2019 - 2020
School District of Indian River County
Benefit Enrollment Guide

Welcome to your 2019-2020 Benefit Enrollment Guide!

Our Commitment to You

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The School District of Indian River County (the "District") is committed to providing our employees with a benefits program that is both comprehensive and competitive. Our benefits program offers health care, dental and vision coverage, as well as products that help to provide income protection in an emergency.

This guide provides a general overview of your benefit choices and enrollment information to help you select the coverage that's right for you.

As a new hire and at Open Enrollment, we ask you to make benefit elections for you and your family so that you will be financially prepared for any health and life challenges you may face. Here are two easy steps you can follow to do just that:

1. Review the Benefit Guide. This guide provides highlights of your benefits, points out what is new and tells you where to get more information.

2. Consider your needs and those of your covered dependents. Life changes and so do your healthcare needs. Check to be sure your dependents are eligible for coverage and make sure their Social Security numbers and your beneficiary designations are up-to-date.

Open Enrollment

Open Enrollment for plan year 2019-20 will be

August 19th thru August 30, 2019.

Plan year 2019-20 begins on October 1, 2019 and ends on September 30, 2020.

If you do not want to make any changes to your current benefits; you do not need to take any further action unless you have a Flexible Spending Account.

Everyone with a Flexible Spending Account must re-enroll for plan year 2019-20
(The FSA provider is Chard Snyder).

If you choose to make changes to your current benefits; you must do so during open enrollment (8/19 to 8/30/2019).

Changes must be submitted on-line through the enrollment portal at www.sdirc-benefits.com.

You may call 1-321-250-1806 for assistance with the enrollment portal.

Please be sure to print a hard copy of your benefits summary to ensure that any changes you make are accurate.

No changes can be made after Open enrollment ends on August 30th.

You must confirm the accuracy of your payroll deductions with the first pay period in October to be ensure they are correct.

Payroll corrections must be requested in writing by sending an email to: Amy Yeitter at amy.yeitter@indianriverschools.org or to Joan Martin at Joan.Martin@indianriverschools.org

Corrections must be made within 30 days of the first pay period.

Reminders

- Be sure to review this 2019-2020 Benefit Guide and plan summaries **prior** to going through your enrollment process.
- Be prepared by gathering dependent and beneficiary information (i.e. Social Security Numbers and Dates of Birth). A convenient Enrollment Preparation Worksheet has been provided at the back of this guide to help you prepare for your enrollment.

WHAT'S CHANGING THIS YEAR?

CareHere Missed Appointments:

Effective immediately, we are implementing a new policy that is designed to reduce the number of "No Shows" at the Wellness Center. "No Show" appointments prevent others from being served and add to the cost of our health care. Therefore, when an employee or dependent has missed three appointments in a calendar year without cancelling, that member or dependent will be charged a $25.00 fee, deducted through payroll. The member will then be charged an additional $25.00 fee for any future missed appointments, without prior cancellation, for the remainder of that calendar year.

Eligibility

As a Benefit eligible employee of the School District of Indian River County, working the required number of hours, you will be eligible for the benefits offered in this guide. The effective date of coverage for a new employee is the first of the month, following one full calendar month of continuous active employment. Our benefit period runs from October through September each year and benefits are payroll deducted to pay for the current month of coverage. ***All new hires must enroll in benefit elections within 30 days of their hire date.***

Dependent Eligibility

You can enroll your dependents in plans that offer dependent coverage. Eligible dependents are defined as your legal spouse and eligible children who reside in your household and depend primarily on you for support. This includes: your own children, legally adopted children, stepchildren, a child for whom you have been appointed legal guardian, and/or a child for whom the court has issued a Qualified Medical Child Support Order (QMCSO) requiring you or your spouse to provide coverage. Age limits vary depending on coverage, so be sure to check each benefit.

Medical Plan Dependent Coverage

Under the Affordable Care Act, you can cover your children under the District's medical plan until the end of the month in which they reach age 26 regardless of full-time student status, marital status or place of residency.

Under Florida legislation, you may cover your eligible dependent children through the end of the calendar year in which they turn 30. To qualify, your adult child must meet all of the following eligibility criteria:

- ✓ Be unmarried and have no dependent children of his/her own
- ✓ Be a resident of the state of Florida or a full or part-time student whose parents reside in Florida
- ✓ Have no medical insurance as a named subscriber, insured enrollee or covered person under any group or not to be entitled to benefits under the Title XVII of the Social Security Act.

Other Plans Offering Dependent Coverage (Dental, Vision and Life)

Dependent children under the dental plan are covered until the end of the year in which they turn **25**. Vision coverage for dependent children will cease at the end of the month in which an eligible dependent reaches **age 25**, regardless of student status, if the dependent is unmarried.
Voluntary child life coverage is available for unmarried child through age 25.

Please Note: The School District of Indian River County will be conducting a Dependent Eligibility Verification Audit after the 2019-2020 Open Enrollment. This audit will be completed to verify if your dependents are truly eligible for benefits under School District of Indian River County. Information regarding this audit will be mailed to your home.

Paying for your Benefits

All benefits are paid through payroll deductions and some are provided to you at no cost, such as Basic Life and AD&D and EAP. The cost of other benefits, such as medical, is shared by you and the District. Additional benefits, such as Dental, Vision, Additional Life, Accidental Death and Dismemberment, and Disability insurance are paid for by you at discounted group rates.

BENEFIT	WHO CONTRIBUTES?	TAX BASIS
Medical & Prescription	Employee & The District	Pre-Tax
Basic Life/AD&D, EAP	The District	Not Applicable
Dental, Vision, Additional Life/AD&D, Disability, Retirement Plans	Employee	Pre-Tax
Additional Elective Benefits	Employee	Post-Tax

Benefits and Leave

Family Medical Leave Act — Approved Leave with Benefits

The District will continue to pay the employer's contributions for your health insurance coverages for up to 12 weeks while you are on approved FMLA leave; however, you are responsible for paying the employee cost for any health insurance coverage you have elected for yourself, and if applicable, your family.

These payments will continue to be payroll deducted until such time you go into an "unpaid leave status." At that time, you will be required to make premium payments directly to the District for each pay period as premiums cannot be payroll deducted.

Direct payment can be made by check or money order (cash payments are not accepted) to the address below. Please include your Employee ID on the check. **Failure to pay insurance premiums by the 30th of the month will result in immediate cancellation of coverage.** The amount owed is the amount normally deducted per pay as shown on your paystub in Focus.

Make payments to: School District of Indian River County (SDIRC)

Mailing Address: Employee Benefit Department

6500 57th Street, Vero Beach, Fl 32967

NON-FMLA Leave

If you go out on an approved Non-FMLA leave, you will be responsible for paying 100% of your health insurance premium. You will no longer receive the Board paid contribution.

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

1. **What happens to my benefits when I go out on Leave?** If you are on approved FMLA leave, the District will continue your benefits and pay the District cost of benefits. However, you will be required to submit payment for your share of the health insurance premiums . If you are on Non-FMLA leave, you will be responsible for paying 100% of the cost of the health insurance along with your cost of any other benefits you have elected. You will no longer receive the Board contribution to the health insurance.
2. **How do I know how much I will owe and where do I send the payment?** When you reach an unpaid leave status and benefit premiums can no longer be payroll deducted, the Employee Benefits Department will mail you a personalized leave worksheet or letter informing you of your health insurance coverage(s) and payment requirements. You may also determine your amount from your paystub.
3. **Can I add my newborn to my policy?** Yes, your newborn may be enrolled on your plan within 30 days from the birth by going online to www.sdirc-benefits.com and processing a qualifying event.
4. **Can I add other family members to my policy at the same time I add my newborn?** Yes, you can add your spouse or other dependent children at the time you add your newborn.
5. **What happens to my benefits if I don't come back from leave after my FMLA expires?** If you are on leave beyond the FMLA period, you will stop receiving the Board contribution towards the District health insurance and will be responsible for paying the total premium, whether through payroll deductions or direct payment. If payments are not received by the end of each month, benefits will be cancelled immediately.

Qualifying Events

Making Changes During the Year

Choose your benefits carefully! Contributions for plans such as medical, dental, and vision are made on a pre-tax basis and **IRS regulations state that you cannot change your benefit options during the year unless you have a qualified life event.** Qualified Life Events include:

- ✓ Marriage or divorce;
- ✓ Death of your spouse or dependent;
- ✓ Birth or adoption of a child;
- ✓ Your spouse terminating or obtaining new employment (effects eligibility for coverage);
- ✓ You or your spouse switching employment status;
- ✓ Your dependent no longer qualifies as an eligible dependent.

Qualifying Events—Additional Information

- ◊ **Newborns** will be covered under your medical plan if you have any of the District medical plans for the first 30 days from birth at no charge. YOU MUST contact the Employee Benefits Department within the initial 30 days for this coverage to be added to your health insurance deductions. If you wish to enroll the newborn and other eligible dependents to your health insurance, please read below.
- ◊ **If you do not have family coverage,** you may enroll the newborn, as well as other eligible dependents, within 30 days of the birth. If you do not complete the enrollment for the newborn/other dependents within 30 days from the date of birth, you will not be able to add them until the next Open Enrollment period unless you have another qualifying event. NOTE: You will be required to pay the Employee + Family premium (see Benefits Rate Sheet) from the date the insurance coverage is added (back to date of birth).
- ◊ **If you already have family coverage**, be sure to complete the Qualifying Event Form within 30 days to add the newborn as a new dependent. There is no increase in your family premium when adding the newborn to your existing family coverage.

A copy of the birth certificate and any other dependent documentation will be required, as backup to the qualifying event.

Submitting Qualifying Events

1. To submit a qualifying event to Employee Benefits please visit www.sdirc-benefits.com.
2. Follow the login instructions on page 9.
3. Select your applicable life event and enter the date of your life event.
4. Follow the instructions provided in the system on each life event to advise what date should be used.
5. Complete the process by following the system prompts.
6. Upload required documentation by clicking on the paper icon above the Florida Blue section.

Benefit Termination

Benefit Termination Policy

Assuming that the required premium has been paid, during the plan year, terminating employees are covered until the last day of the month:

- In which employment ends (interim employees are in this category).
- In which you cease being in a benefit eligible position.
- In which you retire.

Exceptions

◊ If You qualify for the Family Medical Leave Act (FMLA) coverage your benefits will continue as long as premiums are paid either through payroll deductions or direct payment to the District if employee goes into unpaid leave status. If leave is approved, but is Non-FMLA, you can continue benefit coverage as long as 100% of the premium are paid, see Benefits and Leave Section. Employee would no longer be eligible for Board contributions towards health premiums.

◊ If You are an instructional employee and you work through the last day of your contract period and subsequently resign, not retire, coverage will be in force **through the period already covered by paid premiums.**

When an employee leaves the District, either by involuntary or voluntary termination, benefits will end the last day of the month in which the last day was worked, so long as premiums were paid.

How to Enroll

Enrollment has never been easier. It is accessible 24 hours a day, and contains information about all of your options to help you make informed decisions.

The School District of Indian River County provides electronic enrollment through **Explain My Benefits**. Explain My Benefits provides eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment, new hire orientation and qualifying events.

You can log into the Explain My Benefits, benefits portal at any time or download the Mobile App, to review your benefits, access carrier links, update your personal information for yourself and dependents, update your beneficiaries and process qualifying life events.

How to Enroll

Decide which of these two convenient enrollment options best fits your needs:

Self-Service

- Visit www.SDIRC-Benefits.com, click on the blue "Log into Your Benefit System" button and move through the enrollment system at your own pace.
- Please see login instructions on page 5.
- If choosing this option, be sure to click "submit" at the end of the process and make note of your confirmation number. **If you do not receive a confirmation number you have not completed your enrollment and you will not be enrolled in benefits**.
- Return to the system anytime and click your confirmation number to view your confirmation statement.

Mobile App

Log into the SDIRC mobile app, select enroll from the menu on the right. Go through the enrollment process and finalize by clicking "SUBMIT".

You may call the EMB Customer Service Center at 1-321-250-1806 for assistance with the enrollment portal.

Reminders

- Be sure to review this 2019-2020 Benefit Guide and plan summaries **prior** to going through your enrollment process.
- Be prepared by gathering dependent and beneficiary information (i.e. Social Security Numbers and Dates of Birth). A convenient Enrollment Preparation Worksheet has been provided at the back of this guide to help you prepare for your enrollment.

Login Instructions

ACCESSING EMB ENROLL

Access your company's ***Benefit Resource Website*** and select ***"Log Into Your Benefit System"***

A **Access** the system using your Username and Password

B **Forgot username**
- Enter your 9-digit ID (SSN without dashes)
- Answer your three security questions
- Your username will be emailed to your email address on file (watch for an email from autobenestatus@autobene.com)

C **Forgot password**
- Enter your username
- Answer your three security questions
- Enter and confirm your new password
- Confirm your email address; you will receive a confirmation of the change

For New Users and Prior Users That Have Not Accessed EMB Enroll Since March 1, 2018

Create a New Account

A **Hover** over the question mark next to each field for specific instructions

B **Enter** the required Employee ID and PIN as instructed

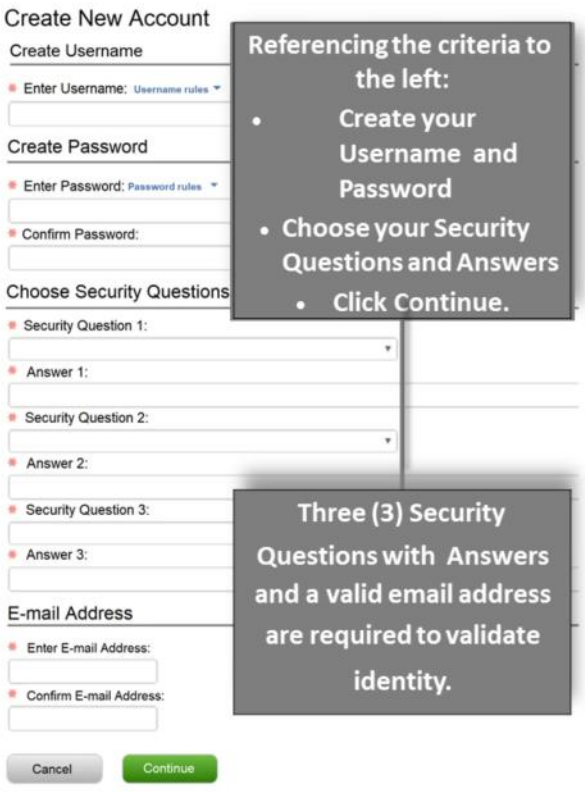
C Click ***"Create New Account"***

*In the event the system advises that an account already exists, return to the **"Log In"** steps above.*

USERNAME AND PASSWORD CRITERIA

Username:
- At lease one (1) letter and one (1) number
- Between 8 - 32 characters
- Not the same as your password
- No more than three sequential characters *(abc, cba, 123, 321)*
- No more than three repeating characters *(aaa, 111)*
- Permitted special characters: @ . - _ *
- Your username must be unique

Password:
- At least one (1) uppercase letter and one (1) lowercase letter
- At least one (1) number
- Between 8 - 20 characters
- Not the same as your username
- No more than three sequential characters *(abc, cba, 123, 321)*
- No more than three repeating characters *(aaa, 111)*
- Permitted special characters: @ . - _ *
- Password cannot be the same as your previous 10 passwords on this system



Medical - Florida Blue

The District seeks to provide the best possible medical and prescription drug benefits at a reasonable cost to you. The information below is a summary of medical coverage only. Please contact Florida Blue, the Benefit Administrator, at www.floridablue.com, for plan summaries detailing coverage information and exclusions.

Benefit	Blue Options 05770		Blue Options 05772		Blue Options 05774	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible						
Single	$1,000	$3,000	$2,000	$6,000	$3,000	$6,000
Family	$3,000	$6,000	$6,000	$18,000	$9,000	$18,000
Out-of-Pocket Maximum						
Single	$3,500	$7,000	$5,500	$11,000	$6,350	$15,000
Family	$7,000	$14,000	$11,000	$22,000	$12,700	$30,000
Coinsurance (% member pays of bill)	20%	50%	20%	50%	20%	50%
Physician Services						
Doctor's Office Visit	$25	50% after ded.	$35	50% after ded.	$40	50% after ded.
Specialist Office Visit	$25	50% after ded.	$65	50% after ded.	$100	50% after ded.
Preventive Care	No Charge	50%	No Charge	50%	No Charge	50%
Imaging (CT/PET scans, MRIs)	$100	50% after ded.	$300	50% after ded.	$400	50% after ded.
Hospital Facility Fees						
Inpatient	20% after ded.	$3,500	$100 + 20% after ded.	$500 + 50% after ded.	$500 + 20% after ded.	$500 + 50% after ded.
Outpatient	Ambulatory Surgical Center: $150 Hospital Option 1: 20% after ded.	50% after ded.	Ambulatory Surgical Center: $250 Hospital Option 1: 20% after ded.	50% after ded.	Ambulatory Surgical Center: $350 Hospital Option 1: 20% after ded.	50% after ded.
Emergency Care	$200		$300		$400	
Pregnancy and Maternity Care (prenatal and postnatal) - Office Services	$25	50% after ded.	$65	50% after ded.	$100	50% after ded.
Semi-Monthly Per Paycheck Deductions						
Employee Only	$106.00		$56.50		$12.00	
Employee + Spouse	$360.50		$278.50		$208.50	
Employee + Child(ren)	$347.50		$267.50		$199.00	
Family	$435.50		$344.00		$266.00	
2 Credit Employee + Spouse	$45.25 each		$4.25 each		$0.00 each	
2 Credit Employee + Family	$82.75 each		$37.00 each		$0.00 each	
Note: The District's Contribution for the 2019/2020 school year is $270.00 per pay or $540.00 per month.						

Note: Any deductibles ("ded") and copays in the chart above are amounts for which you are responsible. Deductibles, copays and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary and Reasonable charges apply for all out-of-network benefits. Option 2 hospitals may have higher cost shares. Prior authorization may be required for imaging services.

Prescription Drugs - Express Scripts

With the election of a medical plan, employees are automatically enrolled in the corresponding Express Scripts' Prescription Drug Plan. The information below is a summary of prescription drug coverage only. Please contact Express Scripts, the Prescription Drug Benefits Administrator, at Express-Scripts.com for more information detailing coverage information, limitations and exclusions.

The deductibles and copays shown are amounts for which you are responsible.

Benefit	Blue Options 05770		Blue Options 05772		Blue Options 05774	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail (31 day supply)						
Generic	$10	$10	$10	$10	$10	$10
Preferred Brand	$30	$30	$50	$50	$50	$50
Non-preferred Brand	$60	$60	$80	$80	$80	$80
Mail Order (90 day supply)						
Generic	$20	$20	$20	$20	$20	$20
Preferred Brand	$60	$60	$100	$100	$100	$100
Non-preferred Brand	$120	$120	$160	$160	$160	$160

NEW Pharmacy Programs

Exclusive Smart90

Are you currently taking a maintenance medication with only a 30 day supply? Under this program you will now be required to switch your prescription to a 90-day supply at an in-network pharmacy (retail Smart90 pharmacy or Home Delivery) or pay 100% of the prescription cost. This program allows members two 30-day courtesy fills so that members have time to contact their provider(s) regarding this change.

Express Advantage Network

Use any pharmacy in the Express Scripts Express Advantage Network and continue to pay the copays listed above. If you use a pharmacy outside of the Express Advantage Network you will pay higher copays. Contact Express Scripts to learn more about the pharmacies in this network.

SaveonSp

Are you currently taking a specialty medication? You will now be required to obtain your refills through Express Scripts Specialty Pharmacy Accredo. Depending on the type of Specialty medication you are taking you may or may not receive courtesy retail refills. Contact Express Scripts to learn more about Accredo.

Opt-Out Medical Insurance Option

If you want to opt-out of the District's medical coverage, you must indicate this during your enrollment. If you choose to decline and opt-out of the District's medical coverage, the District will deposit $480 in a health reimbursement account for your use effective October 1, 2019. You **MUST elect the "OPT-OUT" flex during Open Enrollment** to receive the $480 annually. If you are a late hire or leave the district early you will only have a pro-rated amount of $20.00 per pay deduction available to you based on the time you are with the district during the plan year. Additionally, if you opt-out and are hospitalized for any reason, the District will reimburse you up to $225 per day to a maximum of 14 days or $3,150 per calendar year, whichever comes first. This check will be mailed directly to you. Please send all requests with backup documentation to amy.yeitter@indianriverschools.org.

Medical Terms Glossary

Important Terms

Insurance can sometimes sound like a foreign language. Take a moment to review the meaning of these common terms to best understand your benefit plans.

Preventive and Non-Preventive Services

Preventive care services are those that are generally linked to routine wellness exams. Non-preventive services are those that are considered treatment or diagnosis for an illness, injury, or other medical condition. There are limits on how often you can receive preventive care treatments and services. You should ask your health care provider whether your visit is considered preventive or non-preventive care. Examples of preventive care include:

- Annual routine physicals
- Bone-density tests, cholesterol screening
- Immunizations, mammograms, Paps smears, pelvic exams, PSA exams
- Sigmoidoscopies, colonoscopies

Annual Deductible

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. Some services, such as office visits, require copays and do not apply to the deductible. This is an annual calendar year deductible.

After you meet your deductible, the plan pays for a percentage of eligible expenses (coinsurance) until you meet your out-of-pocket maximum. If you receive services from an out-of-network provider, the plan pays a lower percentage of coinsurance. Refer to your health care plan summaries for more information.

Copayment and Coinsurance

A copayment (copay) is the fixed dollar amount you pay for certain in network services. In some cases, you may be responsible for coinsurance after a copay is made.

Coinsurance is the percentage of covered expenses shared by the employee and the plan. In some cases, coinsurance is paid after the insured meets a deductible. For example, if the plan pays 90% of an in-network covered charge, you pay 10%.

Out-of-Pocket Maximum

Some plans feature an out-of-pocket maximum, which limits the amount of coinsurance you will pay for eligible health care expenses. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in and out-of-network annual out-of-pocket maximums. Copays, deductible and coinsurance accumulate towards your out-of-pocket maximum.

Care Coordination

When you need hospital care or have complex health care needs, Florida Blue's Care Coordinators are available to assist you and your family. From handling benefit and approvals, to scheduling follow up care and connecting you with health programs and resources, you'll have extra help so you can focus on getting well and staying well. Call Florida Blue at **888-476-2227.**

NURSES ON CALL 24/7:

When you need answers right away, call a nurse 24/7. Whether you or your family members have health concerns or general health questions, the **nurseline** is available at no cost. Simply call **877-789-2583.**

In-Network Advantage

Within some of the medical, dental and vision plans, you have the freedom to use any provider. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible to pay for the difference of the Usual, Customary and Reasonable (UCR) charges and what the provider bills. You also may need to submit claim forms.

The Employee Health & Wellness Center

The Indian River Health & Wellness Center is a primary care facility treating both acute and chronic conditions at NO COST for both employees and dependents enrolled in a District health plan. CareHere also provides NO COST wellness programs and health coaches to guide you through the process of losing weight, quitting smoking, controlling your blood pressure and more.

CareHere is a well-known and trusted healthcare organization skilled at delivering innovative, high-quality, cost-effective primary care.

- NO COST for visits or 200+ generic medications
- NO COST for labs
- Convenient schedule that includes early morning, late evening and Saturday hours
- 24/7 Scheduling and Nurse Advice Line
- Less than 5 minute average wait time
- NO COST for annual Health Risk Assessment
- NO COST for wellness programs and health coaching
- NO COST for well-man, well-woman, sports and school physicals
- Certain imaging services available at NO COST when referred by a CareHere provider to Indian River Radiology
- Home Delivery Pharmacy program for many chronic medications

SCHEDULE ANYWHERE

844.422.7343 | CareHere.com | CareHere App

Register with your access code **NRSE2**

CareHere abides by all federal HIPAA and confidentiality regulations.

Indian River Health & Wellness Center
5255 41st Street | Vero Beach

IMPORTANT NOTICE

REGARDING MISSED APPOINTMENTS

AT WELLNESS CENTER

Effective immediately, we are implementing a new policy that is designed to reduce the number of "No Shows" at the Wellness Center. "No Show" appointments prevent others from being served and add to the cost of our health care. Therefore, when an employee or dependent has missed three appointments in a calendar year without cancelling, that member or dependent will be charged a $25.00 fee, deducted through payroll. The member will then be charged an additional $25.00 fee for any future missed appointments, without prior cancellation, for the remainder of that calendar year.

Employee Assistance Program (EAP) Resources for Living

The District has partnered with Aetna's **Resources for Living** to provide an employer sponsored Employee Assistance Program (EAP). Aetna's Resources for Living, will help you resolve personal, wellness, and professional concerns that can adversely affect workplace productivity. This service is available for all employees, anyone living in your household and dependent children living out of your home up to the age of 26. Services are free and confidential and available 24 hours a day, 7 days a week.

Employee Assistance Program (EAP)
1-800-272-3626
www.resourcesforliving.com
Username: Indian River County School Board
Password: 8002723626

Emotional well-being support

You can call 24 hours a day for in-the-moment emotional well-being support. You can also access up to 6 counseling sessions per issue per year.

Visit with a counselor face-to-face, online with televideo or get in-the-moment support by phone. Services are free and confidential. The EAP is always here to help with a wide range of issues including:

- Relationship Support
- Stress Management
- Work/Life Balance
- Family Issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse and more
- Self-esteem
- Personal development

Online Resources

Your member website offers a full range of tolls and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app

You'll also find access to these helpful tools:

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel and more.

Fitness Discounts

Save on gym memberships at over 9,000 locations nationwide and home fitness equipment. Participating gyms and programs include 24 Hour Fitness, LA Fitness, Anytime Fitness®, Zumba®, Nutrisystem® and more.

myStrength

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance mis-use and/or chronic pain.

Legal Services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal law
- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25 percent discount.

*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial Services

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions and preparation

You can also get a 25 percent discount on tax preparation services.

*Services must be for financial matters related to the employee and eligible household member.

Other Services

Identity theft services - One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Flexible Spending Account - Chard Snyder

Note: Services must be rendered or purchases made within the plan year of 10/1 - 9/30. Employees MUST RE-ENROLL EVERY YEAR. FSA's do not roll over into the new plan year.

Are you losing money on your family's health and wellness costs?

A Flexible Spending Account will give you significant savings on health and wellness costs not covered by insurance.

Pay 25-40% Less for Your Family's Health and Wellness Costs

Insurance probably doesn't cover all your family's health costs. You might have to pay a small copay when you see the doctor or maybe even some extra charges if your doctor or hospital is not covered by your plan. Maybe you need services your insurance just doesn't cover. These costs can add up quite a lot over the course of a year.

Wouldn't you like to save 25-40% on all those charges?

It's Simple

You choose how much to put into the account and pay for health and wellness expenses using tax-free dollars, up to a maximum of $2,700 yearly.

Without the FSA you pay for those expenses with what's left after taxes have been deducted. Instead of the $100 you earned, you actually have only $60 to $75 left to spend.

With tax-free dollars, $100 put into your account is $100 you can spend. Your savings will add up quickly.

Are There Rules?

A few, and they're easy to follow:

- You must decide how much you want to put in the plan for the year.
- You can't change your mind later (unless you experience specific work/life events).
- You must use the money for eligible expenses and keep the receipts.
- You must spend your money within the deadlines of your plan.
- You may not spend the money for anything cosmetic.

Use the Benny Card and Save Your Cash

Benny® helps you keep it all straight. It pays at locations that offer eligible merchandise and services...and usually knows exactly what is eligible. When you use the card your payment comes right out of your account.

Don't Think an FSA's for You?

You'll be surprised by some of the items eligible for savings:

Alternative medicine
Childbirth classes
Dental treatment
Learning disability services
Medical equipment
Prescriptions
Speech training
Vision
With a doctor's note:
Herbal supplements
Massage Therapy
Weight loss programs
Stop smoking aids

Does the cost of dependent daycare drain too much of your salary?

Save 25-40% off the cost of dependent daycare by using a Dependent Daycare Flexible Spending Account.

Pay Less for Dependent Daycare While You Work

Dependent daycare is a big drain on family income and we're all looking for ways to slow the flow. Paying for daycare through a dependent daycare flexible spending account can help you keep more of your money in your pocket.

How does it work?

You choose how much to put into the account, and pay dependent daycare expenses using tax-free dollars, up to a maximum of $5,000 per household.

Without the FSA you pay for your dependent daycare with what's left after taxes have been deducted. Instead of the $100 you earned, you actually have only $60 to $75 left to pay for care.

With tax-free dollars, $100 put into your account is $100 you can use to pay for daycare.

What is an Eligible Expense?

Any type of daycare you choose:

In-home babysitter
Nursery schools
After-school activities
Summer day camp
Elder custodial care
Outside babysitter
Daycare center
Latchkey program
Elder daycare

Dependent Daycare Isn't Just Kid Stuff

If your child is 12 or less, this program is for you. If your dependent of any age can't be left alone for mental or physical reasons, this program is for you.

Are There Rules?

Yes, but they're simple:

- Services you claim must be provided while you and your spouse are at work, looking for work or attending classes as a full-time student.
- You must decide how much you want to put in the plan for the year.
- You can't change your mind later (unless you experience specific work/life events).
- You must spend your money within the claims deadline for your plan
- You may only be reimbursed for the amount of money in your plan at the time of your claim.
- Your provider must report this as income.

Dental - Cigna

Dental coverage is key to your overall health. The District offers employees three dental plan options through Cigna. For more information about your plan and to find a Cigna dentist near your, visit www.cigna.com, or call **800-244-6224.**

Your dental plan covers four main types of expenses:

- Preventive and diagnostic services like exams and cleanings, fluoride treatments, and sealants
- Basic services such a simple fillings, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontia (DHMO Only)*

Benefit	PPO High Plan	PPO Low Plan	DHMO
Annual Calendar Year Maximum (Per Enrollee)	$1,000	$1,000	N/A
Calendar Year Deductible (Per Enrollee)	$50	$50	N/A
Preventive Services	No Charge	No Charge	No Charge
Basic Services	No Charge	20%	$0 - $345
Major Services	40%	50%	$20 - $415

Note: Coinsurance shown is member paid for In-Network providers. Non-contracted providers would include balance billing. Members can see dentists that are part of the Advantage network; which is the highest tier providing coverage at the full in-network benefit level, DPPO network which still offers a discount on the services however benefits are paid based on the out of network benefit levels, and full Out of network, your benefits may be lower and you may have to file your own claims. DHMO plan members are encouraged to select a dentist.

*Maximum benefit of 24 months of interceptive orthodontics and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.

	PPO High Plan	PPO Low Plan	DHMO
Semi-Monthly Per Paycheck Deductions			
Employee Only	$17.25	$14.80	$10.04
Employee + Spouse	$36.94	$31.70	$17.24
Employee + Child(ren)	$34.57	$29.67	$17.36
Family	$54.38	$46.67	$25.01

Vision - UnitedHealthcare

Please keep in mind that some providers' network status may have changed. Please confirm with your provider if they are in-network or speak to a UnitedHealthcare representative at **800-638-3120.**

The District offers employees two vision plans through **UnitedHealthcare Group** that includes coverage for eye exams and eyeglasses or contact lenses. Please access www.myuhcvision.com and utilize the "Provider Quick Search" feature, or you can call **800-638-3120** to get the names and addresses of the network providers nearest you.

Benefit	Option 1	Option 2
Exam	$10 copay (Once every 12 months)	$10 copay (Once every 12 months)
Frames* (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)	$130 allowance (Once every 24 months)	$130 allowance (Once every 12 months)
Contact Lenses (in lieu of eyeglasses)		
Contact Lenses (Non-Collection)	$125 allowance (copay waived) (Once every 12 months)	$125 allowance (copay waived) (Once every 12 months)
Selection Contact Lenses (Conventional/Disposable)	$25 (up to 4 boxes) (Once every 12 months)	$25 (up to 4 boxes) (Once every 12 months)
Medically Necessary (with prior approval)	$25 copay (Once every 12 months)	$25 copay (Once every 12 months)
*Please Note: Additional charges may apply for Out-of-Network services. Please refer to the plan summary.		

	Option 1	Option 2
Semi-Monthly Per Paycheck Deductions		
Employee Only	$2.70	$3.00
Employee + Spouse	$4.53	$5.05
Employee + Child(ren)	$4.63	$5.17
Family	$7.32	$8.15

Basic Life & AD&D Insurance - The Standard

The Standard is the Group Life and AD&D partner for the District and it's employees. The Standard also has offered an expanded AD&D Living Needs Package at no additional cost to District employees.

The District provides employees with basic life insurance and accidental death and dismemberment (AD&D) coverage in the amount of $25,000 at no cost to you. Board-paid basic life and AD&D insurance protects your family's financial future if you die or if you experience a loss of limb, eyesight, or other dismemberment. Supplemental term life insurance is an option that gives you the opportunity to enhance the basic life insurance that the District provides for you.

Additional Life and AD&D

Active full-time employees may purchase additional life and AD&D coverage for yourself and dependent life coverage for your family. The amount and cost of additional coverage that you may elect can be found on the next page.

To purchase coverage for either your spouse or child(ren), you must enroll yourself for voluntary life coverage. You pay 100% of the cost for this coverage. Statement of Health application will be required if you elect coverage for you or your spouse over the guaranteed issue amount, increase your current elected coverage or if you enroll after your initial eligibility period. Age reductions after age 65 apply to life and AD&D insurance amounts.

Other information:

- New hire guaranteed issue amount is $150,000. Spouse life guaranteed issue amount is $25,000
- The beneficiary you elect for your basic life and AD&D insurance will be the same for your employee voluntary term life insurance.
- Employees cannot elect life coverage for a spouse who is also a District employee.
- Voluntary spouse life premiums are calculated based on the employee's age.
- The child life benefit will now be a flat $5,000 or $10,000. ***If both parents work for the District, both cannot purchase dependent coverage for the same children.***

AD&D Living Needs Features:

These benefits are included at no additional cost to District employees and the insured:

- **Career Adjustment Benefit:** Pays for qualifying tuition expenses incurred by an employee's eligible spouse for training aimed at obtaining employment or increased earnings within 36 months of the insured's death.
- **Child Care Benefit:** Pays for qualifying child care expenses for all children under age 13 incurred by an employee's eligible spouse within 36 months of the insured's death.
- **Higher Education Benefit:** Covers tuition expenses for up to four consecutive years for children attending or who will be attending college within 12 months after the insured's death.
- **Seat Belt Benefit:** Paid if you or your insured dependent dies as a result of a car accident and is found to be wearing a seat belt.
- **Occupational Assault Benefit:** Pays for qualifying loss resulting from an act of physical violence against the employee while at work; assault must involve a police report and be punishable by law.
- **Public Transportation Benefit:** Pays for qualifying loss of life while riding as a fare-paying passenger on public transportation.

Voluntary Life & AD&D Rates

Employee (Life/AD&D)	Up to $300,000 in increments of $25,000
Spouse (Life only)	Increments of $12,500 to a maximum of $75,000. Cannot exceed 100% of employee's Plan 2 Life Insurance
Child(ren) (Life only)	$5,000 or $10,000

Employee Age	Employee Life and AD&D Semi-Monthly Premiums											
	$25,000	**$50,000**	**$75,000**	**$100,000**	**$125,000**	**$150,000**	**$175,000**	**$200,000**	**$225,000**	**$250,000**	**$275,000**	**$300,000**
<30	$0.88	$1.75	$2.63	$3.50	$4.38	$5.25	$6.13	$7.00	$7.88	$8.75	$9.63	$10.50
30-34	$1.25	$2.50	$3.75	$5.00	$6.25	$7.50	$8.75	$10.00	$11.25	$12.50	$13.75	$15.00
35-39	$1.38	$2.75	$4.13	$5.50	$6.88	$8.25	$9.63	$11.00	$12.38	$13.75	$15.13	$16.50
40-44	$1.50	$3.00	$4.50	$6.00	$7.50	$9.00	$10.50	$12.00	$13.50	$15.00	$16.50	$18.00
45-49	$2.13	$4.25	$6.38	$8.50	$10.63	$12.75	$14.88	$17.00	$19.13	$21.25	$23.38	$25.50
50-54	$3.13	$6.25	$9.38	$12.50	$15.63	$18.75	$21.88	$25.00	$28.13	$31.25	$34.38	$37.50
55-59	$5.25	$10.50	$15.75	$21.00	$26.25	$31.50	$36.75	$42.00	$47.25	$52.50	$57.75	$63.00
60-64	$7.75	$15.50	$23.25	$31.00	$38.75	$46.50	$54.25	$62.00	$69.75	$77.50	$85.25	$93.00
65-69*	$9.91	$19.83	$29.74	$39.65	$49.56	$59.48	$69.39	$79.30	$89.21	$99.13	$109.04	$118.95
70-74*	$11.38	$22.75	$34.13	$45.50	$56.88	$68.25	$79.63	$91.00	$102.38	$113.75	$125.13	$136.50
75+*	$7.96	$15.93	$23.89	$31.85	$39.81	$47.78	$55.74	$63.70	$71.66	$79.63	$87.59	$95.55

*Coverage amounts for ages 65 and over reduce due to age reduction.

Employee Age	Spouse Life Semi-Monthly Premiums					
	$12,500	**$25,000**	**$37,500**	**$50,000**	**$62,500**	**$75,000**
<30	$0.31	$0.63	$0.94	$1.25	$1.56	$1.88
30-34	$0.50	$1.00	$1.50	$2.00	$2.50	$3.00
35-39	$0.56	$1.13	$1.69	$2.25	$2.81	$3.38
40-44	$0.63	$1.25	$1.88	$2.50	$3.13	$3.75
45-49	$0.94	$1.88	$2.81	$3.75	$4.69	$5.63
50-54	$1.44	$2.88	$4.31	$5.75	$7.19	$8.63
55-59	$2.50	$5.00	$7.50	$10.00	$12.50	$15.00
60-64	$3.75	$7.50	$11.25	$15.00	$18.75	$22.50
65-69*	$4.88	$9.75	$14.63	$19.50	$24.38	$29.25
70-74*	$5.63	$11.25	$16.88	$22.50	$28.13	$33.75
75+*	$3.94	$7.88	$11.81	$15.75	$19.69	$23.63

*Coverage amounts for ages 65 and over reduce due to age reduction.

Age	Child(ren) Life Semi-Monthly Premiums	
	$5,000	**$10,000**
Child	$0.25	$0.50

Short Term Disability - Cigna

What is Short Term Disability Insurance?

Short Term Disability Insurance helps protect your income for a short duration. If you become disabled and are unable to work, disability insurance can help replace some of your lost income, help you pay bills and protect your long-term savings.

Employees are eligible to receive short-term disability (STD) benefits for a qualified non-work illness or injury after being continuously disabled through your elected elimination period. **This plan will pay 66.67% of your weekly salary but no more than $2,000 (in $100 increments) per week.**

If you are not in active employment due to injury or sickness, or if you are on a covered layoff or leave of absence any increased or additional coverage will begin on the date you return to active employment.

Option 1: **7 day waiting period**	Benefit Waiting Period 0 Days for Accident 7 Days for Sickness			Maximum Benefit Period 13 Weeks for Accident 12 Weeks for Sickness			
Age	**<24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**
Per Pay Rate Per $100	$2.73	$2.94	$2.59	$2.05	$2.01	$1.95	$2.32
Age	**55-59**	**60-64**	**65-99**				
Semi-Monthly Rate Per $100	$3.28	$3.99	$4.33				

Option 2: **14 day waiting period**	Benefit Waiting Period 14 Days for Accident 14 Days for Sickness			Maximum Benefit Period 11 Weeks for Accident 11 Weeks for Sickness			
Age	**<24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**
Per Pay Rate Per $100	$2.49	$2.76	$2.29	$1.84	$1.67	$1.67	$2.01
Age	**55-59**	**60-64**	**65-99**				
Semi-Monthly Rate Per $100	$2.59	$3.14	$3.58				

Option 3: **30 day waiting period**	Benefit Waiting Period 30 Days for Accident 30 Days for Sickness			Maximum Benefit Period 9 Weeks for Accident 9 Weeks for Sickness			
Age	**<24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**
Per Pay Rate Per $100	$1.64	$2.01	$1.64	$1.40	$1.30	$1.40	$1.81
Age	**55-59**	**60-64**	**65-99**				
Semi-Monthly Rate Per $100	$2.25	$2.59	$2.70				

How to Calculate Your Semi-Monthly Cost:

Step 1: Use the chart above to find your monthly rate based on age. Multiply this rate by your gross weekly benefit.
Step 2: Divide the total by 100. The result is your **semi-monthly** cost.

Calculate Your Cost

_____ x _____ / 100 = _____
Semi-Monthly Rate | Gross Monthly Benefit | Semi-Monthly Cost

Long Term Disability - Cigna

What is Long Term Disability Insurance?

Long Term Disability Insurance helps safeguard your financial security by replacing a portion of your income while you are unable to work. LTD benefits are intended to protect your income for a long duration after you have depleted short-term disability or available paid time off.

Employees are eligible to purchase long-term disability (LTD) insurance which pays a monthly benefit in the event you cannot work because of a long-term illness or injury. You must be continuously disabled through your elimination period of **90 days** to be eligible for LTD benefits.

This plan will pay 66.67% of your monthly salary but no more than $8,000 (in $100 increments) per month. Benefit and maximum period of payment are based on age when disability occurs.

Age	Semi-Monthly Rate Per $100	Age	Semi-Monthly Rate Per $100
<24	$0.082	50-54	$0.875
25-29	$0.106	55-59	$0.932
30-34	$0.202	60-64	$0.983
35-39	$0.315	65-69	$1.021
40-44	$0.471	70+	$0.775
45-49	$0.634		

How to Calculate Your Semi-Monthly Cost:

Step 1: Use the chart above to find your monthly rate based on age. Multiply this rate by your gross monthly benefit.

Step 2: Divide the total by 100. The result is your **semi-monthly** cost.

Calculate Your Cost

_____ x _____ / 100 = _____

Semi-Monthly Rate | Gross Monthly Benefit | Semi-Monthly Cost

Accident/Critical Illness/ Cancer - MetLife

These additional benefits are offered to strengthen your overall benefits package. You customize the benefit based on need and affordability.

- Ownership - Policies are fully portable and belong to you if you leave your employer, same price and same plan
- Benefits are payroll deducted
- ***Cash benefits are paid directly to you, not to a hospital or a doctor***
- ***Benefits are paid regardless of any other coverage you may have***
- Guaranteed Renewable
- Designed to provide additional cash flow to assist with out-of-pocket medical costs and other bills

Accident Plan

Accident insurance provides a financial cushion for life's unexpected events. You can use it to help pay costs that aren't covered by your medical plan. It provides you with a lump-sum payment - one convenient payment all at once - when you or your family need it most. The extra cash can help you focus on getting back on track, without worrying about finding the money to help cover the cost of treatment.

The plan provides a lump sum payment for over 150 different covered events, such as:

- Fractures
- Dislocations
- Second and third degree burns
- Skin grafts
- Torn knee cartilage
- Ruptured disc
- Concussions
- Cuts or lacerations
- Eye injuries
- Coma
- Broken teeth

You'll receive a lump sum payment when you have these covered medical services:

- Ambulance
- Emergency Care
- Inpatient Surgery
- Outpatient Surgery
- Medical Testing Benefits (including X-rays, MRIs, CT scans)
- Physician follow-up visits
- Transportation
- Home modifications
- Therapy services (including physical and occupational therapy)

Per Pay Period	Employee	Employee & Spouse	Employee & Child(ren)	Family
High Plan	$6.25	$13.29	$12.67	$15.89
Low Plan	$3.38	$7.23	$6.77	$8.67

Guaranteed Issue

Benefits are paid directly to the employee based on flat schedule (not reimbursement) and there is no coordination with other insurance coverage. An assignment of benefits to a hospital or healthcare facility will be available when required by applicable law.

Accident/Critical Illness/Cancer - MetLife

Critical Illness

Critical illness insurance can help safeguard your finances by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend as you see fit and in addition to any other insurance you may have.

MetLife Critical Illness Insurance provides a lump-sum payment if you or a covered family member is diagnosed with one of the following medical conditions: **Full Benefit Cancer, Stroke, Partial Benefit Cancer, Coronary Artery Bypass Graft, All Other Cancer, Kidney Failure, Heart Attack, Alzheimer's Disease, Major Organ Transplant and 22 additional conditions.**

A Recurrence Benefit is paid for the following covered conditions: Heart Attack, Stroke, Coronary Artery Bypass Graft, Full Benefit Cancer and Partial Benefit Cancer. See Plan Summary for a full explanation of Recurrence Benefit limitations.

$50 Health Screening Benefit included: A benefit is paid for health screening tests for each covered person, such as: **Annual Physical Exam, HPV Vaccination, Colonoscopy, Pap Smear, Mammogram, Endoscopy.** See Plan Summary for a full list.

Critical Illness Per Pay Rate Per $1,000 of Coverage (Non-Tobacco)											
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
EE	$0.30	$0.32	$0.41	$0.51	$0.71	$0.94	$1.22	$1.52	$1.82	$2.07	$2.50
EE & SP	$0.54	$0.58	$0.72	$0.91	$1.24	$1.62	$2.09	$2.57	$3.03	$3.43	$4.12
EE & CH	$0.52	$0.54	$0.63	$0.74	$0.93	$1.16	$1.45	$1.75	$2.05	$2.30	$2.72
Family	$0.76	$0.81	$0.95	$1.14	$1.46	$1.85	$2.31	$2.80	$3.26	$3.66	$4.34
Critical Illness Per Pay Rate Per $1,000 of Coverage (Tobacco)											
EE	$0.38	$0.41	$0.56	$0.74	$1.08	$1.47	$1.94	$2.45	$2.97	$3.43	$4.21
EE & SP	$0.66	$0.74	$0.97	$1.29	$1.84	$2.50	$3.28	$4.12	$4.93	$5.66	$6.92
EE & CH	$0.60	$0.64	$0.79	$0.97	$1.30	$1.70	$2.17	$2.68	$3.20	$3.65	$4.43
Family	$0.89	$0.96	$1.20	$1.51	$2.07	$2.72	$3.51	$4.35	$5.15	$5.89	$7.14

Cancer Insurance

Cancer insurance works to compliment your medical coverage - and pays a lump sum in addition to what our medical plan may or may not cover. It's coverage that provides financial support when you or a loved one become seriously ill. Preventive measures, early detection, and quality care and treatment are all important in the fight against cancer. While you can't always prevent it, cancer insurance is there to make life a little easier.

Upon initial verified diagnosis of a covered cancer condition, it provides you with a lump-sum payment of up to $15,000 or $30,000. If a Full Cancer Benefit was received and there is a recurrence, you will receive 50% of the Full Cancer Benefit. If a Partial Cancer Benefit was received, you will receive 12.5% of the Partial Cancer Benefit.

$50 Health Screening Benefit included: A benefit is paid for health screening tests for each covered person, such as: **Annual Physical Exam, HPV Vaccination, Colonoscopy, Pap Smear, Mammogram, Endoscopy.** See Plan Summary for a full list.

Cancer Per Pay Rate Per $1,000 of Coverage (Non-Tobacco)											
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
EE	$0.14	$0.15	$0.19	$0.23	$0.32	$0.42	$0.52	$0.63	$0.71	$0.72	$0.71
EE & SP	$0.24	$0.26	$0.32	$0.39	$0.53	$0.69	$0.88	$1.06	$1.20	$1.23	$1.24
EE & CH	$0.27	$0.28	$0.32	$0.36	$0.45	$0.54	$0.65	$0.76	$0.84	$0.85	$0.84
Family	$0.37	$0.39	$0.45	$0.52	$0.65	$0.82	$1.01	$1.19	$1.33	$1.36	$1.37
Cancer Per Pay Rate Per $1,000 of Coverage (Tobacco)											
EE	$0.20	$0.21	$0.29	$0.38	$0.54	$0.73	$0.94	$1.15	$1.31	$1.35	$1.34
EE & SP	$0.32	$0.36	$0.46	$0.61	$0.87	$1.18	$1.55	$1.91	$2.19	$2.27	$2.30
EE & CH	$0.32	$0.34	$0.42	$0.51	$0.67	$0.86	$1.07	$1.28	$1.44	$1.48	$1.47
Family	$0.45	$0.49	$0.59	$0.74	$1.00	$1.31	$1.68	$2.04	$2.32	$2.40	$2.43

Legal and Identity Theft Protection - LegalShield & IDShield

Affordable Legal and Identity Theft Protection

Legal Protection - LegalShield

Every year millions of people have legal issues and do not receive the legal counsel they need and deserve. Protect Your Legal Rights with LegalShield

LegalShield Plan Benefits Include*:

- Legal Consultation and Advice
- Court Representation
- Dedicated Law Firm
- Legal Document Preparation and Review
- Letters and Phone calls Made on Your Behalf
- Speeding Ticket Assistance
- 24/7 Emergency Legal Access

*Restrictions may apply. See your summary plan description for details.

Identity Theft Protection - IDShield

Millions of people have their identity stolen each year. IDShield provides the identity theft protection and identity restoration services you not only need but deserve.

IDShield Plan Benefits Include*:

- Identity Consultation and Advice
- Identity and Credit Monitoring
- Identity and Credit Threat Alerts
- Complete Identity Restoration
- Direct Access to Licensed Private Investigators
- Monthly Credit Score Tracker
- Social Media Monitoring
- Mobile App

*Restrictions may apply. See your summary plan description for details.

	LegalShield Only Per Pay	IDShield Only Per Pay	Combo Plan Per Pay
Employee Only	$7.63	$3.00	$10.13
Employee + Spouse	$7.63	$5.50	$12.63
Employee + Child(ren)	$7.63	$5.50	$12.63
Employee + Family	$7.63	$5.50	$12.63

Retirement Savings

The District understands that saving for retirement is an important priority for our employees. We offer 401(a) Plan and 403 (b)/457(b) Plans, so you can make sure that more of your money is working for your future. The plans allow you to save money for retirement through convenient pre-tax payroll deduction. These are plans available to you in addition to the Florida Retirement System (FRS) pension plan, so there is no set contribution and no district contribution.

For additional information regarding any of the plan provisions, please reach out to the vendors below.

Our 403(b)/457(b) Plan Administrator is TSA Consulting Group and may be reached at **888-796-3786** or visit www.tsacg.com.

The 401(a) Plan Administrator is Bencor. Please visit www.bencorplans.com for more information.

For more information regarding the FRS plan please visit www.myfrs.com or call **866-446-9377.**

Important Contacts

Vendor	Website	Phone Number / E-mail
The School District of Indian River County (the "District")	www.indianriverschools.org	
Amy Yeitter Employee Benefits Specialist	www.indianriverschools.org/employee-benefits	772-564-3175 amy.yeitter@indianriverschools.org
Joan Martin Employee Benefit Admin Assistant	www.indianriverschools.org/employee-benefits	772-564-3011 joan.martin@indianriverschools.org
Adalia Medina-Graham Retirement/FMLA Coordinator	www.indianriverschools.org/human-resources	772-564-3001 adalia.medina-graham@indianriverschools.org
On-Site Representative for Florida Blue - Marlanna Platt		772-564-3122 marlanna.platt@bcbsfl.com
Medical Florida Blue	www.floridablue.com	800-664-5295
Prescription Drug Express Scripts, Inc. (ESI)	www.express-scripts.com	866-262-6427
District Health & Wellness Center CareHere	www.carehere.com	844-422-7343 help@carehere.com
Employee Assistance Program (EAP) Resources for Living	www.resourcesforliving.com Username: Indian River County School Board Password: 8002723626	800-272-3626
Flexible Spending Accounts Chard Snyder	www.chard-snyder.com	(t) 800-982-7715 (f) 888-245-8452 askpenny@chard-snyder.com
Dental Cigna	www.cigna.com	800-244-6224
Vision United Healthcare Group	www.myuhcvision.com	800-638-3120
Life Insurance The Standard	www.standard.com	800-628-8600
Disability Cigna	www.cigna.com	800-362-4462
Accident/Critical Illness/Cancer MetLife	www.metlife.com/MyBenefits	800-438-6388
Legal & Identity Theft Protection LegalShield (Group #203750)	membersupport@legalshield.com	888-807-0407
403(b)/457(b) Retirement Plan TSA Consulting Group	www.tsacg.com	888-796-3786
401(a) Retirement Plan Bencor	www.bencorplans.com	888-258-3422
Florida Retirement System MyFRS Financial Guidance	www.myfrs.com	866-446-9377
Explain My Benefits Enrollment Assistance	www.sdirc-benefits.com	888-734-6937

Important Legal Notices

Continuation Coverage Rights Under COBRA Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee, extends until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally extends for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Important Legal Notices

Continuation of COBRA Information:

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact:

Contact:	Amy Yeitter, Employee Benefits Specialist
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3175
Email:	amy.yeitter@indianriverschools.org

Contact	Joan Martin, Employee Benefits Admin. Assistant
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3011
Email:	joan.martin@indianriverschools.org

Newborn's and Mother's Health Protection Act Disclosure

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 or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

If you do not elect to continue to participate in the Plan during an absence for military duty that is more than 31 days, or if you revoke a prior election to continue to participate for up to 12 weeks after your military leave began, you and your covered family members will have the opportunity to elect COBRA Continuation Coverage only under the medical insurance policy for the 24-month period (18-month period if you elected coverage prior to December 10, 2004) that begins on the first day of your leave of absence. You must pay the premiums for Continuation Coverage with after-tax funds, subject to the rules that are set out in that plan.

When an employee leaves the District, either by involuntary or voluntary termination, benefits will end the last day of the month in which the last day was worked.

Important Legal Notices

Creditable Coverage Notice: Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer better coverage for a higher monthly premium.
2. The District has determined that the prescription drug coverage offered under the Florida Blue group health care plans under the District Group Insurance Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Because your existing coverage is 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. For 2019, you may enroll from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current the District coverage will not be affected. If you drop your coverage with the District and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. 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.

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 the District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

For more information about this notice or your current prescription drug coverage, contact the Benefits Administrator.

Note: You'll get this notice each year. You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You may request a copy of this notice at any time.

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

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

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available from the Social Security Administration (SSA).

For more information, visit SSA online at www.ssa.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this notice. If you enroll in one of the Medicare approved plans offering prescription drug coverage, you may need to provide a copy of this notice when applying for the coverage to show that you are not required to pay a higher premium amount.

Summaries of Benefits and Coverage (SBCs)

SBCs are available on the School District of Indian River County's website by visiting www.indianriverschools.org/departments/50-risk- management-and-employee-benefits. You can get a paper copy of the SBCs (free of charge) by contacting the District Employee Benefits Specialist at 772-564-3175. The SBCs summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice.

This guide contains information about the creditable status of the Rx coverage.

Important Legal Notices

Family Medical Leave Act (FMLA)

What does the Family and Medical leave act provide?

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

Who can take FMLA leave?

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

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

When can an eligible employee use FMLA leave?

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

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

Responsibilities to the District Employees Requesting Leave.

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

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

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

Women's Health and Cancer Rights Act of 1998

Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes). The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Medicaid and the Children's Health Insurance Program

Medicaid and the Children's Health Insurance Program (CHIP) offer free or low-cost health coverage to children and families. If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. Some states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. 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, you can contact your State Medicaid or CHIP office or dial **877-KIDS-NOW** or visit www.insurekidsnow.gov to find out how to apply. You must request coverage within 60 days of being determined eligible for premium assistance.

Contact:	Amy Yeitter, Employee Benefits Specialist
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3175
Email:	amy.yeitter@indianriverschools.org

Contact	Joan Martin, Employee Benefits Admin. Assistant
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3011
Email:	joan.martin@indianriverschools.org

Contact:	Adalia Medina-Graham, Human Resources FMLA
Address:	6500 57th Street, Vero Beach, FL 32967
Phone:	772-564-3001
Email:	adalia.medina-graham@indianriverschools.org

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)**.

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

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 January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid	**KANSAS – Medicaid**
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/ healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/ premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531

Important Legal Notices

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the School District of Indian River County may use aggregate information it collects to design a program based on identified health risks in the workplace, the Employee Health and Wellness Center will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual who will receive your personally identifiable health information is a registered nurse available 24/7 by telephone for emergencies in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Amy Yeitter at amy.yeitter@indianriverschools.org.

About This Guide

This guide highlights all employee benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. The School District of Indian River County reserves the right to make changes at any time to the benefits, costs and other provisions relative to benefits.

Enrollment Preparation Worksheet

	Current Election	New Election
Medical **Tier**	**Florida Blue** 5770 / 5772 / 5774 EE ES ECH FAM $_____	**Florida Blue** 5770 / 5772 / 5774 EE ES ECH FAM $_____
Flex Spending	**Chard-Snyder** Medical $_____ Dependent Care $_____	**Chard-Snyder** Medical $_____ Dependent Care $_____
Dental **Tier**	**Cigna Dental** High PPO / Low PPO / DHMO EE ES ECH FAM $_____	**Cigna Dental** High PPO / Low PPO / DHMO EE ES ECH FAM $_____
Vision **Tier**	**United Healthcare** Option 1 / Option 2 EE ES ECH FAM $_____	**UnitedHealthcare** Option 1 / Option 2 EE ES ECH FAM $_____
Life Insurance	**The Standard** Employee Coverage $_____ Deduction $_____ Spouse Coverage $_____ Deduction $_____ Child(ren) Coverage $_____ Deduction $_____	**The Standard** Employee Coverage $_____ Deduction $_____ Spouse Coverage $_____ Deduction $_____ Child(ren) Coverage $_____ Deduction $_____
Short Term Disability	**Cigna Disability** Monthly Benefit $_____ Deduction $_____	**Cigna Disability** Monthly Benefit $_____ Deduction $_____
Long Term Disability	**Cigna Disability** Weekly Benefit $_____ Deduction $_____	**Cigna Disability** Weekly Benefit $_____ Deduction $_____
Accident/Critical Illness/Cancer	**MetLife** Accident EE ES ECH FAM $_____ Critical Illness EE ES ECH FAM $_____ Cancer EE ES ECH FAM $_____	**MetLife** Accident EE ES ECH FAM $_____ Critical Illness EE ES ECH FAM $_____ Cancer EE ES ECH FAM $_____
Legal & Identity Theft Protection	**LegalShield Only** EE ES ECH FAM $_____ **IDShield Only** EE ES ECH FAM $_____ **Combo Plan** EE ES ECH FAM $_____	**LegalShield Only** EE ES ECH FAM $_____ **IDShield Only** EE ES ECH FAM $_____ **Combo Plan** EE ES ECH FAM $_____

EE = Employee ES = Employee & Spouse ECH = Employee & Child(ren) FAM = Family

Benefit Guide Description

Please Note: This guide provides information regarding the District's benefit program. More detailed information is available from the plan documents and administrative contacts. The plans and policies stated in this information are not a contract or a promise of benefits of any kind, and therefore, should not be interpreted as such.