MONROE COUNTY
SCHOOL DISTRICT

EMPLOYEE BENEFIT GUIDE

2024

Make Positive Connections for Health and Happiness












SUPERINTENDENT'S MESSAGE

THERESA AXFORD
Superintendent of Schools

MONROE COUNTY
SCHOOL DISTRICT

Members of the Board

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Dear District Employees,

We are fortunate to work in a District where the safety and health of students and employees is of utmost importance. You perform your best when you feel your best. We want all of our employees to have the opportunity to reach their full potential - professionally and in their personal lives. Investing in your health now can provide priceless, long-term benefits in the future.

The Monroe County School District and I encourage you to research the right benefits plan to meet your family's needs. To help you choose the plan that best fits your health care needs, we encourage you to take time to assess your own wellness, as well as your family's health needs. An easy way to do so is by scheduling a physical so you will know your numbers and establish a baseline for the year. Knowledge is your greatest ally in the fight against illness, and is a great preventative measure as well. We're committed to making sure you are fully informed and prepared when choosing your 2024 benefits plan.

Our District offers a wide range of detailed benefit plans that were crafted to ensure you and your family members receive the coverage you need if illness or an injury occurs. The School Board put forth substantial funding and time to provide the best programs possible for the employees of Monroe County School District. With the well-being of our students and staff in mind, we know our investment in offering you great healthcare options will reap invaluable benefits for our district as a whole. Please take the time to carefully review the options available to you. Having peace of mind is the greatest gift you can give yourself and your family.

Sincerely,

Theresa Axford
MCSD Superintendent

241 Trumbo Road • Key West, FL 33040
Tel (305) 293-1400
www.KeySchools.com

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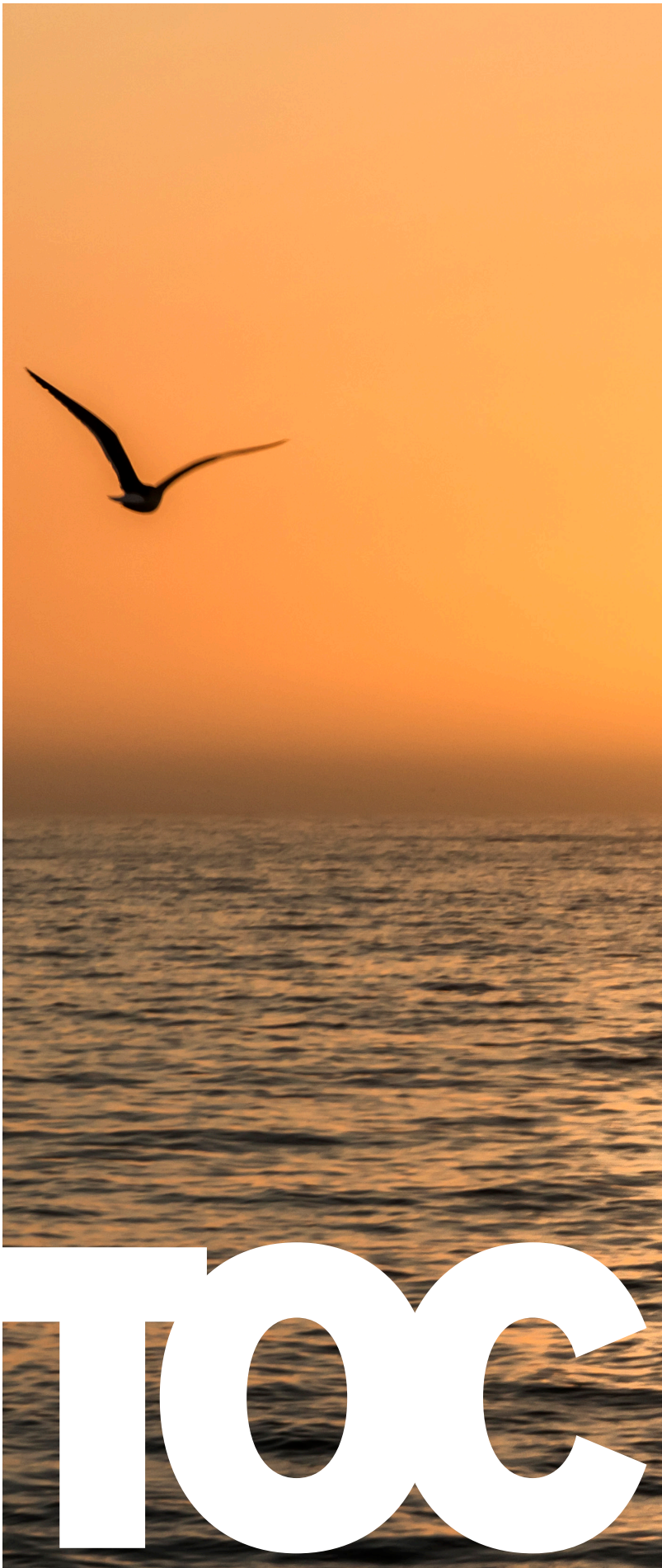
NOTE: *If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 18 for more details.*



LET'S GET STARTED

OPEN ENROLLMENT IS OCT. 1-15, 2023

Important Notes

- Please note that your Healthcare FSA allows a maximum carry-over of $600. If you do not exhaust your 2023 FSA balance and elect a Healthcare FSA in 2024, up to $600 may be used to pay for 2024 medical claims. This does not apply for Dependent Care FSA.
- If you do not have District medical coverage and do not wish to receive your employer contribution of $21.08 per pay period, check the waiver box on your enrollment form.
- You will be assessed a $50 per pay period surcharge if you enroll your spouse in the District medical plan and your spouse is offered medical coverage through an outside employer.

The District Provides All Employees:

- $10,000 Life and AD&D Insurance
- Partially paid medical coverage for employees who choose medical insurance
- A contribution amount of $21.08 per pay period may be used to purchase pretax voluntary benefits, excluding 401(k), if you do not enroll in medical insurance through the District, If you do not have medical insurance through the District. Any unused balances will revert back to the District.

Dual Spouse Provision

The Dual Spouse Enrollment Option is available for both instructional and non-instructional employees. Employees should call the Employee Benefits Department at 305-293-1400, ext. 53340 for details.

When Does My Period of Coverage Begin?

Current Employees: Your period of coverage is Jan. 1, 2024 through Dec. 31, 2024. See “Changing Your Coverage” on page 41 for additional information.

New Employees: If you are a new full-time employee, you are eligible for the SMART Choices Plan on the first day of the month following 15 calendar days of active employment. If you do not enroll before your period of coverage begins, you will not be elligible to do so until the next plan year or until you have a valid change in status event.

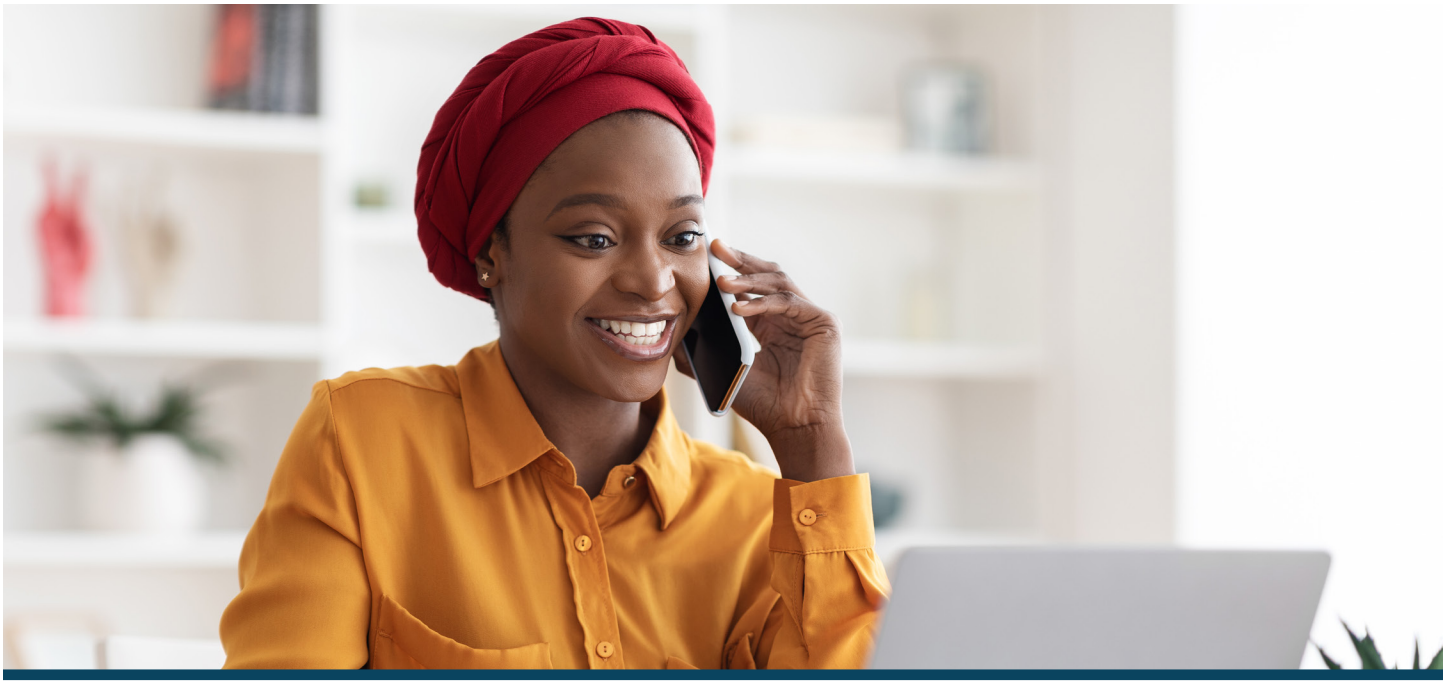
If you enroll during open enrollment, your period of coverage is the same as the plan year (Jan. 1, 2024 through Dec. 31, 2024).

Dependent Verification Requirements

Dependent verification is required for all newly added dependents and overage dependents (OAD). OAD affidavits must be submitted each year they are still part of your medical plan prior to the insurance becoming effective 01/01/24.

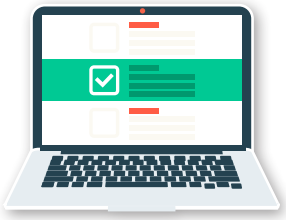
Refer to **page 10** for required documents.

HOW TO ENROLL



Enroll Online

Employees will now enroll through MCSD's online enrollment platform Focus. Use your MCSD account credentials to log into Focus. If you require assistance logging into Focus, please contact the IT Technician at your school or site.



Please note: If this is your first-time accessing Focus from a new computer, you will enter the computer name to complete the login.

Keep Your Address Updated

In order to protect your family's rights, you should keep the District informed of any changes in the addresses of family members and keep your Focus profile up to date. You should also keep a copy for your records.

Accessing Your Online Benefits

Accessing the online enrollment website:

- Log in to Focus.
- Use your MCSD account credentials to log in.
- Once logged into Focus, access the Benefits module from the Employee Self Service tab to complete Open Enrollment.
- Verify your demographic information.
- Add or update any dependent or beneficiary information.
- Begin the enrollment process.
- For each benefit, choose your coverage level or election amounts and then go to the next benefit.
- Continue until your enrollment is complete.
- Print out your confirmation statement containing all your benefit elections for you and your family.

HOW TO ENROLL

Enrolling Online through Focus

Employees will complete Open Enrollment from within the Focus system. Use your MCSD account credentials to log into Focus. If you require assistance logging into Focus, please contact the IT Technician at your school or site.

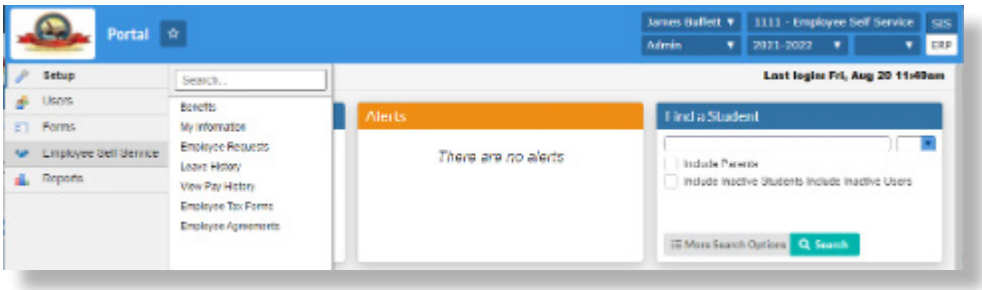
Accessing Your Benefits Online via Focus

Once logged into Focus, access the Benefits module from the Employee Self Service tab to complete Open Enrollment.

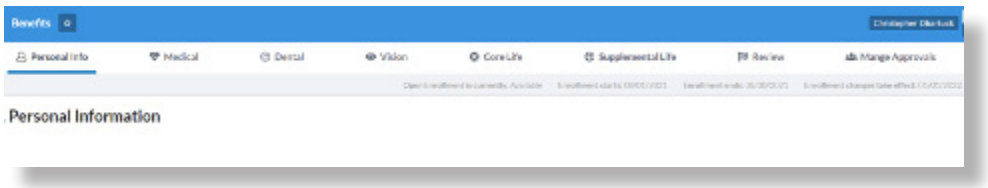
Login to Focus using your district account credentials. (Note: if this is your first-time accessing Focus from a new computer, you will enter the computer name to complete the login.)

In the top bar of Focus, be sure to have the "**1111 – Employee Self Service**" center selected.

Select the **Employee Self Service** menu and click **Benefits** to begin the Open Enrollment process.



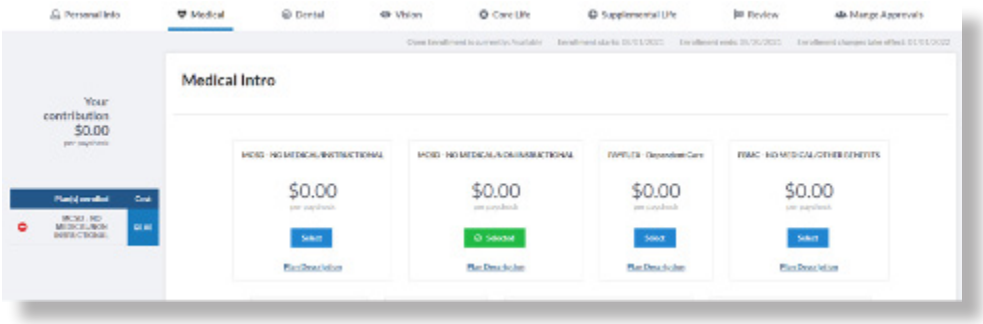
Review your demographic information, dependents, and beneficiaries for accuracy, within the **Personal Info** tab. You will also be able to add, update, or remove any dependents or beneficiaries.



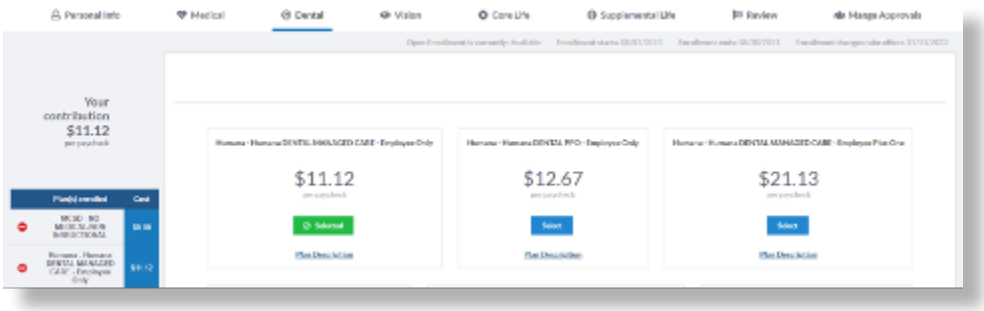
HOW TO ENROLL

If you need additions or changes to your demographic info, please use the Employee Self Service module to submit an Employee Request.

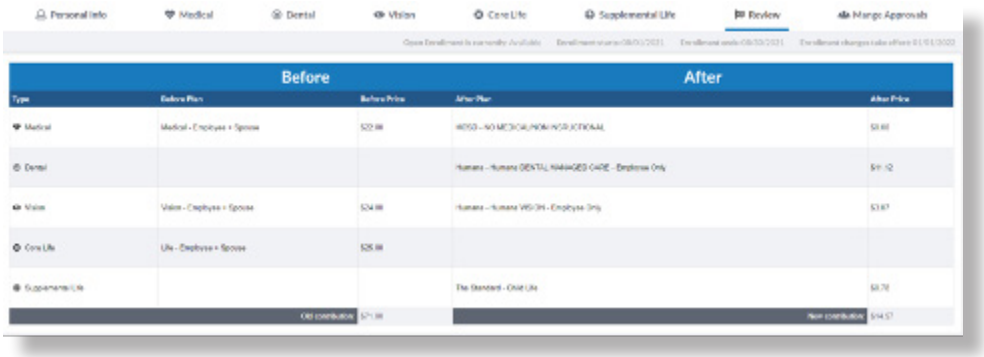
Click the **Medica**l tab to view all available plans. Use the blue **Select** button to select the medical plan that is best for you and or your family. The icon will turn green, and the plan will be added to the **Plan(s) Enrolled** calculator on the left-side of the screen. Click the **Next Plan** button at the bottom of the list or click the **Dental** tab to navigate to the next section



Upon choosing a plan, it will be added to the **Plan(s) Enrolled** calculator. The sum of all selected benefits will be shown and totaled above the calculator—this will be your total deduction amount per pay period. Continue making your selections from each additional benefits tab (Dental, Vision, Core Life, and Supplemental Life).



Review and confirm that all elections are accurate and submit for approval, from the **Review** tab. You will receive an email notification, once your enrollment has been approved.



Login to Focus and see the status of your enrollment approval or finalized benefits, at any time, by opening the **Employee Self Service** menu, selecting the Benefits module, and utilizing the **Review** and **Manage Approvals** tabs. If you require any assistance logging in, please contact the IT Technician located at your school or operation site.

If you should need assistance with the Benefits module while choosing your Benefits, please contact The Benefits Department at 305-293-1400 (ext. 53333).

THE SMART CHOICES PLAN

How Does the SMART Choices (Flexible Benefits) Plan Work?

1. An employer contribution is applied to your District medical coverage. If you do not choose to have medical coverage, the Board Contribution in the amount of $21.08 per pay period may be used to purchase pretax voluntary benefits, dental, vision, dependent care, and Flexible Spending Accounts (FSAs). Unused balances revert back to the District.
2. You may choose any pretax voluntary benefits you and your family need. The premium costs are then deducted tax-free from your gross pay, which is before income and Social Security taxes are calculated.
3. Taxes are calculated on the amount of your salary remaining after all premiums have been deducted. Then, any other post-tax payroll deductions you have are taken out of your paycheck.
4. The amount remaining in your paycheck is your take-home pay for each pay period. Since you paid less tax, you have more income to spend.

If you choose to contribute to a Healthcare or Dependent FSA, you need to:

- Review the FSA guidelines and become familiar with how the program works. You can find out more about Healthcare and Dependent FSA accounts on page 27.
- Submit your supporting documentation and completed reimbursement request form (for paper claims) for reimbursement processing. Once the plan year ends, you have a 90-day run-out period to submit your supporting documentation. Any unused balances will revert back to the District.

Direct Deposit

Enroll in direct deposit to ensure that your FSA reimbursement checks are automatically deposited into your checking or savings account. There is no fee for this service, and you don't have to wait for postal service delivery of your reimbursement. To apply, complete the application form available

ELIGIBILITY REQUIREMENTS

Who is Eligible for Benefits?

If you are a full-time instructional or non-instructional employee of the District who works at least 51 percent of the average time required for your position, you are eligible to enroll in the SMART Choices Plan.

Dependents eligible for benefits include:

- Spouse
- Dependent Children**
- Overage Dependent (ages 26-30)***

* Your spouse is considered your eligible dependent for as long as you are lawfully married.

** Children can include natural born children, stepchildren, adopted children.

***The Affordable Care Act permits married or unmarried dependent children to be covered under the medical plans to the last day of the calendar year that they turn 26. An **unmarried** dependent child may be covered for medical beyond age 26 to age 30, if criteria established by Florida Statutes is satisfied. **Affidavit is also required each year.**

Overage Dependent (OAD) Affidavit is required every year the OAD is included within the medical plan. See Special Dependent Eligibility below for more special dependent information.

Who is Eligible Under COBRA?

Upon certain triggering events, employees going from full-time to part-time status and their dependents may be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Please see page 42 for more information.

How Will Retiring Affect My Eligibility?

During the plan year, except as otherwise provided by law and in accordance with the district's plan(s), an employee who retires is covered until the last day of the month following 31 days of retirement. Some plans may be continued at the same premium rates while others require conversion to an individual policy and may have an increase in premium rates. During the 90 days preceding your scheduled retirement, it's important that you contact customer care for continuation of flexible benefits. You may not continue disability income protection or a dependent care FSA upon retirement.

A retiree is a former full-time employee of the District who is currently receiving income under the Florida Retirement System (FRS).

Does Employee Leave Affect My Eligibility?

Employees on leave of absence are eligible for certain types of coverage depending on the type of leave (A or B).

A. District-Approved Paid Medical Leave, and District-Approved Nonpaid Medical Leave:
The District continues to pay the employer contributions toward benefits for up to one year if you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications). Your premium deductions will continue through the SMART Choices Plan as long as you receive a salary. The Family Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Consult with your Employee Benefits and Risk Management Department for further information.

B. District-Approved Nonpaid Personal Leave:
The District does not pay for your benefits. You can continue to receive coverage under your benefits for up to one year if you pay the District contribution and your premiums directly to the District. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Consult with your Employee Benefits Department for further information.

If you go on District-approved leave for any reason, you may pay your premiums to the District to maintain your benefits except for VISTA 401(k). If you have not maintained a current premium status while on leave, you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law.

How Does the Flexible Benefits Plan Affect Other Benefits?

Your contributions to the flexible benefits plan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS. Any salary directed to your flexible benefits plan is included in the compensation reported to the Florida Retirement System.

Special Dependent Eligibility

In the State of Florida, anyone up to the age of 30 may be considered a dependent for the purposes of health insurance eligibility and access. For all health coverage offered under the district's plan, you may continue to cover your dependent child until the end of the calendar year in which the child reaches the age of 30 if the child:

- Is age 26-30, unmarried and does not have (a) dependent child(ren) of his or her own;
- Is a resident of Florida or a full-time or part-time student;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act; and
- Has not had a gap in "creditable coverage" of more than 63 days

Special Dependent Premiums

Premium rates for covering dependents are applicable through the end of the plan year in which the dependent(s) turn(s) age 26. From the age of 27-30, through to the end of the plan year the dependent(s) turn(s) age 30, additional premiums will apply.

ELIGIBILITY REQUIREMENTS

Dependent Eligibility Verification

Official documents of birth and/or marriage from anywhere in the United States may be obtained through vitalcheck.com or by calling 866-285-7453 (some fees may apply).

All documents provided during the dependent verification audit are securely stored and protected through physical, electronic and procedural safeguards.

The Spouse Verification Requirement includes:

- Valid legal or religious marriage certificate
- **AND ONE** of the following:
  - Federal 1040 or State Income tax return
  - Utility Bill
  - Joint Bank Account or Financial Institution statement
  - Insurance document (home, renters or automobile)
  - Mortgage document or current lease
  - Valid Vehicle Registration

All documents must be dated within the last 12 months, contain employee and spouse names, and name of entity.

The child verification requirements include:

- Joint Bank Account or Financial Institution statement
- Federal 1040 or State Income tax return
- Birth Certificate

Special Dependent Extension of Coverage Limitations

The extension of coverage up to age 30 does not apply to accident only, specified disease, disability income, Medicare supplement, or long-term care insurance policies. The premiums for such continued coverage must be on a post-tax basis, unless covering a disabled child. The District is responsible for ensuring the proper tax treatment for any dependent coverage elected under these provisions.

Special Dependent Coverage Outside of Florida

If you reside outside of the State of Florida and have a dependent who meets the above criteria, they are eligible for coverage. For any dependents covered, regardless of the above until the end of the calendar year the dependent reaches age 26, deductions are eligible to be taken on a pretax basis.

The Internal Revenue Service allows employees to receive health insurance subsidies for themselves and their eligible dependents tax-free as defined under IRS guidelines, excluding amounts attributable to coverage of an adult child(ren) (AC). Therefore the District must include the fair market value of AC benefits in the employee's income, referred to as "imputed income" and this imputed income will be taxed accordingly. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

Spousal Coverage Affidavit

If you are enrolling your spouse in your medical plan, you must sign and submit a Spousal Coverage Affidavit or pay the surcharge. See page 11 for more information.

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.

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 the Monroe County School District offers coverage that doesn't meet certain standards. Your household income will determine the amount of available savings on your premium.

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

Yes. If you have an offer of health coverage from the district that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in the employer health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if the district does not offer coverage that meets certain standards. If the cost of a plan from the District that would cover you (and not any other members of your family) is more than 9.5 percent 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.

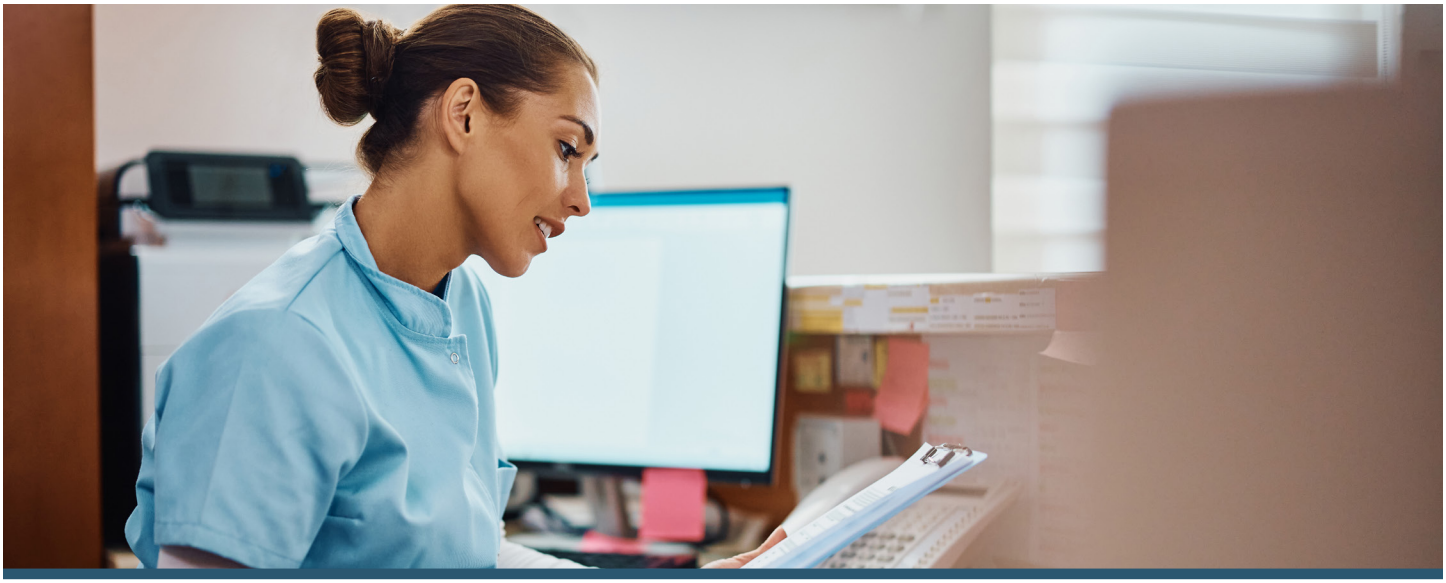
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by the District, then you may lose the employer contribution (if any) to the District-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered 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, please check your summary plan description or contact the Employee Benefits 305-293-1400, ext. 53340.

The Health Insurance Marketplace can help you evaluate coverage options, 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.

HEALTH PLANS



Premium Rates (pretax)

Coverage Level	Buy-Up Plan 03768	Core Plan 03559	CHDP 05360
Employee Only	$153.68	$92.47	$36.98
Employee + Spouse*	$295.80	$216.83	$138.19
Employee + Children	$255.60	$185.81	$119.15
Employee + Family*	$366.32	$280.62	$193.19

* An additional spousal surcharge may apply, see below.

While no one can predict the future, you can prepare for it. Your Florida Blue benefits provide you with access to people, resources and tools to help you when you aren't feeling your best. We have also created unique programs to help you improve your health and wellness. We believe knowledge is the heart of your healthcare, so we want to give you resources to help you:

- Be active with your health care
- Make healthy choices
- Find answers
- Save money
- Take charge of your health

Always Carry Your ID Card

Your ID card has key information about you and your coverage. Put your card in your wallet or pocketbook so you won't forget it. When you're at doctors' offices, drugstores and hospitals, show it to make sure you are not billed unnecessarily. You may also be asked to show a picture ID, such as your driver's license or another government ID card with a picture on it, so be sure to bring this with you, too.

What is the Spousal Surcharge?

The spousal surcharge is a premium added if your spouse has access to medical coverage through an outside employer but is enrolled in the Monroe County School District medical plan. The amount of the surcharge that will be assessed is $50 deducted on a per-pay-period basis.

The spousal surcharge will be waived if:

- You do not enroll your spouse in the District's medical plan.
- Your spouse is not employed.
- You and your spouse both work for the Monroe County School District.
- Your spouse is employed, but is not offered medical coverage through her/his employer.
- Your spouse is eligible for and/or enrolled in Medicare/ Medicaid, causing the District's medical plan to be listed as secondary insurance.

If you enroll your spouse as a dependent on your medical plan, you must sign and turn in an affidavit attesting to one of the above criteria applying in order to have this fee waived. If you are enrolling online during open enrollment, this affidavit will be offered on the enrollment site during the enrollment process.

Plan Benefits

Cost Sharing	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
Deductible (DED) (Per Person/Family Aggregate)			
• In-Network	$1,000 / $2,000	$1,500 / $3,000	$2,000 / $4,000
• Out-of-Network	Combined with In-Network	Combined with In-Network	Combined with In-Network
Coinsurance (Member Responsibility)			
• In-Network	25%	25%	25%
• Out-of-Network	40%	40%	40%
Out-of-Pocket Maximum (Per Person/Family Aggregate)	Includes Deductible, Coinsurance and all Copays (Excludes Rx) Maximums shown refer to the Benefit Period Maximum (BPM)		
• In-Network	$5,850 / $10,960	$5,850 / $10,960	$5,850 / $10,960
• Out-of-Network	Combined with In-Network	Combined with In-Network	Combined with In-Network
Lifetime Maximum	No Maximum	No Maximum	No Maximum
Professional Provider Services			
Allergy Injections			
• In-Network Family Physician	$10	$10	$10
• In-Network Specialist	$10	$10	$10
• Out-of-Network	$10	$10	$10
E-Office Visit Services			
• In-Network Family Physician	$10	$10	$10
• In-Network Specialist	$10	$10	$10
• Out-of-Network	Not Covered	Not Covered	Not Covered
Office Services			
• In-Network Family Physician	$30	$40	$50
• In-Network Specialist	$30	$50	DED + 25%
• Out-of-Network Family Physician	$40	$50	$60
• Out-of-Network Specialist	$40	$70	DED + 40%
Provider Services at Hospital			
• In-Network Family Physician	$50	$50	DED + 25%
• In-Network Specialist	$50	$50	DED + 25%
• Out-of-Network Family Physician	$50	$50	DED + 40%
• Out-ofNetwork Specialist	$50	$50	DED + 40%
Provider Services at ER			
• In-Network Family Physician	$50	$50	DED + 25%
• In-Network Specialist	$50	$50	DED + 25%
• Out-of-Network Family Physician	$50	$50	In-Ntwk DED + 25%
• Out-of-Network Specialist	$50	$50	In-Ntwk DED + 25%
Provider Services at Other Locations			
• In-Network Family Physician	$30	$40	DED + 25%
• In-Network Specialist	$30	$50	DED + 25%
• Out-of-Network Family Physician	DED + 40%	DED + 40%	DED + 40%
• Out-of-Network Specialist	DED + 40%	DED + 40%	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center			
• In-Network Specialist	$45	$75	DED + 25%
• Out-of-Network	$45	$75	DED + 40%

Plan Benefits

Cost Sharing	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
Preventive Care			
Adult Wellness Office Services			
• In-Network Family Physician / Specialist	$0 / $0	$0 / $0	$0 / $0
• Out-of-Network Family Physician	$40	$50	DED + 40%
• Out-of-Network Specialist	$40	$70	DED + 40%
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies		
• In-Network	$0	$0	$0
• Out-of-Network	$0	$0	$0
Mammograms (Routine)			
• In-Network	$0	$0	$0
• Out-of-Network	$0	$0	$0
Well Child Office Visits (No BPM)			
• In-Network Family Physician / Specialist	$0 / $0	$0 / $0	$0 / $0
• Out-of-Network Family Physician	$40	$50	DED + 40%
• Out-of-Network Specialist	$40	$70	DED + 40%
Emergency / Urgent / Convenient Care			
Ambulance Maximum (Per Day)	**No Per Day Maximum**	**No Per Day Maximum**	**No Per Day Maximum**
• In-Network	DED + 25%	DED + 25%	DED + 25%
• Out-of-Network	In-Ntwk DED + 25%	In-Ntwk DED + 25%	In-Ntwk DED + 25%
Convenient Care Centers (CCC)			
• In-Network	$20	$20	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Emergency Room Facility Services			
• In-Network	$250	$350	DED + 25%
• Out-of-Network	$250	$350	In-Ntwk DED + 25%
Urgent Care Centers (UCC)			
• In-Network	$50	$50	DED + 25%
• Out-of-Network	DED + $50	DED + $50	DED + 25%
Facility Services - Hospital / Surgical / Lab / Independent Diagnostic Testing Facility			
Ambulatory Surgical Center			
• In-Network	$200	$250	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Independent Clinical Lab			
• In-Network	$0	$0	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Independent Diagnostic Testing Facility - X-rays and Advanced Imaging Services (AIS)			
• In-Network - AIS + Physician Services	$200	$200	DED + 25%
• In-Network - Other Diagnostic Services	$50	$50	DED + 25%
• Out-of-Network - AIS + Physician Services	$200	$200	DED + 40%
• Out-of-Network - Other Diagnostic Services	DED + 40%	DED + 40%	DED + 40%

Cost Sharing	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
Inpatient Hospital (Per Admit)			
• In-Network	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Inpatient Rehab Maximum	30 Days	30 Days	30 Days
Outpatient Hospital (Per Visit)			
• In-Network	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Therapy at Outpatient Hospital			
• In-Network	Option 1 - $45 Option 2 - $60	Option 1 - $50 Option 2 - $70	Option 1 - DED + 25% Option 2 - DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Mental Health and Substance Abuse			
Inpatient Hospitalization			
• In-Network	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Outpatient Hospitalization (Per Visit)			
• In-Network	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Provider Services at Hospital			
• In-Network Family Physician	$30	$40	DED + 25%
• In-Network Specialist	$30	$50	DED + 25%
• Out-of-Network Family Physician	$40	$50	DED + 40%
• Out-of-Network Specialist	$40	$70	DED + 40%
Provider Services at ER			
• In-Network Family Physician	$30	$40	DED + 25%
• In-Network Specialist	$30	$50	DED + 25%
• Out-of-Network Family Physician	$40	$50	In-Ntwk DED + 25%
• Out-of-Network Specialist	$40	$70	In-Ntwk DED + 25%
Physician Office Visit			
• In-Network Family Physician	$30	$40	$50
• In-Network Specialist	$30	$50	DED + 25%
• Out-of-Network Family Physician	$40	$50	$60
• Out-of-Network Specialist	$40	$70	DED + 40%
Emergency Room Facility Services (Per Visit)			
• In-Network	$250	$350	DED + 25%
• Out-of-Network	$250	$350	In-Ntwk DED + 25%
Provider Services at Locations other than Hospital and ER			
• In-Network - Family Physician / Specialist	$30 / $30	$40 / $50	DED + 25% / DED + 25%
• Out-of-Network Family Physician	$40	$50	DED + 40%
• Out-of-Network Specialist	$40	$70	DED + 40%

Plan Benefits

Cost Sharing & Benefit Period Maximums (BPM)	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
Other Special Services and Locations			
Advanced Imaging Services in Physician's Office			
• In-Network Family Physician	$200	$200	DED + 25%
• In-Network Specialist	$200	$200	DED + 25%
• Out-of-Network	$200	$200	DED + 40%
Birthing Center			
• In-Network	DED + 25%	DED + 25%	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics BPM	**No Maximum**	**No Maximum**	**No Maximum**
• In-Network	DED + 25%	DED + 25%	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Enternal Formulas	**$2,500 Maximum**	**$2,500 Maximum**	**$2,500 Maximum**
• In-Network	DED + 25%	DED + 25%	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Home Healthcare BPM	**30 Visits**	**30 Visits**	**30 Visits**
• In-Network	DED + 25%	DED + 25%	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Hospice (Inpatient, Outpatient and Home)	**No Maximum**	**No Maximum**	**No Maximum**
• In-Network	DED + 25%	DED + 25%	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Outpatient Therapy (PT, OT, ST, Cardiac and Spinal Manipulations)	**122 Visits (Includes up to 26 Spinal Manipulations)**	**122 Visits (Includes up to 26 Spinal Manipulations)**	**122 Visits (Includes up to 26 Spinal Manipulations)**
• In-Network Free Standing Rehabs	$30	$50	DED + 25%
• In-Network Family Physician / Specialist	$30 / $30	$40 / $50	DED + 25%
• Out-of-Network Family Physician / Specialist	$40 / $40	$50 / $70	DED + 40%
• Out-of-Network - All Other Locations	DED + 40%	DED + 40%	DED + 40%
Skilled Nursing Facility BPM	**60 Days**	**60 Days**	**60 Days**
• In-Network	DED + 25%	DED + 25%	DED + 25%
• Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Acupuncture (Covers up to 28 visits per CYM)			
• In-Network	$30	$50	DED + 25%
• Out-of-Network	$40	$70	DED + 40%
Bariatric Surgery	Covered	Covered	Covered
Removal of Impacted Wisdom Teeth	Covered	Covered	Covered

Diabetic Supplies (lancets, strips, etc.) are available through DME. Diabetic Equipment (insulin pumps, tubing) are covered under the medical benefits.

The information contained in this Summary of Benefits includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Healthcare Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. Additionally, interim rules released by the Federal Government Feb. 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE).

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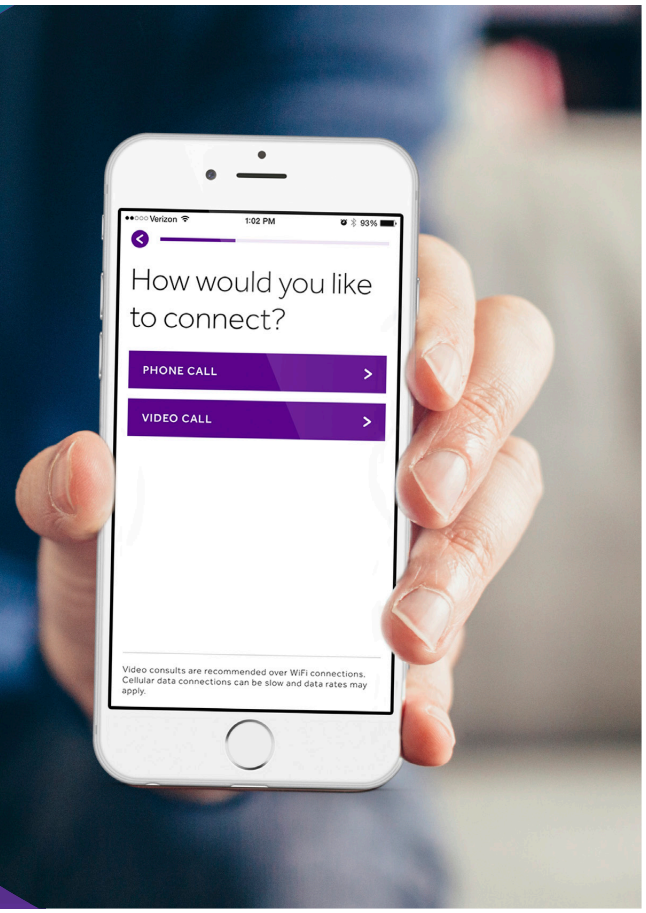

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TELADOC™

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*median call back time

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1

SET UP YOUR ACCOUNT

Set up your account by phone, web or mobile app.

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Go to Teladoc.com and click **"set up account"**.

Mobile app:
Download the app and click **"Activate account"**. Visit teladoc.com/mobile to download the app.

Call Teladoc:
Teladoc can help you register your account over the phone.

2

PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3

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PRESCRIPTION DRUG PLAN

OptumRx in 2024

We know how important your pharmacy benefits are to you. OptumRx provides safe, easy and cost-effective ways for you to get the medication you need.

OptumRx Home Delivery

Get medications you take regularly through the OptumRx home delivery service:

- Order up to a 3-month supply
- Pharmacists are available 24/7
- Set up medication reminders and automatic refills

Pick Up at the Pharmacy

Use our large pharmacy network to fill your new and existing prescriptions:

- Includes more than 9,700 CVS locations
- Includes more than 9,650 Walgreens locations

Take a Specialty Medication? We Are Here to Help

At OptumRx, we're here to help you with your specialty pharmacy needs. We provide resources and personalized support to help you manage your condition.

Manage Your Medications Online

After coverage starts, use our mobile app or website to help manage your medications. You'll be able to find a network pharmacy, check medication coverage, track home delivery orders and much more.

OptumRx Is Here to Help

Here are a few helpful resources in case you have questions before or after your coverage begins. Throughout the year, OptumRx will send you helpful information so you can feel confident managing your medications and your health. Watch for:

- Information about your medication and any action you may need to take
- Information about clinical or home delivery programs your plan may offer

What You Can Do Before Your Coverage Begins

You can do a few things now to help make the most of your plan once it starts.

- Understand brand-name vs. generics medications and how they affect cost
- Understand your coverage and what you need to do to get your medication

What You Can Do After Your Coverage Begins

Take advantage of convenient options that make it easier for you to get your medication.

- Register for an account and manage your medications online
- Download the OptumRx app to manage your medication on the go
- Locate a pharmacy in your plan's network near you on the OptumRx app or on optumrx.com. Remember to present your member ID card at the pharmacy counter.
- Use the pricing tool on the OptumRx app or on optumrx.com to see how much your medication will cost
- Learn about our home delivery service to see if it's right for you.

PRESCRIPTION DRUG PLAN

Plan Rates

Co-payment	Buy-Up Plan 03768	Core Plan 03559	CHDP 05360
Deductibles			
Individual	$100	$100	$100
Family	$200	$200	$200
Out-of-Pocket Maximums			
Individual	$1,500	$1,500	$1,500
Family	$2,740	$2,740	$2,740
Prescription Co-Payments			
Generic			
Retail	$10	$15	$15
Home Delivery	$20	$30	$30
Preferred Brands			
Retail	$45	$55	$60
Home Delivery	$90	$110	$120
Non-Preferred Brand			
Retail	$60	$75	$85
Home Delivery	$120	$150	$170

Plan Provider

OptumRx is a pharmacy care services company helping clients and more than 65 million members achieve better health outcomes and lower overall costs through innovative prescription drug benefit services, including network claims processing, clinical programs, formulary management and specialty pharmacy care. OptumRx is part of Optum®, a leading information and technology-enabled health services business dedicated to making the health system work better for everyone. For more information, visit optum.com/optumrx.

Important Information from the District 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 Monroe County School District's Healthcare Plan 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:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Monroe County School District has determined that the prescription drug coverage offered by the Monroe County School District's Healthcare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from **Oct. 15 to Dec. 7, 2024.**

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. Creditable prescription drug coverage meaning coverage that meets or exceeds Medicare coverage standards for your perscriptions.

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 Monroe County School District Healthcare Plan coverage will be affected. For those individuals who elect Part D coverage under the entity's plan, that coverage will end for the individual and all covered dependents, etc. See the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current District Healthcare Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Monroe County School District's Healthcare Plan 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 19 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

The District's health insurance plan's prescription program is administered by OptumRx.

Contact the Employee Benefits Department at 305-293-1400, ext. 53340 for further information.

NOTE: You will receive this notice each year, and again before the next period you can join a Medicare drug plan, and again if this District Healthcare Plan coverage changes. You may request a copy of this notice at any time.

For More Information About Options Under Medicare Prescription Drug Coverage

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

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

Keep this Creditable Coverage Notice

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).

DENTAL PLANS

Premium Rates (pretax)

Coverage	Managed Care Plan C150	Custom PPO Dental Plan
Employee	$14.24	$14.57
Employee + 1	$27.06	$28.97
Employee & family	$36.88	$43.10

How the Dental Care Plan Works for You

You know that professional dental care is important. Unfortunately, fitting this expense into your budget isn't always easy. That's why the District gives you a choice of two plans, the Managed Care Plan C150, and the PPO/Indemnity Plan, to make dental care more affordable.

If you are planning major dental work for you and/or your dependents during the upcoming plan year, enrolling in a dental care plan could dramatically reduce your out-of-pocket expenses.

Plan Provider

The dental plans are underwritten by Humana. For the most up-to-date listing of providers in your area, go to Humana.com, or call 1-800-233-4013, Monday through Friday, 8 a.m. to 6 p.m.

OPTION I - Humana Managed Care Plan C150

The Humana Plan C150 is a network-based plan that emphasizes prevention and cost containment. There is no deductible and no lifetime maximum. In order to receive services, you must select a primary dentist who participates in the Humana Managed Care network within the state of Florida. Your primary dentist will provide all of your routine dental care. When you visit your primary care dentist, you may be required to pay a co-payment for some services. The plan provides the highest standards of quality care and allows members to seek care from in-network specialists at a 25% discount off normal fees.

Plan Features

- Preventive services are 100% covered after a $5 office visit co-payment.
- Most other common dental procedures are covered for a fixed co-payment, so there are no hidden costs.
- Specialist services are discounted at 25% off normal fees.
- For any procedure not specifically listed, you will receive a 25% discount off the dentist's normal fees.
- There are no deductibles.
- There are no claims to file.
- There are no waiting periods.
- There are no benefit maximums.

An extensive list of procedures and costs for this plan are available on the District website.

Plan Benefits

Managed Care Plan C150	
Service	**Fee**
Preventative Care	
Routine exams	No charge
Prophylaxis (general cleaning, one per 6 mo.)	No charge
Fluoride treatment (one per 12 mo.)	No charge
Office Visits	$5
Basic Services	
Emergency treatment	$20 (during office hrs.)
X-ray (bitewings)	No charge
Simple extraction (single tooth)	No charge
Restorative Services (fillings)	
Amalgam "silver"	
• (primary, three surface)	No charge
• (permanent, three surface)	No charge
Composite Resin "white"	
• (anterior, one surface)	$35
• (anterior, three surfaces)	$50
Root Canal	
Root canal therapy—anterior (excluding final restoration)	$100
Endodontic therapy, premolar tooth (excluding final restorations)	$200
Endodontic therapy, molar tooth (excluding final restorations)	$250
Periodontics	
Scaling and root planning (per quadrant)	$50 (limit 4 per year)
Periodontal maintenance	$50
Major Procedures	
Crowns (porcelain fused to base metal)	$280
Crowns (porcelain fused to noble metal)	$280*
Prosthetics	
Complete Dentures (standard upper or lower)	$300 + lab
Orthodontia (braces)	
Consultation	25% discount
Treatment plan, records	25% discount
Routine 24-month (fully banded case)	25% discount
Calendar year maximum	None
Calendar year deductible	None
Claim forms	Not required

* Additional cost applies for high noble and noble metal.

OPTION II - Humana PPO Dental Plan

The Humana PPO plan is similar to traditional dental insurance plans. Under this plan you do not have to preselect a primary dentist. When you want dental services, simply make your appointment with any licensed dentist. For maximum benefits, select a dentist from Humana's extensive PPO network. Humana's PPO participating dental providers have agreed to accept a contracted fee for each dental procedure. These discounts can be as much as 30% off the usual fees. Once services are performed, you or your dentist must file a claim form in order to receive reimbursement. Your claim will be paid based on your PPO plan schedule of benefits. The plan will pay a percentage of the eligible charges, up to the plan's annual limit for benefits.

Plan Features

- You have the freedom to select any licensed dentist.
- You pay lower out-of-pocket costs when you select an in-network dentist.
- Quick claims turnaround with state of the art claims centers that provide fast reimbursement for your claims

Plan Benefits

Humana Custom PPO		
Partial List of Covered Services*	In-Network Reimbursements	Out-of-Network Reimbursements
Type I - Diagnostic & Preventative	100%*	75%
• Oral examination (once per 6 months) • Prophylaxis (cleaning, once per 6 months) • Topical fluoride (children under 16, once per 12 months)	• X-rays (limitations may apply) • Sealants (once per 3 years for children under 16, for non-carious molars only)	
Type II - Basic Services	75%*	50%
• Non-surgical tooth extractions • Non-surgical periodontics	• Simple restorative (amalgam, synthetic or composite filings) • Space maintainers (for children under 16)	
Type III - Major Services	50%*	25%
—12 month waiting period— • Major restorative (crowns/inlays/onlays) • Bridge, denture repair • Prosthetics (bridges and dentures)	• Emergency palliative treatment • Endodontics (root canals) • Surgical tooth extractions • Surgical periodontics	
Type IV - Orthodontics (children)	50%*	50%
—12 month waiting period—	• Dependent children (18 years of age or younger)	
Maximum Benefits	In-Network	Out-of-Network
Lifetime		
• Type I, II, III • Type IV	Unlimited $1,000	Unlimited $1,000
Calendar Year		
• Type I, II, III • Type IV	$1,500 $500	$1,500 $500
Deductible†		
• Type I • Type II, III, IV	None $50	None $50

** Coverage based on contracted fees for the Preferred Provider Network*

† Maximum of 3 per family

VISION PLAN

Premium Rates (pretax)

Coverage	Humana Vision 100
Employee	$3.07
Employee + 1	$6.13
Employee & family	$11.29

Vision Health Helps Overall Health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.

The District plan offers a network of providers that service your eyecare needs with only a modest member copayment shown in the Plan Benefits table on the following page. The out-of-network-benefit allows you to select any out-of-network provider and reimburses a fixed dollar amount based on the schedule shown for the out-of-network services.

Know What Your Plan Covers

The Plan Benefits section contains a summary of services covered. The full details will be contained in your certificate of insurance. You can find your certificate on Humana.com or call 1-877-398-2980.

Here's what you can expect:

- Quality routine eye healthcare from independent eye care professionals and national retail locations
- Services and materials provided on a prepaid basis, and the plan pays in-network providers directly, you also have the freedom to use out-of-network providers if you prefer
- Life without claim forms! With HumanaVision, you pay your eye care professional directly for copayments and any extra cosmetic options selected at the time of service
- With choice from more 109,000 access points nationwide, including independent, retail and online options.

Some items and services not included in HumanaVision are:

- Orthoptics or vision training, subnormal vision aids or Plano (non-prescription) lenses
- Replacement of lost or broken lenses, except at the regularly-scheduled plan intervals
- Medical or surgical treatment of eyes
- Care provided through or required by any government agency or program, including Workers' Compensation or a similar law

Select a vision provider from our network simply by visiting Humana.com, or call us at 1-877-398-2980. A full list of limitations and exclusions will be included with your certificate of insurance.

VISION PLAN

Plan Benefits

Humana Vision 100		
Covered Services	In-Network Member Costs	Out-of-Network Reimbursements
Routine Eye Exam		
Exam with dilation, as necessary	$10	Up to $30
Retinal imaging[1]	Up to $39	Not Covered
Contact Lens Exam Options[2]		
Standard contact lens fit and follow-up	Up to $55	Not Covered
Premium contact lens fit and follow-up	10% off retail	Not Covered
Frames[3]	Up to $100, 20% off balance over $100	Up to $50
Standard Plastic Lenses[4]		
Single vision	$15	Up to $25
Bifocal	$15	Up to $40
Trifocal	$15	Up to $60
Lenticular	$15	Up to $100
Lens Options[4]		
UV coating	$15	Not Covered
Tint (solid and gradient)	$15	Not Covered
Standard scratch-resistance	$15	Not Covered
Standard polycarbonate		
• Adults	$40	Not Covered
• Children <19	$40	Not Covered
Standard anti-reflective coating	$45	Not Covered
Premium anti-reflective coating		
• Tier 1	$57	Not Covered
• Tier 2	$68	Not Covered
• Tier 3	80% of charge	Not Covered
Standard progressive (add-on to bifocal)	$25	Up to $40
Premium Progressive		
• Tier 1	$110	Not Covered
• Tier 2	$120	Not Covered
• Tier 3	$135	Not Covered
• Tier 4	$90, 80% of charge, then up to $120	Not Covered
Photochromatic / plastic transitions	$75	Not Covered
Polarized	20% off retail	Not Covered
Contact Lenses (applies to materials only)		
Conventional	Up to $100, 15% off balance over $100	Up to $80
Disposable	Up to $100	Up to $80
Medically necessary	$0	Up to $200

1 Member costs may exceed $39 with certain providers. Ask your provider what costs or discounts are available.

2 Standard contact lens exam fit and follow-up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Ask your provider to determine what costs or discounts are available.

3 Discounts available on all frames except when prohibited by the manufacturer.

4 Lens option costs may vary by provider. Ask your provider for an available costs list.

VISION PLAN

Plan Benefits

Humana Vision 100		
Covered Services	In-Network Member Costs	Out-of-Network Reimbursements
Frequency		
Examination	Once every 12 months	Once every 12 months
Lenses or contact lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months
Diabetic Eye Care (care and testing for diabetic members)		
Exam	$0	Up to $77
Retinal imaging	$0	Up to $50
Extended ophthalmoscopy	$0	Up to $15
Gonioscopy	$0	Up to $15
Scanning laser	$0	Up to $33
(Up to 2 services per benefit year for each listed service)		
Optional Benefits		
Polycarbonate Lenses for Children <19	Provides for standard polycarbonate lens	
Additional Plan Discounts		

Member may receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.

Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location.

FLEXIBLE SPENDING ACCOUNTS

Healthcare FSA

A Healthcare FSA is used to pay for eligible medical expenses which aren't covered by your insurance or other plans. These expenses can be incurred by you, your spouse, a qualifying child or relative, who can be claimed on your taxes. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as before and after school care, day time baby-sitting fees, elder care services, nursery and preschool. Eligible dependents include your qualifying child, spouse and/or relative.

You can request reimbursement from your Dependent Care FSA after your dependent receives day care services. Unlike the Healthcare FSA, your full annual contribution is not available at the beginning of the plan year. You can only get reimbursed up to the amount that is available in your account at that time.

Annual Contribution Limits

For Healthcare FSA:

- Minimum Annual Contribution: $150
- Maximum Annual Contribution: $3,050

Your Healthcare FSA allows a maximum carryover of $600. If you do not exhaust your 2023 FSA balance, up to $600 may be rolled over to pay for 2024 medical claims.

For Dependent Care FSA:

- Minimum Annual Contribution: $250
- The maximum contribution depends on your tax filing status.
- If you are married and filing separately, your maximum annual contribution is $2,500.
- If you are single and head of household, your maximum annual contribution is $5,000.
- If you are married and filing jointly, your maximum annual contribution is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual contribution is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual contribution is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

Examples of When to Use Your FSA

Healthcare FSA: Paying for an office visit

After paying for your care at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with a claim form to PayFlex. Once your claim is processed and approved, you'll receive payment by check or direct deposit.

If you don't want to pay for the office visit out of your pocket, you can use your PayFlex debit card. Only use your card after insurance has covered their portion of the expense. Be sure to save the documentation from your card purchases. You may be asked to provide documentation to verify that your expenses were eligible. Failure to submit proper documentation can result in deactivation of your card and you may have to pay back the funds at the end of the plan year.

FLEXIBLE SPENDING ACCOUNTS

Dependent Care FSA: Paying for services

Once you have paid for (and received) a dependent care service, send a completed claim form to PayFlex, along with documentation showing the following:

- Provider Name – Facility name or person who provided the service.
- Dates of Service – Start and end dates for services provided.
- Service Description – Detailed description for services provided.
- Amount – The amount incurred for the services.
- Dependent Name & Age – Person who received the service.

If you don't have documentation to support your day care expense, you can have your provider sign a completed claim form and send to PayFlex. Once your claim is processed and approved, payment will be sent to you by check or direct deposit.

Using Your FSA Dollars

The PayFlex debit card is a convenient way to pay for eligible healthcare expenses. After you use the card, save your Explanations of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you have a healthcare FSA, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA. If you need an additional debit card for your spouse or dependent, over the age of 18, you are able to request one free of charge online or by contacting customer service.

Filing a 2024 Claim with PayFlex

Those who participate in a Flexible Spending Account can visit payflex.com to access their account information. For 2024 FSA claims to PayFlex, if you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at payflex.com or through the PayFlex Mobile® app to pay yourself back for your out-of-pocket expenses. Or you can fill out a paper claim form and fax or mail it to:

PayFlex at PayFlex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158

This form can be found in the Resource Center at payflex.com or you may call PayFlex at 1-800-284-4885 to request a form.

After you log in to payflex.com, click on the Financial Center tab and select your account from the drop down. Click on File a Spending Account Claim to get started. If you're a first-time user, be sure to register first.

When you submit a claim, you need to include this supporting documentation:

- Merchant or service provider name
- Name of patient (if applicable)
- Date of service
- Amount you were required to pay
- Description of item or service

How to Register Online

Go to payflex.com and select "CREATE YOUR PROFILE." You will be asked to enter your last name, mailing address, ZIP code, last four digits of your ID number and date of birth.

Once your information is authenticated, you can create a username and password, provide your phone number and email address and select security questions/answers.

Note: If you already have a username and password for healthhub.com, you'll use that to log in to payflex.com.

Claim Filing Tips

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to payflex.com. Click on the "Financial Center" tab. Select your account from the drop down menu and click on Enroll in Direct Deposit to get started.

FLEXIBLE SPENDING ACCOUNTS

FSA Worksheets

Use the worksheets below to determine how much you will contribute per pay period into your FSA. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount (including the administrative fees) cannot exceed established IRS and plan limits (see page 27).

Be conservative in your estimates. $600 can only be carried over for the Healthcare FSA anything over that will be forfeited and any amount left in the DFSA will be forfeited.

Healthcare FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$_____
Coinsurance or copayments	$_____
Vision care	$_____
Dental care	$_____
Prescription drugs	$_____
Travel costs for medical care	$_____
Other eligible expenses	$_____

TOTAL ANNUAL CONTRIBUTION	$_____
(Cannot exceed $3,050)	
DIVIDE by the number of paychecks you will receive during the year.*	÷_____
This is your pay period contribution.	$_____

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services	$_____
In-home care/au pair services	$_____
Nursery and preschool	$_____
Before & after school care	$_____
Summer day camps	$_____

ELDER CARE SERVICES

Day care center	$_____
In-home care	$_____

TOTAL ANNUAL CONTRIBUTION	$_____
(Cannot exceed IRS limits on page 27)	
DIVIDE by the number of paychecks you will receive during the year.*	÷_____
This is your pay period contribution.	$_____

GROUP TERM LIFE INSURANCE

Do You Need Life Insurance?

If you're like most people, you want to make sure that your loved ones are adequately provided for if something happens to you. The District offers Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance coverage to you and your dependents through Standard Insurance Company. All employees receive a minimum of $10,000 Basic Term Life & AD&D (employer paid). See your certificate for details.

Additional Life/AD&D Insurance

Everyone has unique circumstances that can make it difficult to estimate needs. Will the District's basic contribution cover yours? The next step is to determine the right amount of Life insurance to help protect your loved ones. Use our calculator to estimate your needs at standard.com/individual/insurance/group-life/estimate-life-insurance-needs. This simple form can help you find the right amount to protect your loved ones.

All employees are able to elect up to $300,000 in Additional Life/AD&D in increments of $10,000 and matching AD&D insurance coverage.

- Newly eligible employees are able to purchase up to $300,000 on a guaranteed issue basis (no medical questions asked) during their initial enrollment eligibility period.
- Existing employees can purchase or increase their Additional Life/AD&D up to $300,000 with a completed Evidence of Insurability (EOI) during this Open Enrollment only or within the first 31 days following a family status change.

Spouse Life/AD&D Insurance

- Existing employees can purchase or increase coverage for their spouse with a completed Evidence of Insurability (EOI) during this Open Enrollment. You are able to elect Spouse Life/AD&D Insurance in multiples of $5,000 up to $150,000 in life and matching AD&D insurance coverage.
- If you get married, and are currently enrolled in the Additional Life coverage, you may add coverage for your spouse up to the Guarantee Issue amount ($50,000) without Evidence of Insurability (EOI) if you elect the coverage within 31 days of the change. For all other family status changes (e.g. your spouse loses their job or their own Life coverage), an EOI would be required in order to add Additional Life coverage for your spouse.

You must be enrolled in Additional Life/AD&D to enroll in the Spouse Life plan. The amount you can purchase for your spouse cannot exceed 100% of the Additional Life/AD&D Insurance amounts you select. Rates are based on the age of the employee.

Dependent Child(ren) Life Insurance

You must be enrolled in Additional Life/AD&D to enroll in the Child Life plan. You are able to elect $10,000 in life insurance each for any number eligible dependent children aged from live birth through age 25.

Premium Waiver

If you are currently under age 70 and become totally disabled while insured under this plan and complete a waiting period of 180 days, your Basic and Additional Life and your child/spouse's life insurance may continue without premium payment, subject to the terms of the group policy. AD&D will not continue while on waiver of premium. Call FBMC's Service Center at 833-MCSD-4US (833-627-3487) for a waiver of premium application.

Staying Covered at Termination

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

Conversion Privilege at Termination

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

For more information on Portability and Conversion, please refer to your certificate of coverage or contact The Standard at 1-800-378-4668.

Additional Life/AD&D Rates

Payroll deductions are based on 20 pays. Rates are dependent upon your age on the effective date of coverage. Please note that if you move up to the next age bracket, your payroll deduction will change in the January following your birthday.

GROUP TERM LIFE INSURANCE

Employee Life/AD&D Rates (based on 20 payroll deductions)

	Coverage Amount*											
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*	70-74*	75+*
$10,000	$ 0.54	$ 0.54	$ 0.66	$ 0.66	$ 1.02	$ 1.62	$ 2.82	$ 4.62	$ 5.10	$ 6.44	$ 7.18	$ 4.49
$20,000	$ 1.08	$ 1.08	$ 1.32	$ 1.32	$ 2.04	$ 3.24	$ 5.64	$ 9.24	$ 10.20	$ 12.87	$ 14.35	$ 8.97
$30,000	$ 1.62	$ 1.62	$ 1.98	$ 1.98	$ 3.06	$ 4.86	$ 8.46	$ 13.86	$ 15.30	$ 19.31	$ 21.53	$ 13.46
$40,000	$ 2.16	$ 2.16	$ 2.64	$ 2.64	$ 4.08	$ 6.48	$ 11.28	$ 18.48	$ 20.40	$ 25.74	$ 28.70	$ 17.94
$50,000	$ 2.70	$ 2.70	$ 3.30	$ 3.30	$ 5.10	$ 8.10	$ 14.10	$ 23.10	$ 25.50	$ 32.18	$ 35.88	$ 22.43
$60,000	$ 3.24	$ 3.24	$ 3.96	$ 3.96	$ 6.12	$ 9.72	$ 16.92	$ 27.72	$ 30.60	$ 38.61	$ 43.06	$ 26.91
$70,000	$ 3.78	$ 3.78	$ 4.62	$ 4.62	$ 7.14	$ 11.34	$ 19.74	$ 32.34	$ 35.70	$ 45.05	$ 50.23	$ 31.40
$80,000	$ 4.32	$ 4.32	$ 5.28	$ 5.28	$ 8.16	$ 12.96	$ 22.56	$ 36.96	$ 40.80	$ 51.48	$ 57.41	$ 35.88
$90,000	$ 4.86	$ 4.86	$ 5.94	$ 5.94	$ 9.18	$ 14.58	$ 25.38	$ 41.58	$ 45.90	$ 57.92	$ 64.58	$ 40.37
$100,000	$ 5.40	$ 5.40	$ 6.60	$ 6.60	$ 10.20	$ 16.20	$ 28.20	$ 46.20	$ 51.00	$ 64.35	$ 71.76	$ 44.85
$110,000	$ 5.94	$ 5.94	$ 7.26	$ 7.26	$ 11.22	$ 17.82	$ 31.02	$ 50.82	$ 56.10	$ 70.79	$ 78.94	$ 49.34
$120,000	$ 6.48	$ 6.48	$ 7.92	$ 7.92	$ 12.24	$ 19.44	$ 33.84	$ 55.44	$ 61.20	$ 77.22	$ 86.11	$ 53.82
$130,000	$ 7.02	$ 7.02	$ 8.58	$ 8.58	$ 13.26	$ 21.06	$ 36.66	$ 60.06	$ 66.30	$ 83.66	$ 93.29	$ 58.31
$140,000	$ 7.56	$ 7.56	$ 9.24	$ 9.24	$ 14.28	$ 22.68	$ 39.48	$ 64.68	$ 71.40	$ 90.09	$ 100.46	$ 62.79
$150,000	$ 8.10	$ 8.10	$ 9.90	$ 9.90	$ 15.30	$ 24.30	$ 42.30	$ 69.30	$ 76.50	$ 96.53	$ 107.64	$ 67.28
$160,000	$ 8.64	$ 8.64	$ 10.56	$ 10.56	$ 16.32	$ 25.92	$ 45.12	$ 73.92	$ 81.60	$ 102.96	$ 114.82	$ 71.76
$170,000	$ 9.18	$ 9.18	$ 11.22	$ 11.22	$ 17.34	$ 27.54	$ 47.94	$ 78.54	$ 86.70	$ 109.40	$ 121.99	$ 76.25
$180,000	$ 9.72	$ 9.72	$ 11.88	$ 11.88	$ 18.36	$ 29.16	$ 50.76	$ 83.16	$ 91.80	$ 115.83	$ 129.17	$ 80.73
$190,000	$ 10.26	$ 10.26	$ 12.54	$ 12.54	$ 19.38	$ 30.78	$ 53.58	$ 87.78	$ 96.90	$ 122.27	$ 136.34	$ 85.22
$200,000	$ 10.80	$ 10.80	$ 13.20	$ 13.20	$ 20.40	$ 32.40	$ 56.40	$ 92.40	$ 102.00	$ 128.70	$ 143.52	$ 89.70
$210,000	$ 11.34	$ 11.34	$ 13.86	$ 13.86	$ 21.42	$ 34.02	$ 59.22	$ 97.02	$ 107.10	$ 135.14	$ 150.70	$ 94.19
$220,000	$ 11.88	$ 11.88	$ 14.52	$ 14.52	$ 22.44	$ 35.64	$ 62.04	$ 101.64	$ 112.20	$ 141.57	$ 157.87	$ 98.67
$230,000	$ 12.42	$ 12.42	$ 15.18	$ 15.18	$ 23.46	$ 37.26	$ 64.86	$ 106.26	$ 117.30	$ 148.01	$ 165.05	$ 103.16
$240,000	$ 12.96	$ 12.96	$ 15.84	$ 15.84	$ 24.48	$ 38.88	$ 67.68	$ 110.88	$ 122.40	$ 154.44	$ 172.22	$ 107.64
$250,000	$ 13.50	$ 13.50	$ 16.50	$ 16.50	$ 25.50	$ 40.50	$ 70.50	$ 115.50	$ 127.50	$ 160.88	$ 179.40	$ 112.13
$260,000	$ 14.04	$ 14.04	$ 17.16	$ 17.16	$ 26.52	$ 42.12	$ 73.32	$ 120.12	$ 132.60	$ 167.31	$ 186.58	$ 116.61
$270,000	$ 14.58	$ 14.58	$ 17.82	$ 17.82	$ 27.54	$ 43.74	$ 76.14	$ 124.74	$ 137.70	$ 173.75	$ 193.75	$ 121.10
$280,000	$ 15.12	$ 15.12	$ 18.48	$ 18.48	$ 28.56	$ 45.36	$ 78.96	$ 129.36	$ 142.80	$ 180.18	$ 200.93	$ 125.58
$290,000	$ 15.66	$ 15.66	$ 19.14	$ 19.14	$ 29.58	$ 46.98	$ 81.78	$ 133.98	$ 147.90	$ 186.62	$ 208.10	$ 130.07
$300,000	$ 16.20	$ 16.20	$ 19.80	$ 19.80	$ 30.60	$ 48.60	$ 84.60	$ 138.60	$ 153.00	$ 193.05	$ 215.28	$ 134.55

* Your coverage amount decreases to 65% at age 65, to 40% at age 70 and to 25% at age 75. Premiums are also based on the reduced benefit amount. Example: $10,000 coverage amount decreases to $6,500 at age 65, to $4,000 at age 70 and to $2,500 at age 75.

GROUP TERM LIFE INSURANCE

Spouse Life/AD&D Rates (based on employee age)

	Coverage Amount*											
Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	$ 0.27	$ 0.27	$ 0.33	$ 0.33	$ 0.51	$ 0.81	$ 1.41	$ 2.31	$ 2.55	$ 3.22	$ 3.59	$ 2.24
$10,000	$ 0.54	$ 0.54	$ 0.66	$ 0.66	$ 1.02	$ 1.62	$ 2.82	$ 4.62	$ 5.10	$ 6.44	$ 7.18	$ 4.49
$15,000	$ 0.81	$ 0.81	$ 0.99	$ 0.99	$ 1.53	$ 2.43	$ 4.23	$ 6.93	$ 7.65	$ 9.65	$ 10.76	$ 6.73
$20,000	$ 1.08	$ 1.08	$ 1.32	$ 1.32	$ 2.04	$ 3.24	$ 5.64	$ 9.24	$ 10.20	$ 12.87	$ 14.35	$ 8.97
$25,000	$ 1.35	$ 1.35	$ 1.65	$ 1.65	$ 2.55	$ 4.05	$ 7.05	$ 11.55	$ 12.75	$ 16.09	$ 17.94	$ 11.21
$30,000	$ 1.62	$ 1.62	$ 1.98	$ 1.98	$ 3.06	$ 4.86	$ 8.46	$ 13.86	$ 15.30	$ 19.31	$ 21.53	$ 13.46
$35,000	$ 1.89	$ 1.89	$ 2.31	$ 2.31	$ 3.57	$ 5.67	$ 9.87	$ 16.17	$ 17.85	$ 22.52	$ 25.12	$ 15.70
$40,000	$ 2.16	$ 2.16	$ 2.64	$ 2.64	$ 4.08	$ 6.48	$ 11.28	$ 18.48	$ 20.40	$ 25.74	$ 28.70	$ 17.94
$45,000	$ 2.43	$ 2.43	$ 2.97	$ 2.97	$ 4.59	$ 7.29	$ 12.69	$ 20.79	$ 22.95	$ 28.96	$ 32.29	$ 20.18
$50,000	$ 2.70	$ 2.70	$ 3.30	$ 3.30	$ 5.10	$ 8.10	$ 14.10	$ 23.10	$ 25.50	$ 32.18	$ 35.88	$ 22.43
$55,000	$ 2.97	$ 2.97	$ 3.63	$ 3.63	$ 5.61	$ 8.91	$ 15.51	$ 25.41	$ 28.05	$ 35.39	$ 39.47	$ 24.67
$60,000	$ 3.24	$ 3.24	$ 3.96	$ 3.96	$ 6.12	$ 9.72	$ 16.92	$ 27.72	$ 30.60	$ 38.61	$ 43.06	$ 26.91
$65,000	$ 3.51	$ 3.51	$ 4.29	$ 4.29	$ 6.63	$ 10.53	$ 18.33	$ 30.03	$ 33.15	$ 41.83	$ 46.64	$ 29.15
$70,000	$ 3.78	$ 3.78	$ 4.62	$ 4.62	$ 7.14	$ 11.34	$ 19.74	$ 32.34	$ 35.70	$ 45.05	$ 50.23	$ 31.40
$75,000	$ 4.05	$ 4.05	$ 4.95	$ 4.95	$ 7.65	$ 12.15	$ 21.15	$ 34.65	$ 38.25	$ 48.26	$ 53.82	$ 33.64
$80,000	$ 4.32	$ 4.32	$ 5.28	$ 5.28	$ 8.16	$ 12.96	$ 22.56	$ 36.96	$ 40.80	$ 51.48	$ 57.41	$ 35.88
$85,000	$ 4.59	$ 4.59	$ 5.61	$ 5.61	$ 8.67	$ 13.77	$ 23.97	$ 39.27	$ 43.35	$ 54.70	$ 61.00	$ 38.12
$90,000	$ 4.86	$ 4.86	$ 5.94	$ 5.94	$ 9.18	$ 14.58	$ 25.38	$ 41.58	$ 45.90	$ 57.92	$ 64.58	$ 40.37
$95,000	$ 5.13	$ 5.13	$ 6.27	$ 6.27	$ 9.69	$ 15.39	$ 26.79	$ 43.89	$ 48.45	$ 61.13	$ 68.17	$ 42.61
$100,000	$ 5.40	$ 5.40	$ 6.60	$ 6.60	$ 10.20	$ 16.20	$ 28.20	$ 46.20	$ 51.00	$ 64.35	$ 71.76	$ 44.85
$105,000	$ 5.67	$ 5.67	$ 6.93	$ 6.93	$ 10.71	$ 17.01	$ 29.61	$ 48.51	$ 53.55	$ 67.57	$ 75.35	$ 47.09
$110,000	$ 5.94	$ 5.94	$ 7.26	$ 7.26	$ 11.22	$ 17.82	$ 31.02	$ 50.82	$ 56.10	$ 70.79	$ 78.94	$ 49.34
$115,000	$ 6.21	$ 6.21	$ 7.59	$ 7.59	$ 11.73	$ 18.63	$ 32.43	$ 53.13	$ 58.65	$ 74.00	$ 82.52	$ 51.58
$120,000	$ 6.48	$ 6.48	$ 7.92	$ 7.92	$ 12.24	$ 19.44	$ 33.84	$ 55.44	$ 61.20	$ 77.22	$ 86.11	$ 53.82
$125,000	$ 6.75	$ 6.75	$ 8.25	$ 8.25	$ 12.75	$ 20.25	$ 35.25	$ 57.75	$ 63.75	$ 80.44	$ 89.70	$ 56.06
$130,000	$ 7.02	$ 7.02	$ 8.58	$ 8.58	$ 13.26	$ 21.06	$ 36.66	$ 60.06	$ 66.30	$ 83.66	$ 93.29	$ 58.31
$135,000	$ 7.29	$ 7.29	$ 8.91	$ 8.91	$ 13.77	$ 21.87	$ 38.07	$ 62.37	$ 68.85	$ 86.87	$ 96.88	$ 60.55
$140,000	$ 7.56	$ 7.56	$ 9.24	$ 9.24	$ 14.28	$ 22.68	$ 39.48	$ 64.68	$ 71.40	$ 90.09	$ 100.46	$ 62.79
$145,000	$ 7.83	$ 7.83	$ 9.57	$ 9.57	$ 14.79	$ 23.49	$ 40.89	$ 66.99	$ 73.95	$ 93.31	$ 104.05	$ 65.03
$150,000	$ 8.10	$ 8.10	$ 9.90	$ 9.90	$ 15.30	$ 24.30	$ 42.30	$ 69.30	$ 76.50	$ 96.53	$ 107.64	$ 67.28

* Your coverage amount decreases to 65% at age 65, to 40% at age 70 and to 25% at age 75. Premiums are also based on the reduced benefit amount. Example: $10,000 coverage amount decreases to $6,500 at age 65, to $4,000 at age 70 and to $2,500 at age 75.

Dependent Child(ren) Life Rate (based on 20 payroll deductions)

$0.78 for $10,000 of insurance on each eligible child, regardless of the number of children.

DISABILITY INCOME PROTECTION

A disability can put a lot of things in your life on hold. Unfortunately, expenses aren't one of those things. They keep coming. If you become disabled, this insurance plan can help you keep up by providing a stable monthly income, up to a maximum of $1,500 a month, or 60% of your monthly salary, whichever is less.

Plan Features

- Benefits start after you are disabled for 90 days.
- For employees working 30 or more hours per week, benefits are payable to age 65 if disabled before age 62. If you become disabled at age 62 or older, benefits are payable on a decreasing scale.
- For employees working less than 30 hours per week, benefits are payable monthly for a maximum period of five years if disabled before age 62. If you become disabled at age 62 or older, benefits are payable on a decreasing scale.
- Benefits coordinate with the "Other Income Benefits" section on page 35.
- The minimum monthly benefit for employees working 30 or more hours per week is $300 per month. The minimum monthly benefit for employees working less than 30 hours per week is $100 per month. The minimum monthly benefit is the minimum amount payable, once all other income benefits have been applied.
- Premiums are waived while you receive payments under this plan.

Qualifications for Making a Claim

The plan considers you disabled if you:

- Cannot perform all the material and substantial duties of your regular occupation, and
- Are unable to earn more than 80% of your indexed covered earnings, solely due to injury or sickness.

Premium Rates (post-tax)

Coverage	Disability Income
Employee	$8.40

After monthly benefits have been payable for 24 months, the plan considers you disabled if you cannot perform the material and substantial duties of any occupation or employment for which you may reasonably become qualified based on your education, training or experience and are unable to earn more than 80% of your indexed covered earnings, solely due to injury or sickness.

Disabilities Subject to Limited Pay Periods

You can receive payments for a covered disability which does not require hospitalization that results from mental illness, alcoholism or drug abuse for a maximum of 24 months. After 24 months, the benefit will continue only while the disabled employee is confined to a hospital.

Return to Work Incentive Benefit

This benefit offers an effective incentive for employees who are ready to return to work, but not full time. If you are covered for work incentive benefits, you may return to work while disabled and your disability benefits will continue.

For the first 12 months you return to work, if in any month during that period, the sum of your disability benefit, your income from the rehabilitative work and any additional other income benefits exceed 100% of your indexed covered earnings, your disability benefit will be reduced by the excess amount.

After 12 months, your disability benefit will be reduced by 50% of your income received during any month of rehabilitative work.

DISABILITY INCOME PROTECTION

Reasonable Accommodation Expense Benefit

This coverage includes a $25,000 Reasonable Accommodation Expense Benefit, which reimburses employers for workplace modifications that enable employees to return to or remain at work. The Reasonable Accommodation Expense Benefit is separate from the Long-Term Disability (LTD) claim payment.

Rehabilitation During Period of Disability

A Rehabilitation Plan is a written agreement between you and the insurance company in which the insurance company agrees to provide, arrange or authorize vocational and physical rehabilitation services.

The Rehabilitation Plan may, at the insurance company's discretion, allow for payment of your medical expenses, education expenses, moving expenses, accommodation expenses or family care expenses while you participate in the program.

If, while you are disabled, the insurance company determines that you are a suitable candidate for rehabilitation, you may participate in a Rehabilitation Plan. You and the insurance company must mutually agree upon the terms and conditions of the Rehabilitation Plan. The insurance company may require that you participate in a rehabilitation assessment with you, your employer, your physician and others, as appropriate, to develop a rehabilitation plan. If you refuse to participate in the rehabilitation efforts disability benefits will not be payable.

Rehabilitation Plan Benefit

This benefit increases the LTD benefit amount by 10% of pre-disability earnings, not to exceed the maximum benefit, when a member is participating in an approved rehabilitation plan. This benefit will also assist in paying for approved expenses incurred by a disabled member as part of an approved rehabilitation plan.

Eligibility Waiting Period

For employees hired on or before the policy effective date, there is no waiting period.

Employees hired after the policy effective date, must wait until the first of the month following 15 calendar days of active employment.

Termination of Insurance

The insurance on an employee will end on the earliest date below:

- The date the employee is eligible for coverage under a plan intended to replace this coverage
- The date the policy is terminated
- The date the employee is no longer in an eligible class
- The day after the period for which premiums are paid
- The date the employee is no longer in active service

Survivor Benefit

If death occurs after the employee has been receiving the monthly benefits for at least six months, his or her eligible survivor will receive a lump sum equal to three times the non-integrated LTD benefits.

Pre-Existing Conditions

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you incurred expenses, received medical treatment, took prescribed drugs or consulted a physician in the three months before the most recent effective date of your insurance, you will receive no monthly benefits for that condition. However, this limitation does not apply to a total disability which begins more than 12 months after the most recent effective date of your insurance.

Conversion Privilege

If you terminate employment or if your coverage ends for any reason except non-payment of premium, you can convert this plan to an individual policy, but you must apply in writing and pay the first premium to us within 31 days after your insurance ends. To be eligible for conversion, you must have been insured for disability benefits and actively at work for at least 12 months. For more information please call The Standard at 1-800-378-4668.

DISABILITY INCOME PROTECTION

Other Income Benefits

When an employee is disabled, he or she may be eligible for benefits from other income sources. If so, the insurance company may reduce the disability benefits payable by the amount of such other income benefits. The extent to which other income benefits will reduce any disability benefits payable under the policy is shown in the schedule of benefits.

Other income benefits include:

1. Any amounts that the employee or any dependents, if applicable, receive (or are assumed to receive) under:
   - The Canada and Quebec Pension Plans
   - The Railroad Retirement Act
   - Any local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer
   - Any sick leave plan of the employer;
   - Any work loss provision in mandatory "no-fault" auto insurance
   - Any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
2. Any Social Security disability benefits the employee or any third party receives (or is assumed to receive) on the employee's behalf or for his or her dependents, or that his or her dependents receive (or are assumed to receive) because of the employee's entitlement to such benefits.
3. Any retirement plan benefits funded by the Employer. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by an employer. It does not include an individual deferred compensation agreement, a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. Any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same claim for disability and contains the same or similar provision for reduction because of other insurance, the insurance company will pay its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
6. Any wage or salary for work performed. If an employee is covered for work incentive benefits, the insurance company will only reduce disability benefits to the extent provided under the work incentive benefit in the schedule of benefits.

What's Not Covered?

The plan will not pay disability benefits for a disability that results, directly or indirectly, from:

- Suicide, attempted suicide or whenever an employee injures himself or herself on purpose
- War or any act of war, whether or not declared
- Serving on full-time active duty in any armed forces*
- Active participation in a riot
- Commission of a felony or
- Revocation, restriction or non-renewal of an employee's license, permit or certification necessary to perform the duties of his or her occupation, unless due solely to injury or sickness otherwise covered by the policy.

The plan will not pay disability benefits for any period of disability during which the employee:

- Is incarcerated in a penal or corrections institution
- Is not receiving appropriate care
- Fails to cooperate with the insurance company in the administration of the claim including, but not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due
- Refuses to participate in rehabilitation efforts required by the insurance company or refuses to participate in a work transition arrangement or other modified work arrangement.

* If the Employee sends proof of military service, the insurance company will refund the portion of the premium paid to cover the employee during a period of such service.

Important Notice

This information is a brief description of the important features of this plan. It is not a contract. Terms & conditions of the coverage are set forth in group policy #163696 issued in Florida and subject to its laws. The availability of this offer may change. Please keep this material as a reference, and file it with your certificate, should you become insured.

SUPPLEMENTAL RETIREMENT

Who Can Join?

All full-time employees are eligible to participate in the Vista 401(k) Supplemental Retirement Plan.

How Does the Plan Work?

The basic processes are simple:

- Contributions to the plan are made through regular payroll deductions.
- Selections from over 21 mutual funds are available.
- No taxes are paid on any contributions or earnings until they are withdrawn.

How to Enroll

To enroll in your Vista 401(k) Plan simply visit our website at vista401k.com or complete an enrollment form indicating:

- The per pay period amount you want to contribute.
- How you want your money invested (you may defer that decision until after you have enrolled but before the first payroll deductions are received). If no decision is made, your contributions will be made to the target retirement fund closest to your retirement (age 62).
- The beneficiary who will receive your account in the event of your death.

Mail your completed form to Vista 401(k) at:

PO Box 1878
Tallahassee, FL 32302-1878

How to Change Your Investments

You can change your investments by going to the Vista 401(k) website at vista401k.com or contact FBMC's Retirement Services Team at 1-866-325-1278 and request a change of investment form. Either system enables you to:

- Change how your future contributions will be invested.
- Transfer your existing account balance among the fund choices.

There is no minimum time period before transfers or exchanges are allowed.

Participant Statement

You will receive personal account statements on a quarterly basis.

Your statement will show activity in your account including contributions, shares purchased, gains/losses, fund transfers and distributions. You may also create a statement for any time period by visiting our website at vista401k.com.

You can also obtain information from our website or through the IVR.

Contributions

Contribution Limits

The minimum contribution is $25 per payroll. The IRS regulates the maximum contribution. Please visit vista401k.com for current annual amount.

Tax Savings

Each contribution reduces your taxable income. Additionally, no taxes are paid on any earnings in the plan until they are withdrawn. Your contributions are, however, subject to FICA taxes. Visit our website at vista401k.com and perform an investment analysis.

Contribution Changes

You can change or stop your contributions at any time.

Fees and Expenses

Vista 401(k) plan expenses are as follows:

- Overall Management - An annual fee of 0.575% is assessed from your asset balances and paid to FBMC monthly.
- Administration - $1.00 per month is assessed to participants no longer actively contributing to their

401(k) account
- Mutual Fund - There are investment fees that are different for each fund as described in their prospectus. A detailed summary is available at: vista401k.com
- $20 fee for distributions
- Front-end or loading charge - none
- Surrender charge - none
- Fees and/or restrictions on transferring plan assets between funds - none
- Other charges - none
- Loan fee - $65

Restrictions on Plan Distributions

Your 401(k) account is a long-term investment, designed specifically for your retirement needs. Because of this, the IRS restricts when you can withdraw your money. You are able to withdraw your money when you reach age 59½, retire, terminate employment, become totally and permanently disabled, or have a financial hardship (see hardship withdrawal provisions). Federal law imposes these limitations.

Taxes on Distributions

You pay taxes on your Vista 401(k) plan contributions and your earnings when you withdraw them. If a check is written to you, your distribution will have 20% federal income tax withheld. If you want to avoid paying taxes on your withdrawal, you may do a direct rollover to an IRA or your new employer's 401(k) plan.

An additional 10% penalty tax will be imposed for distributions made before the age of 59½ except for the following circumstances:

- Distributions if you have reached age 55 and retired early
- Hardship distributions
- Distributions to an alternate payee under a qualified domestic relations order, issued by the court in the divorce or dissolution of marriage proceeding
- Distributions made due to an employee's death or disability
- A direct rollover to another qualified plan
- Purchase of service credits for a defined benefit plan

Loans

Your 401(k) plan has a loan provision to give you access to your money. The following rules apply:

- You must have a minimum of $2,000 in your account.
- You can borrow up to 50% of your account balance, with a maximum of $50,000.
- The minimum loan amount is $1,000.
- You have a choice of paying your loan back, with interest, in one, two, three, four, or five years.
- You pay back your loan through equal payroll deductions.
- There are no penalties if you prepay your loan, but if you want to pay it off early, you must pay it off in one lump sum.
- You can only have one loan at a time; there is a 30-day waiting period between loans.
- The interest rate will be 2% over the prime rate.
- Your total payment (principal and interest) will be deposited back into your account.
- There is a $65 fee for loan processing, which includes State of Florida Documentary Stamp payment.

Hardship Withdrawal Provisions

The IRS considers your 401(k) account to be a last resort for money. You must meet specific criteria to qualify for a financial hardship. The IRS allows the following six reasons for hardship withdrawal of your 401(k) funds. The withdrawal cannot exceed the cost of your hardship.

- Purchase of a primary residence (excluding mortgage payments).
- Tuition expenses and related educational fees for you or your dependent's next 12 months of post-secondary education.
- Expenses incurred by you or your dependents to obtain medical services.
- Payments to prevent eviction or foreclosure on your primary residence.
- Payments for burial or funeral expenses for the employee's deceased parent, spouse, children or dependents.
- Expenses for the repair of damage to the employee's principal residence that qualifies for the casualty deduction under code section 165.

You must complete a hardship withdrawal application that details your financial situation and provide written documentation for all eligible expenses.

Rollovers

You may roll over, on a tax-free exchange basis, funds from a previous employer's 401(a), 401(k), 403(b), 457 or IRA plans into your Vista 401(k) plan.

Call Vista 401(k) toll-free at 1-866-325-1278 for information.

All investments involve risks. You should carefully consider all of your options before investing.

Enroll Now

The **401(k) enrollment forms** can be downloaded from vista401k.com or contact FBMC Retirement Services at 1-866-325-1278.

Monroe County School District, FL

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION 2023

403(b) PLAN AND 457(b) DEFERRED COMPENSATION PLAN

The 403(b) and 457(b) Plans are valuable retirement savings options. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) and 457(b) Plans offered.

Plan administration services for the 403(b) and 457(b) plans are provided by U.S. OMNI & TSACG Compliance Services. Visit the U.S. OMNI & TSACG Compliance Services' website *(https://www.tsacg.com)* for information about enrollment in the plan, investment product providers available, distributions, exchanges or transfers, 403(b) and/or 457(b) loans, and rollovers.

ELIGIBILITY

Most employees are eligible to participate in the 403(b) and 457(b) plans immediately upon employment; however, private contractors, appointed/elected trustees and/or school board members are not eligible to participate in the 403(b) plan. Please verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to both the 403(b) and 457(b) plans. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS

Traditional 403(b) and 457(b)

Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) and/or 457(b) account(s) up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Contributions to the participant's 403(b) or 457(b) accounts are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b)

Contributions made to a Roth 403(b) account are after-tax deductions from your paycheck. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth 403(b) accounts are tax-free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Distributions may be taken if you are 59½ (subject to plan document provisions) or at separation from service.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. U.S. OMNI & TSACG Compliance Services monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2023 IS $22,500.
Additional provision allowed:

AGE-BASED ADDITIONAL AMOUNT

Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $7,500 to the 403(b) and/or 457(b) accounts.

ENROLLMENT

Employees who wish to enroll in the 403(b) and/or 457(b) plan must first select the provider and investment product best suited for their account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and/or a deferred compensation enrollment form and any disclosure forms must be completed and submitted to the employer. These forms authorize the employer to withhold 403(b)and/or 457(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf.

A SRA form and/or a deferred compensation enrollment form must be completed to start, stop or modify contributions to 403(b) and/or 457(b) accounts. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.

SUPPLEMENTAL RETIREMENT

INVESTMENT PROVIDER INFORMATION

A current list of authorized 403(b) and 457(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com*.

PLAN DISTRIBUTION TRANSACTIONS

Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, unforeseen financial emergency withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing.

PLAN-TO-PLAN TRANSFERS

A plan-to-plan transfer is defined as the movement of a 403(b) and/or 457(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

ROLLOVERS

Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS

Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service in the year in which they turn 55 or older. Generally, a distribution cannot be made from a 457(b) account until you have reach age 59½ or have a severance from employment. In most cases, any withdrawals made from a 403(b) or 457(b) account are taxable in full as ordinary income.

EXCHANGES

Within each plan, participants may exchange account accumulations from one investment provider to another investment provider that is authorized under the same plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange. Exchanges can only be made from one 457(b) plan to another 457(b) plan, or from one 403(b) plan to another 403(b) plan.

403(b) and 457(b) PLAN LOANS

Participants may be eligible to borrow their 403(b) and/or 457(b) plan accumulations depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) and/or 457(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider. Prior to taking a loan, participants should consult a tax advisor.

HARDSHIP WITHDRAWALS

Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must verify and provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com*.

UNFORESEEN FINANCIAL EMERGENCY WITHDRAWAL

You may be able to take a withdrawal from your 457(b) account in the event of an unforeseen financial emergency. An unforeseeable emergency is defined as a severe financial hardship of the participant or beneficiary. The eligibility requirements to receive a Unforeseen Financial Emergency Withdrawal are provided on the Unforeseen Financial Emergency Withdrawal Disclosure form at *https://www.tsacg.com*.

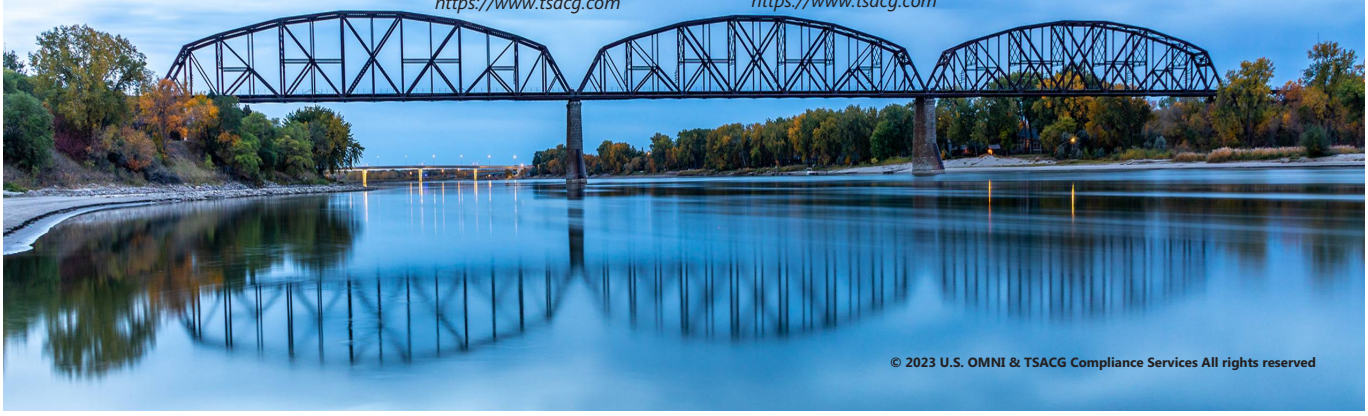
EMPLOYEE INFORMATION STATEMENT

Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) and 457(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

PLAN ADMINISTRATOR CONTACT INFORMATION

Transactions
P.O. Box 4037
Fort Walton Beach, FL 32549
Toll-free: 1-888-796-3786
https://www.tsacg.com

For overnight deliveries
73 Eglin Parkway NE, Suite 202
Fort Walton Beach, FL 32548
Toll-free: 1-888-796-3786
https://www.tsacg.com



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EMPLOYEE ASSISTANCE PROGRAM

A No Cost, Board Paid Benefit

ACI's Employee Assistance Program (EAP) provides a variety of benefits and professional services to help employees and family members address work and life challenges and thrive.

Comprehensive Professional Services to Support Employees at Work and at Home

From the stress of everyday life to relationship issues or work related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

- Three sessions per year of Professional Assessment for Employees and Family Members
- Unlimited Child, Elder and Pet Care Referrals
- Legal and Financial Consultation for Unlimited Number of Issues per Year
- Medical Advocay
- Life Coaching
- Personal Services
- Unlimited Education Referrals and Resources
- Unlimited Identity Theft Recovery Referrals
- Unlimited Community-Based Resource Referrals
- 24/7 Access to ACI Specialty Benefits – My Assistance Program
- Online Legal and Financial Resource Center
- Affinity™ Online Work-Life
- myACI App for Mobile Access
- Monthly Newsletters
- Multicultural and Multilingual Providers Available Nationwide

EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through myAClonline and ACI's 24/7, live-answer, toll-free number.

Accessing EAP Benefits is Easy

Contact ACI Specialty Benefits at 800.932.0034 or go online!

- Go to http://monroe.acieap.com

ACI Specialty Benefits – My Assistance Program provides self-help tools, resources and information for a variety of work-life needs.

Access more than 500+ topics focusing on mental health, personal development and many aspects of daily living. ACI Specialty Benefits – My Assistance Program features:

- Personalized, self-paced assistance
- Strategies for better and healthier living
- Complete anonymity and privacy
- FREE, unlimited access
- Help available 24/7/365

CHANGING YOUR COVERAGE

Qualifying Events for Changing Your Coverage

Under certain circumstances, you experience a "permitted election change event" as permitted by the Plan Document and IRS.

ALL CHANGES MUST BE MADE WITHIN 60 DAYS OF THE QUALIFYING EVENT

Review the Monroe County School District's Plan document for more information and a complete listing of permitted election change events.

Valid Election Change Events

- Marital status
- Change in number of employee's dependents
- Change in employment status
- Gain or loss of dependent's eligibility status
- Coverage and cost changes
- Open enrollment under other employer's plan
- Judgment/decree/order
- Medicare/Medicaid
- Family and Medical Leave Act (FMLA) Leave of Absence
- Revoking Election of Coverage
- Special Enrollment Rights

Within 60 days of a qualifying event, please contact the Benefits Department if you have experienced a qualifying event so they may assist you with filing your election change. Upon the approval of your election change request, your existing elections may be stopped or modified (as appropriate). However, if your election change request is denied, you will have 30 days from the date you receive the denial to file an appeal with Monroe County School District.

Appeals Process

If you have a request for an election change denied during the plan year, you have the right to appeal the decision by sending a written request within 30 days of the denial to FBMC Benefits Management, Inc. (Attn: Appeals Committee).

Your appeal must include the name of your employer and:

- The date of the services for which your request was denied
- A copy of the denied request and the denial letter you received
- Why you think your request should not have been denied
- Any information you think may have a bearing on your appeal

Your appeal will be reviewed upon receipt and its supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

If you have an FSA reimbursement claim denied in whole or in part, you may submit a written appeal to Payflex within 180 days of the initial notice of adverse benefit determination. The appeal should state the reasons you feel the claim should not have been denied and should include any additional facts and/or documents that support your claim.

COBRA Q&A

What Benefits Am I Eligible For If I Terminate Employment?

Your benefits will end on the last day of the month you are employed with the MCSD. You will then become eligible for COBRA.

Overview

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

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

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

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

When is COBRA available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

Options Besides COBRA

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

More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer.

Keep Address Updated

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

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

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

Florida Blue generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Florida Blue at 1-888-387-4962.

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

Taxable Benefits and the IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pretax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and after-tax dollars, then any payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

Notice of Administrator's Capacity

This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder and the insurer:

1. Contract Administrator. FBMC Benefits Management, Inc. has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.
2. Policyholder. This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. Insurer. The insurance companies noted herein have been selected by your employer and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time. However, the tax savings realized through the flexible benefits plan generally outweigh the Social Security reduction. Call the Service Center at 1-855-569-3262 for an approximation.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided not by your employer's flexible benefits plan, but by the health insurance plan(s). The types and amounts of health insurance benefits available under the health insurance plan(s), the requirements for participating in the health insurance plan(s) and the other terms and conditions of coverage and benefits of the health Insurance plan(s) are set forth from time to time in the health insurance plan(s). All claims to receive benefits under the health insurance plan(s) shall be subject to and governed by the terms and conditions of the health insurance plan(s) and the rules, regulations, policies and procedures from the time adopted.

FBMC Privacy Statement

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal, and sometimes sensitive, information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.

FBMC's privacy statement is as follows:

I. **We collect only the customer information necessary to consistently deliver responsive services.**

FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms for example, name, age, address, Social Security number, email address, annual income, health history, marital status, and spousal and beneficiary information.
- Responses from you and others, such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. **Under federal law you have certain rights with respect to your protected health information.**
You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

III. **We maintain safeguards to ensure information security.**
We are committed to preventing unauthorized access to personal information.
We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.

IV. **We limit how, and with whom, we share customer information.**
We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information as we otherwise would. The words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator for more information.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.
The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.
Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.
- outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.
Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan after

the marriage, birth, adoption, or placement for adoption.
To request special enrollment or obtain more information, contact:

Employee Benefits Department
241 Trumbo Road
Key West, FL 33040
833-MCSD-4US (833-627-3487)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Rights and Protections Against Surprise Medical Bills

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

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket-costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plans' deductible or annual out-of-pocket limit. "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

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

Certain services at an in-network hospital or ambulatory surgical center - When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. In addition to the above protections, Florida issued fully insured PPO insurance plans and self-funded plans exempt from ERISA, Florida Statute 627.64194 may provide additional balance billing protection for certain services rendered at an urgent care center. **You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.**

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

• You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

• Generally, your health plan must: Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization"). Cover emergency services by out-of-network providers. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits. Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit. If you think you've been wrongly billed, contact the No Surprises Help Desk (NSHD) at 800-985-3059. Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

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: healthcare.gov

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Florida, 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 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 askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in Florida, you may be eligible for assistance paying your employer health plan premiums.

If you reside outside of Florida, view the entire CHIP Model Notice online at:

dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc

Contact your state for more information on eligibility.

FLORIDA – Medicaid

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

To locate the list of states, current as of July 31, 2023, or to view states that have recently added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 7-31-2023)

PART A: General Information

As a result of the Affordable Care Act, starting in 2014, there became 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 starts November 1, 2023, and ends January 15, 2024, in most states.

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. Starting January 1, 2023, if the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% 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

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	4. Employer Identification Number (EIN)
Monroe County School District	59-6000750
5. Employer address	6. Employer phone number
241 Trumbo Road	
7. City	8. State	9. ZIP code
Key West	FL	33040
10. Who can we contact about employee health coverage at this job?	
Benefits Department	
11. Phone number (if different from above)	12. Email address
(305) 293-1400	Elena.Paez@KeysSchools.com

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

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

☐ All employees. Eligible employees are:

☐ Some employees. Eligible employees are:

Full-time instructional or non-instructional employees of the District who work at least 51% of the average time required for the position.

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

We do offer coverage. Eligible dependents are:
Spouse, Dependent Children* and Over Age Dependents age 26-30*
*(see definitions). Dependent Verification required for all dependents.

☐ 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.

MONROE COUNTY SCHOOL DISTRICT

School Board Office
Mon - Fri, 8 a.m. - 5 p.m. ET
305-293-1400
keysschools.com

FBMC BENEFITS MANAGEMENT, INC.

Contract Administrator
Mon - Fri, 8 a.m. - 5 p.m. ET
833-MCSD-4US (833-627-3487)
myFBMC.com

FLORIDA BLUE

Medical Benefits
1-888-387-4962
floridablue.com

OPTUM RX

Prescription Plan
1-877-633-4461
optumrx.com

Pet Benefit Solutions

Mon - Fri, 8 a.m. - 5 p.m. ET
1-800-891-2565
petbenefits.com/land/keysschools

WASHINGTON NATIONAL

Optional Insurance coverage
727-251-0603
https://www.mybensite.com/keysschools

TSA 403(b) 457(b)

Optional Retirement Services
1-877-633-4461
https://www.tsacg.com/individual/plan-sponsor/florida/monroe-countyschool-district/

HUMANA

Dental Insurance
Mon - Fri, 8 a.m. - 5 p.m. ET
1-850-362-6840
humana.com

Vision Care Plan
1-877-398-2980
humana.com

PAYFLEX

Flexible Spending Accounts
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
Sat, 10 a.m. - 3 p.m. ET
844-PAYFLEX (844-729-3539)

COBRA Administration
800-359-3921

Toll-Free Claims Fax
1-855-703-5305
payflex.com

STANDARD INSURANCE COMPANY

Group Life & AD&D Insurance
Mon - Fri, 8 a.m. - 5 p.m. ET
1-800-325-5757
Life Claims:
1-800-628-8600

Group Long Term Disability Insurance
Mon - Fri, 8 a.m. - 5 p.m. ET
1-800-325-5757
Long-Term Disability Claims
833-240-6609

VISTA 401(K) PLAN

FBMC Retirement Services
Mon - Fri, 8 a.m. - 5 p.m. ET
1-866-325-1278
Automated Services
1-800-213-2310
vista401k.com

ACI SPECIALTY BENEFITS

Employee Assistance Program (EAP)
1-800-932-0034
Text – 1-858-224-2094
myACI Mobile App:
IOS - Username - MCSB
Android - MCSB11933
Password:11933
http://monroe.acieap.com

FBMC BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
PO Box 1878 • Tallahassee, Florida 32302-1878

This guide does not contain a complete listing of all terms, conditions, or exclusions of the benefits listed herein, nor does it constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable. Please refer to the policy and/or certificate of coverage for more information.

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