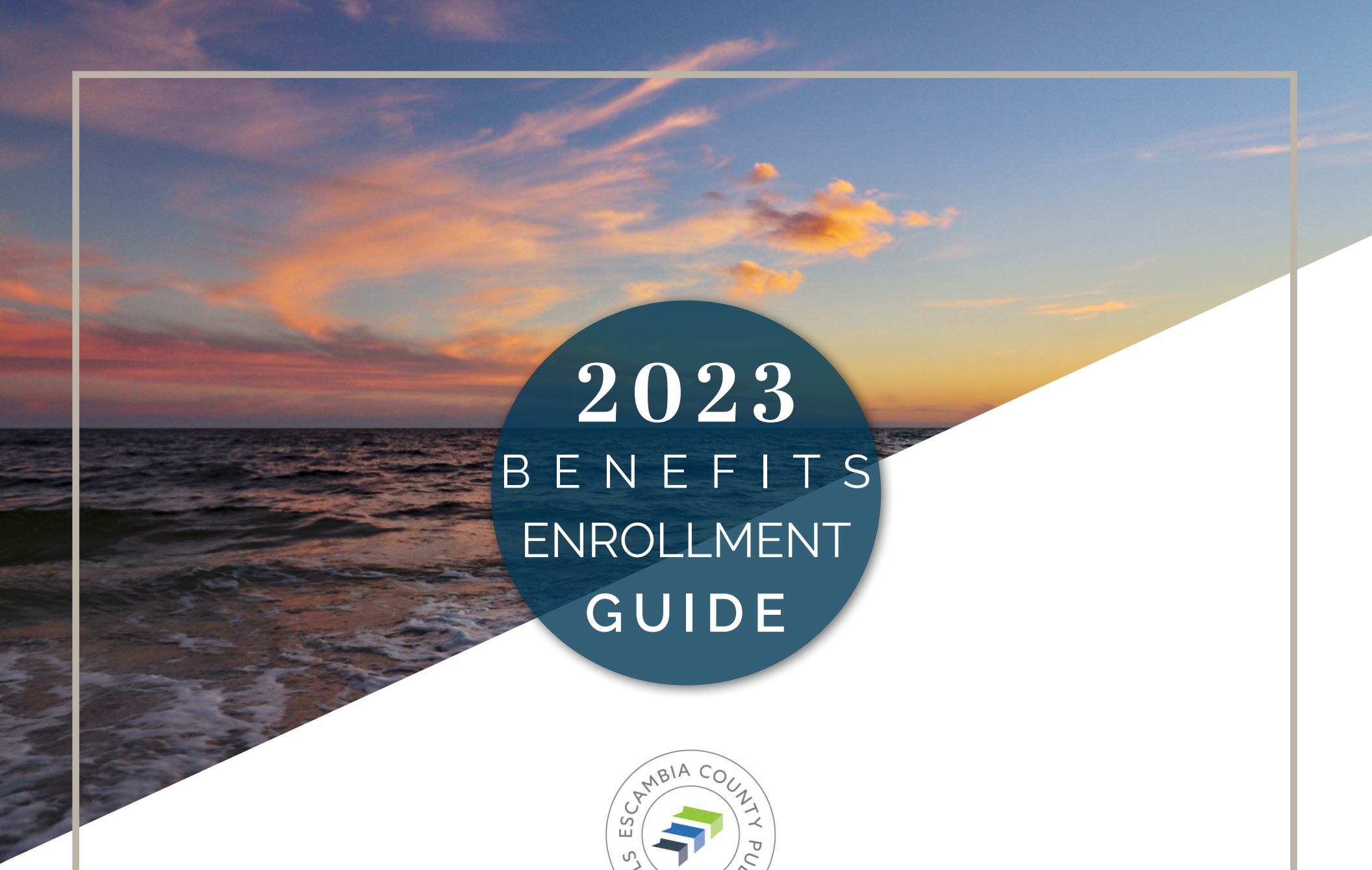
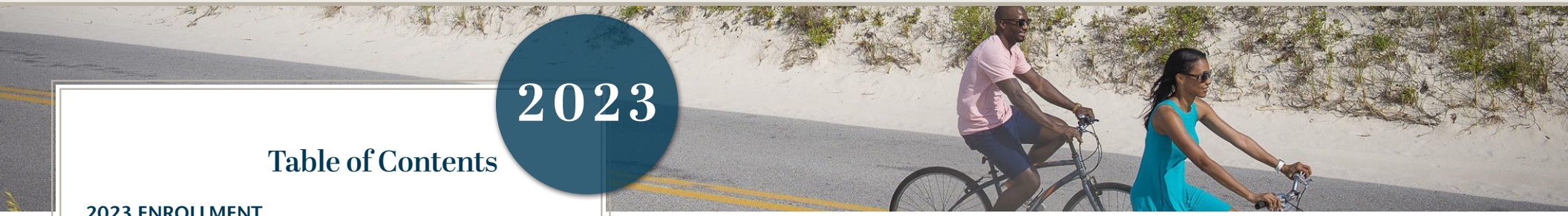


2023 BENEFITS ENROLLMENT GUIDE

ESCAMBIA COUNTY PUBLIC SCHOOLS

Your benefits. Your future.

Get Started



2023

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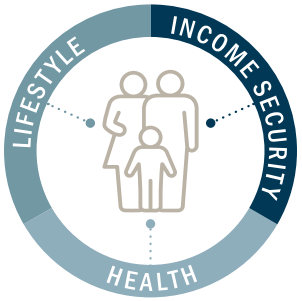
Open Enrollment Begins November 2



Now is the time to focus on you.

You are a vital part of our success. That's the reason we invest so much into a benefits plan that helps protect your health, your income, and so much more. It is important to learn about the options we offer and consider how they can help you build a secure future.

This benefit guide presents highlights of the benefits available to you this year. **For additional plan details and premiums, please visit BenefitFocus's Employee Benefits Enrollment portal located under the District's new website under "Staff". You will use your District's sign-in credentials for direct access into the portal.**

ACTION REQUIRED!

Open Enrollment ends November 16. Each benefit-eligible employee is REQUIRED to complete enrollment online to elect or change coverage by this date. **If you do not participate, your current 2022 benefits will roll forward for 2023, other than your FSA or HSA plans, which require you to re-enroll each year.**

The Importance of Enrollment

If you and/or your dependent 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 24 for more detail.

Open Enrollment is November 2 – November 16

Who We Cover

Employees: You are eligible for benefits if you are a permanent, full-time employee of the District, work at least 20 hours per week, and are eligible for benefits under the Florida Retirement System. You must be actively at work on the plan effective date for new benefits to be effective.

Eligible Dependents May Include:

- Your legal spouse
- Your own children
- Children for whom you have been appointed legal guardian (through the courts)
- Stepchildren and legally adopted children (provided they reside in your household and primarily depend on you for support)

Documentation showing proof of dependent eligibility may be required. Dependent age limits and other restrictions vary by plan.

How To Enroll (For both Open Enrollment and to complete a qualifying mid-year family life event status change)

We offer different ways to enroll to give you the level of support that is best for you.

Benefitplace® Mobile App — Search for "Benefitplace" in the App Store or Google Play and download to your mobile device. Or scan the QR code below. Use Company ID **escambiabenefits** to activate the app. You will need to use your prior BenefitFocus username and password or register if you are a first-time app user.

Google Play Apple App Store

Online Self-Service — Visit BenefitFocus's Employee Benefits Enrollment portal located under the District's main website under "Staff". You will use your District's sign-in credentials for direct access into the portal.

What's New for 2023

- **Enroll via the BenefitFocus App:** Search for "Benefitplace" in the App Store or Google Play and download to your mobile device. Use Company ID **escambiabenefits** to activate the app.
- **BenefitFocus Health Insights Assistance:** Get help determining which medical plan is the right one for you.
- **Medical Premiums:** Please make sure to review the medical premiums/ contributions as there have been some changes for 2023.
- **FSA and HSA Limits for 2023:** FSA limits have increased for Health Care FSA to $3,050. HSA limits have increased for individuals to $3,850 and for families to $7,750.
- **Increased Wellness Credits**

Medical Plans

Health care needs are different for everyone. We offer multiple medical plan options so you can choose the coverage level best-suited to your needs and budget.

UNITED CHOICE HSA **UNITED BASE HRA** **UNITED CHOICE HRA**

All three plans are administered through UnitedHealthcare and give you access to the same network of high-quality medical providers. The difference is that each plan carries different premiums and out-of-pocket costs. In addition, the United Choice HSA plan includes a Health Savings Account option, and the United Choice HRA plan includes a $500 HRA funding allowance to help offset your deductible.

1 in 4

Americans overpay for health care by choosing the wrong medical plan.

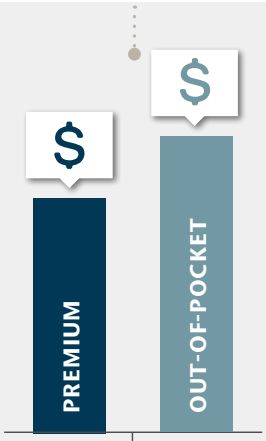
The Quarterly Journal of Economics, Volume 132, Issue 3, 1 August 2017

What's the Right Plan for You?

Balance your premium cost with the amount you expect to spend on medical services. If you're healthy and don't expect to have many doctor's visits, you can greatly reduce your upfront cost by choosing a lower premium plan. If you require a lot of care and need to limit out-of-pocket expenses, the higher premium plan might make more sense.

UNITED CHOICE HSA

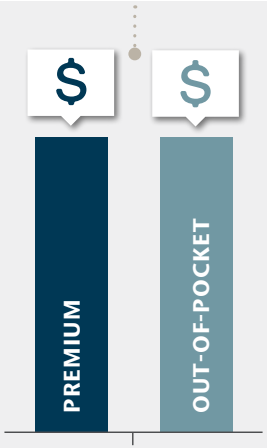
HSA eligible



You save money up front with the lowest premium, but you're exposed to higher out-of-pocket costs.

Best if you are...
healthy, active, and rarely expect to use medical care, allowing you to maximize the premium savings.

UNITED BASE HRA

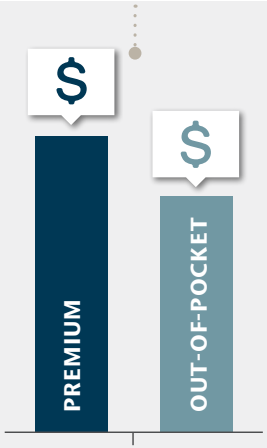


This plan balances premiums with out-of-pocket exposure.

Best if you are...
healthy, but want to balance your risk because you're getting older, have a condition like high cholesterol, or have a big family.

UNITED CHOICE HRA

$500 HRA funding



The plan with the highest premium but the lowest out-of-pocket costs.

Best if you are...
going to require plenty of medical care in the coming year, which could include having a baby.

What's Your Best Fit?

SUTTON FAMILY

Typical family with some risk

Ages: Cyrus, 48; Emily, 44; Devin, 13; and Bettina, 12

Lifestyle: Devin and Bettina both play soccer; Devin is an avid skateboarder

Medical Status: Cyrus has high blood pressure and cholesterol

Financial Risk Factors: Heart and cardiovascular disease; injury risk from sports activities (skateboarding is a very high-risk activity)

BEST FIT: A plan with moderate out-of-pocket costs and premiums makes sense because of Cyrus's risk factors and the chances of injury for the kids. The family chooses the United Base HRA plan. They can also reduce their financial risk with Critical Illness and Accident Insurance.

MIKE & DIANE

Planning a new addition

Ages: 34 and 31

Lifestyle: Trips to the beach, jogging, binge-watching TV shows

Medical Status: Very healthy and planning their first child in the coming year

Financial Risk Factors: Having a baby is expensive

BEST FIT: Mike and Diane normally lean toward a low-premium plan, but the cost of pregnancy changes that calculation. The plan with the lowest out-of-pocket costs is best for them, so they choose the United Choice HRA. They supplement this with Hospital Confinement Insurance to help cover some of their deductible and coinsurance.

DANIELLE

Young, active, and healthy

Age: 26

Lifestyle: Biking, skiing, and hiking

Medical Status: Very healthy

Financial Risk Factors: High-risk activities that could lead to costly injury

BEST FIT: Danielle can expect to spend little on medical services and take advantage of the upfront premium savings of the United Choice HSA plan. If she's worried about a skiing or biking injury, Accident Insurance can give her peace of mind about unexpected treatment and recovery bills.

Your 2023 Medical Plan Summary

Below is a brief overview of the coverage available under each plan. For a full list of benefits, refer to the Summary of Benefits and Coverage.

	UNITED CHOICE HSA PLAN	UNITED BASE HRA PLAN	UNITED CHOICE HRA PLAN
	In-Network	In-Network	In-Network
Employer Funding	$0	$0	$500
Annual Deductible (Individual/Family)	$3,000/$6,000	$2,500/$7,500	$2,300/$5,400
Out-of-Pocket Maximum (Individual/Family)	$6,250/$12,500	$5,250/$13,200	$4,250/$12,500
Coinsurance	80%	80%	80%
Preventive Care	100% covered	100% covered	100% covered
Primary Care Physician (PCP)	80% after deductible	$40 copay + coinsurance	$35 copay
Specialist	80% after deductible	$60 copay + coinsurance	$50 copay
Labs, X-rays & Diagnostics	80% after deductible	80% after deductible	80% after deductible
Imaging (CT, PET Scans, MRIs)	80% after deductible	80% coinsurance	80% coinsurance
Hospital Inpatient	80% after deductible	80% after deductible	80% after deductible
Outpatient Surgery	80% after deductible	80% after deductible	80% after deductible
Urgent Care Center	80% after deductible	$60 copay + coinsurance	$50 copay
Emergency Room	80% after deductible	$300 copay + coinsurance	$300 copay + coinsurance

Remember: Getting care from an in-network medical provider always saves you money.

How Your Medical Plan Works

For a full list of medical terms you should know, go to www.benefitsquest.com/terms-to-know.

Prescription Plan Summary

Prescription coverage is included with your medical plan. Your prescription plan details are as follows:

	UNITED CHOICE HSA PLAN	UNITED BASE HRA PLAN	UNITED CHOICE HRA PLAN
	In-Network	In-Network	In-Network
30-day supply:			
Tier 1	Deductible + coinsurance	$15 copay	$12 copay
Tier 2	Deductible + coinsurance	$40 copay	$35 copay
Tier 3	Deductible + coinsurance	$100 copay	$75 copay
90-day supply:			
Tier 1	Deductible + coinsurance	$45 copay	$36 copay
Tier 2	Deductible + coinsurance	$120 copay	$105 copay
Tier 3	Deductible + coinsurance	$300 copay	$225 copay
Deductible	$3,000 annual deductible must be met before the plan pays toward prescription costs (maximum of $6,000 per family)	$200 per person per plan year (maximum of three per family)	$150 per person per plan year (maximum of three per family)

Controlling Health Care Costs

The rising cost of health insurance is a concern for all of us. Keeping costs to a minimum contributes to lower premiums in future years. Here are tips on how you can help lower the cost of health insurance:

Use the employee medical facility, Marathon Health. You can save money by using Marathon Health for minor illnesses and injuries rather than going to your doctor.

Request generic rather than brand name prescription drugs. Generic medications, while just as effective, are considerably less expensive.

Consider seeing your family physician rather than a specialist. Family physicians can often provide the same level of care for a variety of illnesses and conditions.

Exercise and maintain a proper diet. The healthier you are the less vulnerable you are to disease, reducing doctor's visits and prescription medicines.

If we become more aware consumers, we can each do our part to lower the cost of health care!

In-Hospital Indemnity Plan

The In-Hospital Indemnity Plan is a self-administered plan by the District for employees who would like to retain another medical plan as their primary insurance plan. This is not a major medical plan and only pays daily benefits up to 30 days per plan year (January 1 – December 31). Daily benefits are calculated on a 24-hour period. The plan has a 24-hour (one day) deductible prior to benefits being paid.

All claims are required to be filed with the Risk Management Department within 90 days from your date of discharge to be eligible for consideration.

MEDICAL CARE BENEFITS	EMPLOYEE ONLY
In-Hospital Indemnity Plan Benefits	Amount of Benefit
Hospital Room and Board	
Maximum daily benefit	$75
Waiting period before benefits are paid	24 hours of hospital inpatient care
Extended Care Facility Room and Board	
Maximum daily benefit	$37.50
Maximum number of days	30 days Annually combined hospital and extended care facility benefits All claims must be filed with the District's Risk Management Department within 90 days from the discharge date to be considered for payment.

Critical Illness Insurance

You can protect yourself from the unexpected costs of a serious illness.

Even the most comprehensive medical plans don't cover all of the expenses of a serious medical condition like a heart attack or cancer. Critical Illness Insurance pays a lump sum benefit directly to you if you are diagnosed with a covered illness. The benefit is paid in addition to any other insurance coverage you may have.

Covered Illnesses Include:

- Heart attack
- Stroke
- Cancer
- Major organ transplant
- End stage renal (kidney) failure
- Coronary artery bypass surgery*
- And more

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** You can elect to cover your spouse and children.
- **Health Screening Benefit:** The plan pays a $75 benefit once per calendar year for health screening tests performed as the result of preventive care. This benefit is payable for the covered employee and spouse.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.
- **Value-Added Services:** The plan includes 24/7 access to a Telephonic Employee Assistance Program (EAP) and Telemedicine services.

1 in 5

Households that have medical insurance used up most of their savings to pay medical bills.

The Burden of Medical Debt; Kaiser Family Foundation/ New York Times Medical Bills Survey, 2016.

Why We Offer Supplemental Medical Benefits

Medical insurance does not prevent all of the financial strain of a major illness or injury. Depending on the medical plan you choose, you could be exposed to up to $13,200 in out-of-pocket costs if you or a family member were to become seriously sick or injured.

Many families don't have enough in their savings to cover the deductible and coinsurance of a major medical event. Supplemental medical benefits can help cover this out-of-pocket financial exposure at a reasonable cost.

The benefits are paid directly to you, allowing you to use the funds however you choose. You receive the full benefit even if you have other insurance.

Critical Illness Insurance

**The coverage pays 25% of the face amount of the policy once per lifetime for coronary artery bypass surgery.*

The policy/certificate of coverage or its provisions, as well as covered illnesses, may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.

Accident Insurance

Major injuries are painful. But the financial impact of the medical treatment doesn't have to be.

Accident Insurance pays lump sum benefits directly to you if you suffer a covered injury such as a fracture, burn, or concussion. Benefits are paid even if you have other insurance coverage.

The benefit amount is calculated based on the type of injury, its severity, and what medical services are required in treatment and recovery. The plan covers a wide variety of injuries and accident-related expenses, including:

- Ambulance rides
- Emergency room visits
- Surgery and anesthesia
- Major diagnostic testing
- Injury treatment (fractures, dislocations, concussions, burns, lacerations, etc.)
- And more

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** You can elect to cover your spouse and children.
- **Wellness Rider:** The plan pays a $100 benefit per insured person per calendar year for covered wellness tests performed as the result of preventive care.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.
- **Value-Added Services:** The plan includes 24/7 access to a Telephonic Employee Assistance Program (EAP) and Telemedicine services.

How Accident Insurance Works

Sam tears a knee ligament that requires extensive treatment and rehab. Even with medical insurance, this will cost Sam $3,000 out-of-pocket in deductibles and coinsurance.

Fortunately, Sam has Accident Insurance. This coverage paid Sam a total benefit of $2,640.

Rather than $3,000 out of his savings, the injury only costs Sam $360...much better.

How Sam's Accident Benefit Was Calculated:

Medical Service	Benefit
Emergency Room	$ 300
Ligament Surgery	$1,500
Anesthesia	$ 300
Physical Therapy	$ 540 ($90 per visit for six visits)
TOTAL BENEFIT	**$2,640**

Accident Insurance

This scenario does not reflect the benefits of a specific Accident Insurance plan schedule. The benefits are generic benefits for the purposes of this example to show how the benefit total of an Accident Insurance plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you.

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

Hospital Confinement Insurance

Receive lump sum payments to help cover the cost of a hospital stay.

If you are admitted into a hospital, it doesn't take long for the out-of-pocket costs to add up. Hospital Confinement Insurance pays lump sum benefits directly to you, and benefits are paid even if you have other coverage.

You receive a benefit as soon as you are admitted and then an additional benefit based on the number of days you are confined to the hospital. The benefit increases if you are admitted and confined to an intensive care unit. You'll also receive benefits for inpatient treatment in a rehabilitation facility.

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** You can elect to cover your spouse and children.
- **Health Screening Benefit:** The plan pays a $50 benefit once per calendar year for health screening tests performed as the result of preventive care. This benefit is payable for each covered person.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.
- **Value-Added Services:** The plan includes 24/7 access to a Telephonic Employee Assistance Program (EAP) and Telemedicine services.

Hospital Confinement Insurance

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

How Hospital Confinement Insurance Works

Cindy is injured in a car accident and is in the hospital for four days. She also receives rehabilitation therapy for three days. Cindy's medical insurance carries a $2,500 deductible and a $5,000 out-of-pocket maximum. Even with her medical plan, Cindy's deductible and coinsurance add up to more than $4,000 just for hospital services.

Cindy has Hospital Confinement Insurance. She receives a benefit for being admitted into the hospital, a benefit for each day of her inpatient stay, and benefits for rehab services.

How Cindy's Hospital Confinement Benefit Was Calculated:

Medical Service	Benefit	Total
Hospital Admission	$2,000 per admission	$ 2,000
Four-day Hospital Stay	$200 per day	$ 800
Three Days of Rehab	$75 per day	$ 225
CINDY'S TOTAL BENEFIT		**$3,025**

This scenario does not reflect the benefits of a specific Hospital Confinement Insurance plan schedule. The benefits are generic benefits for the purposes of this example to show how the benefit total of a Hospital Confinement plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you.

Health Savings Account (HSA)

Save for current or future medical costs and reduce your income taxes with this special savings account.

When you enroll in the United Choice HSA medical plan, you are also eligible to open a Health Savings Account.

You fund your HSA through pre-tax payroll deductions up to annual IRS limits. The account can be used to pay for eligible out-of-pocket health care expenses until you meet your deductible.

The money can be spent as needed to cover current expenses tax-free. Any unused balances roll over from year-to-year allowing you to build up a savings for future health care expenses, even in retirement when your medical care expenses may increase.

$4,275

The average amount retirees spend out-of-pocket for health care yearly.

The Center for Retirement Research at Boston College, 2017.

HSAs Deliver Triple Tax Savings

1. You don't pay federal income tax on the money you contribute.
2. You don't pay taxes on the interest you earn in your account.
3. You don't pay taxes when you use the money to pay for qualified medical services.

Keys to Growing Your HSA:

- Try not to use your HSA for routine expenses. If you can pay out-of-pocket, leave your HSA funds alone so that they can grow for when you need them in the future.
- Consider electing Critical Illness, Accident, or Hospital Confinement Insurance to cover big-ticket expenses from unexpected serious illnesses or injuries and ensure they don't wipe away the money in your HSA.
- Monitor your fund's growth. Like a 401(k), your HSA funds earn interest through investments. Make sure your money is growing at an acceptable and safe pace.

ANNUAL MAXIMUM CONTRIBUTION AMOUNTS	
Employee Only	$3,850
Employee + Dependents	$7,750

Individuals age 55 or older can make additional "catch up" contributions up to $1,000.

For a complete list of eligible expenses, see IRS Publication 502 available at www.irs.gov/publications/p502.

Flexible Spending Accounts (FSAs)

Reduce your income taxes while putting aside money for health and dependent care needs.

Flexible Spending Accounts allow you to put aside money for eligible expenses and reduce your income taxes at the same time. The District offers two types of accounts — a Health Care FSA and a Dependent Care FSA.

HEALTH CARE FSA

Deductibles, copays, prescription and over-the-counter drugs, medical equipment, etc.

DEPENDENT CARE FSA

Babysitters, day care, day camp, home nursing care, etc.

Go to www.benefitsquest.com/fsa for a complete list of covered expenses.

How Flexible Spending Accounts Work

1. Each year during Open Enrollment, you decide how much money to set aside for health care and/or dependent care expenses.
2. Your contributions are deducted from your paycheck on a pre-tax basis in equal installments throughout the calendar year.
3. Your plan includes an FSA debit card that you can use to pay for eligible expenses at the point of sale. You can also pay out of pocket and submit a claim form for reimbursement if necessary.

ANNUAL CONTRIBUTION AMOUNTS	
Health Care Flexible Spending Account	$100 – $3,050
Dependent Care Flexible Spending Account	$100 – $5,000 ($2,500 if married and filing separate tax returns)

Health Care Items You Might Not Realize are FSA Eligible:

- Sunscreen
- Heating and cooling pads
- First aid kits
- Shoe inserts and other foot grooming treatments
- Travel pillows
- Motion sickness bands

Use It or Lose It: The District allows a 2 ½-month grace period to spend any money left in your account at the end of the plan year. You have until March 15, 2023 to spend your 2022 FSA funds. Any money left in your account after this date must be forfeited per IRS regulations.

Please note that these accounts are separate. You may participate in one, both, or neither. You cannot use money from the Health Care FSA to cover expenses eligible under the Dependent Care FSA or vice versa.

Dental Plans

The District is offering two new dental plan options through The Standard. Both plans cover the same services, but the Enhanced Buy-up plan offers a higher annual maximum and orthodontia lifetime maximum. To find a participating dentist, visit **www.standard.com**.

	BASE PLAN		ENHANCED BUY-UP PLAN	
	In-Network	Out-of-Network (UCR is at 90th %)	In-Network	Out-of-Network (UCR is at 90th %)
Deductible - Basic & Major Services (Individual/Family)	$50/$100	$50/$100	$50/$100	$50/$100
Annual Maximum	$1,000	$1,000	$1,500	$1,500
Preventive Services (Exams, Cleanings, X-rays)	100%	100%	100%	100%
Basic Restorative Services (Fillings, Extractions, Root Canals)	80%	80%	80%	80%
Major Restorative Services (Crowns, Dentures, Implants)	50%	50%	50%	50%
Orthodontia (Children only)	50%	50%	50%	50%
Orthodontia Lifetime Maximum	$1,000	$1,000	$1,500	$1,500

If charge is less than the 90th UCR, then no charge. If charge is within $10 of 90th UCR, then no charge. If charge is more than $10 of 90th UCR, then the balance is paid (cleaning charge of $82 and UCR is $70, then member owes $12).

What Does Preventive Dental Care Typically Cover?

Every dollar spent on preventive care can save you money later on procedures that are more urgent, complex, and costly.

Routine dental checkups and cleanings should be scheduled every six months. Your dentist may recommend more frequent or fewer visits, depending on your dental health history.

Professional fluoride treatments can be a key defense against cavities if you're at high risk for decay. Professional fluoride treatments have significantly more fluoride than tap water or toothpaste, and take only a few minutes to apply.

Dental sealants go a step beyond fluoride by providing a thin, plastic coating to the chewing surface of your teeth. Most dental plans cover sealants as preventive care for children under 18 on their first and second molars.

X-ray images of your mouth may be taken by your dentist or dental hygienist to better evaluate your oral health. These images go beneath the surface to provide a more detailed look inside your teeth and gums.

Vision Plan

The District offers vision coverage through Humana Insight. The plan provides coverage for annual eye exams, prescription glasses or contacts, and even discounts for laser vision correction.

	VISION PLAN	
	In-Network	Out-of-Network
Eye Exam (every 12 months)	$5 copay	Up to $30
Lenses (every 12 months) Single Vision Bifocal Trifocal Lenticular	 $0 copay $0 copay $0 copay $0 copay	 Up to $25 Up to $40 Up to $60 Up to $100
Frames (every 24 months)	Up to $150, 20% off balance over $150	Up to $65
Contact Lenses (every 12 months) Standard contact lens fit and follow-up Premium contact lens fit and follow-up	 Up to $55 10% off retail	 Not covered Not covered
Laser Vision Correction	15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision	

5 Tips for a Lifetime of Healthy Vision

1. **Schedule yearly eye exams.** Visiting your ophthalmologist regularly helps you see your best, protect your sight, and even detect serious health conditions such as diabetes.
2. **Protect your eyes against UV rays.** No matter what the season, it is important to wear sunglasses. When selecting and purchasing sunglasses, be sure to confirm they offer 100% UVA/UVB protection.
3. **Give your eyes a break from digital devices.** Digital screens emit a specific type of blue and violet light which can negatively impact eye health and cause digital eye strain.
4. **Live a smoke-free lifestyle.** Smoking increases your risk of developing macular degeneration, optic nerve damage, and cataracts.
5. **Practice safe wear and care of contact lenses.** Keep them clean and follow your optometrist's recommendations for use and wear.

Personal Wellness Appraisal Program

The health and well-being of employees is very important to the District. Employees need to feel their best so they can come to work each day and give their best. That's why we sponsor the Personal Wellness Appraisal Program. It is designed to help you develop healthy habits for life. The program focuses on education and prevention as effective ways to reduce the cost of health care. Through early screening of potential medical conditions and appropriate intervention and prevention activities, it helps head off serious health problems that could occur now or in the future.

Marathon Health, the health care provider for our Health Center, is working with District staff to provide the opportunity for all permanent benefit-eligible employees to participate in the Personal Wellness Appraisal Program annually at no cost. In addition, you can earn a wellness credit of $40/month ($480 annually) for completing the four steps listed below. All screenings will be conducted at the Health Center facility at the ECSD Center for Health and Wellness.

How to Earn the Employee Wellness Credit

1. Have a biometrics screening (blood draw).
2. Complete a health risk assessment online at **www.mymarathon-health.com**.
3. Participate in comprehensive Health Review/Health Coaching.
4. Be tobacco-free and/or complete a tobacco cessation counseling program, as defined by the Escambia County Health Department. Proof of completion of the program must be submitted to Marathon.

Spousal Wellness Credit

Employees with spouses covered under a District medical plan can earn an additional $30/month spousal wellness credit when their spouse completes the same steps as the employee. This will be paid to the employee. A monthly qualification and monthly waiting period also applies during the year.

Life and AD&D Insurance

Always be there financially for your loved ones.

Basic Life Insurance

The District pays the full cost of your Basic Life Insurance coverage. If you are under age 70, your benefit is equal to one times your annual salary (rounded to the nearest $1,000) to a maximum of $150,000. If you are age 70 or over, your benefit is equal to 50% of your annual salary.

How Much Life Insurance Do You Need?

Many financial experts recommend you have at least five to eight times your household income in Life Insurance. To calculate the level sufficient to cover your needs, you should consider your current income and how much it costs to maintain your family's standard of living. You should also consider your current expenses and your family's future financial needs such as the following:

Current Expenses

- Home Mortgage
- Car Payments
- Credit Card Debt
- Other Debt

Future Needs

- Child Care
- College Tuition
- Spouse's Retirement
- Routine Household Expenses

After you add your financial responsibilities, how does the sum compare with your current coverage?

Additional Life and AD&D Insurance

You have the option to purchase Additional Life Insurance as a supplement to the employer-paid benefit. You may choose a coverage amount from one to three times your annual salary (rounded to the nearest $1,000) to a maximum of $300,000. This amount will reduce to 50% at age 70.

Accidental Death and Dismemberment (AD&D) Insurance covers accidental loss of life or limb. The plan pays you (or your beneficiary) a scheduled benefit, up to the policy maximum, depending on the nature and extent of the loss. When you purchase Additional Life Insurance, you may also enroll in AD&D coverage. AD&D coverage expires at age 70.

Evidence of Insurability (EOI) is required after your initial 30-day new hire window.

Dependent Life Insurance

The District also offers Dependent Life Insurance to provide coverage for your spouse and children. You may choose from one of three plan options noted below. Dependent coverage cannot exceed 50% of the amount of the employee's Basic and Additional Life Insurance coverage. **Dependent Life benefits are Guaranteed Issue during Open Enrollment.** Spouse coverage elections made outside of Open Enrollment require Evidence of Insurability. Evidence of Insurability for children is never required.

PLAN 1	$20,000 Spouse / $10,000 Child(ren)
PLAN 2	$10,000 Spouse / $5,000 Child(ren)
PLAN 3	$5,000 Spouse / $2,500 Child(ren)

NOTE: Medical Evidence of Insurability is required when increasing coverage amounts at times other than your initial enrollment. Enrollment in additional life is allowed throughout the year with medical evidence of insurability.

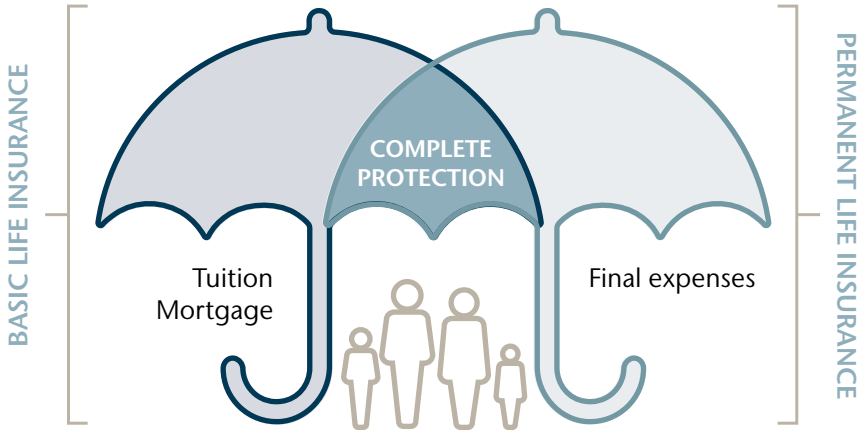
Permanent Life Insurance

Permanent Life Insurance completes your family's protection, providing a cost-effective benefit for final expenses such as funeral costs, credit card debt, and medical bills. As long as premiums are paid, the policy will not expire until maturity. Premiums will not change due to your age. The policy includes an accelerated death benefit rider for terminal conditions and offers an optional accelerated death benefit rider for "living benefits" (care for chronic conditions).*

Plan Features

- **Guaranteed Acceptance:** No physical exams are required to apply for coverage if you are newly eligible (although health questions may be asked).
- **Family Coverage:** You can purchase coverage for yourself, your spouse, and your children.
- **Portable Coverage:** You can take your policy with you if you change jobs and carry your Life Insurance coverage into your retirement.
- **Coverage for Your Needs:** Permanent Life Insurance is voluntary, which means you purchase the precise amount of coverage that is right for your needs.
- **Cash Value:** This policy builds cash value.

Premiums are based on your age and the amount of coverage you elect.



Permanent Life Insurance

Life Insurance Plan Comparison

BASIC LIFE INSURANCE	ADDITIONAL LIFE INSURANCE	PERMANENT LIFE INSURANCE
The premium is fully employer-paid	The premiums increase as you age	The premiums don't change
Replaces your income so that your family can maintain their dreams and lifestyle	Replaces your income so that your family can maintain their dreams and lifestyle	Pays for final expenses, such as funeral costs and nuisance debt such as credit cards
Coverage ends when you leave the District	You may have the option to change to an individual policy that you can continue	This is an individual policy that you can continue

**Terminal Illness and Living Benefits Riders are not included in Issue Ages 76+*
The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

Disability Insurance

Your ability to bring home a paycheck is your most valuable asset. We help you protect it.

Short-Term Disability (STD) Insurance

Short-Term Disability Insurance helps replace a portion of your income if a covered injury or illness keeps you out of work for an extended period of time. The plan pays a weekly benefit of 60% of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit is $1,250. The minimum weekly benefit is $15.

Benefits become payable after a 14-day waiting period. Benefits can continue until you are no longer disabled, or until Long-Term Disability benefits are payable, whichever occurs first, but no longer than the 166th day of disability.

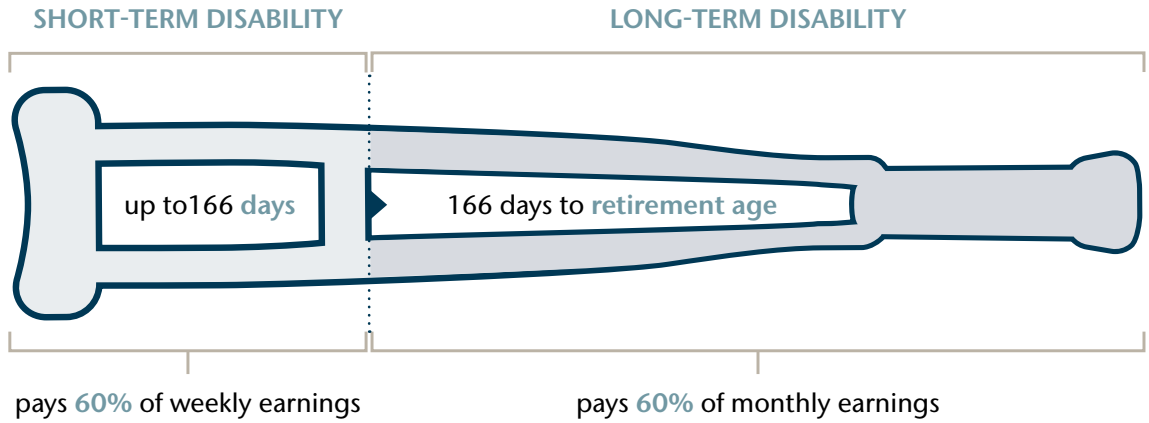
Evidence of Insurability (EOI) is required after your initial 30-day new hire window.

Long-Term Disability (LTD) Insurance

Long-Term Disability Insurance helps protect your finances when your disability continues beyond the period covered by the STD plan. The LTD plan pays a monthly benefit of 60% of the first $10,000 of your pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $6,000. The minimum monthly benefit is the greater of $100, or 10% of your LTD benefit before reduction by deductible income.

Benefits become payable after a 180-day waiting period. If you become continuously disabled before age 62, benefits can continue during disability until age 65, or to Social Security Normal Retirement Age (SSNRA), or three years six months, whichever is longest. Additional rules apply if disability occurs at age 62 or older.

Evidence of Insurability (EOI) is required after your initial 30-day new hire window.



The number of American workers receiving disability benefits nearly doubled from **4.6 million** workers in 1998 to more than **8.5 million** workers in 2018.

Social Security Administration, Disability Insurance, 2018

Identity Theft Protection

Digital thieves constantly discover new ways to extract your personal information, open credit accounts in your name, sell your sensitive data on the dark web, and take over your financial accounts.

We offer comprehensive Identity Theft Protection that safeguards multiple gateways into your identity and credit.

Protection Services Include:

- Credit Reports and Monitoring
- Court Records Monitoring
- Bank Account Monitoring
- Dark Web Monitoring
- Sex Offender Registry Monitoring
- Lost Wallet and Document Replacement
- Change of Address Monitoring
- Child Social Security Number Monitoring
- Social Media Reputation Monitoring
- Full Service Identity Restoration Services
- And more

$1.48 Billion

Total losses from identity theft fraud in the U.S. in 2018.

Federal Trade Commission, Consumer Sentimental Network Data Book, 2019

Monitor Your Child's Credit Report

A child's Social Security number gives ID thieves a fraudulent "clean slate."

Monitor you child's credit report as often as your own.

Increasing Digital Threats

Percentage increase from 2017-2018

Formjacking
stealing credit card information from online payment forms

Account Takeovers

New Account Fraud
opening accounts using the victim's name

Symantec, Internet Security Report, 2019

Legal Plan

The Legal Plan provides you and your covered family members with access to a network of experienced attorneys who can help with a range of personal legal matters. Attorneys are available in person, by phone, or by email, and you will also have access to online tools and resources.

Covered Legal Services Include:

- Money matters – debt collection defense, personal bankruptcy, tax audit representation
- Home and real estate – sale or purchase of a home, landlord/tenant matters
- Estate planning – wills, powers of attorney
- Family matters – adoptions, divorce, prenuptial agreements
- Civil lawsuits – consumer disputes, small claims assistance
- Elder care issues – Medicaid, Medicare, nursing home agreements
- Driving and criminal issues – traffic ticket defense, misdemeanor defense
- And more

How to Use the Plan

1. Visit **members.legalplans.com** or call **1-800-821-6400** to find an attorney that is right for you.
2. Call the attorney you select and schedule a time to talk or meet.
3. Get legal assistance with no copays, deductibles, or claims forms when you use a network attorney for a covered matter.

To learn more, visit **info.legalplans.com** or call **1-800-821-6400**.

Other Benefits

Employee Assistance Program (EAP)

The EAP offers you and your family members free, 24/7 access to professional help through the Cordova Counseling Center. The program offers information, consultation, and counseling (up to four visits per problem per year) for issues such as mental health, substance abuse, financial and legal problems, stress, family problems, bereavement, and more.

To schedule an appointment, call **1-850-474-9882** weekdays between 7 a.m. and 5 p.m. (CT). Counselors are also available for after-hours emergencies or urgent situations.

ECSD Center for Health & Wellness

The ECSD Center for Health and Wellness can diagnose, treat, and prescribe medication for a variety of common illnesses and minor injuries. It can also provide health assessments, coaching, and disease management. To schedule an appointment, call **1-850-444-3400** or visit **www.mymarathon-health.com**.

Virtual Visits

A Virtual Visit lets you talk with a doctor from your laptop or mobile device. You have access to a network of Virtual Visit provider groups. To learn more, log in to **myuhc.com** or the UnitedHealthcare app.

Contact Information

BENEFIT	CONTACT	PHONE NUMBER	WEBSITE
Medical, Prescription & Virtual Visits	UnitedHealthcare	1-866-844-4864	myuhc.com
Critical Illness, Accident & Hospital Confinement	Aflac	1-800-433-3036	www.aflacgroupinsurance.com
Personal Wellness Appraisal Program	Marathon Health	1-850-444-3400	www.mymarathon-health.com
Dental	The Standard	1-800-547-9515	www.standard.com/individual
Vision	Humana Insight	1-877-398-2980	www.humana.com
Health Savings Account	Optum Bank	1-866-234-8913	www.optumbank.com
Flexible Spending Accounts	WageWorks (HealthEquity)	1-877-924-3967	www.wageworks.com
Life and AD&D	Standard Insurance Company	1-800-628-8600	www.standard.com/individual
Permanent Life	Transamerica	1-888-763-7474	www.transamericabenefits.com
Short-Term Disability & Long-Term Disability	Standard Insurance Company	1-800-368-2859 1-800-368-1135	www.standard.com/individual
Identity Theft Protection	CyberScout (Sontiq)	Pre-enrollment/Questions: 1-844-858-9581 Post-enrollment: 1-888-682-5911	www.cyberscout.com
Legal Plan	MetLife	1-800-821-6400	members.legalplans.com
Employee Assistance Program	Cordova Counseling	1-850-474-9882	www.cordovacounselingcenter.com
Employee Medical Center (Marathon Health)	ECSD Center for Health & Wellness	1-850-444-3400	www.mymarathon-health.com

Online Enrollment

Visit BenefitFocus's Employee Benefits Enrollment portal located under the District's main website under "Staff". You will use your District's sign-in credentials for direct access into the portal.

Benefitplace® Mobile App

Search for “Benefitplace” in the App Store or Google Play and download to your mobile device. Use Company ID **escambiabenefits** to activate the app. You will need to use your prior BenefitFocus username and password or register if you are a first-time app user.

2023 Benefit Plan Premiums

Below are the employee premiums for benefits effective January 1, 2023.

Medical Plans

TIER	UNITED CHOICE HSA PLAN		UNITED BASE HRA PLAN		UNITED CHOICE HRA PLAN		IN-HOSPITAL INDEMNITY PLAN	
	MONTHLY RATES	BIWEEKLY RATES	MONTHLY RATES	BIWEEKLY RATES	MONTHLY RATES	BIWEEKLY RATES	MONTHLY RATES	BIWEEKLY RATES
Employee Only	$59.57	$35.74	$122.95	$73.77	$175.63	$105.38	$0.00	$0.00
Employee + Spouse	$293.17	$175.90	$403.49	$242.09	$511.79	$307.07	N/A	N/A
Employee + Child(ren)	$247.76	$148.66	$339.51	$203.71	$430.05	$258.03	N/A	N/A
Employee + Family	$419.11	$251.47	$574.98	$344.99	$729.50	$437.70	N/A	N/A
Dual Spouse	$118.94	$71.36	$215.24	$129.14	$295.81	$177.49	N/A	N/A
Dual Spouse + Family	$243.37	$146.02	$349.95	$209.97	$492.12	$295.27	N/A	N/A

Dental Plans

TIER	BASE PLAN		ENHANCED BUY-UP PLAN	
	MONTHLY RATES	BIWEEKLY RATES	MONTHLY RATES	BIWEEKLY RATES
Employee Only	$5.23	$3.14	$10.19	$6.11
Employee + Spouse	$22.55	$13.53	$38.75	$23.25
Employee + Child(ren)	$22.83	$13.70	$39.15	$23.49
Employee + Family	$40.51	$24.31	$65.03	$39.02
Dual Spouse	$9.90	$5.94	$26.10	$15.66
Dual Spouse + Family	$27.86	$16.72	$52.38	$31.43

Vision Plan

TIER	VISION PLAN	
	MONTHLY RATES	BIWEEKLY RATES
Employee Only	$7.43	$4.46
Employee + Family	$21.28	$12.77

Escambia County Public Schools 2023 Annual Required Notices

The following pages include:

- Health Insurance Marketplace Coverage Options
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- HIPAA Special Enrollment Notice
- Patient Protections Notice
- Notice of Availability – ECSD Health Plan Notice of Privacy Practices
- Women's Health and Cancer Rights Act Notice
- Your Prescription Drug Coverage and Medicare
- Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT
- Coverage Continuation Rights under COBRA
- Notice Regarding Wellness Programs
- Protections from Disclosure of Medical Information

NOTE: This statement is intended to summarize the benefits you receive from The Escambia County School District. The actual determination of your benefits is based solely on the plan documents provided by the carrier of each plan. This summary is not legally binding, is not a contract, and does not alter any original plan documents. For additional information, please contact the Human Resources department.

Important Legal Notices

Important Notice About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current School District of Escambia County will not be affected. If you do decide to join a Medicare drug plan and drop your current School District of Escambia County coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact Employee Benefits for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through School District of Escambia County changes. You also may request a copy of this notice at any time.

For More Information about Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 800-MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: August 2022
Name of Entity/Sender: School District of Escambia County
Contact-Position/Office: Risk Management & Benefits
Address: 75 North Pace Blvd., Pensacola, FL 32505
Phone Number: 850-469-6267

Important Legal Notices

HIPAA Special Enrollment Opportunity

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Also, if you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, contact Florida Blue at 800-545-6565 ext. 25305.

A federal law called HIPAA requires that we notify your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Special Enrollment Provision

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

All enrollment changes due to special enrollment rights are subject to the approval of the Plan Administrator.

HIPAA Privacy Notice Reminder

The health plans offered by School District of Escambia County are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule to maintain the privacy of your health information. The Notices of Privacy Practices for our Health plans are available from the insurance carriers; in addition, you may also request a copy of a Notice by calling your insurance provider. **Be assured School District of Escambia County and our insurance carriers fully comply with this requirement.**

Note: Because this reminder is required by law, you will receive separate reminders from each of the insurance plans in which you enroll as well as other providers describing the availability of their HIPAA notice of privacy practices and how to obtain a copy.

Woman's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the group medical plan.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Legal Notices

Family Medical Leave Act (FMLA)

What does the Family and Medical leave act provide?

The Family and Medical Leave Act (FMLA) provides eligible employees up to 12 work weeks of unpaid leave a year, and requires group health benefits to be maintained during the leave as if employees continued to work instead of taking leave. Employees are also entitled to return to their same or an equivalent job at the end of their FMLA leave.

Who can take FMLA leave?

To be eligible to take leave under FMLA an employee must:

- Have worked 1,250 hours during the 12 months prior to the start of the leave (Note: Full-time teachers and other exempt employees are assumed to have worked 1,250 hours unless proven otherwise), and
- Have worked for the employer for 12 months (in total, not consecutive) within the last 7 years.

When can an eligible employee use FMLA leave?

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid, job-protected leave (26 weeks in the case of military caregiver leave described below) in a 12 month period for one or more of the following reasons:

- For the birth of a child:
- For the placement with the employee of a child for adoption or foster care;
- To take medical leave when the employee is unable to work due to a serious health condition;
- To care for an immediate family member (spouse, child or parent-but **not** parent "in-law") with a serious health condition;
- To care for a spouse, son, daughter, parent or next-of-kin on covered active duty service with a service-related serious health condition or injury;
- To deal with a qualifying emergency arising from a son's, daughter's, spouse's or parent's (but **not** parent "in-laws") active duty service or call to active duty service for deployment to a foreign country.

Responsibilities to the District Employees Requesting Leave.

It is the responsibility of the employee to notify their supervisor and provide at least thirty (30) days notice before the date the FMLA leave is to begin if the need for the leave is foreseeable. If the need for the leave is not foreseeable, you must give notice that you need to take a leave of absence as soon as practicable, but in no circumstances later than the next business day after you become aware of the need for the leave,. If you fail to adhere to these timeframes for notice, your request for leave may be delayed or denied. The required forms will be provided to you by the administrative office at your work location or the Human Resources Department.

Procedures on what you should do when taking a leave under FMLA:

- Inform your immediate supervisor at your work location.
- Request FMLA forms (4 part packet) from your work location or Human Resources.
- Submit a request for leave (normal form submitted when taking time off) it can be signed by your administrator to confirm notification but final approval is received from the Human Resources department.
- Contact Payroll to discuss how this leave will impact your pay.
- Complete and submit all required forms to HR for processing.
- Contact Benefits to discuss premium payment while on unpaid leave OR if leave will be unpaid, contact the Benefits Team to discuss premium payments

Contact:	Employee Benefits Specialist
Address:	75 North Pace Blvd., Pensacola, FL 32505
Phone:	850-469-6267

Important Legal Notices

Summary of Benefits and Coverage (SBC) Availability Notice

As required under the Patient Protection and Affordable Care Act, insurance companies and group health plans are providing consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. The purpose of the summary of benefits and coverage document is to help you better understand the coverage you have while allowing you to easily compare different coverage options. It summarizes the key features of the plan, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

As a result of the Patient Protection and Affordable Care Act (i.e. health care reform), School District of Escambia County is required to make available a Summary of Benefits and Coverage (SBC), which summarizes important health plan information such as plan limits, coinsurance, and copays. The SBC is intended to provide this information in a standard format to help you compare across health plan options.

The SBC is available on the School District of Indian River County's Benefit Landing Page:
http://www.explainmybenefits.com/sdirc/

Please note that an SBC is not intended to be a complete listing of all of the plan provisions. For more detailed information, please refer to the SPD and the plan document, collectively known as the plan documents. If there are any discrepancies between the SBC and the plan documents, the plan documents prevail. Plan Documents are also available by contacting the Employee Benefits Department.

Discrimination is Against the Law

School District of Escambia County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. School District of Escambia County does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

School District of Escambia County

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

Qualified sign language interpreters

- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - ♦ Qualified interpreters
    - ♦ Information written in other languages

If you need these services, contact Equity & Compliance Officer. If you believe that School District of Escambia County has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Name & Title—Kelly Krostag, Director of Human Resources
Address—75 North Pace Blvd., Pensacola, FL 32505
Phone—850-469-6166
Email - kkrostag@ecsdfl.us

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Stacy Haas is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https ://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs .gov/oc r/office/ file/index.html.

Social Security Numbers Generally Required for Enrollment

Under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), the Centers for Medicare and Medicaid Services (CMS) generally requires Social Security numbers for employees and dependents to assist with reporting under the Medicare Secondary Payer requirements. Accordingly, School District of Indian River will require that you provide Social Security numbers at the time of enrollment, so that School District of Escambia County can assist its health plan administrator(s) to comply with this requirement.

For a newborn or newly adopted child, the newborn may be enrolled, provided that School District of Escambia County is notified within 30 days of the birth, adoption, or placement for adoption. However, if a Social Security number is not provided by the later of (1) the end of the plan year, or (2) 90 days following the birth, adoption, or placement for adoption, the child will be disenrolled from the plan and will no longer be considered eligible for coverage. The child cannot be re-enrolled until the Social Security number is provided, and the child meets one of the mid-year enrollment or change in status coverage events.

COBRA

If you, your spouse, or eligible dependent loses coverage under any School District of Escambia County group medical or dental plan because of a COBRA-qualifying event, you may have the right to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For details about qualifying events, refer to the Initial COBRA Notice.

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

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

Important Legal Notices

Your Group Benefits Under Section 125

Your employee benefit program is a Premium Conversion Plan ("Plan") that is administered under the provisions of Section 125 of the Internal Revenue Code ("Code"). These provisions permit your contributions for various employee benefit plans to be deducted from your gross pay before calculation of withholding taxes. The result is that you have fewer taxes deducted from your paycheck, which increases your take home pay.

Plan elections you make during your initial enrollment and annual enrollment periods are binding for the applicable Plan year. In addition to the HIPAA Special Enrollment Right certain permitted mid-year Plan election changes are permitted. These permitted election changes are discussed below.

All enrollment changes due to a permitted election change are subject to the approval of the Plan Administrator. The Plan Administrator will have the discretionary authority to make a determination as to whether an election change has occurred in accordance with the rules and regulations of the Internal Revenue Service

Change in Status

Please see the Notice of HIPAA Special Enrollment Rights for election change during the Plan Year if you experience a Change in Status event. You must notify the Plan Administrator within 31 days of the event. Any election change due to a Change in Status event must be on account of and consistent with your Change in Status as determined by the Plan Administrator.

Generally, an election change will be considered consistent with your Change in Status only if it is on account of and corresponds with a Change in Status that affects an individual's eligibility for coverage under the Plan or a plan maintained by the employer of your Dependent. A Change in Status that affects eligibility under an employer's health plan includes a Change in Status that results in an increase or decrease in the number of your Dependents who may benefit from coverage under the Plan.

Permitted Change in Status events under the Plan include the following:

- Change in your legal marital status due to marriage, divorce, legal separation, annulment, or death of your spouse, or you enter into a domestic partnership, dissolve a domestic partnership or your Domestic Partner dies.
- Change in the number of your Dependents due to birth, death, adoption, or placement for adoption.
- Change in employment status of you, your covered Dependents including a termination or commencement of employment, commencement of or return from an unpaid leave of absence, a change in worksite, or any other change in employment status, if such change in employment status affects eligibility under a plan.
- Change in eligibility status of your Dependent Child(ren) on account of age, or any other circumstance affecting eligibility.
- Change in residence of you or your covered Dependent.

Qualified Medical Child Support Orders. If required by a Qualified Medical Child Support Order ("QMCSO"), you and/or an eligible dependent will be enrolled in the Plan in accordance with the terms of the order. Any required premiums will be deducted from your compensation. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Medical Plan's procedures governing QMCSO determinations.

You may make an election change to cancel coverage for your child if a QMCSO requires your spouse, former spouse, or other individual to provide coverage for the child; and that coverage is actually provided.

Entitlement To or Loss of Entitlement To Medicare or Medicaid. If you or your Covered Dependent becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), you may make a prospective election change to cancel or reduce coverage under the Plan for you or your applicable covered Dependent. In addition, if you or an eligible Dependent has been entitled to coverage under Medicare or Medicaid and loses eligibility for such coverage, you may make a prospective election to commence or increase your or your eligible Dependent's coverage, as appropriate, under the Plan.

Significant Change in Cost or Coverage Changes. You may also change your election mid-year due to a significant change in Plan cost or coverage, as provided below.

Significant cost changes. If the cost you are charged for a coverage option significantly increases or decreases during the Plan Year, you may make a corresponding change to your Plan election. Changes that may be made include commencing participation in the Plan for an option with a decrease in cost, or, in the case of an increase in cost, revoking an election for that coverage and, in lieu thereof, either receiving on a prospective basis coverage under a Plan option providing similar coverage or dropping coverage if no option providing similar coverage is available.

Significant coverage changes curtailment with or without loss of coverage.

Significant Curtailment without loss of coverage. If you or your covered Dependent has a curtailment of coverage under the Plan that is significant, but does not represent a total loss of coverage (for example, there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost sharing limit), you may revoke your Plan election and elect to receive on a prospective basis coverage under another Plan option providing similar coverage. Coverage under the Plan is significantly curtailed only if there is an overall reduction in coverage provided under the Plan so as to constitute reduced coverage generally. Thus, in most cases, the loss of one particular physician in a network does not constitute a significant curtailment.

Significant curtailment with loss of coverage. If you or your covered Dependent has a curtailment of coverage under the Plan that constitutes a total loss of coverage, you may revoke your Plan election and elect either to receive on a prospective basis coverage under another Plan option providing similar coverage or to drop coverage if no similar option is available. A loss of coverage means a complete loss of coverage under the Plan option or other coverage option.

Addition or improvement of a benefit package option. If the Plan adds a new coverage option, or if coverage under an existing coverage option is significantly improved during the Plan Year, the Plan may permit eligible employees (whether or not they have previously made an election under the Plan or have previously elected a coverage option) to revoke their election under the Plan and to make an election on a prospective basis for coverage under the new or improved coverage option.

Change in coverage under another employer plan. You may make a prospective election change that is on account of and corresponds with a change made under another employer plan if (i) the other plan permits participants to change an election as described in this section, and (ii) the other plan permits participants to make an election for a period of coverage that is other than the Plan Year. For example, if you elect coverage through your spouse's employer's plan and that plan has a different annual enrollment period from this Plan, you may make a corresponding election change.

Family and Medical Leave Act. If you take leave under the Family and Medical Leave Act (FMLA) you may revoke an existing Plan election and make another election for the remaining portion of the Plan year as may be provided for under the FMLA and regulations of the Internal Revenue Service.

Exchange Enrollment. Two mid-year election changes will be available to participants who meet the requirements of these election changes.

Reduction of Hours. If your hours are reduced to an expected average of less than 30 hours per week, you may revoke your election for coverage under the Plan if you intend to enroll in coverage offered in a government-sponsored Exchange (Marketplace) or in another group health plan that offers minimal essential coverage. This election change may be made even if the reduction in your hours would not cause you to lose coverage under the Plan. You will be required to provide the Plan Administrator with evidence that you intend to enroll in another plan with coverage effective no later than the first day of the second month following the revocation (i.e., if your coverage is revoked in May, coverage under the new plan must begin on July 1).

Obtaining Cover Through the Health Insurance Marketplace. If you are enrolled in the Plan and are eligible to enroll for coverage in a government-sponsored Exchange (Marketplace) during a special or annual open enrollment period, you may prospectively revoke your election for Plan coverage, provided that you certify that you and any related individuals whose coverage is being revoked have enrolled or intend to enroll for new Exchange coverage that is effective beginning no later than the day immediately following the last day of Plan coverage.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA—Medicaid	IOWA—Medicaid and CHIP (Hawki)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
ALASKA—Medicaid	**KANSAS - Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
ARKANSAS—Medicaid	**KENTUCKY - Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 / Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
CALIFORNIA - Medical	**LOUISIANA - Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 / Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618- 5488 (LaHIPP)
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**MAINE - Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003, TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740, TTY: Main relay 711
FLORIDA - Medicaid	**MASSACHUSETTS - Medicaid and CHIP**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 1-617-886-8102
GEORGIA - Medicaid	**MINNESOTA - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
INDIANA—Medicaid	**MISSOURI - Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) *(Cont'd)*

MONTANA - Medicaid	RHODE ISLAND—Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEBRASKA - Medicaid	**SOUTH CAROLINA- Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA - Medicaid	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW HAMPSHIRE - Medicaid	**TEXAS - Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW JERSEY—Medicaid and CHIP	**UTAH - Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIPWebsite: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NEW YORK—Medicaid	**VERMONT - Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH CAROLINA—Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
NORTH DAKOTA—Medicaid	**WASHINGTON - Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OKLAHOMA—Medicaid and CHIP	**WEST VIRGINIA - Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
OREGON—Medicaid	**WISCONSIN - Medicaid and CHIP**
Website: http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
PENNSYLVANIA—Medicaid	**WYOMING - Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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 & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact .

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health Insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name School District of Escambia County	**4. Employer Identification Number (EIN)** 59-6000597	
5. Employer address 75 North Pace Blvd.	**6. Employer phone number** 850-469-6267	
7. City Pensacola	**8. State** Florida	**9. ZIP code** 32505
10. Who can we contact about employee health coverage at this job? Benefit Specialist—Risk Management & Benefits		
11. Phone number (if different from above) n/a	**12. Email address** benefits@ecsd.us.fl	

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

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

☒ All employees. Eligible employees are:

All regular employees working at least 20 hours per week.

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

An employee's legal spouse, the covered employee's natural newborn, adopted or step child(ren) until the end of the plan year in which he or she turns 26, the newborn child of a covered dependent child for 18 months after birth , and handicapped children beyond age 26. See Summary Plan Description for more information.

☐ We do not offer coverage

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee, or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Important Legal Notices

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must: o
- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact 1-800-985-3059 for information and complaints.
Visit as www.cms.gov/nosurprises/consumersfor more information about your rights under federal law.

Important Legal Notices

Patient Protection Provider Choice
Florida Blue generally requires the designation of a primary care provider for members of the HMO plan. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Florida Blue designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Florida Blue at 1-877-352-2583.
For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Florida Blue or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services,
following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Florida Blue at 1-877-352-2583.

Patient Protection and Affordable Care Act (PPACA, or Health Care Reform)
The Affordable Care Act (ACA) has brought sweeping changes to the U.S. health insurance system. Its goal is to make health insurance available to everyone, regardless of medical history or ability to pay. Many of the ACA changes have already affected our plans, such as covering adult children through age 26, free preventive care, reducing or removing annual or lifetime limits on essential health benefits, and the $2,750 cap on Medical Expense FSA contributions. Some of the biggest changes resulting from the law took effect January 1, 2014. These changes are explained below.
Medical Plan Enhancements
All of the medical plans offered by School District of Indian River comply with the required changes and result in the following changes: (1) The annual maximum includes the annual deductible. (2) The annual out-of-pocket maximum is capped, lowering the maximum that you could pay for eligible health care expenses in a year.

Social Security Numbers
Effective January 2016, the Affordable Care Act (ACA) will require employers and health insurance carriers to file reports under the Internal Revenue Code to establish compliance with the employer mandate. As part of this requirement, School District of Indian River County must provide Social Security numbers for all individuals covered by a School District of Escambia County sponsored medical plan. In compliance with the ACA requirements, you will be asked to provide Social Security numbers for yourself and all dependents enrolled in a School District of Escambia County sponsored medical plan. If you are unable to respond to this request our health insurance carrier may also request Social Security numbers for your enrolled dependents.

Glossary

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

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

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

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

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

Employer Contribution—School District of Escambia County provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

Generic drug—Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

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

Plan year—The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

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