverschools.org/employee-benefits	772-564-3011 sdircbenefits@indianriverschools.org
Adalia Medina-Graham Retirement/FMLA Coordinator	www.indianriverschools.org/human-resources	772-564-3001 adalia.medina-graham@indianriverschools.org
On-Site Representative for Florida Blue - Marlanna Platt	www.floridablue.com	772-564-3122 marlanna.platt@bcbsfl.com
Medical Florida Blue	www.floridablue.com	800-664-5295
Prescription Drug Express Scripts, Inc. (ESI)	www.express-scripts.com	866-262-6427
District Health & Wellness Center CareHere	www.carehere.com	844-422-7343 help@carehere.com
Employee Assistance Program (EAP) Resources for Living	www.resourcesforliving.com Username: Indian River County School Board Password: 8002723626	800-272-3626
Flexible Spending Accounts Chard Snyder	www.chard-snyder.com	(t) 800-982-7715 (f) 888-245-8452 askpenny@chard-snyder.com
Dental Cigna	www.cigna.com	800-244-6224
Vision United Healthcare Group	www.myuhcvision.com	800-638-3120
Life Insurance The Standard	www.standard.com	800-628-8600
Disability Cigna	www.cigna.com	800-362-4462
Accident/Critical Illness/Cancer MetLife	www.metlife.com/MyBenefits	800-438-6388
Legal & Identity Theft Protection LegalShield	membersupport@legalshield.com	888-807-0407
403(b)/457(b) Retirement Plan TSA Consulting Group	www.tsacg.com	888-796-3786
401(a) Retirement Plan Bencor	www.bencorplans.com	888-258-3422
Florida Retirement System MyFRS Financial Guidance	www.myfrs.com	866-446-9377
Explain My Benefits Open Enrollment Assistance	www.sdirc-benefits.com	800-505-8416

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 2020
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 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.

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.

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).

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.

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.

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:	Amy Yeitter, Employee Benefits Specialist
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3175
Email:	sdircbenefits@indianriverschools.org

Contact	Joan Martin, Employee Benefits Assistant
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3011
Email:	sdircbenefits@indianriverschools.org

Contact:	Adalia Medina-Graham, Human Resources FMLA
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3001
Email:	adalia.medina-graham@indianriverschools.org

Important Legal Notices

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.

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—Adalia Medina-Graham
Office—Human Resources, FMLA
Address—6500 57th Street, Vero Beach, FL 32967
Phone—772-564-3001
Email - adalia.medina-graham@indianriverschools.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Adalia Medina-Graham 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.

COBRA

If you, your spouse, or eligible dependent loses coverage under any School District of Indian River County group medical or dental 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 the Initial COBRA Notice.

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

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 January 31, 2020. Contact your State for more information on eligibility –

ALABAMA Medicaid	COLORADO Health First Colorado (Colorado s Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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-plusCHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA Medicaid	**FLORIDA Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/Medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
CALIFORNIA Medicaid	**INDIANA Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA Medicaid and CHIP (Hawki)	**NEBRASKA Medicaid**
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	Website: http://www.ACCESS Nebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KANSAS Medicaid	**NEVADA Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
KENTUCKY Medicaid	**NEW HAMPSHIRE Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI -HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-8 55-4 59-6 328 Email: KIHIPP.PROGRAM@ky.govKCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-8 77-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

LOUISANA Medicaid	NEW JERSEY Medicaid and CHIP
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1- 888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE Medicaid	NEW YORK Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS Medicaid and CHIP	NORTH CAROLINA Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA Medicaid	NORTH DAKOTA Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI Medicaid	OKLAHOMA Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA Medicaid	OREGON Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPPPhone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspxhttp://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid	RHODE ISLAND Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	VIRGINIA Medicaid and CHIP
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
SOUTH DAKOTA Medicaid	WASHINGTON Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
TEXAS Medicaid	WEST VIRGINIA Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH Medicaid and CHIP	WISCONSIN Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT Medicaid	WYOMING Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either: U.S. Department of Labor Employee Benefits Security Administrationwww.dol.gov/agencies/ebsa1- 866-444-EBSA (3272) or U.S. Department of Health and Human Services Centers for Medicare & Medicaid Serviceswww.cms.hhs.gov1- 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 Coverage

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 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 30 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

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.

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.

Enrollment Preparation Worksheet

	Current Election	New Election
Medical **Tier**	**Florida Blue** 5770 / 5772 / 5774 EE ES ECH FAM $_____	**Florida Blue** 5770 / 5772 / 5774 EE ES ECH FAM $_____
Flex Spending	**Chard-Snyder** Medical $_____ Dependent Care $_____	**Chard-Snyder** Medical $_____ Dependent Care $_____
Dental **Tier**	**Cigna Dental** High PPO / Low PPO / DHMO EE ES ECH FAM $_____	**Cigna Dental** High PPO / Low PPO / DHMO EE ES ECH FAM $_____
Vision **Tier**	**United Healthcare** Option 1 / Option 2 EE ES ECH FAM $_____	**UnitedHealthcare** Option 1 / Option 2 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	**Cigna Disability** Monthly Benefit $_____ Deduction $_____	**Cigna Disability** Monthly Benefit $_____ Deduction $_____
Long Term Disability	**Cigna Disability** Weekly Benefit $_____ Deduction $_____	**Cigna Disability** 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 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.