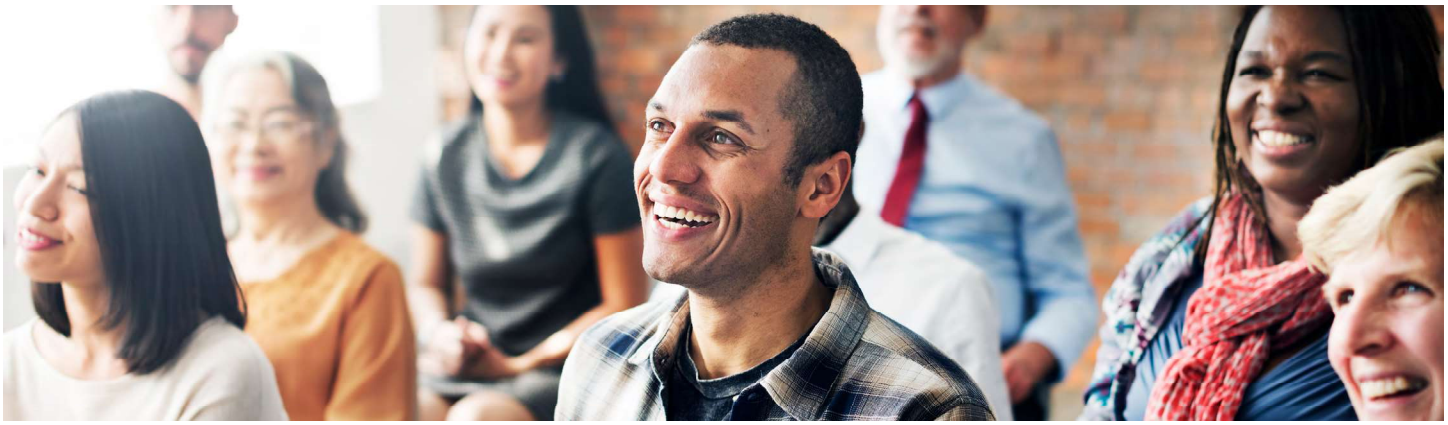
2025 Benefits Guide

MONROE COUNTY
SCHOOL DISTRICT

THERESA AXFORD
Superintendent of Schools

MONROE COUNTY
SCHOOL DISTRICT



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 2025 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.KeysSchools.com

TABLE OF CONTENTS

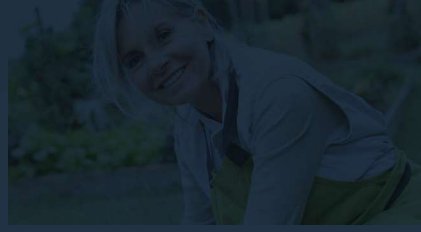
DIRECTORY

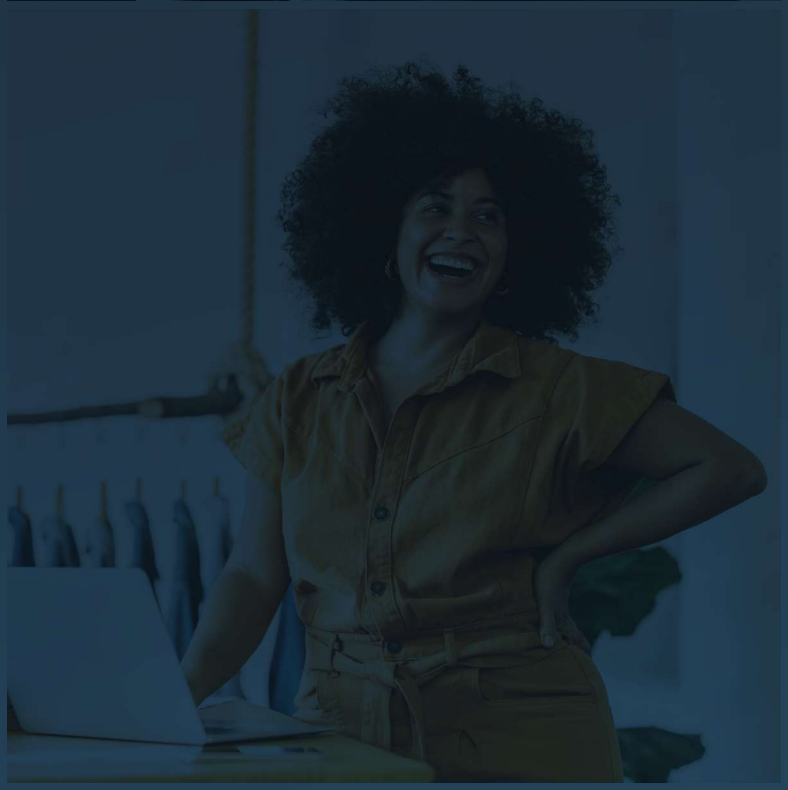
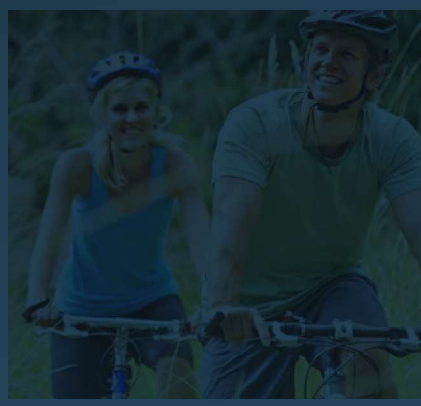
Contacts			
Medical	Florida Blue	**1-888-387-4962**	**www.floridablue.com**
Pharmacy	Optum RX	**1-877-633-4461**	**www.optumrx.com**
Dental	Humana	**1-850-362-6840**	**www.humana.com**
Vision	Humana	**1-877-398-2980**	**www.humana.com**
Pet Benefit Solutions		**1-800-891-2565**	**www.petbenefits.com/land/keysschools**
Optional Insurance Coverage	Washington National	**1-727-251-0603**	**www.mybenefits.com/keysschools**
Optional Retirement Services	TSA 403(b) 457(b)	**1-877-633-4461**	**www.tsacg.com/individual/plan-sponsor/florida/monroe-countyschool-district/**
Flexible Spending Account (FSA)	PayFlex	**1-844-729-3537**	**www.payflex.com**
Employee Assistance Program (EAP)	ACI Specialty Benefits	**1-800-932-0034**	**www.monroe.acieap.com** Company Code: MCSB11933
Long Term Disability	Equitable Insurance Company	**1-866-274-9887**	**www.equitable.com/employeebenefits**
Life & AD&D	Equitable Insurance Company	**1-866-274-9887**	**www.equitable.com/employeebenefits**
Monroe County School District		**1-305-293-1400**	**www.keysschools.com**

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.

LET'S GET STARTED!






IMPORTANT RESOURCES

During enrollment (and beyond), benefits information and support are available to you to help you:

Understand the benefits and resources available to you and your family

Feel supported as you use your benefits throughout the year

During enrollment and throughout the year… YOUR OPTAVISE ADVOCATE IS HERE.

Advocacy is completely confidential and provided as part of your benefits program at no cost to you.

You have big decisions to make during enrollment. Your Advocate can help you:

- ☑ Understand your benefit options so you can make the best choice for your unique situation
- ☑ Determine who you can cover under your plans
- ☑ Verify your doctors are in-network

But your Advocate support doesn't stop there. Contact your Advocate anytime with:

- ☑ Questions about how your benefits work
- ☑ Requests for cost comparisons when you need a test or procedure
- ☑ Assistance finding in-network providers
- ☑ Prescription drug questions and ways to save money
- ☑ Claims or billing issues
- ☑ Qualified Life event topics that impact your benefits, like marriage, divorce, adoption, birth of a child or turning 26

THE BENEFITS DESTINATION

(www.mybensite.com/keysschools) is your year-round, online resource for:

- ☑ Benefit summaries and side-by-side comparisons
- ☑ Insurance provider information
- ☑ Provider search directories
- ☑ Tools and important documents
- ☑ And, during an enrollment period … access to your enrollment platform where you can:
  - o Find step-by-step enrollment guidance
  - o View cost per paycheck for each benefit
  - o Add and manage covered dependents
  - o Update your beneficiaries
  - o Review and submit final elections
  - o Print your Benefit Confirmation Statement (BCS) for your records

To register for access to the Benefits Destination:

1. Go to www.mybensite.com/keysschools
2. Enter your last name, date of birth and last 4 digits for your Social Security Number
3. Enter your email address (if you don't have one, create a free Gmail or Yahoo email). This email will be your username when accessing the site.
4. Create and confirm a password to complete registration.

Please Note: The Benefits Destination will time out after 30 minutes of inactivity, requiring you to log back in.

For additional resources available to you, please see the Directory.

ELIGIBILITY

Employee Eligibility (for enrollment in the SMART Choices Plan)

Full-time instructional or non-instructional District employee who works at least 50% of the average time required for your position. .

Spouse Eligibility

Your lawfully married Spouse.

Spouse Verification Requirements

You must provide the following when covering a spouse:

- 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

Spousal Coverage Affidavit or Increased Premiums

To enroll your spouse in your medical plan, you need to sign and submit a Spousal Coverage Affidavit - attesting one of the below criteria apply - or pay a spousal surcharge. This $50 surcharge applies each pay period if your spouse can get medical coverage through another employer but still joins the Monroe County School District plan.

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 are enrolling online during open enrollment, this Affidavit will be offered on the enrollment site during the enrollment process.

Dependent Child(ren) Eligibility

Your Dependent Children including natural born children, stepchildren, and adopted children

- **Regardless of marital status.** Up to the last day of the calendar year that they turn 26
- **Under Florida Statute §627.6562 FOR HEALTH INSURANCE ONLY:** Florida Statute §627.6562 allows medical coverage (additional premiums will apply) for Dependent Children from age 26 through the end of the year in which they turn 30 years old when the following eligibility requirements are met. The Dependent Child (considered an Over-Age Dependent):
  - Has no dependent child(ren) of their own
  - Resides in the State of Florida
  - Is enrolled as a full-time or part-time student
  - Is not covered under any other group, blanket, franchise health insurance policy, or individual health benefit plans
  - Is not entitled to benefits under Title XVIII of the Social Security Act
  - Has not experienced a gap in "creditable coverage" exceeding 63 days

NOTE: Extending coverage up to age 30 excludes accident only, specified disease, disability income, Medicare supplement, or long-term care policies. Premiums for this continued coverage must be post-tax unless it covers a disabled child. The District must ensure correct tax handling for any dependent coverage chosen under these rules.

Dependent Child Eligibility Verification Requirements

Dependent verification is required for all newly added dependents and over-age dependents. You must provide the following when covering a Dependent Child:

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

A Yearly Requirement for Overage Dependent (OAD) Coverage: You are required to complete an Overage Dependent (OAD) Affidavit each year the OAD is included within the medical plan.

Special Dependent Coverage Outside of Florida

If you live outside Florida and have a dependent who meets the above criteria, they are eligible for coverage. For dependents, until the end of the year they turn 26, deductions can be taken on a pretax basis. The IRS allows employees to receive tax-free health insurance subsidies for themselves and eligible dependents, except for adult children (AC). Hence, the District must include the fair market value of AC benefits in the employee's taxable imputed income. Consult a financial planner or tax consultant to understand your specific situation.

You may obtain copies of official documents of birth and/or marriage from anywhere in the United States 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.

COBRA Eligibility

In specific situations, employees shifting from full-time to part-time and their dependents might qualify for COBRA coverage. Refer to **Understanding COBRA** for details.

Retirement and Eligibility

A retiree is a former full-time District employee now receiving income through the Florida Retirement System (FRS). Upon retiring, employees are covered until the end of the month after 31 days of retirement unless specified otherwise by law and district plans. Some plans may maintain the same premium rates, while others may require conversion to individual policies with possible rate increases. Contact customer care within 90 days before your retirement to continue flexible benefits. Disability income protection and dependent care FSA cannot be continued upon retirement.

How Does the Flexible Benefits Plan Affect Other Benefits?

Your contributions to the flexible benefits plan won't lower your future Florida Retirement System (FRS) benefits or current FRS contributions. Any salary allocated to your flexible benefits plan is counted in the compensation reported to the FRS.

Leave and Eligibility

Employees on leave of absence are eligible for certain types of coverage depending on the type of leave. District-Approved Paid Medical Leave and District-Approved Nonpaid Medical Leave: The District covers employer contributions for benefits for up to a year if you're on medical leave due to your own disability, including pregnancy and disabilities resulting from pregnancy complications. Premium deductions continue via the SMART Choices Plan as long as you receive a salary.

District-Approved Nonpaid Personal Leave: The District doesn't cover your benefits while on nonpaid personal leave. To keep coverage for up to a year, you must pay both the District contribution and your premiums directly to the District.

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 haven't kept your premium status during leave, you must meet the eligibility criteria again once you return to active status, unless specified otherwise by law.

THE FAMILY AND MEDICAL LEAVE ACT (FMLA) might impact your health benefits during unpaid leave. For more information see **FMLA-Approved Leave** and **Non-FMLA Leave** at the back of this guide. Contact the Employee Benefits Department for more details.

Understanding the Health Insurance Marketplace

Due to the Affordable Care Act, a new method for purchasing health insurance emerged in 2014: the Health Insurance Marketplace. To help you and your family evaluate your options, refer to **Legal Notices: New Health Insurance Marketplace Coverage Options and Your Health Coverage**. This section contains essential information about the Marketplace and the health coverage provided by the District.

HOW TO ENROLL

IMPORTANT DATES TO REMEMBER:

- Open Enrollment Period: **October 1 – October 21, 2024**
- Benefits Effective Date: **January 1, 2025 – December 31, 2025.**

New Hires

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 eligible to do so until the next plan year or until you experience a qualified change in status event (also known as a Qualified Life Event). If you enroll as a new hire during open enrollment, your period of coverage is January 1, 2025 through December 31, 2025.

HOW TO ENROLL

To enroll, visit **www.mybensite.com/keysschools** and login using the credentials you secured when you initially visited the Benefits Destination. If you are new to the Benefits Destination, see Important Resources for instructions on registration.

Once you access the site, click Enroll Now to begin the enrollment process. Follow the onscreen prompts to walk through your benefit selections and coverage options.

Keep These Things in Mind as You Enroll

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.

MEDICAL COVERAGE

If you add your spouse to the District medical plan and they have access to medical coverage through their own employer, a $50 surcharge will be applied to each pay period.

MEDICAL OR PRETAX VOLUNTARY BENEFITS EMPLOYER CONTRIBUTION

Your District medical coverage includes an employer contribution. If you opt out of medical coverage, the Board Contribution of $21.08 per pay period can be used for pretax voluntary benefits, such as dental, vision, dependent care, and Flexible Spending Accounts (FSAs). Should you decide not to utilize this employer contribution, you have the option to waive it during enrollment. Any unused amounts will return to the District.

FLEXIBLE SPENDING ACCOUNT

- You must elect FSA contributions each year during enrollment.
- You may carry over up to $600 of unused funds from your Healthcare FSA. If you have unused funds in your 2024 FSA and choose a Healthcare FSA for 2025, you can use up to this amount for 2024 medical expenses. This rule does not apply to Dependent Care FSAs.

MID-YEAR CHANGES IN COVERAGE

You may make certain changes to your benefits outside of annual benefits enrollment if you experience a qualifying life event (or permitted election change event) such as:

- 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
- Judgement/decree/order
- A change in Medicare/Medicaid eligibility
- Family and Medical Leave Act (FMLA) Leave of Absence
- Revoking Election of Coverage
- Special Enrollment Rights

All changes must be made within 30 days of the qualifying life event. To submit a change for a QLE login to the Optavise System. 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 Optavise Benefits (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

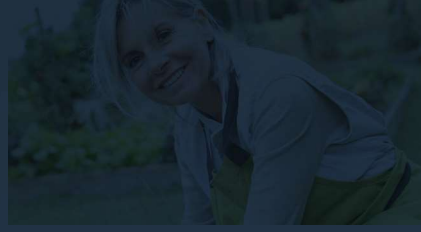
Your appeal and its documentation will be reviewed upon receipt. You will be notified of the results of this review within 30 business days from receipt of your appeal. Complex cases needing extra documentation might take longer. Approved appeals may require more time to update your benefits.

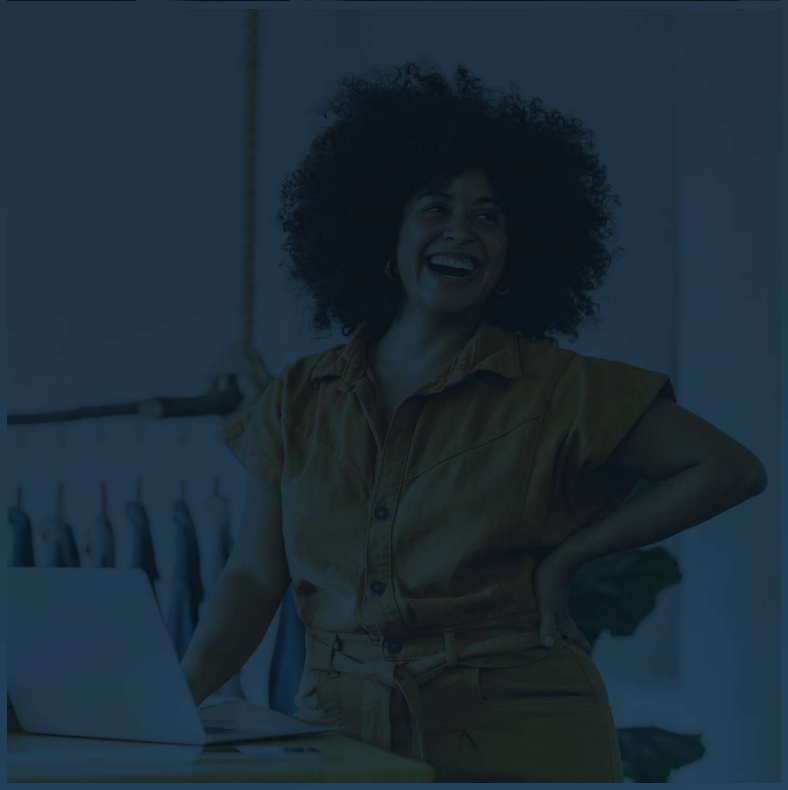
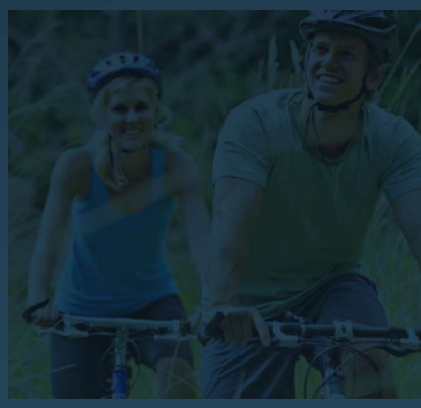
Note: Appeals are approved only if they align with regulations from your employer, insurance provider, and IRS.

If an FSA reimbursement claim is denied, you can appeal in writing to Payflex within 180 days, explaining why the claim should not have been denied and including any supporting facts or documents.

HEALTH






HEALTH PLANS

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.

Premium Rates (pretax)

Coverage Level	Buy-Up Plan 03768	Core Plan 03559	CHDP 05360
Employee Only	$175.10	$104.71	$41.08
Employee + Spouse*	$346.81	$256.00	$166.85
Employee + Children	$291.30	$211.04	$135.10
Employee + Family*	$428.55	$329.99	$231.16

* An additional spousal surcharge may apply, see below.

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 / Out-of-Network	$1,000 / $2,000	$1,500 / $3,000	$2,000 / $4,000
Coinsurance (Member Responsibility) In-Network / Out-of-Network	25% / 40%	25% / 40%	25% / 40%
Out-of-Pocket Maximum (Per Person/Family Aggregate) In-Network / Out-of-Network	Includes Deductible, Coinsurance and all Copays (Excludes Rx) Maximums shown refer to the Benefit Period Maximum (BPM) $5,850 / $10,960	$5,850 / $10,960	$5,850 / $10,960
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	$30	$50
In-Network Specialist	$30	$30	DED + 25%
Out-of-Network Family Physician	$40	$40	$60
Out-of-Network Specialist	$40	$40	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-of-Network 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%

Cost Sharing	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
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 + 25%
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%

Cost Sharing	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
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%
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%

Cost Sharing	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
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 Hospital			
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%
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			
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%

Cost Sharing	Plan 03768 BUY UP PLAN	Plan 03559 CORE PLAN	Plan 05360 HIGH DEDUCTIBLE
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)	**60 Days**	**60 Days**	**60 Days**
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).

VIRTUAL CARE WITH TELADOC HEALTH

As part of your Florida Blue medical plans, you can connect with doctors in minutes by phone or video through Teladoc Health when you need care for non-urgent and common conditions.

With Teladoc, you can:

- Talk to U.S. board-certified doctors and nurse practitioners from anywhere, 24/7 in one of three ways:

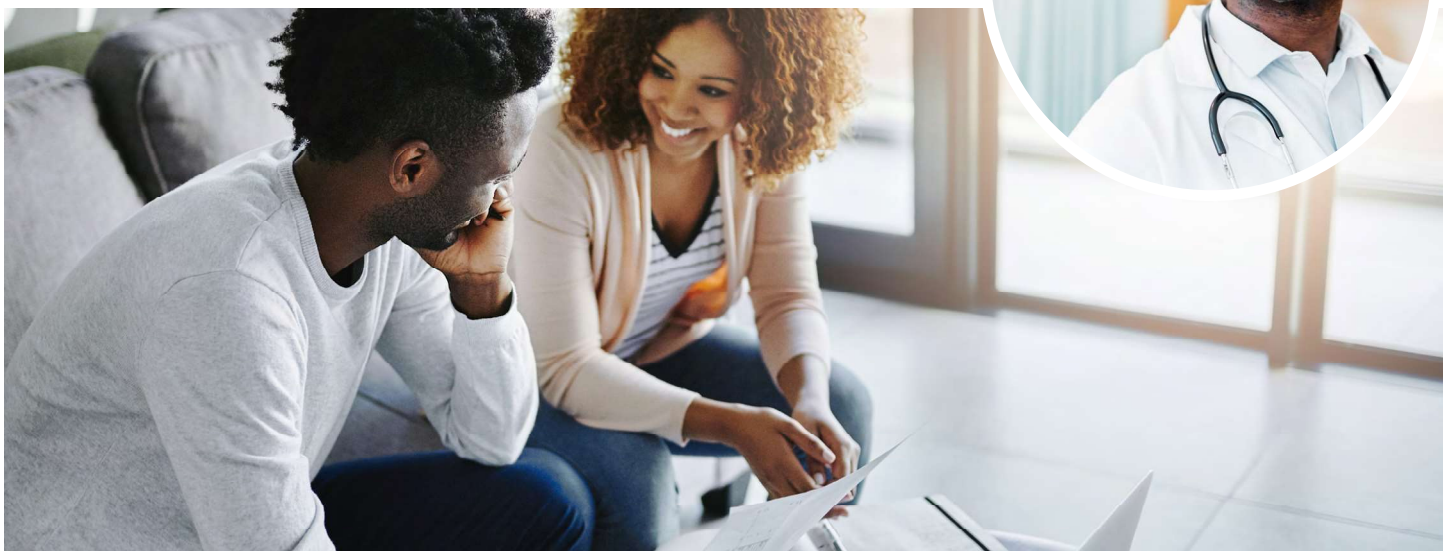
BY PHONE
1-800-TELADOC
(800-835-2362)

ONLINE
www.teladoc.com

THROUGH THE
TELADOC APP

- Once you are registered with Teladoc, setting up time with a provider is three simple steps online or in the Teladoc app:
    1. Choose how you would like to speak with a provider: video or phone
    2. Select the State in which you reside (this is to make sure that the provider chosen to speak with you is licensed in your State)
    3. Choose the time you would like to speak to the provider.

Virtual care through Teladoc is free for a wide range of medical conditions, such as flu, bronchitis, rashes, sinus infections and more. However, you will pay a copay for dermatology and mental health care.



PRESCRIPTION DRUG BENEFITS

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.

The prescription drug plan is offered as part of participation in one of the medical plan options. This means that you will present your Florida Blue ID card to your pharmacist when filling an existing or new prescription drug. Below is an overview of your Prescription Drug Benefit.

Retail Pharmacy: Use the OptumRx pharmacy network to fill your prescriptions at one of the more than 9,700 CVS locations or more than 9,650 Walgreens locations.

Home Delivery: Get up to a 3-month supply of your medications you take regularly delivered directly to your home. You also have the option to set up medication reminders and automatic refills through this service.

Specialty Pharmacy: While retail pharmacies offer prescriptions for common illnesses and conditions, specialty pharmacies, like Optum Specialty Pharmacy, serve patients that require complex therapies with personalized patient care, outreach, and resources for special conditions.

OptumRx Resources

Once your coverage is effective, you have resources at your fingertips to help you manage your medications, find network pharmacy locations, check medication coverage, track home delivery order and much more. Use these resources to take advantage of all OptumRx has to offer:

BY PHONE
1-877-633-4461

ONLINE
www.optumrx.com

THROUGH THE OPTUMRX APP

NOTE: Keep an eye out for helpful communications from OptumRx, such as action items on current medications or explanations of coverage, before and after your coverage begins.

Prescription Drug Schedule of Benefits

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

Prescription Drug Coverage and Medicare

Employers that provide health care coverage with a prescription drug benefit are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is "creditable." The **Notice of Creditable Coverage: Important Information from the District About Your Prescription Drug Coverage and Medicare** (provided for you in the Legal Notices section) provides details about your current prescription drug coverage with Monroe County School District's Healthcare Plan and outlines your choices under Medicare's prescription drug coverage, helping you decide whether to enroll in a Medicare drug plan.

KEYS AHEC

For the past 11 years, Keys AHEC Health Centers have collaborated with Monroe County School District to provide on-site primary medical care in schools. The Health Clinic is available a ½ hour before school begins to a ½ hour after school ends. All full-time and part-time staff can use our Clinical Health Centers for general health care needs; however, we do recommend that patients also have a Primary Care Physician or Specialist for specific needs.

How It Works

MONROE COUNTY KEYS AHEC HEALTH CENTERS

1 APPOINTMENTS ENCOURAGED:
Call **1-305-743-7111**, ext 210 to book an appointment.

2 WALK-INS WELCOMED:
Keys AHEC accepts walk-ins on designated days at the school Health Clinic. Check our Days and Times schedule (**https://keysahec.org/locations**) as it rotates weekly across 10 schools with 7 medical providers. If a provider is unavailable, you'll be given a suitable time to return later that day or the next.

3 PATIENT REGISTRATION CONSENT FORM REQUIRED:
Complete the Patient Registration and Consent Form at **https://keysahec.org/parents-paperwork** or at your school's Health Clinic if you haven't already done so.

4 NO PAYMENT REQUIRED:
Keys AHEC never charges for its services but may bill your health insurance. There are no co-pays or deductibles. Note: You'll still get an Explanation of Benefits (EOB) form from the company. If Keys AHEC refers you to outside for things such as (but not limited to) lab work, imaging, prescription fills, or referrals to other physicians, they will come with fees from those providers.

What We Offer:

Keys AHEC offers access to Primary Care Medical Services:

- General Sick and Wellness Visits
  - Physicals
  - Diagnosis, Treatment and Prescriptions (as necessary)
- Flu, Cold, Strep and Covid-19 Testing and Treatment
- Glucose Testing
- Prescription Refills
  - May need your PCP record or proof of prescription (RX Bottle)
- Pregnancy Testing
- Assistance w/Management of Chronic Diseases
  - Hypertension
  - Diabetes
  - Obesity/Overweight
- Referral for Lab and/or Imaging Testing
- Minor Injuries/Suture Removal
- Referral for Specialty Care

**Keys AHEC does not offer women's gynecological exams or men's prostate exams.

DENTAL PLANS

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.

Premium Rates (pretax)

Coverage Level	Managed Care Plan C150	Custom PPO Dental Plan
Employee Only	$14.24	$14.57
Employee + 1	$27.06	$28.97
Employee & Family*	$36.88	$43.10

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 surface)	$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)	X-rays (limitations may apply) Sealants (once per 3 years for children under 16, for non-carious molars only)	
Prophylaxis (cleaning, once per 6 months)		
Topical fluoride (children under 16, once per 12 months)		
Type II - Basic Services	75%*	50%
Non-surgical tooth extractions	Simple restorative (amalgam, synthetic or composite filings) Space maintainers (for children under 16)	
Non-surgical periodontics		
Type III - Major Services	50%*	25%
—12 month waiting period—	Emergency palliative treatment Endodontics (root canals) Surgical tooth extractions Surgical periodontics	
Major restorative (crowns/inlays/onlays)		
Bridge, denture repair		
Prosthetics (bridges and dentures)		
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	Unlimited	Unlimited
Type IV	$1,000	$1,000
Calendar Year		
Type I, II, III	$1,500	$1,500
Type IV	$500	$500
Deductible †		
Type I, II, III	None	None
Type IV	$50	$50

* Coverage based on contracted fees for the Preferred Provider Network
† Maximum of 3 per family

VISION PLANS

Regular eye exams help detect vision issues and diseases like diabetes, hypertension, MS, high blood pressure, osteoporosis, and rheumatoid arthritis early. Here's how your plan works:

- The District plan features a network of providers that deliver quality eye care from independent professionals and national retailers.
- HumanaVision covers the cost directly, leaving you to pay only the copayment and any extra cosmetic options.
- If you choose an out-of-network provider, the Plan reimburses a specific amount as outlined in the Schedule of Benefits.

To review full plan details in the Certificate of Insurance, a list of network providers, and limitations and exclusions, visit www.humana.com or call **1-877-398-2980**.

Vision Plan Rates

Coverage Level	Humana Vision 100
Employee Only	$3.07
Employee + 1	$6.13
Employee & Family	$11.29

Vision 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	Upt 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 (solida 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
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

- Receive a 20% discount on items not covered by the plan at network Providers. This discount does not apply to EyeMed Provider's professional services or contact lenses.
- Plan discounts cannot be combined with other discounts or promotional offers.
- Services or materials covered by another group benefit plan providing vision care may not be included.
- Certain brand-name Vision Materials may be excluded from discounts if the manufacturer enforces a no-discount policy.
- The discounts on frames, lenses, and lens options are valid only when buying a complete set of eyeglasses; if purchased separately, members get 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.
- Receive 15% off the retail price or 5% off the promotional price for LASIK or PRK from the US Laser Network, owned by LCA Vision. However, as these elective procedures are performed by specially trained providers, the discount may not always be available locally. Please check with your provider before your procedure.

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.

EMPLOYEE ASSISTANCE PLAN (EAP)

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. ACI's Employee Assistance Program (EAP) provides a variety of benefits and professional services to help employees and family members address these challenges and thrive. EAP benefits are free of charge, 100% confidential, available to all family members regardless of location.

NO COST/NO ENROLLMENT

Monroe County School District covers the full cost for you and your family members, regardless of location. You are automatically enrolled.

VARIOUS FORMS OF SUPPORT

Offers short-term counseling, referral and follow-up services and various topics.

MULTILINGUAL SUPPORT

Multicultural and Multilingual Providers Available Nationwide

COUNSELING SESSIONS

Receive counseling services that fit your lifestyle via phone, video, in person, and text and chat (through Member Portal). Benefit includes 3 professional assessment sessions per year.

CONFIDENTIAL

Details of your participation and your discussions with EAP cannot generally be released to anyone without your consent.

EASY ACCESS TO SUPPORT

24/7/365 access. Contact ACI Specialty Benefits at **1-800-932-0034** or go online to **http://monroe.acieap.com**
Register to create a new account using your company code: MCSB11933

WHAT'S COVERED?

The following services are free to use, confidential, and available to you and your family members:

- ☑ **MENTAL HEALTH SESSIONS:** Up to 3 telephonic sessions to help manage stress, anxiety and depression, resolve conflict, improve relationships, overcome substance abuse and address any personal issues.
- ☑ **LIFE COACHING:** To help reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.
- ☑ **LEGAL CONSULTATION:** To help with a variety of personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.
- ☑ **FINANCIAL CONSULTATION:** To help build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identify theft, and saving for retirement or tuition.
- ☑ **LIFE MANAGEMENT:** To provide information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.
- ☑ **MEDICAL ADVOCACY:** To help navigate insurance, obtain doctor referrals, secure medical equipment or transportation, and plan for transitional care and discharge.
- ☑ **PERSONAL ASSISTANT:** To help manage everyday tasks and give back time by providing information and referrals for home services, repairs, travel, entertainment, dining and personal services.
- ☑ **MEMBER PORTAL AND APP:** Access your benefits 24/7/365 with online requests and chat options, and explore thousands of articles, webinars, podcasts and tools covering total well-being.

PROTECTION

GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Like many, ensuring your loved ones are cared for if something happens to you is important. The District provides Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance through Equitable Insurance Company.

Basic Employee Term Life and AD&D	All employees receive a minimum of $25,000 Basic Term Life and AD&D (employer paid). See your certificate for details.
Additional Employee Term Life and AD&D	• **Employees** can choose up to $300,000 in Additional Life and AD&D insurance in $10,000 increments with matching AD&D coverage. • **Current employees** can buy or increase this insurance up to $300,000 (with Evidence of Insurability) during Open Enrollment only or within 31 days of a status change. • **Newly eligible employees** can get up to $100,000 without medical questions during their initial enrollment period.

Spouse Life and AD&D Insurance

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

Spouse Term Life and AD&D	• **Current employees** can buy or increase coverage for their spouse in multiples of $5,000 up to $150,000 (with Evidence of Insurability) during Open Enrollment only. • **If you marry and are enrolled in Additional Employee Term Life and AD&D at the time**, you can add up to $35,000 (the guaranteed issue amount) without EOI within 31 days of your marriage. For other status changes, like your spouse losing their job or their own life insurance coverage, EOI is required to add coverage.

Dependent Child(ren) Life Insurance

You must be enrolled in Additional Life and AD&D to elect Child(ren) Life Insurance. You can choose a $10,000 life insurance policy for each eligible dependent child from birth up to age 26.

Waiver of Premium and Disability

If you are under 70, become fully disabled while insured by this plan, and complete a 180-day waiting period, your Basic and Additional Life and your child/spouse's life insurance may continue without premium payments (subject to the group policy terms). AD&D will not be covered during the waiver of the premium. For a waiver application, contact Equitable Insurance at **1-866-274-9887**.

Staying Covered When Employment Ends

If your insurance ends because your employment ends, you may qualify to purchase portable group term life insurance or convert your current life policy to an individual one (if your insurance reduces or ends) without submitting proof of good health.

For details on Portability and Conversion, check your certificate of coverage or call Equitable Insurance at **1-866-274-9887**.

Additional Employee Term Life and AD&D Rates

Payroll deductions are calculated over 20 pays and depend on your age at the start of coverage. If you move to a higher age bracket, expect your payroll deduction to adjust in January following your birthday. Please review the following charts for premium rates for additional coverage.

Employee Life Monthly Rates

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	$0.77	$0.77	$0.97	$0.97	$1.57	$2.57	$4.57	$ 7.57	$8.37	$ 16.37	$29.77	$ 29.77
$20,000	$1.54	$1.54	$1.94	$1.94	$3.14	$5.14	$9.14	$15.14	$16.74	$32.74	$59.54	$59.54
$30,000	$2.31	$2.31	$2.91	$2.91	$4.71	$7.71	$13.71	$22.71	$25.11	$49.11	$89.31	$89.31
$40,000	$3.08	$3.08	$3.88	$3.88	$6.28	$10.28	$18.28	$30.28	$33.48	$65.48	$119.08	$119.08
$50,000	$3.85	$3.85	$4.85	$4.85	$7.85	$12.85	$22.85	$37.85	$41.85	$81.85	$148.85	$148.85
$60,000	$4.62	$4.62	$5.82	$5.82	$9.42	$15.42	$27.42	$45.42	$50.22	$98.22	$178.62	$178.62
$70,000	$5.39	$5.39	$6.79	$6.79	$10.99	$17.99	$31.99	$52.99	$58.59	$114.59	$208.39	$208.39
$80,000	$6.16	$6.16	$7.76	$7.76	$12.56	$20.56	$36.56	$60.56	$66.96	$130.96	$238.16	$238.16
$90,000	$6.93	$6.93	$8.73	$8.73	$14.13	$23.13	$41.13	$68.13	$75.33	$147.33	$267.93	$267.93
$100,000	$7.70	$7.70	$9.70	$9.70	$15.70	$25.70	$45.70	$75.70	$83.70	$163.70	$297.70	$297.70

* Your coverage amount decreases to 65% at age 65, to 50% at age 70 and to 25% at age 75. Premiums are also based on the reduced benefit amount. Example: $50,000 coverage amount decreases to $32,500 at age 65, to $25,000 at age 70 and to $12,500 at age 75.

Employee AD&D Monthly Rates (only if Life is elected)

Coverage Amount*										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
All	$0.13	$0.26	$0.39	$0.52	$0.65	$0.78	$0.91	$1.04	$1.17	$1.30

Spouse Life Monthly 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	$ 0.39	$ 0.39	$0.49	$ 0.49	$0.79	$1.29	$2.29	$3.79	$4.19	$8.19	$14.89	$14.89
$10,000	$ 0.77	$ 0.77	$0.97	$ 0.97	$1.57	$2.57	$4.57	$7.57	$8.37	$16.37	$29.77	$29.77
$15,000	$1.16	$1.16	$1.46	$1.46	$2.36	$3.86	$6.86	$11.36	$12.56	$24.56	$44.66	$44.66
$20,000	$1.54	$1.54	$1.94	$1.94	$3.14	$5.14	$9.14	$15.14	$16.74	$32.74	$59.54	$59.54
$25,000	$1.93	$1.93	$2.43	$2.43	$3.93	$6.43	$11.43	$18.93	$20.93	$40.93	$74.73	$74.43
$30,000	$2.31	$2.31	$2.91	$2.91	$4.71	$7.71	$13.71	$22.71	$25.11	$49.11	$89.31	$89.31
$35,000	$2.70	$2.70	$3.40	$3.40	$5.50	$9.00	$16.00	$26.50	$29.30	$57.30	$104.20	$104.20
$40,000	$3.08	$3.08	$3.88	$3.88	$6.28	$10.28	$18.28	$30.28	$33.48	$65.48	$119.08	$119.08
$45,000	$3.47	$3.47	$4.37	$4.37	$7.07	$11.57	$20.57	$34.07	$37.67	$73.67	$133.97	$133.97
$50,000	$3.85	$3.85	$4.85	$4.85	$7.85	$12.85	$22.85	$37.85	$41.85	$81.85	$148.85	$148.85

* 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.

Spouse AD&D Monthly Rates (only if Life is elected)

Coverage Amount*										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
All	$ 0.07	$ 0.13	$ 0.20	$ 0.26	$0.33	$0.39	$0.46	$0.52	$0.59	$0.65

Dependent Child(ren) Life Monthly Rates

Coverage Amount*										
Age	**$1,000**	**$2,000**	**$3,000**	**$4,000**	**$5,000**	**$6,000**	**$7,000**	**$8,000**	**$9,000**	**$10,000**
All	$ 0.09	$ 0.17	$ 0.26	$ 0.34	$0.43	$0.52	$0.60	$ 0.69	$0.77	$ 0.86

* Regardless of the number of children covered.

Dependent Child(ren) AD&D Monthly Rates (only if Life is elected)

Coverage Amount*										
Age	**$1,000**	**$2,000**	**$3,000**	**$4,000**	**$5,000**	**$6,000**	**$7,000**	**$8,000**	**$9,000**	**$10,000**
All	$ 0.04	$ 0.09	$ 0.13	$ 0.18	$0.22	$0.26	$0.31	$ 0.35	$0.40	$ 0.44

* Regardless of the number of children covered.

FINANCIAL BENEFITS & PROGRAMS

DISABILITY INCOME PROTECTION

This information highlights the key aspects of the plan and should not be considered a contract. The details of coverage are outlined in group policy #021252, issued in Florida and subject to state laws. The availability of this offer may change. Keep this document with your certificate if you get coverage.

A disability can disrupt many aspects of your life, but unfortunately, expenses continue unchanged. This benefit provides offers you a portion of your earnings to help with expenses if you become disabled.

Important Plan Features	
Benefit	Receive up to $1,500 per month or 60% of your monthly earnings—whichever is less—in the event of disability.
Waiting Period	Employees hired on or before the policy's effective date have no waiting period, while those hired after must wait until the first of the month following 15 days of active work.
Definition of Disabled	You are classified as disabled if you cannot perform your regular job duties and earn less than 80% of your indexed covered earnings due to injury or illness. After 24 months of benefits, you're considered disabled if you can't perform any qualified job based on your education, training, or experience and still earn less than 80% of your indexed covered earnings because of the injury or illness.
Benefit Start Date	Benefits begin after you are disabled for 90 days.
Employees working 30 or more hours per week	• Disabled *before* age 62: Benefits are payable to age 65 • Disabled at age 62: Benefits are payable on a decreasing scale • Minimum Monthly Benefit*: $150 per month
Employees working less than 30 hours per week	• Disabled *before* age 62: Benefits are payable monthly for a maximum period of five years • Disabled at age 62: Benefits are payable on a decreasing scale • Minimum Monthly Benefit*: $100 per month
Disabilities subject to Limited Pay Periods	For disabilities stemming from mental illness, alcoholism, or drug abuse that do not necessitate hospitalization, payments can be received for up to 24 months. Beyond this period, benefits will only persist if the disabled employee remains hospitalized.
Reasonable Accommodation Expense Benefit	This policy provides a $25,000 Reasonable Accommodation Expense Benefit, reimbursing employers for modifications to the workplace that help employees return to or stay at work. This benefit is separate from the Long-Term Disability (LTD) claim payment.
Rehabilitation Plan Benefit	Participating in an approved rehabilitation plan** increases the LTD benefit by 10% of pre-disability earnings, up to the maximum amount, and covers approved rehab-related expenses.
Survivor Benefit	If an employee dies after receiving monthly benefits for at least six months, their eligible survivor will receive a lump sum payment equal to three times the non-integrated LTD benefits.
Pre-Existing Conditions	You won't get monthly benefits if your disability stems from a pre-existing condition that required medical attention, incurred expenses, or involved prescribed drugs within three months prior to your insurance's effective date. This restriction doesn't apply if the total disability starts over 12 months after the insurance's effective date.
Return to Work Incentive	This benefit offers an effective incentive for employees who are ready to return to work, but not full time. • If in any month during the first 12 months back at work your total income exceeds 100% of your indexed covered earnings, your disability benefit will be reduced by the excess amount. • After 12 months, your disability benefit is reduced by 50% of your income from rehabilitative work each month.
Premiums	Premiums are waived while you receive payment under the Plan.

* The minimum monthly benefit is the minimum amount payable, once all other income benefits have been applied.
** A Rehabilitation Plan is a contract with the insurance company to offer vocational and physical rehab services. It may include costs for medical care, education, relocation, housing, or family care. If considered fit for rehab while disabled, you can join the plan with agreed terms. The insurer might need an assessment with you, your employer, your doctor, and others. Refusing to join means no disability benefits.

Premiums

Premiums are waived while you receive payment under the Plan.

Monthly Rates Per $100 of Monthly Covered Payroll	
Age	**Rate**
<25	$0.095
25-29	$0.095
30-34	$0.095
35-39	$0.185
40-44	$0.271
45-49	$0.376
50-54	$0.476
55-59	$0.476
60-64	$0.469
65+	$0.469

Other Income Benefits

If an employee is disabled, they might qualify for benefits from other income sources. The insurance company may then reduce the disability benefits by that amount. Other income benefits include:

Source	Description
Canada and Quebec Pension Plans	Amounts received (or assumed to receive) under these plans
Railroad Retirement Act	Amounts received (or assumed to receive) under this act
Government Disability or Retirement Plan	Amounts received (or assumed to receive) under any local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer
Sick Leave Plan	Amounts received (or assumed to receive) under any sick leave plan of the employer
No-Fault Auto Insurance	Amounts received (or assumed to receive) under any work loss provision in mandatory "no-fault" auto insurance
Workers' Compensation	Amounts received (or assumed to receive) under any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law
Social Security Disability Benefits	Amounts received (or assumed to receive) under any Social Security disability benefits the employee or any third party receives on the employee's behalf or for their dependents
Retirement Plan Benefits	Amounts received under any retirement plan benefits funded by the Employer[1]
Franchise or Group Insurance	Amounts received under any franchise or group insurance or similar plan[2]
Loss of Earnings	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
Wage or Salary	Any wage or salary for work performed[3]

1 "Retirement plan" refers to any employer-sponsored or funded defined benefit or defined contribution plan. It excludes individual deferred compensation agreements, profit-sharing plans, supplementary retirement or savings plans, and any employee savings plans such as thrift, stock option, stock bonus, individual retirement, or 401(k) plans.
2 If multiple insurance policies cover the same disability claim and have similar reduction clauses, the insurer will pay its portion of the total claim. This "pro rata share" is the fraction of the total benefit that one policy's amount makes up compared to all policies combined.
3 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.

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

Conversion Privilege

If your employment ends or your coverage ceases for any reason other than non-payment of premium, you can convert this plan to an individual policy by applying in writing and paying the first premium within 31 days. You must have been insured for disability benefits and actively working for at least 12 months to be eligible. For more information, call Equitable Insurance at **1-800-877-8973**.

SUPPLEMENTAL RETIREMENT

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

The Vista 401(k) Retirement Plan offers you the opportunity to save for your future on a pretax basis. Each contribution you make to the Plan 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.

Here's how it works:

☑ Once you select your contribution amount, your contributions are made through regular payroll deductions.

Minimum Contribution	$25 per payroll
Maximum Contribution	Regulated by the IRS (Visit **www.vista401k.com** for current annual amounts)

☑ You can change or stop your current and future contributions at any time and diversify your fund choices. There is no minimum time period before transfers or exchanges are allowed.

☑ You will receive personal account statements on a quarterly basis. This statement will show activity in your account including contributions, shares purchased, gains/losses, fund transfers and distributions.

How the Plan Works

To enroll in your Vista 401(k) Plan visit www.vista401k.com or complete an enrollment form indicating the per pay period contribution amount, how you want your money invested, and name 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

Note: You may defer investment decisions 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 age 62 retirement.

Visit our website at www.vista401k.com or call FBMC Retirement Services at 1-866-325-1278 to:

☑ Enroll in the Plan

☑ View and download your personal account statement

☑ Download 401(k) enrollment forms

☑ Perform an investment analysis

☑ Change or stop your contributions

☑ Understand current IRS maximum contribution amounts

☑ Download a change of investment form

☑ View investment fees for each mutual fund

Loans from the Plan

Your 401(k) plan allows you to borrow up to 50% of your account balance, with loans ranging from $1,000 to $50,000. A $65 processing fee applies, and the interest rate is 2% above the prime rate. Note: You can only take one loan at a time, with a 30-day wait between loans.

A minimum of $2,000 must be in your account. You can repay the loan with interest over one to five years through equal payroll deductions, one lump sum (if you want to pay your loan off early). This payment will be deposited back into your account.

Distributions from the Plan

Your 401(k) account is a long-term investment, designed specifically for your retirement needs. Because of this, the IRS restricts and Federal law imposes when you can withdraw your money. You can withdraw your money when:

- You reach age 591/2,
- Retire,
- Terminate employment,
- Become totally and permanently disabled, or
- Have a financial hardship (see Hardship Withdrawal Provisions).

You pay taxes on your Vista 401(k) plan contributions and your earnings upon withdrawal. 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 591/2 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

Hardship Withdrawal

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, and the withdrawal cannot exceed the cost of your hardship. The IRS allows the following six reasons for hardship withdrawal of your 401(k) funds.

1. Buying a primary residence (excluding mortgage payments)
2. Tuition and education fees for the next 12 months for you or a dependent
3. Medical expenses for you or dependents
4. Payments to prevent eviction or foreclosure on your primary home
5. Burial or feral costs for a parent, spouse, child, or dependent
6. Repairs to your principal home that qualify under code section 165

You must complete an application detailing your financial situation and provide documentation for all eligible expenses.

Rollovers

You can transfer funds tax-free from your previous employer's 401(a), 401(k), 403(b), 457, or IRA plans into your Vista 401(k) plan. For more details, please contact Vista 401(k) toll-free at 1-866-325-1278.

Fees and Expenses

The Vista 401(k) plan fees are as follows:

- Overall Management: Annual fee of 0.575% deducted monthly by FBMC from your asset balances.
- Administration: $1.00 monthly for participants no longer contributing.
- Mutual Fund: Fees vary per fund, detailed in their prospectus.
- Distribution fee: $20
- Loan fee: $65

FLEXIBLE SPENDING ACCOUNTS (FSAs)

If you do not make an election during Annual Open Enrollment, you will not be able to participate in a flexible spending account for 2025 unless you have a qualified life event.

A great way to plan ahead and save money over the course of a year is to participate in an FSA. An FSA lets you redirect a portion of your salary on a pre-tax basis into a reimbursement account, saving you money on taxes.

Three important things to remember about FSA participation:

- **You must enroll each year to participate.** FSA participation does not carry over – you must elect the amount you want to contribute.
- **Up to $660 dollars in unused FSA funds will roll-over into the next plan year.**

The District offers two types of FSAs that can help you save on a pre-tax basis for out-of-pocket expenses.

Flexible Spending Account	Contribution Maximum
Healthcare FSA *Use to pay for eligible health care expenses that are not covered by your insurance or other plans.*	$3,200 (employee only)
Dependent Care FSA *Use to pay for eligible dependent care expenses.*	• $250 (Minimum annual contribution) • $5,000 (Single) • $2,500 (Married and filing separately) • $5,000 (Married and filing jointly) • Equal to the lower of two incomes (Either you or your spouse earn less than $5,000/year) • $3,000/one dependent or $5,000/two or more dependents (Spouse is full-time student or incapable of self-care)

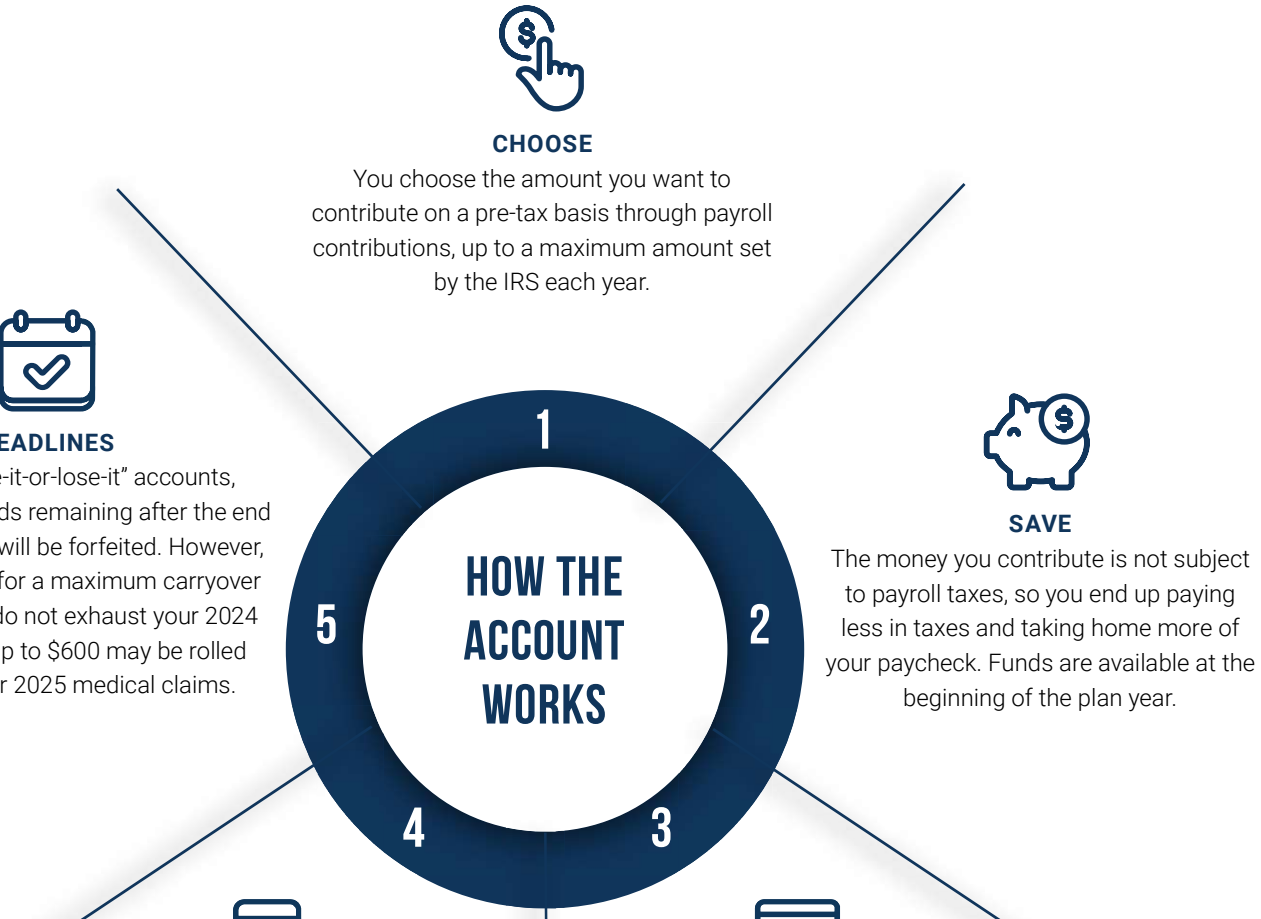
Action Items:

- **Register for PayFlex account:** Go to **www.payflex.com** and select "Create Your Profile." Enter your last name, mailing address, ZIP code, last 4 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 emails address, and select security questions/answers.
  NOTE: If you already have a username and password for healthhub.com, you will use that to log in to PayFlex.
- **Download the PayFlex app:** You can do this once you register online and set up your username and password. The app can be downloaded from the PayFlex member website or through the Apple or Google App Store.
- **Sign Up for Direct Deposit:** To receive claims quickly, sign up for direct deposit through the PayFlex member website. Go to **www.payflex.com**> Financial Center > Select Account > Enroll in Direct Deposit to begin.
- **(Healthcare FSA) Look for your debit card:** If you contribute to the Healthcare FSA, you will receive a debit card that can be used at the time of service. Look for this card in your mailbox, and make sure to take time to activate it.
- **File a Claim:** For 2025 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 **www.payflex.com**> Financial Center > Select Account > File a Spending Account Claim. Or, you may call PayFlex at 1-800-284-4885 to request a form. When you submit a claim, include the merchant or service provider name, name of patient (if applicable), date of service, amount your were required to pay, and description of item or service.

HEALTHCARE FSA

The Health Care Flexible Spending Account (FSA) is a great way to save on income taxes while you budget for health care expenses. Every dollar you set aside in your account reduces your taxes and allows you to be reimbursed for qualified expenses that you are already paying for—making Health Care FSAs an easy, convenient way to help stretch your health care dollars.



1 CHOOSE

You choose the amount you want to contribute on a pre-tax basis through payroll contributions, up to a maximum amount set by the IRS each year.

2 SAVE

The money you contribute is not subject to payroll taxes, so you end up paying less in taxes and taking home more of your paycheck. Funds are available at the beginning of the plan year.

3 USE

Use your funds to pay for qualified health care expenses such as medical, dental, and vision copays, deductibles, and other out-of-pocket costs.

4 ACCESS FUNDS

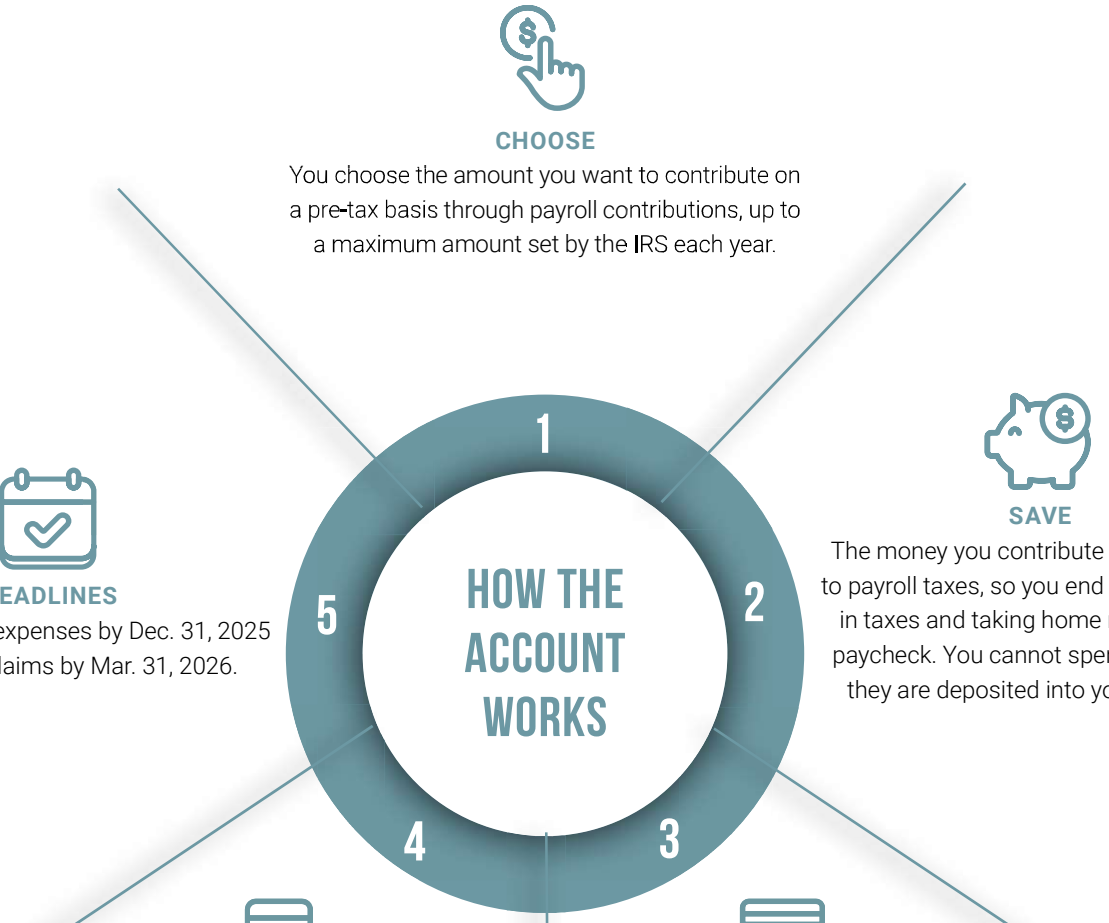
You can access your Health Care FSA funds through a debit issued by PayFlex. With this card, you can pay your expenses directly, without the need to complete a reimbursement form. After you use the card, save your Explanation of Benefits, itemized statements and detailed receipts, in case they are requested.

5 DEADLINES

FSAs are "use-it-or-lose-it" accounts, meaning any funds remaining after the end of the plan year will be forfeited. However, our plan allows for a maximum carryover of $600. If you do not exhaust your 2024 FSA balance, up to $600 may be rolled over to pay for 2025 medical claims.

DEPENDENT CARE FSA

The dependent care FSA allows you to set aside money pre-tax to pay eligible out-of-pocket day care services, 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.



CHOOSE

You choose the amount you want to contribute on a pre-tax basis through payroll contributions, up to a maximum amount set by the IRS each year.

SAVE

The money you contribute is not subject to payroll taxes, so you end up paying less in taxes and taking home more of your paycheck. You cannot spend funds until they are deposited into your account.

USE

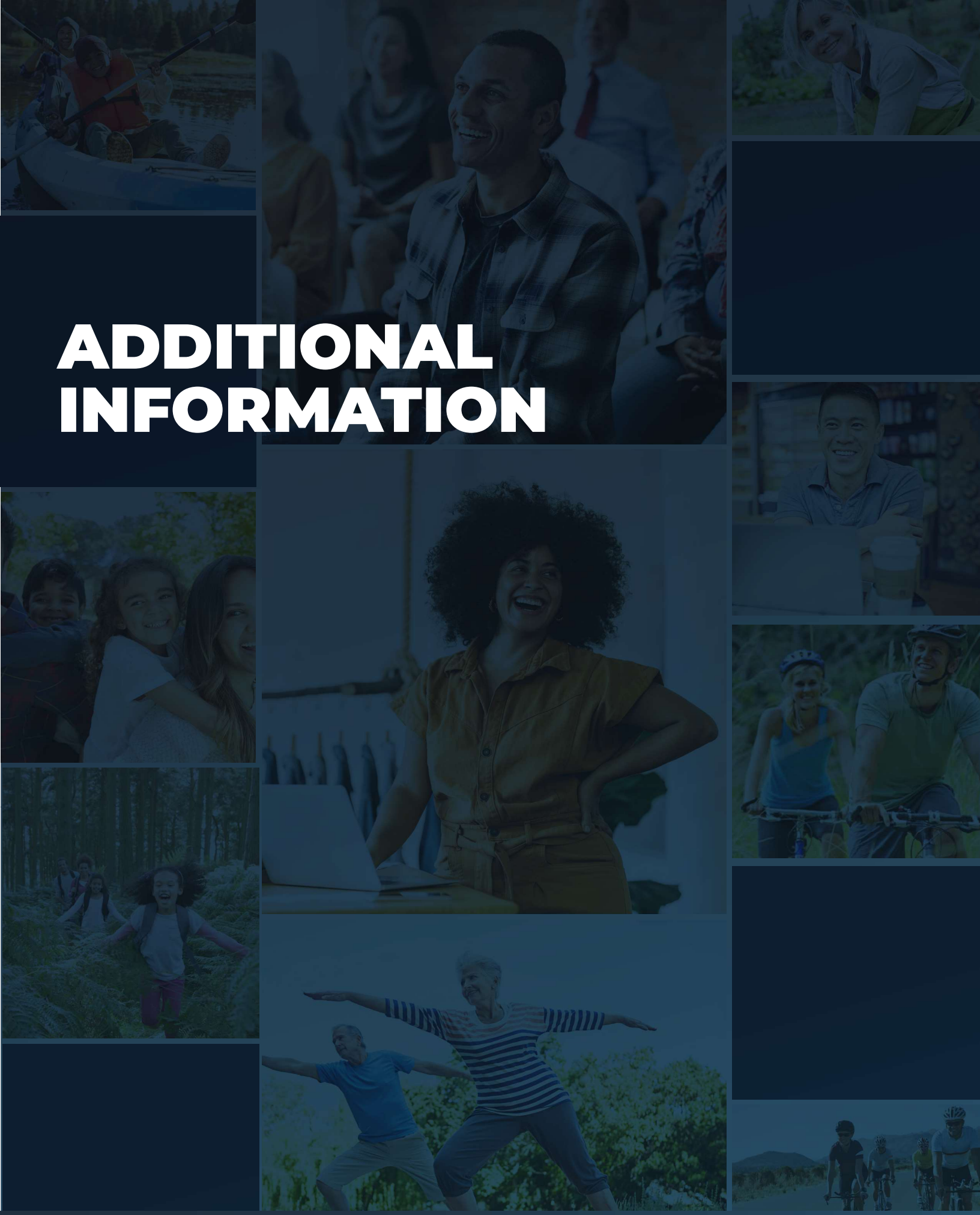
Use your funds to pay for qualified out-of-pocket expenses. Note: Unlike the Healthcare FSA, your full annual contribution is not available at the beginning of the plan year. You can only get reimbursed up to the amount that is available in your account at the time.

ACCESS FUNDS

After you pay out-of-pocket for expenses, you submit claim forms online or through the Payflex mobile app.

DEADLINES

You must incur expenses by Dec. 31, 2025 and submit claims by Mar. 31, 2026.



ADDITIONAL INFORMATION

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 30 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.

Within 30 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.

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
- Cover age 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

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 Optavise Benefits (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.

BENEFITS AND LEAVE

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

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

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

Make payments out to:
Monroe County school District (MCSD)
Mailing Address: Monroe County School District
Attention: Benefits Department
241 Trumbo Rd Key West, FL 33040
Or
By credit card on RevTrak
https://mcsd.revtrak.net/
Please call the Benefits department for your member ID

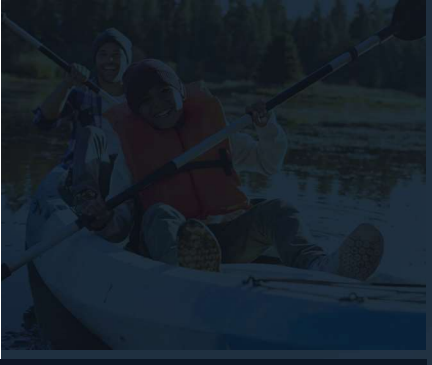
NON-FMLA Leave

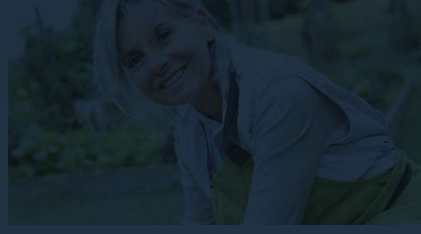
If you go out on an approved Non-FMLA leave, you will be responsible for paying 100% of your insurance premiums (for all plans). You will no longer receive the Board contribution towards the health premiums. Failure to pay insurance premiums within 60 days will result in immediate cancellation of coverage.

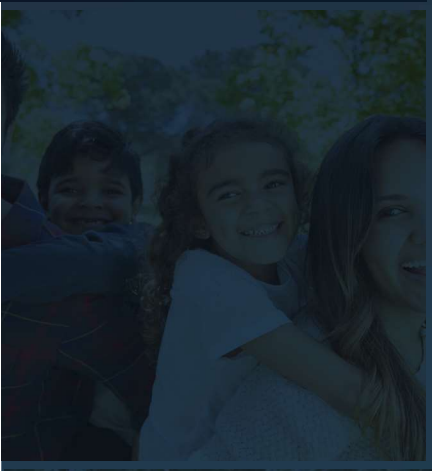
FMLA or Approved Leave of Absence— Frequently Asked Questions and Answers

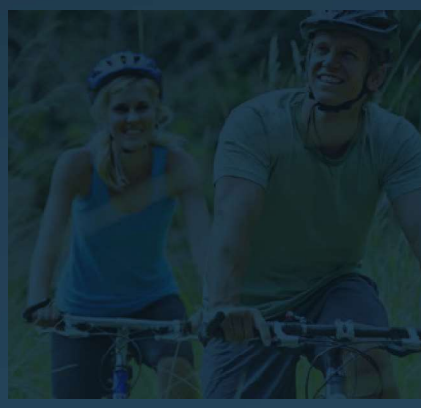
1. How do I know how much I will owe? You may determine the cost of your benefits by reviewing your printed hard copy of the benefit confirmation sheet or your most recent pay stub.
2. What happens to my benefits if I don't come back from leave after my FMLA expires? If you are on leave beyond the FMLA period, the Board contribution towards the district medical coverage will stop. Therefore, you will be responsible for paying the total cost, whether through payroll deductions or direct payment. Failure to pay insurance premiums within 60 days will result in immediate cancellation of coverage.

REQUIRED NOTICES










MEANINGFUL NOTICE/ PLAN SUMMARY INFORMATION 2024

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.

Roth403(b/

Contributions made to a Roth 403(b) account are aher-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 2024 IS $23,000.

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.

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, 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. Prior to taking a loan, participants should consult a tax advisor.

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. 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.

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 certify and may be asked to 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

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.

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.

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 **www.healthcare.gov**.

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

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

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

If you live in 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
www.dol.gov/agencies.ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
www.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 employmentbased 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 the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

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

  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.*

NOTES