MONROE COUNTY
SCHOOL DISTRICT

RETIREE BENEFIT GUIDE

2024

Make Positive Connections for Health and Happiness

SUPERINTENDENT'S MESSAGE

THERESA AXFORD
Superintendent of Schools

MONROE COUNTY
SCHOOL DISTRICT

Dear District Retirees,

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 retirees to have the opportunity to reach their full potential in any professional endeavors post retirement from Monroe County School District 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 benefit plan to meet your family's 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. Your knowledge is a great preventative measure, and your greatest ally in the fight against illness. We're committed to making sure you feel fully informed and prepared when choosing your 2024 benefits plan.

Our District offers retirees medical, dental and vision plans crafted to ensure you and your family members receive the coverage you need if illness or injury occurs. The School Board has put forth substantial funding and time to provide the best programs possible for the retirees of the Monroe County School District. Please take the time to carefully review the options available to you. Having peace of mind is the greatest gift you can give yourself and your family.

Sincerely,

Theresa Axford
MCSD Superintendent

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

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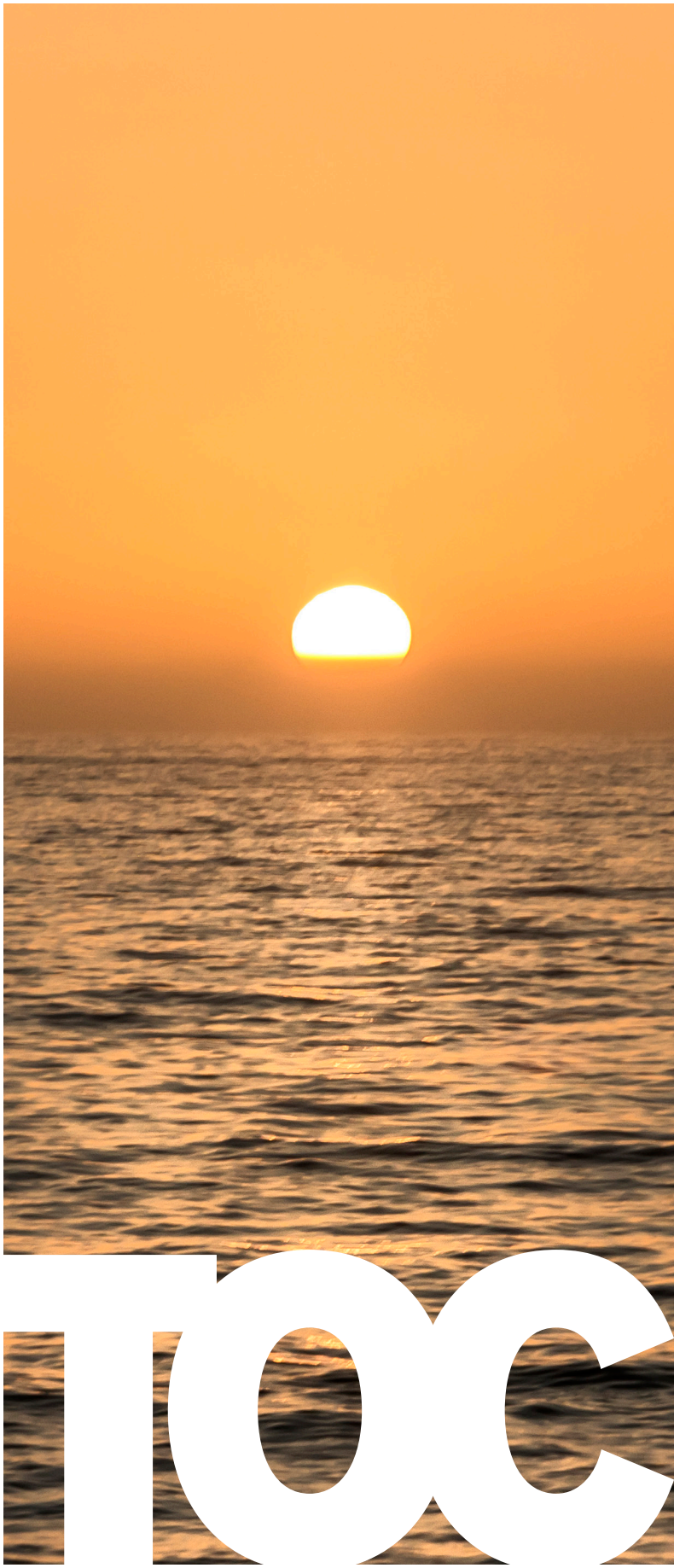

NOTE: *If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 13 for more details.*

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LET'S GET STARTED

OPEN ENROLLMENT IS OCT. 1-15, 2023

Welcome to the 2024 Monroe County School District Retiree Open Enrollment

This is a "**changes only**" enrollment. To make changes regarding your benefits, dependents, or beneficiaries, you will need to complete and sign the applicable form. If changes are made, please mail your original signed form to Monroe County School District, Employee Benefits & Risk Management. Please use the enclosed return envelope which **MUST** be postmarked by **Oct. 15, 2023.**

- A Retiree participant may continue medical coverage in their current plan only. You may continue or decrease your tier of coverage.
- A Retiree may continue dental and vision in their current plan. You may continue or decrease your tier of coverage.
- An employee retiring this year can elect the Basic Life Plan Policy for a $1.00 monthly premium for $2,500 life insurance policy, without electing medical. This policy only covers the retiring employee.
- Many retirees already have their medical premium automatically deducted from their Florida Retirement System (FRS) monthly benefit check. You can have that same convenience when paying your dental and vision premiums too! See "Method of Payment" on the next page.

Retiree Open Enrollment

During Open Enrollment, Retirees may continue, cancel, or decrease coverage; unless HIPAA special enrollment rights apply, you may not add coverages, add dependents or increase coverage. Once a coverage is canceled, it may not be reinstated or added at a later date.

To continue your current coverages *without* change, you do not need to complete an Enrollment Form. The coverages will remain at the same levels, excluding group changes such as premium rate changes.

To make changes to your group health plans, you must enroll. See page 6 for instructions. Please also make sure to include all benefits you want to *continue* in the new plan year. You must postmark your form by **Oct. 15, 2023**, which is the last day of enrollment. Late forms will not be accepted.

If you wish to drop coverage after Open Enrollment, written authorization is required. Send to:

Monroe County School District
Employee Benefits & Risk Management
Attn: Risk Manager
241 Trumbo Road
Key West, FL 33040

Once your written request is received, changes will be made as soon as possible. After FRS and ACH deduction changes have been verified, refunds will be sent to those that qualify. **Any coverage you elect to cancel cannot be**

reinstated.

Method of Payment

Retirees continuing their eligible **group health plans** can pay premiums through Florida Retirement System (FRS) benefit checks or make payments directly to the District. The District provides forms for FRS deduction authorization and information for making payments directly to the District. If you wish to change your method of payment for your medical benefits, please contact benefits, Risk Manager, at 305-293-1400, ext 53341 to receive the appropriate paperwork.

Retirees continuing either **Dental, Term Life and/or Vision plans** can elect to pay premiums through Florida Retirement System (FRS) benefit checks, Automated Clearing House (ACH), or make payments directly to FBMC. Payments via phone call to FBMC are available to use when necessary, otherwise an ACH form will be needed to continuously take payment. For those who pay FBMC via check, the company provides monthly statements. FBMC also provides forms for FRS and ACH deduction authorization. **Choose the payment method you would prefer then complete and return the appropriate form to FBMC Retiree & Direct Bill Dept.** FBMC will accept one-time payments over the phone through the Service Center at 1-833-MCSD-4US (1-833-627-3487) until deductions begin.

Any automatic deductions will start as soon as possible. Please be aware that retirees must make payments via personal check or money order until FRS or ACH deductions begin. FRS payers may receive delinquency notices before deductions begin. Please pay the amount on the notice by the due date specified. Premiums received more than 31 days after the due date will not be accepted and coverage will terminate. Upon ACH activation, they will withdraw the full accumulated amount due. **Upon FRS activation, FBMC may deduct up to $100 in addition to the monthly premiums if there is an outstanding balance on the account.**

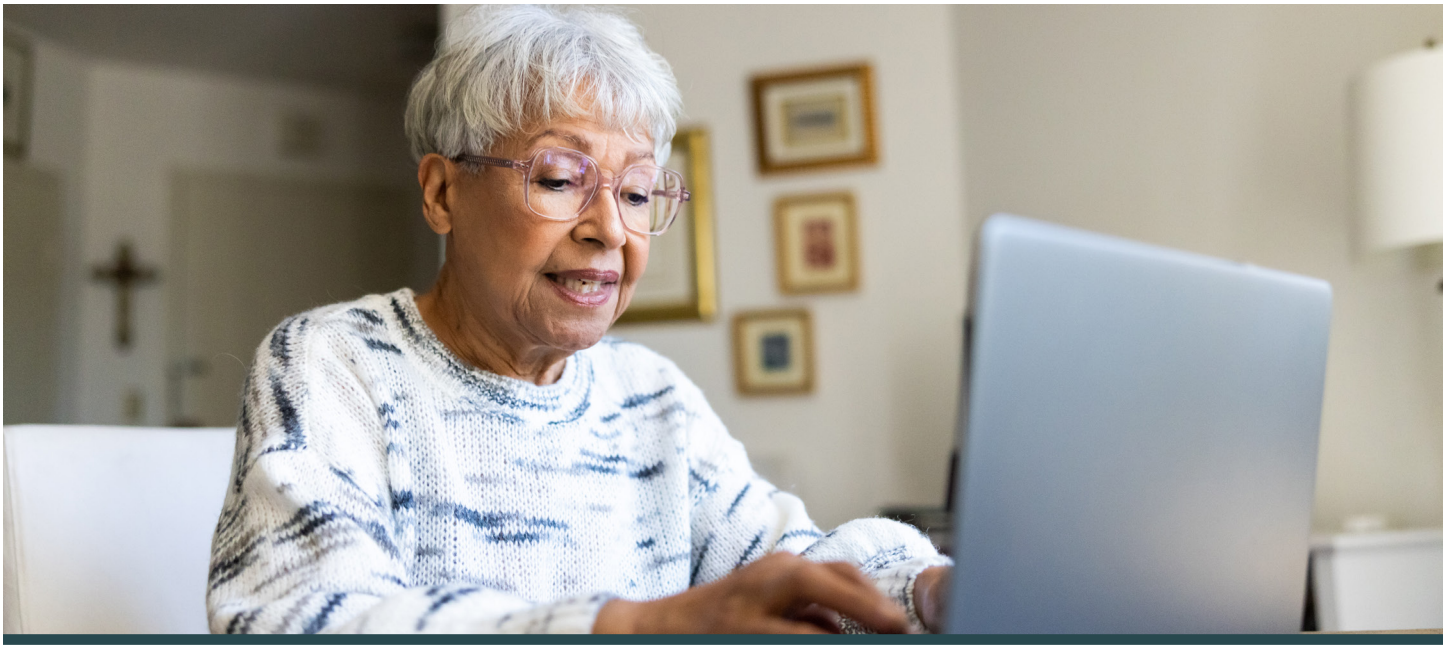
Who Are Eligible Dependents?

Eligible dependents are:

- Your legal spouse/domestic partner
- Your own unmarried children
- Children for whom you have been appointed legal guardian
- Stepchildren and legally adopted children (provided they reside in your household and primarily depend on you for support); and
- Grandchildren up to the age of 18 months (provided the parent is a covered dependent)

Dependent children who have reached age 26 can continue coverage up to the end of the calendar year in which they reach age 30 provided the child is unmarried and does not have a dependent of their own and is a resident of Florida or a full-time or part-time student and is not provided coverage as a named subscriber, insured, or enrollee.

HOW TO ENROLL



This is a "**changes only**" enrollment. If you have no changes, no further action is needed and your benefits will remain the same. There will be no need to fill out a form or make any appointments if you have no changes to make.

Enroll Telephonically or Via Mail

You can make changes via mail or call to make an appointment with benefits for a telephonic or virtual enrollment. You should have received an enrollment form in the mail, if not contact the District. For any questions or to schedule an appointment, please contact Risk Manager at 305-293-1400 ext. 53341.

When completing the form, please write in ALL CAPITAL LETTERS, in blue or black ink pen.

For the benefit selections you are not altering, check the "Continue Coverage" box. If you complete an enrollment form, but do not indicate your desire to cancel or change an existing benefit, that benefit will continue regardless of other benefits which may or may not be indicated on the enrollment form.

If you are selecting "Employee & Children", "Employee & Spouse" or "Employee & Family" coverage, you must complete the dependent information section on the enrollment form. Use an additional sheet of paper as needed for additional dependents.

Sign and date the form at the bottom. Return your completed enrollment form to the Employee Benefits and Risk Management Department no later than **Oct. 15, 2023.**

Keep Your Address Updated

In order to protect your family's rights, you should keep the District and FBMC Benefits Management, Inc. (FBMC) informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the District and FBMC. Please contact the Please contact the Risk Manager at 305-293-1400, ext. 53341.

Monthly Premium Rates

2024 RATES	BUY-UP PLAN 03768			CORE PLAN 03559			CHDP 05360		
Retiree Years of Service	<10 yrs /65+	10-20 yrs	> 20 yrs	<10 yrs /65+	10-20 yrs	> 20 yrs	<10 yrs /65+	10-20 yrs	> 20 yrs
Participant Only	$1,079.56	$810.30	$541.04	$982.39	$713.13	$443.87	$896.28	$627.02	$357.76
Participant + Spouse/ Domestic Partner	$1,392.63	$1,094.19	$795.76	$1,267.28	$968.84	$670.41	$1,156.21	$857.77	$559.34
Participant + Children	$1,230.70	$932.25	$633.83	$1,119.93	$821.48	$523.05	$1,021.77	$723.33	$424.90
Participant + Family	$1,511.38	$1,195.81	$880.25	$1,375.35	$1,059.78	$744.22	$1,254.80	$929.23	$623.67

Retiree Years of Service

- If you are under age 65 and retiring with less than 10 years of service with the Monroe County School District, you will be responsible for 100% of the Health Insurance Premium.
- If you are under age 65 and retiring with at least 10 years of service, but less than 20 years of service with the Monroe County School District, you will receive 50% of the District Contribution for Retiree Medical.
- If you are under age 65 and retiring with at least 20 years of service with the Monroe County School District, you will receive 100% of the District Contribution for Retiree Medical.

Medicare Eligible Retirees and Spouses

- If you reach Medicare Age (65), the District will no longer contribute toward your medical premium. Therefore, your medical plan will terminate, or you will be responsible for 100% of the Health Insurance Premium.

Plan Benefits

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

HEALTH PLANS

Plan Benefits

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

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

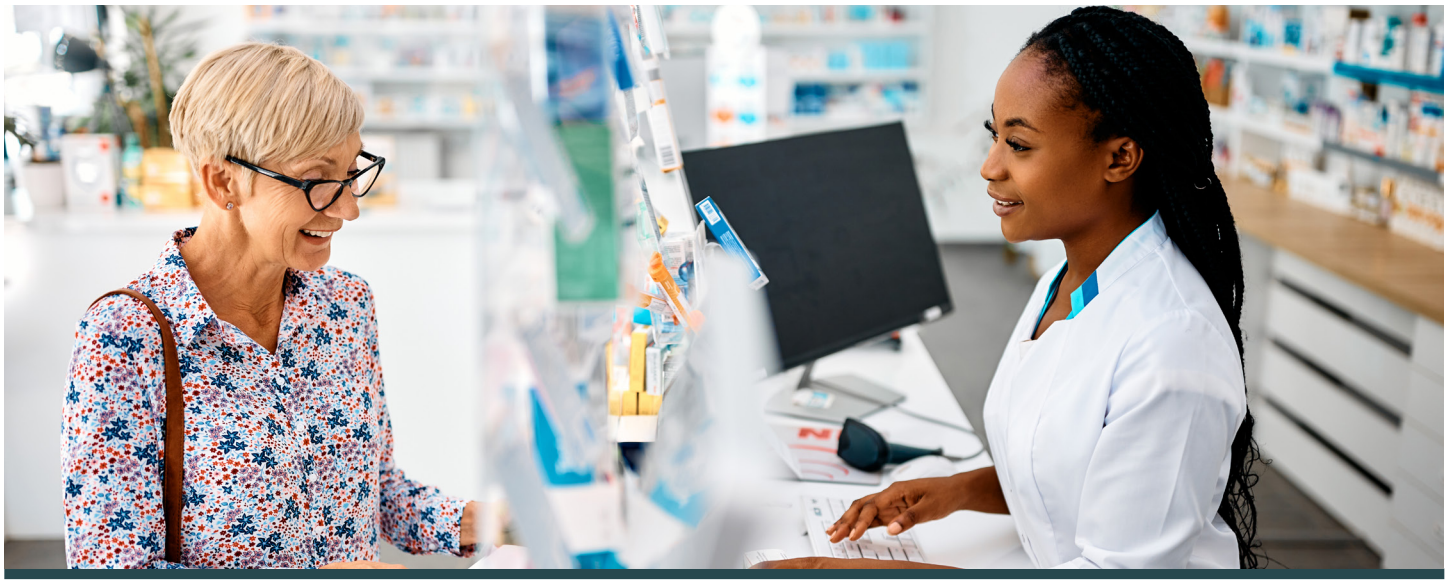
Plan Benefits

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

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

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

PRESCRIPTION DRUG PLAN



Welcome to OptumRx in 2024

Let's get started making the most of your pharmacy 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.

OptumRx Home Delivery

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

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

Pick Up at the Pharmacy

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

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

Take a Specialty Medication? We Are Here to Help

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

Manage Your Medications Online

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

OptumRx Is Here to Help

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

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

What You Can Do Before Your Coverage Begins

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

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

What You Can Do After Your Coverage Begins

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

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

PRESCRIPTION DRUG PLAN

Plan Rates

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

Plan Provider

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

Important Information from the District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Monroe County School District's Healthcare Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7, 2022.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

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

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage

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

Contact the Risk Manager at 305-293-1400, ext. 53341 for further information.

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

For More Information About Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage

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

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

Date: October 1, 2023

Name of Entity/Sender: Monroe County School District

Contact--Position/Office: Benefits Department

Address: 241 Trumbo Road, Key West, Florida 33040

Phone Number: 305-293-1400; 53333

DENTAL PLANS

Monthly Premium Rates (pretax)

Coverage	Managed Care (DHMO) Plan C150	Custom PPO Dental Plan
Retiree	$23.74	$24.29
Retiree + 1	$45.10	$48.28
Retiree & Family	$61.46	$71.83

How the Dental Care Plan Works for You

You know that professional dental care is important. Unfortunately, fitting this expense into your budget isn't always easy.

That's why the District gives you a choice of two plans: the Managed Care (C-150) Plan, and the PPO/Indemnity Plan.

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

Plan Provider

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

OPTION I - Humana Managed Care (DHMO) Plan C150

The Humana DHMO C150 plan 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 DHMO 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 provided by your primary care dentist. 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 (C-150)	
Service	**Fee**
Preventative Care	
Routine exams	No charge
Prophylaxis (general cleaning, one per 6 mo.)	No charge
Fluoride treatment (one per 12 mo.)	No charge
Office Visits	$5
Basic Services	
Emergency treatment	$20 (during office hrs.)
X-ray (bitewings)	No charge
Simple extraction (single tooth)	No charge
Restorative Services (fillings)	
Amalgam "silver"	
• (primary, three surface)	No charge
• (permanent, three surface)	No charge
Composite Resin "white"	
• (anterior, one surface)	$35
• (anterior, three surfaces)	$50
Root Canal	
Root canal therapy—anterior (excluding final restoration)	$100
Endodontic therapy, premolar tooth (excluding final restorations)	$200
Endodontic therapy, molar tooth (excluding final restorations)	$250
Periodontics	
Scaling and root planning (per quadrant)	$50 (limit 4 per year)
Periodontal maintenance	$50
Major Procedures	
Crowns (porcelain fused to base metal)	$280
Crowns (porcelain fused to noble metal)	$280*
Prosthetics	
Complete Dentures (standard upper or lower)	$300 + lab
Orthodontia (braces)	
Consultation	25% discount
Treatment plan, records	25% discount
Routine 24-month (fully banded case)	25% discount
Calendar year maximum	None
Calendar year deductible	None
Claim forms	Not required

* Additional cost applies for high noble and noble metal.

OPTION II - Humana Dental Plan

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

Plan Features

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

Plan Benefits

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

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

† Maximum of 3 per family

VISION PLAN

Monthly Premium Rates (pretax)

Coverage	Humana Vision 100
Retiree	$5.12
Retiree + 1	$10.22
Retiree & Family	$18.82

Vision Health Helps Overall Health

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

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

Know What Your Plan Covers

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

Here's what you can expect:

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

Some items and services not included in HumanaVision are:

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

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

VISION PLAN

Plan Benefits

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

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

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

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

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

VISION PLAN

Plan Benefits

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

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

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

GROUP TERM LIFE INSURANCE

Group Term Life Insurance

Monroe County Schools is pleased to offer Group Term Life Insurance coverage through Standard Insurance Company.

Basic Life Insurance

Retiring employees are eligible to continue basic life insurance in the amount of $2,500. You may not purchase additional coverage.

If You Retired Before 2018

If you retired before January 1, 2018, and you have medical coverage through the District, this policy may already be in effect, with the District paying the full premium for this plan.

If you elect to reduce or cancel medical coverage through the District, the District will cease paying this premium on your behalf, and you will be responsible for paying a **$1** monthly premium in order to continue in the plan.

Plan Provider

Standard Insurance Company insures this plan. Founded in 1906, The Standard has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance.

Monthly Premium Rates (post-tax)

Coverage	$2,500 Basic Life
Retiree	$1.00

LEGAL NOTICES

Notice of Administrator's Capacity

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

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

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

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

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

FBMC Privacy Statement

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal, and sometimes sensitive, information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect.

Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.

FBMC's privacy statement is as follows:

I. **We collect only the customer information necessary to consistently deliver responsive services.**
FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

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

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

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

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

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

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

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.

Determination of when the hospital stay begins is based on the following:

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

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

To request special enrollment or obtain more information, contact your Plan Administrator.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

DIRECTORY

MONROE COUNTY SCHOOL DISTRICT

School Board Office
Mon - Fri, 8 a.m. - 5 p.m. ET
305-293-1400 ext. 53341
keysschools.com

FBMC Contract Administrator
FBMC Benefits Service Center:
833-MCSD-4US (833-627-3487)
Mon - Fri, 8 a.m. - 5 p.m.

FLORIDA BLUE

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

HUMANA

Dental Insurance
Mon-Fri, 8 a.m. - 5 p.m. ET
1-800-233-4013
humana.com

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

OPTUM RX

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

VISTA 401(K) PLAN

FBMC Retirement Services
Mon - Fri, 8 AM - 5 PM
1-866-325-1278
Automated Services
1-800-213-2310
vista401k.com

STANDARD INSURANCE COMPANY

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

NOTES

NOTES

FBMC
BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
PO Box 10789 • Tallahassee, Florida 32302-10789

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.