Madison County School Board



EMPLOYEE BENEFIT GUIDE

October 1, 2025 through September 30, 2026

This document is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

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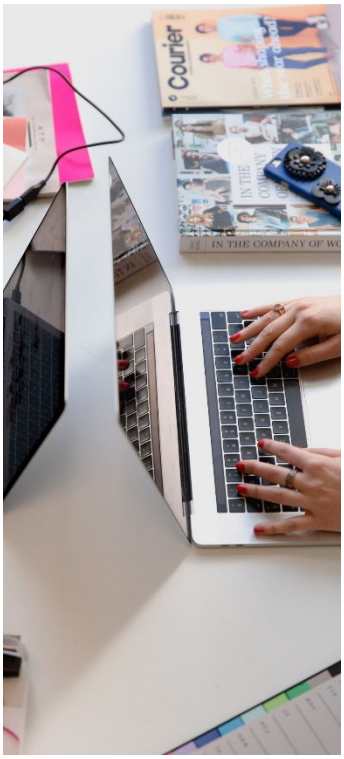
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WELCOME

Madison County School Board is committed to providing our employees with a comprehensive benefits program to help you stay healthy and feel secure. This booklet will describe those benefits which include medical, dental, vision, life/AD&D, voluntary life/AD&D, disability and lifestyle benefits. For a detailed description of these benefits please refer to the applicable Certificates of Coverage.



ANNUAL OPEN ENROLLMENT

During the annual open enrollment period, you may make changes to your benefit plan elections and/or the family members you cover. Changes can only be made outside of the annual enrollment period if you experience a qualified life event. Now is the time to carefully review your plan options. Open Enrollment for our benefit plans will be conducted August 19th through August 22nd. Elections you make during open enrollment will become effective October 1, 2025.

WHAT'S NEW FOR 2025-2026

Medical and Dental insurance are renewing with Florida Blue

- No change to plans or premiums

Vision Insurance is renewing with VSP

- No change in plans or premiums

Life Insurance is renewing with The Standard

- No change to plans or premiums unless you change voluntary life coverage or move to a new age band

Long Term Disability is renewing with USAble

- No change to plans or premiums
- Coverage will continue to be employer paid for employees on the HIP plan who have declined medical coverage

WHO WE COVER

Employees are eligible to participate in the Madison County School Board employee benefits program:

- if they work 20 or more hours a week. Coverage will be effective 1st of the month following 30 days of employment.

Dependent Eligibility

A dependent is defined as the participant's legal spouse and dependent child(ren) who reside in the household and depend primarily on the participant for support. Dependent children may be covered as follows:

- Medical
  - ❑ To end of the calendar year following their 30th birthday with no eligibility requirements
  - ❑ Florida's over age dependent mandate law requires that eligibility requirements for dependents between ages 26 and 30 can only be equal to or less than the requirements stated in the law. Those dependent eligibility requirements are:

    From their 26th birthday to the end of the calendar year of their 30th birthday if they are unmarried and do not have a dependent of his or her own, are a resident of Florida or a student, not enrolled in any other health plan, and not entitled to benefits under Title XVIII of the Social Security Act unless the child is disabled
- Dental
  - ❑ Until age 30
- Vision
  - ❑ Until age 25, or until the end of the calendar year in which the child reaches the age of 25 if living in the household, or a full time or part-time student
- Voluntary Life
  - ❑ Unmarried dependent children from live birth to age 20, or to age 24 if full time student



QUALIFIED LIFE EVENTS

Premiums for medical, dental, and vision insurance are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

• Marriage	• Divorce or legal separation (subject to State regulations)
• Death of spouse, child or other qualified dependent	• Birth, gain legal custody or adoption of child
• Gain or loss of other group coverage (including Medicare coverage)	• Change in employment status for employee, spouse or dependent
• Change in residence due to an employment transfer	• Change of dependent status
• An increase or decrease in your work hours causes eligibility or ineligibility	• Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60-day notification period).

IMPORTANT

If you experience a qualifying event, **you must contact Human Resources within 30 days of the qualifying event** to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. You will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

MEDICAL INSURANCE TERMS

Coinsurance
Coinsurance is the percentage of the medical services you are responsible to pay after the deductible has been met. Once you have met your deductible for the plan year, you pay the coinsurance amount up to the out-of-pocket maximum.

Copay
A fee you pay every time you get medical care or a prescription. Copays can vary based on where you get care.

Deductible
A deductible is the amount of money you must pay before the plan begins paying benefits for specified services. Deductibles do not apply to all services- see summary plan description for application.

Embedded Deductible
Plan begins paying benefits that require cost sharing for the first family member who meets the per-person deductible. Once one or more of the remaining family members meet the family deductible the plan pays benefits for all covered family members.

Explanation of Healthcare Benefits (EOB)
A letter you receive after getting care that shows costs, the amount the health plan is expected to pay and the amount you are expected to pay. You do not pay anything when you receive an EOB.

Non-Embedded Deductible
When the family deductible is met the plan beings sharing costs for each member. The deductible can be met by one or combination of family members.

Out-of-Pocket Maximum
The out-of-pocket maximum is the maximum amount you will pay, inclusive of copayments/coinsurance and deductibles for covered services, in a plan year. Once you have reached the out-of-pocket maximum during a policy year the plan pays any remaining eligible services at 100%.

Premium
Your regular payment to your health plan. Generally, a higher premium means lower monthly out-of-pocket costs, and a lower premium means higher out-of-pocket costs. Your premium does not count towards your deductible or out-of-pocket maximum.



Plan Milestones and Stages

1. When your plan begins, you're in the first stage. You pay for all your covered medical costs until you hit the **deductible**.
2. After hitting your deductible, you enter the next stage. You now pay only a percentage of your medical costs and the health plan pays the rest. This is the **coinsurance** stage of your plan.
3. The coinsurance stage lasts until you reach the **out-of-pocket** maximum. At that point, the plan starts paying for all covered medical costs for the rest of the plan year.

MEDICAL INSURANCE TERMS

In-Network
In-network refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider because those networks provide services at lower cost to the insurance companies with which they have contracts. Example: You go to a doctor and the total charge is $250. You will receive a discount of $75 because you went to an in-network doctor and the negotiated rate with the doctor is lower. The insurance company pays $155. You pay what's left, which is $20.

Out-of-Network
Out-of-network refers to physicians, hospitals or other health care providers who are considered nonparticipants in an insurance plan or network. Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-network health professionals may not be covered or covered only in part by the individual's insurance company. Example: You go to a doctor and the total charge is $250. You will not receive a discount because the doctor is out-of-network. The insurance company still pays $155, but you'll be responsible for what's left, which is $95.

PPO/Copay Plan vs. High Deductible/HSA Plan
A copay plan offers convenient copays for office visits and prescriptions for ease and low costs for your everyday care needs. The High-Deductible Health Plan has higher deductible limits which apply to all non-preventative services and no copays but offers an HSA to save for current and future out-of-pocket healthcare expenses. Remember, your annual wellness visit is covered at 100%, regardless of plan choice, so don't forget to have your annual wellness visit with your Primary Care Physician.



Helpful Tools

MyBlueService™: MyBlueService ™ is a personalized web portal designed to help provide answers to some of your most common health needs. Your unique and confidential user identification code and password gives you access to your personal benefit information 24 hours a day, 7 days a week. With MyBlueService ™ you can:

- Check the status of any claims
- Get details on your plan's benefits
- Order a replacement identification card
- Request a benefits booklet
- Access claim forms and other frequently requested forms
- Search for a participating hospital or provider
- Access a map with detailed directions to participating providers and hospitals

Blue365™:

Florida Blue offers its members a program of products and services called Blue365™ to help offset the rising costs associated with healthcare by offering discounts on a variety of products and services. Some of these programs and discounts include:

- Enhanced vision care discount program
- Weight management programs
- Family health & wellness facilities
- Fitness centers
- Contact lens mail order service
- Hearing aid discount programs
- Alternative Medicines, and much more….

For more information on Blue365 ™ visit www.blue365deals.com

Healthy Resources

As a Florida Blue member, health-related information and support is available to you at no cost, 24 hours a day, 7 days a week. Information and support is provided through:

- Health Coaches — You can speak privately with experienced, licensed, health care professionals, including RN's, dieticians, and respiratory therapists 24 hours a day, 7 days a week.
- Web-based information tools where you can search over 27,000 pages of up-to-date, easy to understand information on more than 1,900 clinical topics including medical tests and medications.
- Audio tapes — Via the telephone, you may listen to audiotapes on more than 300 health care topics.

Florida Blue Mobile

A mobile website designed for everyone, that works on any Smartphone—just type in bcbsfl.com from your mobile browser. On Florida Blue Mobile you can access health information, get a snapshot of your benefits and accumulators such as deductible and out of pocket maximum. You can also access and see an image of your ID card. You can find a doctor, hospital or specialist in the provider directory customized to your plan. Get details and map it using your GPS location.

FLORIDA BLUE MEDICAL INSURANCE

Network: BlueOptions

Website: www.floridablue.com

Medical Plan Highlights	BlueOptions 05781	
	PPO Network	Non-Network
Annual Deductible	$1,500 Single | $4,500 Family	$4,500 Single | $13,500 Family
Coinsurance	30%	50%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$5,500 Single | $11,000 Family	$11,000 Single | $22,000 Family
Preventive Care	$0	Coinsurance
Virtual Visit	$0 Copay PCP | $55 Copay Specialist	Not Covered
Office Visit (PCP/Specialist)	$30 Copay PCP | $55 Copay Specialist	Deductible + Coinsurance
Outpatient Surgery	Hopsital: Deductible + Coinsurance Ambulatory Surgery Center: $200 Copay	Deductible + Coinsurance
Inpatient Hospitalization	Deductible + Coinsurance	$500 Per Admission Deductible + Deductible + Coinsurance
Emergency Room (Facility Only)	$250 Copay	$250 Copay
Urgent Care	$60 Copay	Deductible + $60 Copay
Lab/X-Ray	Lab: $0 | X-Ray: $50 Copay	Deductible + Coinsurance
Advanced Imaging	$250 Copay	Deductible + Coinsurance
Prescription Drugs Preferred Generic Preferred Brand Non-Preferred Specialty	 $10 Copay $300 Deductible + $60 Copay $300 Deductible + $100 Copay Subject to cost share	 Coinsurance $300 Deductible + Coinsurance $300 Deducible + Coinsurance Subject to cost share
Mail Order Prescription Preferred Generic Preferred Brand Non-Preferred Specialty	 $25 Copay $300 Deductible + $150 Copay $300 Deductible + $250 Copay Specialty not covered through mail order	N/A

****$1,000 basic life benefit included with BlueOptions 05781****

	Employee Monthly Premium
Employee Only	$381.74
Employee + Spouse	$1,547.46
Employee + Child(ren)	$1,158.90
Family	$2,240.14

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

FLORIDA BLUE MEDICAL INSURANCE

Network: BlueOptions

Website: www.floridablue.com

Medical Plan Highlights	BlueOptions 05196/05197	
	PPO Network	Non-Network
Annual Deductible	$3,500 if employee only coverage $7,000 per person with dependents	$7,000 if employee only coverage $14,000 per person with dependents
Coinsurance	20%	40%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$6,850 if employee only coverage $7,000 per person with dependents $14,000 family with dependents	$13,700 if employee only coverage $27,400 per person with dependents $27,400 family with dependents
Preventive Care	$0	Coinsurance
Virtual Visit	Primary Care: Deductible Specialist: Deductible + $75 Copay	Not covered
Office Visit (PCP/Specialist)	Deductible + $30 | Deductible + $75	Deductible + Coinsurance
Outpatient Surgery	Deductible + Coinsurance	Deductible + Coinsurance
Inpatient Hospitalization	Deductible + Coinsurance	$500 Per Admission Deductible + Deductible + Coinsurance
Emergency Room (Facility Only)	Deductible + $350 Copay	In Network Deductible + $350 Copay
Urgent Care	Deductible + $100 Copay	Deductible + $100 Copay
Lab/X-Ray	Deductible + Coinsurance	Deductible + Coinsurance
Advanced Imaging	Deductible + Coinsurance	Deductible + Coinsurance
Prescription Drugs Preferred Generic Preferred Brand Non-Preferred Specialty	Access to Discounts	Not Covered
Mail Order Prescription Preferred Generic Preferred Brand Non-Preferred Specialty	N/A	N/A

****$1,000 basic life benefit included with BlueOptions 05196/05197****

	Employee Monthly Premium
Employee Only	$0
Employee + Spouse	$569.13
Employee + Child(ren)	$369.65
Family	$924.72

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

FLORIDA BLUE MEDICAL INSURANCE

Network: BlueOptions

Website: www.floridablue.com

Medical Plan Highlights	BlueOptions 05907	
	PPO Network	Non-Network
Annual Deductible	$7,500 Single | $15,000 Family	$15,000 Single | $30,000 Family
Coinsurance	20%	50%
Annual Out of Pocket Maximum (Includes Deductible & Copays)	$8,200 Single | $16,400 Family	$16,400 Single | $32,800 Family
Preventive Care	$0	Coinsurance
Virtual Visit	$0 Primary Care | $60 Specialist	Not Covered
Office Visit (PCP/Specialist)	PCP: Visits 1-3 - $0; remaining visits: $30 Copay | Specialist: $60 Copay	Deductible + Coinsurance
Outpatient Surgery	Deductible + Coinsurance	Deductible + Coinsurance
Inpatient Hospitalization	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room (Facility Only)	Deductible + Coinsurance	In-Network Deductible + 20% Coinsurance
Urgent Care	$100 Copay	Deductible + $100 Copay
Lab/X-Ray	Lab: $0 | X-Ray: $60 Copay	Deductible + Coinsurance
Advanced Imaging	Deductible + Coinsurance	Deductible + Coinsurance
Prescription Drugs Preferred Generic Preferred Brand Non-Preferred Specialty	$10 Copay $300 Deductible + $60 Copay $300 Deductible + $100 Copay Subject to cost share	Coinsurance $300 Deductible + Coinsurance $300 Deducible + Coinsurance Subject to cost share
Mail Order Prescription Preferred Generic Preferred Brand Non-Preferred Specialty	$25 Copay $300 Deductible + $150 Copay $300 Deductible + $250 Copay Specialty not covered through mail order	N/A

****$1,000 basic life benefit included with BlueOptions 05907****

	Employee Monthly Premium
Employee Only	$177.08
Employee + Spouse	$1,060.41
Employee + Child(ren)	$765.97
Family	$1,585.28

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

HEALTH EQUITY HEALTH SAVINGS ACCOUNT (HSA)

A health savings account (HSA) combines high-deductible health insurance with a tax-favored savings account. Money in the savings account can help pay the costs of qualified medical expenses not covered by medical insurance for you and your dependents. Money left in the savings account earns interest and is yours to keep.

Maximum Annual Contributions	2025	2026
Self-Only Contribution Limit	**$4,300**	**$4,400**
Family Contribution Limit	**$8,550**	**$8,750**
Catch-up Contribution (Age 55 & Older)	**$1,000**	**$1,000**

Available only with medical plans 05196 and 05197

**Maximum contribution limits include both employee and employer contributions*

- Employee-owned account
- Pre-tax contribution
- Pay for any qualified medical, dental, and vision expenses for yourself, spouse, or dependents even if they are enrolled under another medical plan. (See IRS Publication 502 for a complete list of qualified medical expenses- *sample list is below*.

Acupuncture	Blood Pressure monitor	Crutches/Wheelchair	Lasik/Vision Correction Surgery	Psychologist fees
Alcohol or Drug addiction treatment	Breast pump and supplies/accessories	Dental services	Long-Term Care	Smoking Cessation
Ambulance	Chiropractor Care	Diabetic monitors, test kits, strips & supplies	Medicines (prescriptions & over-the-counter)	Speech therapy
Bandages	Coinsurance & copayments	Fertility treatment	Oxygen	Sunscreen
Birth control	Contact lenses & glasses	Hearing aids & batteries	Psychiatric care	Vasectomy

To be HSA-eligible, an individual must:

- Be covered by an HDHP – plan (BlueOptions 05196/05197 qualifies)
- Not be covered by other health coverage that is not an HDHP (with certain exceptions);
- Not be enrolled in Medicare; and
- Not be eligible to be claimed as a dependent on another person's tax return.

Why might an HSA be the right choice for you?

- It **saves you money**. For individuals with few regular health expenses, paying a traditional health plan premium can feel like throwing money out the window. HDHPs come with much lower premiums than traditional health plans, meaning less money is deducted from your paychecks. Plus, HSAs are basically "cash" accounts, so you may be able to negotiate pricing on many medical services.
- It's **portable**. Even if you change jobs, you get to keep your HSA.
- It's a **tax saver**. Contributions to your HSA are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you pay less in taxes.
- It allows for an **improved retirement account**. Funds roll over at the end of each year and accumulate tax-free, as does the interest on the account. Also, once you reach the age of 55, you are allowed to make additional "catch-up" contributions to your HSA until age 65.
- It puts **money in your pocket**. You never lose unused HSA funds. They always roll over to the next year.

FLORIDA BLUE HOSPITAL INDEMNITY PLAN

Claim Filing

HIP & Life: 800-696-8562

LTD: 877-254-0085

Hospital Indemnity Benefit

- 100% employer paid
- $250 per day for a hospital stay
- Maximum of 100 days

Life Insurance

- 100% employer paid for employees on the HIP Plan
- $25,000 in coverage
- Includes an Employee Assistance Plan
- Must be an active full-time employee

Long Term Disability

- 100% employer paid for employees on the HIP plan
- Benefit amount is 60% of basic monthly salary
- Maximum monthly benefit of $5,000

****Employees who decline medical coverage are automatically enrolled in this coverage****

FLORIDA COMBINED LIFE LIFE INSURANCE

Included only for employees enrolled on the HIP plan
$25,000 benefit

FOR ALL ACTIVE FULL TIME EMPLOYEES ON HIP WITHOUT HEALTH

GROUP TERM LIFE	**EMPLOYER CONTRIBUTION: 100%**

AMOUNT OF COVERAGE: Pays a benefit of $25,000 without evidence of insurability.

Benefits reduce, based on your age, to 65% at age 65, to 50% at age 70, to 25% at age 75, and terminate when you are no longer eligible or your retirement, whichever occurs first.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Beneficiary Assistance Program
- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Travel Assistance
- Identity Theft Protection

GROUP HOSPITAL CARE	**EMPLOYER CONTRIBUTION: 100%**

IMPORTANT: This is a fixed indemnity policy, NOT health insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

FLORIDA COMBINED LIFE LIFE INSURANCE

Included only for employees enrolled on one of the medical plans
$1,000 benefit

FOR ALL ACTIVE FULL TIME EMPLOYEES NOT ON HIP WITH HEALTH

GROUP TERM LIFE	EMPLOYER CONTRIBUTION: 100%

AMOUNT OF COVERAGE: Pays a benefit of $1,000 without evidence of insurability.

Benefits reduce, based on your age, to 65% at age 65, to 50% at age 70, to 25% at age 75, and terminate when you are no longer eligible or your retirement, whichever occurs first.

GROUP TERM LIFE insurance is designed to provide benefits to your designated beneficiary for loss of life.

GROUP TERM LIFE ALSO INCLUDES THE FOLLOWING:

- Beneficiary Assistance Program
- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Travel Assistance
- Identity Theft Protection

Life & Disability Notices

If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of Florida Combined Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. Florida Combined Life's policies set forth the rights and obligations of covered persons and Florida Combined Life. Please be aware that certain participation requirements, limitations, or exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully.

FLORIDA COMBINED LIFE EMPLOYEE ASSISTANCE PROGRAM (EAP)

Must be enrolled in medical coverage

Lucet | Employee Assistance Program

USAble Life

Support is more convenient than ever.

BetterHelp is the largest online therapy platform worldwide that makes mental health care more convenient, discreet and accessible to a licensed therapist. Professional therapy is available anytime, anywhere, through a computer, tablet or smartphone. You can connect with a licensed therapist through chat messages, phone or video calls.

Access BetterHelp

1. Login at eap.lucethealth.com, select **Request Counseling** then select **Online**.
2. Complete registration and get matched with a therapist.
3. Download the BetterHelp app and start your EAP therapy sessions. These can include individual, couple and teen therapy.
4. Verify the number of sessions covered within your EAP benefit.
5. You will receive an email from BetterHelp outlining your options after you have exhausted the covered benefit sessions.

Check sessions on your BetterHelp account

- Navigate to the upper right of your homepage and select the down arrow.
- Select **Account Settings**.
- Scroll to **Payment Settings** then view your number of remaining sessions.
- Check with your employer about questions regarding the number of available sessions.

betterhelp Message Chat Phone Video



✦ Your well-being is our priority.

Lucet EAP provides confidential support, counseling services and resources to help you overcome life challenges and live a happy, balanced life.

Call 800-624-5544 | Visit eap.lucethealth.com

Your company code: USAL903

counseling/coaching sessions, per topic, per year.

Scan to learn more at eap.lucethealth.com

FLORIDA BLUE MEMBER CARE PROGRAMS

A Community Caring for Your Health



When it comes to your health, you want the support of an experienced team that understands your needs, budget and goals. With Florida Blue, you get a network of local experts — a community of doctors, hospitals, clinics, specialists, health coaches and nutritionists — striving to improve every aspect of your health care experience. Whether you're healthy, at risk or have a serious health condition, you'll get access to the right care — where, when and how you need it.

Learn ways your health plan connects you to care in your neighborhood

You may have questions about how your plan works. Or need help finding doctors, wellness programs or community resources. You can get one-on-one support from a Florida Blue Center nurse, community specialist or local sales and service specialists.

Visit **floridabluecenters.com** or call **877-352-5830** to talk with a member of your local Florida Blue Center team.

Get your health questions answered 24/7

If you need answers right away to a general question or concern, a health coach is standing by. Nurseline is available 24/7. Simply call **877-789-2583.**

Enjoy a wellness program tailored to you

Live healthier with help from Better You Strides, an online health and wellness program personalized to your needs. You'll get tips and an action plan that will help you eat better, move more and feel happier. As you get healthier, you can earn rewards.[1]

Find the **Better You Strides** program[2] under **Health and Wellness** when you log in to your member account at **floridablue.com**.

Moms-to-be learn what to expect

If you're a mom-to-be, let the Healthy Addition® Prenatal Program be your go-to resource. Nurses will walk you through the steps of a healthy pregnancy, birth and baby, and also supply you with materials and gifts. This educational program is especially important if you have a high-risk pregnancy.

Call **800-955-7635** (option 6) to learn more.

FLORIDA BLUE MEMBER CARE PROGRAMS

Navigate a health issue

Perhaps you've had a sudden change in your health from an accident or illness. Or maybe you need extra support to get the care you need.
A care consultant can guide you through it. When you contact the Care Consultant Team, they will:

- Show you how your benefits work to manage costs
- Help you find the doctors, programs and community services you need to get well

Call the Care Consultation and Advocacy program at **888-476-2227.**

Advanced illness care and planning

If you're dealing with an advanced illness, a trained clinical specialist can help you lay out your advanced directives to ensure your care aligns with your wishes. You'll also get hospice and palliative care services, should you need them.

Reach out to the Florida Blue Care Team at **844-730-2583** to learn more.



Support for serious and chronic health conditions

If you're facing a complex health problem or a chronic condition, it can be hard to manage all you need to do. We have condition programs that can help you stay on track and let you choose how you want to engage with us:

- Nurses and other care professionals from our Care Team will work hand-in-hand with you and your doctors to keep you on the path to achieve your health goals. Between consultations with your doctor, your nurse care manager will track your progress and stay in touch with you by phone and email.
- You can also connect digitally with your nurse care manager through a secure mobile app called BlueForMe.[3] Our digital program allows you to interact through secure messaging and daily engagement, so you stay on track with a health program designed just for you.

Receive education and referrals to clinical and social services to support you through medical conditions and complex needs, like:

- Organ transplant
- Cancer treatment
- High-risk pregnancy
- Neonatal intensive care
- Diabetes
- Asthma
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Heart failure

Call your Florida Blue Care Team at **844-730-2583.**

WHERE TO GO WHEN SEEKING MEDICAL ATTENTION

Do not pay more than you must for medical care. The emergency room is meant for emergencies such as life threating illnesses and injuries. Walk-in-clinics are designed to treat common ailments, provide basic primary health care, and are typically staffed by nurse practitioners and sometimes a physician's assistant. Urgent care facilities are designed to treat patients who are suffering from acute, non-life-threatening illnesses and injuries that are beyond the capacities of a regular walk-in-clinic and are typically open for extended hours. To maximize savings, use in-network facilities.

Reasons to see your Primary Care Physician:

Chronic Conditions such as:

- Hypertension/High Blood Pressure
- Diabetes/High Blood Sugar
- High cholesterol
- Heart disease
- Arthritis
- Depression

Acute Conditions such as:

- Headache and/or fever
- Urinary tract infection
- Minor injuries
- Back, neck, shoulder, knee and/or hip pain

Benefits of visiting your PCP:

- Low copay
- Medical history is available
- Established relationship with your doctor and clinical staff

Reasons to use a Virtual Visit:

- Cough, cold or flu
- Minor strains & sprains
- Bronchitis & sinus infection
- Skin & eye issues
- Upset stomach
- Urinary tract/bladder infections
- Rashes
- Pink eye
- Pediatric issues
- Psychological issues
- Visit with a licensed therapist

Benefits of virtual visits:

- 24/7 access to care
- Low copay
- Board certified physicians
- Nationwide network
- Available on smartphone or tablet
- Use when PCP, Urgent care or Extended Hour Care Center are unavailable to you

Reasons to visit an Urgent Care:

- Acute minor trauma
- Cough, cold or flu
- Upper respiratory infections
- Strains, sprains & fractures
- Minor allergic reactions and asthma attacks
- Immunizations
- Back, neck, shoulder, knee and/or hip pain
- Minor lacerations, burns and other small wounds
- Urinary tract/ bladder infections

Benefits of urgent care visits:

- Low copay
- Shorter wait time
- Same-day appointments
- Significant savings over ER

Reasons to visit the Emergency Room:

- Any life-threatening emergency
- Any severe illness or injury
- Unresponsiveness
- Chest pain
- Weakness on one side
- Inability to speak
- Spine or head injury
- Change in mental status
- Difficulty breathing
- Uncontrolled bleeding
- Poisoning
- Severe abdominal pain



FLORIDA BLUE VIRTUAL CARE

When You Don't Have Time to Wait, You've Got Teladoc!

Provides 24/7 Access to Care

When you or a family member don't feel well and your primary care doctor or your child's pediatrician can't see you right away, you can now get care within minutes without leaving home with Teladoc.

For a cost that's less than an urgent care or ER visit, Teladoc gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It's a more convenient and affordable option for quality medical care. And there's no obligation or extra monthly fee.

Getting Started

Set up your account today—so when you need care, a Teladoc doctor is a just a call or click away.

How Does Teladoc Work?

1. **Register**
   3 easy ways: download the mobile app, visit the Teladoc website or call the number below.
2. **Provide Medical History**
   Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.
3. **Request a Visit**
   That's it! The next time you need immediate care for a non-emergency illness, you have another option

The Teladoc Difference

Teladoc can help with many non-emergency illnesses, including:

- Sinus infection
- Flu
- Cough
- Sore throat
- Rash
- Allergies
- Upset stomach
- Nausea
- Other minor health issues and more

TELADOC®

Talk to a doctor anytime.

Call today 1-800-Teladoc (835-2362) or visit Teladoc.com

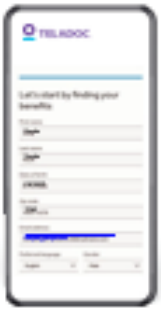
Teladoc is an independent company contracted by Florida Blue to provide physician visits via phone or online video to members with non-emergent medical issues. Teladoc is only available in the U.S. Teladoc® is a trademark of Teladoc, Inc. Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. For more information, visit floridablue.com/ndnotice. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

FLORIDA BLUE VIRTUAL CARE

How to set up your Teladoc account



Simply download the Teladoc app and follow the four steps you see below.



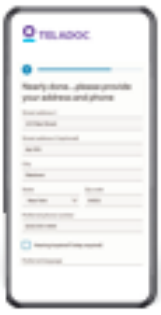
1 Confirm benefits

Provide some information about yourself to confirm your eligibility.



2 Benefit confirmation

We'll confirm that we found your benefits so you can finish creating your account.



3 Create account

Provide your contact information and preferred language.



4 Complete account

Create a username, password and pick security questions to ensure your account is secure.

Set up your Teladoc account today

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

COST SAVINGS TOOLS

Prescription Drug Cost Comparison Tools:

Use GoodRx and SingleCare's drug price search to compare prices (just like you do for travel or electronics on other sites) for your prescription at pharmacies near you. GoodRx as well as SingleCare do not sell the medications, the free website and mobile app will tell you where you can get the best deal on them. If you have insurance, your co-pay might not be the best price. Hundreds of generic medications are available for $4 or even free without insurance. Every week both GoodRx and SingleCare collect millions of prices and discounts from pharmacies, drug manufacturers and other sources. GoodRx and SingleCare will show you prices, coupons, discounts and savings tips for your prescriptions at pharmacies near you. There is no cost or membership required to use either of these cost savings tools. Please visit the websites at **www.goodrx.com and www.singlecare.com. You can also download these apps on your smartphone. Please note: amounts paid for prescriptions using GoodRx or SingleCare's discount programs do not apply toward your medical plan's deductible or annual out of pocket maximum.**



SingleCare

Pharmacy Discount Programs:

Before you pay for your next prescription, check to see if they are available for free or at a lower cost than traditional copays. Pharmacies such as Wal-Mart, Costco, CVS/Target, and Publix offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30 day Supply (see each Pharmacy for specifics on their prescription discount program). If your local pharmacy is not listed below, please check with them to see if they offer any discounts.



Walmart Pharmacy

COSTCO PHARMACY
COSTCO MEMBER PRESCRIPTION PROGRAM

TARGET
CVS/pharmacy

Publix.

TRANSAMERICA SUPPLEMENTAL MEDICAL INSURANCE

Help with your medical expenses

INPATIENT HOSPITAL BENEFITS **$1,000** (multiplied by 3 for family)

Your policy pays benefits for inpatient hospital stays, inpatient procedures, inpatient physician charges, and even routine nursery care for dependent children.

OUTPATIENT HOSPITAL BENEFITS **$500**

Your policy also pays benefits (separate from the inpatient hospital benefits) for:

- Radiological diagnostic testing performed in a hospital outpatient facility or a magnetic resonance imaging (MRI) facility
- Radiation therapy or chemotherapy authorized by a designated specialist for outpatient cancer treatment
- Outpatient surgery performed in a hospital facility, free-standing surgery center, or physician's office
- MRIs, CT scans, PET scans, diagnostic ultrasounds, and electrocardiogram (EKG) test performed in a physician's office (X-rays and lab fees are not included)
- Cardiac catheterizations and stress tests
- Accident, injury, or emergency condition treatment in a hospital ER or urgent care center

ACCIDENT-ONLY AMBULANCE BENEFIT **$1,000**

This benefit is payable when ambulance transportation (ground or air) is required to a hospital or emergency center for injuries sustained in an accident. Ambulance transportation must be within 72 hours of the accident and must be provided by a licensed professional ambulance company

ELIGIBILITY

You must be actively employed qualifying as an eligible insured and have an employer's basic, major medical, or comprehensive medical plan

****Only available with medical plans 05781 and 05907****

FLORIDA COMBINED LIFE DENTAL INSURANCE

Network: BlueDental Choice

Website: www. floridabluedental.com

Benefits	Dental Low Plan	
	PPO Network	Non-Network[1]
Annual Deductible	$50 Individual | $150 Family	$50 Individual | $150 Family
Annual Plan Maximum	$1,000	$1,000
Orthodontia Lifetime Maximum	N/A	N/A
Diagnostics & Preventive Services		
Exams, Cleanings, X-Rays	100%	100%
Basic Services		
Sealants, Fillings, Extractions	60%	60%
Major Services		
Implants, Crowns, Bridges, Dentures	40%	40%
Orthodontic Services		
Orthodontia Treatment - Child to Age 19	N/A	N/A

1 If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount. **Out of network benefits are based on MAC (Maximum Allowable Charge)**

	Employee Monthly Premium
Employee Only	$24.45
Employee + Spouse	$46.94
Employee + Child(ren)	$53.90
Family	$76.36

For dental frequencies, please refer to certificate of coverage or benefit summary.

FLORIDA COMBINED LIFE DENTAL INSURANCE

Network: BlueDental Choice Plus

Website: www.floridabluedental.com

Benefits	Dental High Plan	
	PPO Network	Non-Network[1]
Annual Deductible	$50 Individual | $150 Family	$50 Individual | $150 Family
Annual Plan Maximum	$1,000	$1,000
Orthodontia Lifetime Maximum	N/A	N/A
Diagnostics & Preventive Services		
Exams, Cleanings, X-Rays	100%	100%
Basic Services		
Sealants, Fillings, Extractions	80%	80%
Major Services		
Implants, Crowns, Bridges, Dentures	50%	50%
Orthodontic Services		
Orthodontia Treatment - Child to Age 19	N/A	N/A

1 If you use a non-network provider, you are responsible for paying the difference in cost between the non-network provider's charges and the allowed amount. **Out of network benefits are based on 90th percentile.**

	Employee Monthly Premium
Employee Only	$31.77
Employee + Spouse	$60.95
Employee + Child(ren)	$70.00
Family	$99.17

For dental frequencies, please refer to certificate of coverage or benefit summary.

FLORIDA COMBINED LIFE DENTAL ROLLOVER BENEFIT

Included on both the Low and High Dental Plans

Website: www. floridabluedental.com

Plan Year Maximum Rollover Benefit

A Rollover Benefit is a portion of a member's un-used Plan Year Maximum that may be carried over to the next Plan Year, thereby increasing the next Plan Year Maximum amount, provided the following conditions are met:

1. the member is an active member of the plan on the last day of the plan year;
2. the member submits at least one (1) claim for a covered service during a Plan Year;
3. the member's total claims paid during a Plan Year do not exceed the Yearly Threshold Amount, as stated in the table below; and
4. the Accumulated Rollover Maximum has not been reached.

Plan's Annual Maximum* Benefit Amount	Yearly Threshold Amount	Available Rollover Amount to use next year/beyond.	Accumulated Rollover Maximum
$500 - $749	$200	$150	$500
$750 - $999	$300	$200	$500
$1,000 - $1,249	$500	$350	$1,000
$1,250 - $1,499	$600	$450	$1,250
$1,500 - $1,999	$700	$500	$1,250
$2,000 - $2,499	$800	$600	$1,500
$2,500 - $2,999	$900	$700	$1,500
$3,000 or more	$1,000	$750	$1,500

Beginning with the second (2nd) plan year of coverage under the Certificate, a member's Plan Year Maximum, as shown on the Schedule of Benefits, may be increased by the amount shown on the table above if all the above listed conditions are met. If coverage under this Rider is first provided during a partial Plan Year, the Rollover Benefit will be calculated as if coverage was provided for a full Plan Year.

Here's an example of how the Rollover Benefit works.

Plan Year	One (1)	Two (2)	Three (3)	Four (4)
Plan Year Maximum* shown on the schedule of benefits	$1,000	$1,000	$1,000	$1,000
Accumulated Rollover Amount credit from prior year	$0	$350	$700	$700
Adjusted Plan Year Maximum	$1,000	$1,350	$1,700	$1,700
Covered Service received	Yes	Yes	No	
Total Claims Paid during Plan Year	$275	$480	$350	
Rollover Amount	$350	$350	$0	
Accumulated Rollover Amount	$350	$700	$700	

The Rollover Amount can be accumulated from one Plan Year to the next, up to the Accumulated Rollover Maximum, unless:

1. the member's total claims paid during a Plan Year exceed the Yearly Threshold Amount (in this instance, there will be no additional Rollover Amount for that Plan Year), or
2. no claims for covered services are incurred during a Plan Year (in this instance, there will be no additional Rollover Amount for that Plan Year).

VSP VISION INSURANCE

Network: VSP Choice

Website: www.vsp.com



Benefits	Vision	
	PPO Network	Non-Network Reimbursements
Eye Exams | Materials	$10 Copay | $25 Copay	Up to $45 | N/A
Routine retinal screening	Up to $39 Copay	N/A
Eyeglass Lenses and Frames		
Single Standard Lenses	$25 Copay	Up to $30
Bifocal Standard Lenses	$25 Copay	Up to $50
Trifocal Standard Lenses	$25 Copay	Up to $65
Frames	$130 Allowance Featured Brands: $150 Allowance (20% savings on amount over allowance)	Up to $70
Contact Lenses		
Standard Fit and Follow Up	Up to $60 Copay	N/A
Elective Lenses	$130 Allowance	Up to $105
Medically Necessary Lenses	Covered in full after $25 Copay	Up to $210
Frequency		
Eye Exam	Once every 12 months	
Lenses—Eyeglass or Contact	Once every 12 months	
Frames	Once every 24 months	

	Employee Monthly Premium
Employee Only	$5.84
Employee + Spouse	$11.92
Employee + Child(ren)	$12.76
Family	$20.37

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

STANDARD BASIC AND VOLUNTARY LIFE/AD&D INSURANCE

Life insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help pay your mortgage, rent, run your household, send your children to college, pay off debts, etc. **Madison County School Board provides eligible, full-time employees with $10,000 of Life and AD&D at no cost to the employee**. Employees can also enroll in Voluntary Life and AD&D insurance at a group rate for themselves, spouses, and children up to the age of 20.

Summary: Voluntary Life insurance
Employee Coverage:

Guarantee Issue	$125,000
Maximum Benefit Amount	$300,000
Increments of	$5,000

Spouse Coverage: coverage based on employee age

Spouse Guarantee Issue	$25,000
Maximum Benefit Amount	$150,000
Increments of	$2,500

Not to exceed 50% of employee voluntary amount

Child(ren) Coverage

Birth to 20 years	$10,000

Not to exceed 50% of employee voluntary amount

How to calculate your Voluntary Life/AD&D costs per paycheck:

1. Indicate your elected benefit amount (EBA)
2. Divide EBA by $1,000
3. Enter age rate from cost table
4. Multiply Step 2 by Step 3
5. This amount will be your monthly payroll deduction

Employee Age	Rates per $1,000 Employee / Spouse
Under 30	$0.060
30 – 34	$0.070
35 – 39	$0.080
40 – 44	$0.120
45 – 49	$0.210
50 – 54	$0.340
55 – 59	$0.530
60 – 64	$0.830
65 – 69	$1.490
70 – 74	$2.390
75 – 79	$3.780
80+	$5.90
AD&D	$0.030
Child Life	$1.00 per month, per member

Important Reminders

- Group Life and AD&D insurance benefits reduce to 65% at age 65, 50% at age 70, and 25% age 75.
- Voluntary Life and AD&D insurance benefits reduce to 65% at age 65, 50% at age 70, and 25% at age 75.
- You must be actively at work on the effective date, or your coverage will be delayed until you return to active employment.
- Evidence of Insurability (EOI) is required for employees who want to increase coverage at Open Enrollment, and for new hires electing over the Guarantee Issue.

For limitations & exclusions, please refer to certificate of coverage or benefit summary.

The Life Services Toolkit

Resources and Tools to Support You and Your Beneficiary

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Health Advocate℠ to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard.



Services to Help You Now

Visit the Life Services Toolkit website at **standard.com/mytoolkit** and enter username "assurance" for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and advance directives.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees, and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website for guidance on how to begin, to educate yourself on funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Death Benefit,[1] you may access the services for beneficiaries outlined on the next page.

STANDARD LIFE SERVICES AND RESOURCES

Services for Your Beneficiary

Life insurance beneficiaries[2] can access services for 12 months after the beneficiary receives the Life claim letter from The Standard. Recipients of an Accelerated Death Benefit can access services for 12 months after the date of payment.

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Care Managers with advanced training are on call to provide confidential grief sessions by phone or in person. Your beneficiaries are eligible for up to six face-to-face sessions.

  Our Care Managers may offer your beneficiaries additional grief support through support kits sent to their home, based on each individual's needs. As part of this program, age-appropriate books can be sent for children and teens.

- **Legal Services:** In addition to online estate planning tools, your beneficiaries can obtain legal assistance from experienced attorneys. They can schedule an initial office visit or a telephone consultation for up to 30 minutes with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25% rate reduction from the attorney's normal hourly or fixed-fee rates.

- **Financial Assistance:** Your beneficiaries can schedule up to 30-minute telephone sessions with financial counselors who can help with issues such as budgeting strategies, and credit and debt management.

- **Support Services:** During an emotional time, your beneficiaries can receive help planning a funeral or memorial service. WorkLife advisors can guide them to resources to help manage household repairs and chores, find child care and elder care providers or organize a move or relocation.

- **Online Resources:** Your beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources about funeral costs, find funeral-related services and make decisions about funeral arrangements.



Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

For beneficiary services, visit **standard.com/mytoolkit (user name: support)** or call the assistance line at **800.378.5742**

STANDARD LIFE SERVICES AND RESOURCES

ASSIST AMERICA TRAVEL ASSISTANCE

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator



Reference Number:
01-AA-STD-5201

Download on the App Store | GET IT ON Google Play

USABLE VOLUNTARY LONG-TERM DISABILITY

If you become unable to perform your regular job duties for an extended time due to sickness or accidental injury, you can be covered by the long-term disability (LTD) policy.

Your income replacement benefit would equal 60% of your basic monthly earnings. The maximum monthly benefit you can receive is $5,000. Benefits begin after you have been unable to work for 90 days due to a covered sickness or accident and will continue to be paid for up to two years if you are disabled in your own occupation. If you are disabled in any occupation, benefits will be paid for up to age 65.

Your LTD benefit will be reduced by any disability income you receive from other sources, such as Social Security, worker's compensation, and/or state disability plans, to provide you with a combined monthly benefit equal to 60% of your basic monthly earnings.

The LTD plan contains a pre-existing condition exclusion. The exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received or for which a reasonably prudent person would have sought care within the 3-month period prior to the effective date of coverage, and the disability begins within 12 months of the effective date of coverage.

The Estimated Rate Calculation below will be based on your monthly gross income. The final premium calculations will be done by USAble.

Long-Term Disability Calculation – Cost Per Paycheck	
Annual salary divided by 12 = monthly salary	$
Enter lesser of monthly salary above or $8,333.33 (max monthly salary = max benefit divided by benefit percentage)	$
Monthly salary times rate ($0.730) divided by 100 = monthly premium	$

LTD Rate Per $100 Covered Payroll
$0.730

Long-Term Disability Calculation Example $60,000 annual salary	
Annual salary divided by 12 = monthly salary **($60,000/12) = $5,000**	**$5,000**
Enter lesser of monthly salary or max monthly salary **(max monthly salary = $5,000/.60 = $8,333.34)**	**$5,000**
Monthly salary times rate ($0.730) divided by 100 = monthly premium **($5,000 x $0.730) = $3,650; $3,650/100=$36.50**	**$36.50**

LTD insurance is covered in full for employees who decline medical coverage and are enrolled on the HIP plan

For Limitations & Exclusions, please refer to the certificate of coverage or benefit summary.

AFLAC SUPPLEMENTAL INSURANCE

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance is arranged through Aflac. Hospital Indemnity Insurance benefit payments are made directly to you, no matter what other coverage you may have, and can be used however you choose. These benefit payments can help pay for out-of-pocket healthcare costs or other household expenses which can pile up during a hospital stay. Please see the Aflac Benefit Summary for a schedule of benefits and information regarding limitations and exclusions. Coverage can be purchased for you and your eligible dependents.

ACCIDENT INSURANCE

Accident Insurance arranged through Aflac pays a benefit for over 40 different circumstances to you and/or your covered dependents which can be used for any purpose. Payments an insured person received depend on the type of injury, such as burns, dislocations, fractures, conscussions, eye injuries and lacerations. The plans also feature an organized athletic activity rider that pays an additional 10% for injuries that happen while taking part in an organized athletic event. A Wellness Rider pays when a covered wellness test is performed. Please see the Aflac Benefit Summary for a schedule of benefits and information regarding limitations and exclusions.

CRITICAL ILLNESS INSURANCE

Voluntary Critical Illness with Cancer Insurance offered through Aflac provides a lump sum benefit payment upon diagnosis of any qualified Critical Illnesses listed under covered conditions. Benefits will be paid for each reoccurrence or each different critical illness when the date of diagnosis is separated by at least 6 months. Benefits are paid directly to you when you need it most. Expenditure for claim proceeds are not limited to medical expenses but can be used at your discretion for things such as childcare, transportation and medical plan copays and deductibles. The benefits are paid even if medical insurance is paying 100% of the cost. A health screening benefit is payable once per calendar year for covered health screening tests performed as the result of preventive care. Your cost is based on your issue age, amount of coverage you select, and whether you are a tobacco user or not. Please see the Aflac Benefit Summary for a schedule of benefits and information regarding limitations and exclusions.

GROUP LIFE INSURANCE

Supplemental group life insurance is arranged through Aflac. Life insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help pay your mortgage, rent, run your household, send your children to college, pay off debts, etc. Coverage can be purchased for you and your eligible dependents. Your cost is based on your issue age, amount of coverage you select, and whether you are a tobacco user or not. Please see the Aflac Benefit Summary for a schedule of benefits and information regarding limitations and exclusions.

SHORT-TERM DISABILITY

Short-Term Disability Insurance offered through Aflac provides payment of a monthly disability benefit when a covered employee is disabled and unable to work due to an injury or sickness. Benefit payments begin after any applicable elimination period is satisfied and continue during disability, up to the disability benefit duration. Please see the Aflac Benefit Summary for a schedule of benefits and information regarding limitations and exclusions.

IMPORTANT NOTICES

Newborns' and Mothers' Health Protection Act

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. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice of Special Enrollment Rights

This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage
If you are declining coverage 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).

Marriage, Birth or Adoption
If you have a new dependent as a result of a 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, or placement for adoption.

Medicaid or CHIP
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. 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, please contact the plan administrator at (800) 352-2583.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

For additional information, contact your plan administrator at (800) 352-2583.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (800) 352-2583.

Patient Protections

FL Blue generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at (800) 352-2583.

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

You do not need prior authorization from FL 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 plan administrator at (999-999-9999).

Women's Health and Cancer Rights Act

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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan. If you would like more information on WHCRA benefits, contact HR at (850) 973-1536.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that an individual sought or received genetic services, and genetic information about a fetus carried by an individual or family member, or of an embryo legally held by an individual or family member using assisted reproductive technology.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long-Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http://www.dol.gov/vets An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

IMPORTANT NOTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

IMPORTANT NOTICES

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

IMPORTANT NOTICES

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: October 1, 2025

IMPORTANT NOTICES

Important Notice from Madison County School Board about Your Prescription Drug Coverage and Medicare, Creditable Coverage. Florida BlueOptions 05781 & 05907

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Madison County School Board 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 importantthings you need to know aboutyour 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.
- Madison County School Board has determined that the prescription drug coverage offered by Florida Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. 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 HappensTo Your Current Coverage If You Decideto Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Madison County School Board coverage will be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. Florida Blue administers the group health coverage available to Madison County School Board employees, retirees and dependents. The included prescription drug benefit provides:

Plans 05781 & 05907	Network	Non-Network	Mail Order (90-day supply)
Tier 1	$10 Copay	Coinsurance	$25 Copay
Tier 2	$300 Deductible + $60 Copay	$300 Deductible + Coinsurance	$300 Deductible + $150 Copay
Tier 3	$300 Deductible + $100 Copay	$300 Deductible + Coinsurance	$300 Deductible + $250 Copay
Tier 4	Subject to cost share	Subject to cost share	Not available through mail order

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Madison County School Board 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 the person listed below 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 Madison County School Board changes. You also may request a copy of this notice at any time.

For More Information About Your Options UnderMedicarePrescription 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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).

Or contact the person listed below.

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 Madison County School Board changes. You also may request a copy of this notice at any time.

Date: **10/01/2025**
Name of Entity/Sender: **Madison County School Board**
Contact – Position/Office: **Brandy Siplin/Employee Benefits & Payroll**
Address: **210 NE Duval Ave, Madison, FL 32340**

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options & Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

1Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023. 2An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options & Your Health Coverage

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your employers. 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.

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.

1. Employer Name Madison County School Board	**4. Employer Identification Number (EIN)** 59-6000721	
5. Employer Address 210 NE Duval Ave	**6. Employer Phone Number** 850-973-1536	
7. City Madison	**8. State** Florida	**9. ZIP Code** 32340
10. Who can we contact about employee health coverage at this job? Brandy Siplin		
11. Phone Number 850-973-1530	**12. Email Address** Brandy.Siplin@mcsbfl.us	

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options & Your Health Coverage

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

As your employer, we offer a health plan to:

☐ All employees.

☒ Some employees. Eligible employees are working 30 or more hours per week.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are a spouse of the employee, a natural child, a stepchild, a legally adopted child, a child for whom legal guardianship has been awarded to the employee or spouse, the newborn child of an enrolled dependent until the newborn reaches 18 months of age.

☐ 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. The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒**Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____(mm/dd/yyyy)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒**Yes** (Go to question 15) ☐**No** (Stop and return this form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a) How much would the employee have to pay in premiums for this plan? $0.00

b) How Often? ☐ Weekly ☐ Every 2 Weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16.What change will the employer make for the new plan year?

☐Employer won't offer health coverage

☐Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a) How much will the employee have to pay in premiums per month for that plan? $_____

Date of Change: _____

b) How Often? ☐ Weekly ☐ Every 2 Weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐Yearly

IMPORTANT NOTICES

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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – 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

To see if any other states have added a premium assistance program since March 17, 2025, 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

WHO TO CALL

Benefit	Carrier	Phone #	Website
Broker	Brown & Brown	Melanie Stegall 386-239-5779 Morgan Legath 386-239-4067	Bbrown.com
Medical	Florida Blue	800-352-2583	Floridablue.com
Hospital Indemnity Subsidy	Florida Combined Life	(800) 696-8562 (877) 254-0085	Floridablue.com
Health Savings Account	Health Equity	(866) 346-5800	Healthequity.com
Life	Florida Combined Life Lucent/ USAble	800-624-5544 Code: USAL903	Eap.lucenthealth.com
Dental	Florida Combined Life	888-223-4892	Floridabluedental.com
Vision	VSP	800-877-7195	Vsp.com
Life/AD&D	The Standard	800-628-8600	Standard.com
Long-Term Disability	USAble	800-370-5856	Usablelife.com
GAP	TransAmerica	(800) 763-7474	Transamericabenefits.com
Employee Assistance Program	USAble	Online Only	ndbh.com Company Code: USAL903
Supplemental Coverages	Aflac	(800) 433-3036	aflac.com
Travel	Assist America	(800) 872-1414	standard.com
Virtual Care	Teladoc	(800) 835-2362	teladoc.com

NOTES:

Brown & Brown

www.bbrown.com