Taylor County School District

2016–2017
Annual Benefit Booklet



Table of Contents

2016–2017 Annual Open Enrollment

August 3–9 | 8 a.m.–2 p.m.

Health Fair

August 4, 8 a.m.–2 p.m. | Taylor County High School

Under the new healthcare legislation, it is required that you carry or maintain medical insurance either through your employer or independently. When the employer you work for provides minimal essential health insurance coverage, you must participate in the employer-sponsored (parents/spouse's) plan or you will be subject to the loss of a subsidy or tax credit. At Taylor County School District, we believe that benefits are an integral part of your total compensation—that is why it's important that you get the maximum value from your benefit plans. Take the time to know and understand all of your benefits and make the elections that keep pace with the changes in your life. The choices you make during open enrollment stay in effect throughout the entire plan year of 2016/17, unless you experience a qualifying event.

Examples of Qualifying Events

- Marriage/Divorce
- Death
- Changing full-time status
- Loss of employment
- Dependent to longer eligible
- Spouse obtains employment

If you experience a change in status during the plan year, it is your responsibility to contact your Human Resources Department and report the change within 30 days of the event or 60 days of a Children's Insurance Program Reauthorization Act of 2009 (CHIPRA) special enrollment, you will not be able to make your changes and will have to wait until the next Annual Open Enrolment Period to make the change.

Note: This Employee Benefit Booklet is merely a summary and overview of the School District's group insurance benefit programs and does not include all of the terms, coverage, exclusions, limitations and conditions of the actual plan language. The plan document (s) governing the group insurance benefit programs are the controlling documents for all purposes, including terms, coverage, exclusions, limitations, conditions and interpretation of such coverage. Therefore, the terms of the plan document (s) will be the final authority.

Eligibility

All full-time newly hired employees are eligible to participate in the Taylor County School Board's group insurance plans effective the 1st day of the month following 30 days of employment. Questions regarding eligibility should be directed to Chris Olson 850.508.8468

Enrollment

Taylor County School Board has a "passive enrollment" meaning if you do not have any changes to your 2015/16 benefits you will automatically be enrolled in those same benefits effective October 1, 2016, and the appropriate payroll deductions will occur.

What you need

Verification of your current address and personal information (phone number, email etc)

Your Social Security number and if applicable the social security number for each of your claimed dependents.

The name, current address and evidence of dependent status for EVERY claimed dependent including, birth certificate, marriage certificate for added spouse and children.

How to Enroll or Make Changes

If you would like to make changes to any benefit you chose during the 2015/16 benefit period or you need to enroll for the first time, you have two options:

1. Call 866.364.9755—8 a.m. to 8 p.m. EST—August 3–9 or;

2. Log on to: **www.nextgenerationenrollment.com/nge/login**
   Username: 1st initial of your first name
   1st six (6) letters of your last name
   Last 4 digits of your social security number
   Password: Date of Birth: yyyymmdd

Dependent Eligibility

Eligible dependents are defined as follows:

Medical

» Employee's legal spouse and dependent children.

» Employee's dependent children
- End of the calendar year in which they reach age 26
- Whether married or not, even if the adult child is working and has access to coverage.

» Dependent Child Ages 26–30
- Employee may request to continue coverage on dependent when the dependent reaches the limiting age or during Open Enrollment period if the dependent:
  - Is not yet 30 years old; and
  - Is unmarried with no dependents; and
  - Is a Florida resident or full- or part-time student; and
  - Is not eligible for Medicare; and
  - Is not enrolled in any other health coverage; and
  - Is not entitled to benefits under Social Security Act

Dental

» Employee's legal spouse and dependent children.

» Employee's dependent children.

» **Dependent** refers to:

a. an Insured's spouse
b. each child through the end of the year in which they turn age 30, for whom the Insured or the Insured's spouse, is legally responsible, including:
   i. natural born children
   ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code
   iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

The child must be dependent upon the certificate holder for support and either living in the household of the certificate holder or its a full or part-time student.

c. each child age 30 or older who:
   i. is Totally Disabled due to mental or physical reasons; and
   ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limit age. Any costs for providing continuing proof will be at our expense.

Accuracy of Enrollee Information

As we all work toward managing the Taylor County School Board's overall health plan costs, it is important that only individuals eligible for benefits are actually enrolled. This helps make coverage more affordable for active employees, Taylor County School Board and retirees who pay the full cost for their benefits. It is also very important that when a dependent no longer qualifies for Taylor County School Board-paid coverage, the person is removed and has the opportunity to continue benefits through COBRA.

PPO Blue Options—05770 and 05901

The PPO Plans offer services outside the network and provides for freedom of choice for care within the network. Services rendered outside the network are subject to balance billing, which means the member may be responsible for the difference between the Florida Blue negotiated fee and the provider or facility's retail charge. The physician network for this plan is Blue Options. The PPO Plans do not require members to choose a PCP. Florida Blue Customer Service: 800.352.2583.

A brief summary is as follows:

	Blue Options 05770		Blue Options 05901	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Year Deductible (BYD) (Individual/Family)	$1,000/$3,000		$2,000/N/A	$6,000/N/A
Coinsurance	20% after CYD	40% after CYD	50% after CYD	50% after CYD
Out-Of-Pocket Maximum (Individual/Family)	$3,000/$6,000	$5,000/$10,000	$6,350/$12,700	$30,000/$30,000
PCP Office Visit—PCP	$35 copay	40% after CYD	$35 copay	50% after CYD
Specialist Office Visit	$65 copay	40% after CYD	$75 copay	50% after CYD
Preventive Care—Adult And Children Wellness Service	$0 copay	40% after CYD	$0 copay	50% after CYD
Mammogram	$0 copay	$0 copay	$0 copay	$0 copay
Routine Colonoscopy (See Age)	$0 copay	$0 copay	$0 copay	$0 copay
Emergency Room Visits (Facility copay waived if admitted)	$100 copay	$100 copay	50% after CYD	
Urgent Care Facility	$65 copay	$65 copay after CYD	50% after CYD	50% after CYD
Convenient Care Centers	$35 copay	40% after CYD	$35 copay	50% after CYD
Advanced Imaging—CT/CAT, MRA, MRI, PET Scans	$65 copay	40% after CYD	$200 copay	50% after CYD
Outpatient Surgery—Ambulatory	$100 copay	40% after CYD	50% after CYD	50% after CYD
Outpatient Surgery—Hospital	Option 1: $100 copay Option 2: $300 copay	40% after CYD	Option 1: $300 copay Option 2: $400 copay	50% after CYD
Inpatient—Hospital	Option 1: $750 copay Option 2: $1,000 copay	40% after CYD	Option 1: $2,000 copay Option 2: $3,000 copay	50% after CYD
Professional Services	20% after CYD	INN—20% after CYD	—	—
Medical Rates—Employee (10 month rate September – June)				
Employee Only	$244.14		$111.81	
Employee/Spouse	$715.38		$509.47	
Employee/Child(ren)	$628.16		$441.67	
Family	$700.65		$664.12	
School District's Contribution				
Employee Only	$310.00			
Employee/Spouse	$310.00			
Employee/Child (Ren)	$310.00			
Family	$310.00			

Dental Insurance

Taylor County School Board offers a PPO dental program through Ameritas. Members have the ability to receive services via an in-network provider or receive services via an out-of-network provider. Members are not required to select a primary dental provider to coordinate their care. It is important to remember that members maximize savings when services are performed by an in-network dental provider. Services performed outside the network are based on a "reasonable and customary" fee schedule and members will be subject to balance billing. Ameritas Customer Service: **800.487.5553**

Dental Plan Summary	
Plan Benefit Type 1 Type 1 Type 1	 100% 80% 50%
Deductible	$200 Lifetime Type 3 Waived Type 1,2 No Family Maximum
Maximum (per person)	$1,500 per calendar year
Allowance	
Waiting Period	12 Months—Type 3 New Hires
Annual Open Enrollment	Included

Dental Rates	Monthly (10 month rate September – June)
Employee	$39.98
Employee + Spouse	$77.76
Employee + Child(ren)	$90.52
Family	$127.20

Sample Procedure Listing		
Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period) • Bitewing X-rays (2 per benefit period) • Full Mouth/Panoramic X-rays • (1 in 3 years) • Periapical X-rays • Cleaning (2 per benefit period) • Fluoride for Children 18 and under (1 per benefit period) • Sealants (age 16 and under) • Space Maintainers	• Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Vision Benefits

Humana Vision Plan

Customer Service: 866.537.0229

Vision Rates	Monthly (10 month rate September – June)
Employee Only	$7.84
Family	$25.25

An outline of the benefits is as follows:

Copays apply to in-network benefits. Copays for out-of-network visits are deducted from reimbursements. Contact lenses are in lieu of eyeglass lenses and frames benefit.

	In-Network	Out-of-Network
Exam with dilation as necessary	100% after $10 copay	$35 allowance
Lenses Single Bifocal Trifocal	 100% after $15 copay 100% after $15 copay 100% after $15 copay	 $20 allowance $40 allowance $60 allowance
Frames	$45 wholesale allowance	$45 retail allowance
Contact Lenses[1] Elective (conventional and disposable)[2] Medically necessary (limit one pair)[3]	 $120 allowance 100%	 $120 allowance $150 allowance
Frequency (based on date of service) Examination Lenses or contact lenses Frame	 Once every 12 months Once every 12 months Once every 24 months	 Once every 12 months Once every 12 months Once every 24 months

Additional plan discounts through participating providers

- Members receive additional fixed copayments on lens options, including anti-reflective and scratch-resistant coatings.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam and available through the participating provider who sold the initial pair of eyeglasses.
- After copay, standard polycarbonate available at no charge for dependents less than 19 years old

[1]If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of all other benefits (including frames).

[2]The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members receive a 15 percent discount on participating provider professional services. The discount for professional services is available for 12 months after the covered eye exam.

[3]Benefit provides coverage for professional services and one pair of medically necessary contact lenses with prior plan authorization.

Employee Basic Life Insurance

Employee Life and Accidental Death and Dismemberment Insurance

The School District offers employee Basic Life Insurance through Cigna. Each employee is covered for a flat amount of $ 20,000. The School District pays the cost of this insurance.

Voluntary Life (employee/retiree paid benefit)

Class 1	
All active, Full-Time Employees of the Employer working a minimum of 20 hours per week	
Units of $10,000 up to the lesser of 5 time your annual compensation to a minimum benefit $10,000 maximum benefit $100,000	Guaranteed Issue—$100,000

Class 2			
Retirees			
Option 1—$5,000	Option 2—$10,000	Option 3—$15,000	Option 4—$20,000

Class 3		
Dependent: (employee must participate in the voluntary life plan for dependents to participate—Class 1 only		
• Spouse—Units of $5,000 to a maximum of $50,000 » **Guaranteed Issue** $10,000	• Infant—14 days to (6) six months $500	• Child—6 months to 19 years (26 year if a full time student) » Units of $2,000 to a maximum benefit of $10,000 » **All are Guaranteed Issue**

Federal Notices

Please find below notices regarding Taylor County School District's medical plan. If you'd like additional information about any of these notices or your rights under them, please contact Chris Olson, Employee Services Coordinator, at 850.838.2500, **chris.olson@taylor.k12.fl.us**.

1. HIPAA Special Enrollment
2. Children's Health Insurance Program (CHIP)
3. Women's Health and Cancer Rights Act
4. Newborns' and Mothers' Health Protection Act
5. Michelle's Law
6. COBRA General Notice
7. Notice of Creditable Drug Coverage
8. HIPAA Privacy Notice
9. USERRA Rights

HIPAA Special Enrollment

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

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

To request special enrollment or obtain more information, contact Chris Olson, Employee Services Coordinator, at .850.838.2500.

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 NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1.877.KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1.866.444.EBSA** (3272).

If you live in Florida, you may be eligible for assistance paying your employer health plan premiums. The contact information is as follows:

Florida — Medicaid
Website: http://flmedicaidptlrecovery.com/hipp/ Phone: 1.877.357.3268

Women's Health and Cancer Rights Act

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

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

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

If you would like more information on WHCRA benefits, call your plan administrator Chris Olson, Employee Services Coordinator, at **850.838.2500**.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Michelle's Law

Michelle's Law requires group health plans to provide continued coverage for certain dependents who are covered under the School District's group health plan as a student if they lose their student status because they take a medically necessary leave of absence from school. This continuation of coverage is described below.

If your dependent is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your dependent may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your dependent was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions). For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the dependent at the institution, that:

1. begins while the dependent is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the dependent to lose student status for purposes of coverage under the plan.

The coverage provided to dependents during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your dependent had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed under the plan during this one-year period, the plan will provide the changed coverage for the dependent for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for these dependents.

If you believe your dependent is eligible for this continued coverage, the dependent's treating physician must provide a written certification to the plan stating that your dependent is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

COBRA General Notice of Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 and other members of your family when group health coverage would otherwise end. For more 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.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Taylor County School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation 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. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Chris Olson, Employee Services Coordinator, at 850.838.2500.

How is COBRA continuation 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 that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

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 the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

Chris Olson, Employee Services Coordinator, 850.838.2500.

Certificate of Creditable Drug Coverage

Important Notice from Taylor County School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Taylor County School District and about your options

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

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

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

When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Taylor County School District coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

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

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

You should also know that if you drop or lose your current coverage with Taylor County School 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 nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current Prescription Drug Coverage…

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

For more information about your options under medicare Prescription Drug Coverage…

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

For more information about Medicare Prescription Drug Coverage

Visit **www.medicare.gov**

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

Call **1.800.MEDICARE** (1.800.633.4227). TTY users should call **1.877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1.800.772.1213** (TTY 1.800.325.0778).

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

Date:	10/1/2016
Name of Entity:	Taylor County School District
Contact Position/Office:	Employee Services Coordinator
Address:	318 North Clark Street, Perry, FL 32347
Phone Number:	850.838.2500

HIPAA Privacy Notice

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

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

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1.877.696.6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

» Marketing purposes
» Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

» We can use and disclose your information to run our organization and contact you when necessary.
» We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

» Preventing disease
» Helping with product recalls
» Reporting adverse reactions to medications
» Reporting suspected abuse, neglect, or domestic violence
» Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

» We can share health information about you with organ procurement organizations.
» We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers compensation, law enforcement, and other government requests

We can use or share health information about you:

» For workers compensation claims
» For law enforcement purposes or with a law enforcement official
» With health oversight agencies for activities authorized by law
» For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

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

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

Changes to the Terms of this Notice

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

Other Information

» Privacy Notice Effective Date: 9/1/2013
» Contact Information: Chris Olson, Employee Services Coordinator, **850.838.2500**, **chris.olson@taylor.k12.fl.us**

Your Rights Under USERA

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—October 2008

Notes

Notes

Important Contacts

Making sure your benefit questions are answered is important to us. We realize, however, that it is not always possible for you to call during business hours or for the Benefits Office to be available when you call. Alternatively, you may call the vendor directly at the customer service numbers listed below:

Benefit	Phone	Website
Human Resources	850.838.2500	Chris Olson Employee Services Coordinator **chris.olson@taylor.k12.fl.us**
Medical Insurance Florida Blue—Group #41073	800.352.2583	www.floridablue.com
Dental Insurance Group #350317	800.487.5553	www.ameritasgroup.com
Vision Insurance Group #VS3200	866.537.0229	www.humanavisioncare.com
Life Insurance Voluntary Life Insurance Basic Life	800.732.1603	N/A

This benefit summary prepared by

Arthur J. Gallagher & Co.

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