2019-2020

Wakulla County School Board

WAKULLA COUNTY SCHOOLS

COMMITTED TO SUCCESS

WAKULLA COUNTY SCHOOL BOARD

69 ARRAN ROAD POST
OFFICE BOX 100
CRAWFORDVILLE, FLORIDA 32326
TELEPHONE: (850) 926-0065
FAX: (850) 926-0123

Dear Employee,

It's benefit enrollment time once again and we are excited about the coming year. We recognize the importance of benefits for you and your family and that is why we are expanding available resources to assist you when considering benefit options. In addition to continuing our partnership with American Fidelity Assurance Company for open enrollment, the District has contracted with Rogers, Gunter, Vaughn Insurance Company to provide assistance during the year following open enrollment regarding any issues or concerns you may have with your health, dental, or life insurance benefits. Also, the Finance and Human Resources Departments developed the following benefit guide to provide you with information about your benefit options for the new plan year, explain the enrollment and change process, and serve as a valuable resource for information about all the benefits available to you. It's a good idea to take some time to read this guide before attending open enrollment and/or completing your enrollment forms.

Your open enrollment will be for all core (Medical/Dental/Vision) plus supplementary benefits. For 2019, we are proud to continue our partnership with American Fidelity and other existing companies for the following supplementary benefits:

Disability Income Insurance, Term Life Insurance, Accident Insurance, Cancer Insurance, and Critical Illness Insurance

Enrollment counselors will be available throughout the open enrollment process to assist you in enrolling in all of your benefits and to answer any questions you may have. To see a complete schedule of this year's open enrollment sessions, please see page 6.

Thank you in advance for taking the time to review this benefit guide and we look forward to seeing you during open enrollment.

Sincerely,

Robert R. Pearce

Bobby Pearce,
Superintendent of Schools

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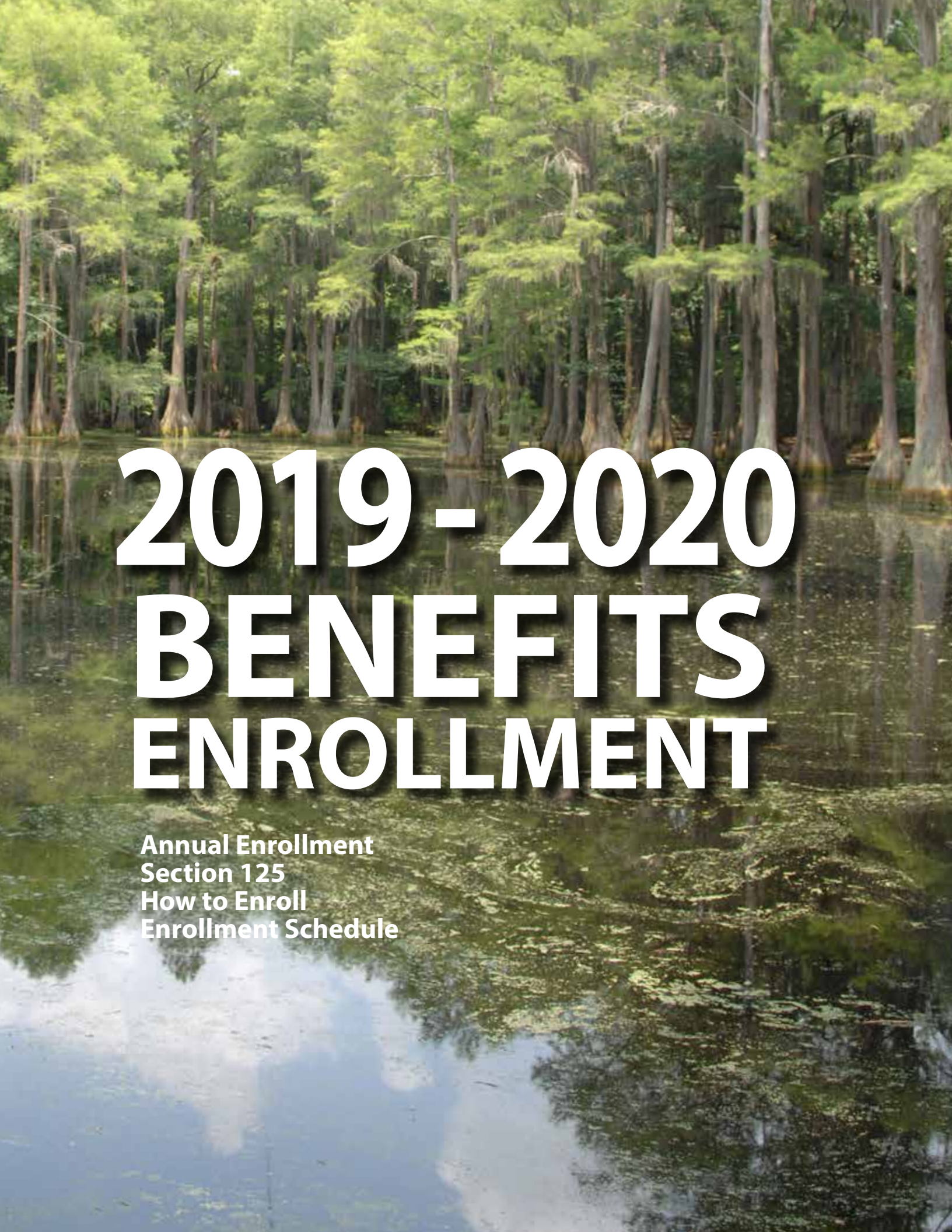

2019-2020 BENEFITS ENROLLMENT

Annual Enrollment
Section 125
How to Enroll
Enrollment Schedule

Your Annual Enrollment

Important Dates to Remember

Your Open Enrollment Dates are:

July 29, 2019 - August 23, 2019

Your Plan Year is:

October 1, 2019- September 30, 2020

Note: Changes to insurance plans will go into effect October 1st.

Annual Open Enrollment

Each year Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Your election deductions begin in September and will remain in effect through the plan year (October 1, 2019 - September 30, 2020) for your Voluntary benefits.

NOTE: If eligibility changes during the year you must notify Payroll Department within 31 days of the qualifying event.

Before you meet with your American Fidelity Representative, take time to evaluate your current coverage and decide how well it serves the needs of you and your family.

Important Points To Consider

- Figure an estimate of out-of-pocket medical expenses. Remember that over-the-counter drugs and medicines now require a prescription to be reimbursed.
- Figure an estimate of child care expenses.
- Review your beneficiaries.
- Review American Fidelity's options of portable insurance plans that you can keep if your employment changes.
- Evaluate your need for life insurance.
- Consider increasing your Disability Income Insurance policy amount to match your current salary.

Your Section 125 Plan

Save Money With Section 125

If there was a program available that could dramatically save money on your taxes, would you take advantage of it? That's exactly what the Section 125 Plan does—reduces your taxes and increases your spendable income! Plus, the Plan is available to you at no cost* and you're already eligible, all you have to do is enroll.

The Plan works like this: You are allowed to deduct needed benefits from gross earnings before taxes are computed. This means that current after-tax expenses, such as insurance products and benefits, can be paid for with pre-tax dollars.

The advantage of this Plan is simple: The eligible premiums you pay under the Plan are paid on a pre-tax basis. You could be on your way to increased savings, just by signing up and taking advantage of this Plan!

Benefits Eligible For The Section 125

Group Medical and Dental Insurance

- Accident Insurance
- Cancer Insurance
- Flexible Spending Accounts

How Can This Plan Help Me?

The sample paycheck below shows the benefits under the Section 125 Plan compared to benefits outside of the Plan. In this example, the employee gained $55 more spendable income per month!

Pre-Tax Example		After-Tax Example
$1,500.00	Monthly Gross Salary	$1,500.00
- $150.00	Pre-Tax Medical Insurance	$0.00
- $25.00	Pre-Tax Disability Insurance	$0.00
- $25.00	Pre-Tax Accident Insurance	$0.00
$1,300.00	Adjusted Monthly Gross Salary	$1,500.00
- $260.00	Estimated Federal Tax (20%)	- $300.00
- $99.45	Estimated FICA (7.65%)	- $114.75
$0.00	After-Tax Medical Insurance	- $150.00
$0.00	After-Tax Disability Insurance	- $25.00
$0.00	After-Tax Accident Insurance	- $25.00
$940.55	**Take-Home Pay**	**$885.25**

** Taxes are a sample average of State, Federal and FICA taxes. Your own average tax rate may vary.*

How to Enroll

Wakulla County School Board makes it easy for you to enroll in your 2019 benefits. Employees can enroll on-site with your American Fidelity representative.

Enroll On-site

See your American Fidelity's Representative during your enrollment to complete your benefit election form and discuss the options that are available to you.

What To Bring To Your Appointment

- Driver's license.
- Bank account information (to sign up for direct deposit)
- Spouse and children's DOB and Social Security number if considering coverage for them.
- Beneficiary information, including (if a trust) full name and date of trust.
- If adding a dependent for Medical, Dental or Vision please bring one of the following: marriage license, birth cert, college transcripts, state certs, guardianship papers, current tax forms.

Don't Miss It!

- Have you recently received a pay increase?
- Have you or are you planning on getting married, having children, or buying a home?
- What would happen if you were suddenly ill or disabled?

These questions and others will be addressed during your benefit consultation to make sure you are properly covered. It takes just a few moments to review your coverage and protect the welfare of you and your family.

By enrolling on-site you can enroll in:

- Dental Insurance
- Vision Insurance
- Group Life Insurance
- Disability Income Insurance
- Cancer Insurance
- Accident Only Insurance
- Life Insurance
- Health Flex Spending Account
- Dependent Care FSA

Enrollment Schedule

It's time to meet with your American Fidelity Assurance Company Representative and enroll in the Section 125! You can meet with them while they visit your District. They will be happy to assist you with any questions you may have regarding your Section 125 plan and available benefits.

Wakulla County School District Enrollment Schedule

Wakulla HS	Aug 5th, 6th, 7th	2 Reps
Wakulla MS	Aug 8th, 9th	2 Reps
Riversprings	Aug 12th, 13th	2 Reps
Riversink	Aug 14th, 15th	2 Reps
Transportation	Aug 16th	2 Reps
Medart & Board Meeting at District Office	Aug 19th	2 Reps
Wakulla Ed	Aug 19th, 20th	2 Reps
Medart	Aug 20th	2 Reps
Shadeville	Aug 21st, 22nd	2 Reps
Crawfordville	Aug 21st, 22nd	2 Reps
Wakulla Institute & Adult Ed	Aug 23rd	1 Rep
District Office	Aug 23rd	3 Reps

Any concerns or conflicts
with schedule, please contact
877-425-1104
American Fidelity Florida Branch

EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

Enrollment Made Simple

Wakulla Benefits Enrollment

July 29th – August 23rd

Enrollment Options

We know no two employees are alike. That's why American Fidelity Assurance Company is providing you with multiple enrollment options. Choose which benefits enrollment best suits you: one-on-one, either in person, by phone, or online, at home or at work. Learn more about each option below.

Self-Enrollment: Online

July 29th - August 4th

Through AFenroll®, you can enroll through our secure online system that is accessible from any desktop browser. The site also contains educational benefit and enrollment preparation videos to answer any questions you may have. To get started on your online enrollment, follow the instructions on the back of this flyer.

One-on-One: In-Person

August 5th - August 23rd

The one-on-one in-person enrollment allows you to meet individually with an American Fidelity account manager at your place of work to get your questions answered as well as enroll in the benefits that best meet your needs.

One-on-One: By Phone

July 29th - August 23rd

With the American Fidelity Benefit Enrollment Center option, you can enroll in your benefits at your convenience. Call 888-659-1531 anytime between 8 am to 6 pm EST to discuss your options as well as enroll in your benefits.

AFenroll® Instructions

How to Login

To access the online enrollment site, go to **www.afenroll.com/enroll**

1. At the login screen, you will enter the site using the following information:
   - **Type in your user ID:** Your Social Security Number (SSN)
   - **Type in your Password:** DOB in MMDDYY format
2. Click the **'Log On'** button.

To view a step-by-step video on how to enroll using AFenroll®, our online enrollment system, please visit **americanfidelity.com/howtoenroll**.

If you have questions or need help at any time during the online enrollment process, please contact the American Fidelity Benefit Enrollment Center at 888-659-1531.

American Fidelity Benefit Enrollment Center
9000 Cameron Parkway
Oklahoma City, OK 73114
888-659-1531
americanfidelity.com

AMERICAN FIDELITY
a different opinion

SB-30877-0317

INSURANCE PLANS

Medical Plan
Dental Plan
Vision Plan
Group Life Insurance
Disability Income Insurance

TX Life Insurance
Accident Insurance
Cancer Insurance
Critical Illness Insurance

Medical Insurance

Capital Health Plan

Wakulla County School Board Medical Rates

CHP Quality Choice				CHP Value Selection			
Plan Type	Total Cost Per Month	School Board Contribution	Employee Cost (10 pay/year)	Plan Type	Total Cost Per Month	School Board Contribution	Employee Cost (10 pay/year)
Family	**$1,991.87**	**$1031.96**	**$959.91**	**Family**	**$1,701.66**	**$1031.96**	**$669.70**
Single	**$830.14**	**$553.07**	**$277.07**	**Single**	**$709.19**	**$553.07**	**$156.12**

Rates

The Wakulla County School Board contributes $5530.70 per year for single coverage and $10,319.60 per year for family coverage to our health care plan for each regular employee working twenty (20) or more hours per week. (Exception: Based on our Health Benefit Measurement Period Policy found on page 32 a temporary employee working more than 30 hours/week may become eligible for such contributions.) If an employee works less than twenty (20) hours a week (part-time employees), he/she has the option to enroll in the health care plan provided they pay the total premium.

Cancelling a Pre-Tax Deduction

All payroll deductions which are made for Capital Health Plan medical coverage and Assurant/Sun Life Dental and Vision Insurance programs are automatically pre-taxed unless a waiver form is completed. After open enrollment, employees will not be able to cancel or change any pre-taxed payroll deductions unless certain Internal Revenue Code Requirements are met.

All changes or cancellations must be in the Payroll Office by the date listed in the "Due in County Office" section of the Payroll Reporting Salary Schedule (see page 55) for that particular paycheck date. If a change or cancellation is made after the pre-taxed deduction is deducted from your paycheck, the school board will not refund your deduction. It will be your responsibility to seek a refund from the appropriate company.

All deductions are withheld from your pay September through June. These deductions are listed on each paycheck. It is the employee's responsibility to check all paycheck deductions on a monthly basis. The School Board will not refund deduction errors after the next month's payroll has been processed.

If you are enrolled in ANY PRE-TAXED payroll insurance deduction, you WILL NOT BE ABLE TO CANCEL OR CHANGE THE DEDUCTION during the plan year, unless they meet one of the following qualifications and inform the Payroll Department within 31 days of the qualification:

Marriage or divorce, the death of your spouse or a dependent, the birth or adoption of one of your children, the termination or commencement of the employment of your spouse, a change in your or your spouse's employment status from part-time to full-time, or vice-versa, the taking of an unpaid leave of absence by yourself or your spouse, a significant increase in the cost of coverage, or a significant change in health coverage of employee or spouse attributable to spouse's employment.

An Individual may be added upon becoming an Eligible Dependent of a Subscriber.

Newborn Child -- To enroll a newborn child who is an Eligible Dependent, submit a Member Status Change from to Capital Health Plan prior to or during the 60-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

If the newborn child is enrolled within 30 days of the date of birth, Premium will not be charged for the first 30 days of coverage. If the newborn child is enrolled after this 30-day period, Premium will be charged from the moment of birth. Coverage will be denied if notice is not given within 60 days of the date of birth of the newborn child; however such newborn child may be enrolled during the next Annual Open Enrollment Period.

Quality Choice $15/$50/$100 Rx

Coverage Period: Plans beginning on or after 10/01/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Employee or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.capitalhealth.com/sbc. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-850-383-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical : $2,000 single coverage / $4,500 family coverage Pharmacy: $4,850 single coverage / $9,200 family coverage	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers.	Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not Covered	————none————
	Specialist visit	$75 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$250 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown.
	Tier 2 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 3 drugs	$100/30-day supply $200/60-day supply $300/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Specialty drugs	$100 /30-day supply	Not Covered	Limited to 30 day supply and may be limited to certain pharmacies. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center:$250 / visit Hospital: $500 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$75 / provider	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$750 / visit $500 / observation	$750 / visit $500 / observation	Copayment is waived if inpatient admission occurs; however if moved to observation status an additional copayment may apply based on services rendered.
	Emergency medical transportation	$250 / transport	$250 / transport	Covered if medically necessary.
	Urgent care	Urgent care: $50 / visit Telehealth: $15 / visit	Urgent care: $50 / visit Telehealth: $15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission $500 / observation	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge if admitted. $75 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 / visit	Not Covered	————none————
	Inpatient services	$500 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you are pregnant	Office visits	$75 / visit	Not Covered	————none————
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$500 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Rehabilitation services	$75 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 850-383-3311, 1-877-247-6512.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-383-3311, 1-877-247-6512.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *copayment*	$75
Hospital (facility) *copayment*	$500
Other *copayment*	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$14,000

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,960

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *copayment*	$75
Hospital (facility) *copayment*	$500
Other *copayment*	$15

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,500

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,455

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *copayment*	$75
Hospital (facility) *copayment*	$500
Other *copayment*	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$3,100

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,000

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination and Accessibility Notice (ACA §1557)

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

Capital Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

If you need these services, contact Member Services at one of the numbers listed below.

If you believe that Capital Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: memberservices@chp.org. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - February 14; 8:00 a.m. - 8:00 p.m., Monday - Friday, February 15 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 8:00 p.m.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–368–1019, 800–537–7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Have a disability? Speak a language other than English? Call to get help for free.
1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

Vous souffrez d'un handicap ? Vous parlez une autre langue que l'anglais ? Appelez pour obtenir une aide gratuite. 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

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અપંગતા છે? ઇંગલિશિ કરતાં અન્ય ભાષા બોલો છો? નશિુલ્ક મદદ મેળવવા કૉલ કરો. 1-877-247-6512, TTY/TDD 850-383-3534 અથવા 1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis?
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Approved by Compliance Committee: 8/23/2016; Revised 5/3/17

Value Selection HDHP $15/$50/$100 Rx Coverage Period: Plans beginning on or after 10/1/2019

(this plan not an HSA qualifies plan)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Employee or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.capitalhealth.com/sbc. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-850-383-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 single coverage $5,000 family coverage	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible. Retail pharmacy prescription drugs are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $4,000 single coverage / $8,500 family coverage Pharmacy: $2,850 single coverage / $5,200 family coverage	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers.	Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not Covered	————none————
	Specialist visit	$75 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$250 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown.
	Tier 2 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 3 drugs	$100/30-day supply $200/60-day supply $300/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Specialty drugs	$100 /30-day supply	Not Covered	Limited to 30 day supply and may be limited to certain pharmacies. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $250 / visit Hospital: $500 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$75 / provider	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$500 / visit $500 / observation	$500 / visit $500 / observation	Copayment is waived if inpatient admission occurs; however if moved to observation status an additional copayment may apply based on services rendered.
	Emergency medical transportation	$250 / transport	$250 / transport	Covered if medically necessary.
	Urgent care	Urgent care: $50 / visit Telehealth :$15 / visit	Urgent care: $50 / visit Telehealth: $15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission $500 / observation	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge if admitted. $75 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 / visit	Not Covered	————none————
	Inpatient services	$500 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you are pregnant	Office visits	$75 / visit	Not Covered	————none————
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$500 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Rehabilitation services	$75 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 850-383-3311, 1-877-247-6512.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-383-3311, 1-877-247-6512.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$75
Hospital (facility) copayment	$500
Other copayment	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$14,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$75
Hospital (facility) copayment	$500
Other copayment	$15

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,455**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$75
Hospital (facility) copayment	$500
Other copayment	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$3,200**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination and Accessibility Notice (ACA §1557)

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

Capital Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

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

If you need these services, contact Member Services at one of the numbers listed below.

If you believe that Capital Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: memberservices@chp.org. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - February 14; 8:00 a.m. - 8:00 p.m., Monday - Friday, February 15 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 8:00 p.m.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–368–1019, 800–537–7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Have a disability? Speak a language other than English? Call to get help for free.
1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

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અપંગતા છે? ઇંગલિશિ કરતાં અન્ય ભાષા બોલો છો? નશિુલ્ક મદદ મેળવવા કૉલ કરો. 1-877-247-6512, TTY/TDD 850-383-3534 અથવા 1-877-870-8943 પર

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พิการหรือเปล่า? พูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษหรือเปล่า? โทรเพื่อขอความช่วยเหลือฟรี
1-877-247-6512, TTY/TDD 850-383-3534 หรือ 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí. 1-877-247-6512, TTY/TDD 850-383-3534 hoặc 1-877-870-8943

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Approved by Compliance Committee: 8/23/2016; Revised 5/3/17

amwell

A faster, easier way to see a doctor with mobile or web access 24/7/365.

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Step 1: Enroll to create your account
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Step 3: Select the doctor you'd like to see

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amwell

The doctor is always in - midnight or midday - we're available 24/7/365, using your phone, tablet or computer.

You can use Amwell when:

- You need to see a doctor, but they are not available
- Your doctor's office is closed
- You feel too sick to leave the house
- You need care for your child(ren)
- You're traveling and need a doctor

For only **$15***, you can use Amwell for common health issues, such as:

- Cold/Flu
- Fever/Rash
- Ear Infection
- Bronchitis
- Sinusitis
- Pink Eye
- UTI
- Strep Throat

*The $15.00 copayment may vary depending on your plan type. Not a covered benefit for State of Florida members.

Capital Health PLAN

2018.03.003

Health Plan Benefits

Health Plans Contact Directory

Vendor	Member Services	Website
Capital Health Plan	850-383-3311	www.capitalhealth.com
Sun Life Financial - Vision	1-800-877-7195	www.vsp.com
Sun Life Financial - Dental	1-888-901-6377	www.sunlife.com
USAble Life	800-333-3256	_

Information will be communicated and included in this benefits guide when it is available.

Dental Plan

Sun Life Employee Benefits

Wakulla County School Board
Dental/Vision Rates
2019-2020

Rates
(10 pay/year)

	Dental High Plan	Dental Low Plan	Vision plan
Employee	$31.87	$22.22	$8.54
Employee/Spouse	$62.86	$43.78	$17.10
Employee/Child(ren)	$64.33	$50.24	$18.82
Family	$95.38	$72.53	$27.36

No Board contribution is provided for the dental/vision plans.

Dental insurance

Benefit Highlights

For all eligible employees of Wakulla County School Board, Policy # 914053

All Eligible Employees

- Dental insurance can help lower your out-of-pocket expenses so you and your family can maintain healthy smiles—and better overall health, too
- It pays all or part of your dental expenses, depending on the type of procedure. Benefits will be paid after any applicable deductible has been met, up to the annual maximum
- Cover your spouse[1] and your dependent children so you can help your whole family stay healthy
  - An eligible child is defined as a child to age 26[2]
- Benefit from group rates that may be more affordable than buying dental insurance on your own

Compare the annual cost of your Dental insurance with paying your dental expenses yourself

National Average Retail charge[3] for dental procedures:

Adult cleaning	$89 twice yearly =$178
Oral examination	$49 twice yearly =$98
Bitewing x-rays	$60
Total annual cost for preventive care	**$336**
Other services you or a dependent may need:	
Fluoride Treatment	$35
One surface filling	$155
Root canal	$1,089
Crown	$1,108

Additional plan features

- Your Enhanced Plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as brush biopsies for the early detection of oral cancer
- Your plan includes Preventive Max Waiver® which allows covered dental expenses for preventive service to not apply to the annual maximum
- Sun Life Dental Network®, the PPO network for your plan, includes 125,000+ unique dentists, offers you more options to help save on fees and can make your annual maximum go even further[7]

How Sun Life's Dental insurance can help

- Encourages routine cleanings and checkups at the dentist
- Cover your family's dental bills and reduce dental care costs for you and your family
- Maintain oral health to prevent infections and tooth loss

Dental Plan

Sun Life Financial

Basic Dental Coverage Overview -LOW PLAN

Calendar Year Maximum	In-Network	Out-of-Network
Types II and III (Basic and Major) Services	$750 per person	$750 per person
Calendar Year Deductible		
Procedure Type	**In-Network**	**Out-of-Network**
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$0 family	$50 individual/$0 family
Type IV Ortho Services	N/A	N/A
The plan pays the following percentage for procedures		
Procedure Type	**In-Network**	**Out-of-Network**
Type I Preventive Services	100%	70%
Type II Basic Services	80%	40%
Type III Major Services	50%	30%

Type I Preventive Dental Services, Including:

- Oral evaluations – once in any 6 month period
- Routine dental cleanings – once in any 6 month period (frequency combined with periodontal maintenance)
- Fluoride treatment – once in any 6-month period. *Only for children under age 14*
- Sealants – no more than once per tooth in any 36-month period, only for permanent molar teeth. *Only for children under age 14*
- Genetic test for susceptibility to oral diseases
- Bitewing x-rays – once in any 12 month period

Type II Basic Dental Services, Including:

- New fillings
- Space maintainers – *Only for children under age 19*
- Intraoral complete series x-rays – once in any 60-month period

Type III Major Dental Services, Including:

- Dentures and Bridges, subject to 10 year replacement limit
- Stainless steel crowns. *Only for children under age 19*
- Inlay, onlay, and crown restorations – once per tooth in any 10 year period.
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – once per tooth in any 24 month period
- Complex oral surgery
- General anesthesia and IV sedation when medically required
- Minor gum disease treatment: (non-surgical periodontics)
  - Scaling and root planing – once in any 24-month period per area
  - Localized delivery of antimicrobial agents
  - Periodontal maintenance – once in any 6 consecutive months
- Major gum disease treatment: (surgical periodontics)

Waiting Periods

For a complete description of services and waiting periods, please review the certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive, basic, or major services.

Your employer is offering you a choice of two plans. Please review the information for this plan as well as the Enhanced Dental plan. Then, choose the one plan that best fits your needs

Dental Plan

Sun Life Financial

Enhanced Dental Coverage Overview -HIGH PLAN

Calendar Year Maximum	In-Network	Out-of-Network
Types II and III (Basic and Major) Services	$1,000 per person	$1,000 per person
Calendar Year Deductible		
Procedure Type	**In-Network**	**Out-of-Network**
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$0 family	$50 individual/$0 family
Type IV Ortho Services	N/A	N/A
The plan pays the following percentage for procedures		
Procedure Type	**In-Network**	**Out-of-Network**
Type I Preventive Services	100%	80%
Type II Basic Services	80%	60%
Type III Major Services	50%	40%

Type I Preventive Dental Services, Including:

- Oral evaluations – once in any 6 month period
- Routine dental cleanings – once in any 6 month period (frequency combined with periodontal maintenance)
- Fluoride treatment – once in any 6-month period. *Only for children under age 14*
- Sealants – no more than once per tooth in any 36-month period, only for permanent molar teeth. *Only for children under age 14*
- Genetic test for susceptibility to oral diseases
- Bitewing x-rays – once in any 12 month period

Type II Basic Dental Services, Including:

- New fillings
- Space maintainers – *Only for children under age 19*
- Endodontics (includes root canal therapy) – once per tooth in any 24 month period
- Intraoral complete series x-rays – once in any 60-month period
- Minor gum disease treatment: (non-surgical periodontics)
  - Scaling and root planing – once in any 24-month period per area
  - Localized delivery of antimicrobial agents
  - Periodontal maintenance – once in any 6 consecutive months

Type III Major Dental Services, Including:

- Dentures and Bridges, subject to 10 year replacement limit
- Stainless steel crowns. *Only for children under age 19*
- Inlay, onlay, and crown restorations – once per tooth in any 10 year period.
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Complex oral surgery
- General anesthesia and IV sedation when medically required
- Major gum disease treatment: (surgical periodontics)

Waiting Periods

For a complete description of services and waiting periods, please review the certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive, basic, or major services.

Your employer is offering you a choice of two plans. Please review the information for this plan as well as the Basic Dental plan. Then, choose the one plan that best fits your needs

Dental Q&A

How does a PPO work?

PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?

Simply visit www.sunlife.com/findadentist . Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance.

Do I have to choose a dentist in the PPO network?

No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Where do I find my dental ID card?

Your personalized electronic dental ID card is available through Online Advantage. You can register at www.sunlife.com/onlineadvantage . Please present this card to your dentist at your next visit to show that you are covered by a Sun Life Dental plan.

What if I have already started dental work…like a root canal or braces…that requires several visits?

Your coverage with us and your prior plan may handle these procedures differently. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Is it necessary to request a pre-determination of benefits prior to receiving services?

A pre-determination of benefits allows Sun Life to review your provider's plan for treatment before the work is done. We can tell you ahead of time how much of the work will probably be covered by the plan, and how much you may need to cover. If the charge for any dental treatment is expected to exceed $300, it is recommended that a dental treatment plan be submitted for review before treatment begins.

Do I have to file the claim?

Dentists in the PPO network will file claims for you. Some non-network dentists will file claims for you as well. If a non-network dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life Financial
P.O. Box 2940
Clinton, IA 52733

How can I get more information about my coverage?

After the effective date of your coverage, you can visit www.sunlife.com/onlineadvantage to create an account with Online Advantage.[6] Once you're logged in, you'll be able to see your plan details, personalized dental ID card, and more. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

Get benefits information on the go!

Download our Benefit Tools app for quick access to:

- An overview of your coverage details[8]
- Your electronic dental ID card[8]
- Find a dentist near you

Apple download

Android download

Dental plan provisions

Benefit adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

Late entrant

If you apply for dental insurance more than 31 days after a covered person first becomes eligible, the person is a late entrant. The benefits for the first 12 months of coverage for late entrants will be limited as follows:

Time Insured Continuously Under the Policy	Benefits Provided for Only These Services
• Less than 6 months	Preventive Dental Services
• At least 6 months but less than 12 months	Preventive and Amalgam and Composite Fillings under Basic Dental Services
• At least 12 months	Preventive, Basic and Major Dental Services

We will not pay for any treatment that is started or completed during the late entrant limitation period.

This summary represents a general overview and is not a complete description of your plan. It is being provided before your certificate is issued. All of our dental policies include exclusions, limitations, and frequency requirements. The actual provisions of your dental policy will be used to determine coverage for any claims that you submit.

This plan does not provide coverage for pediatric oral health services that satisfies the requirements for “minimum essential coverage” as defined by The Patient Protection and Affordable Care Act (PPACA).

Please read the Important Plan Provisions section located at the end of this document for Limitations and Exclusions.

1. If permitted by the Employer’s employee benefit plan and not prohibited by state law, the term “spouse” in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
2. Please see your employer for more specific information.
3. Average Retail Costs were determined by our national claims analysis for the year 2017. The costs represent a mean average rounded to the nearest dollar representing what you may pay without plan services.
4. Classification of services varies by plan design.
5. Total number of combined prophylaxis cleaning and periodontal maintenance procedures cannot exceed 4 in a 12 month period.
6. There may be tax consequences to you and your employees.
7. Sun Life’s dental networks include dentists contracted with Dental Health Alliance, L.L.C.® (D.H.A.®) and dentists under access arrangements with other dental networks.
8. You will need to register for Online Advantage to access these features.

Important Plan Provisions

Dental Insurance

Limitations and exclusions

Exclusions may prevent expenses from being covered based on certain circumstances. The following expenses may not be covered:

- Procedures not performed by a licensed dentist
- Procedures not listed as covered dental expenses
- Dental care for injuries that are work related, self-inflicted, or not caused by an accident
- Orthognathic surgery
- Dental care resulting from active participation in a riot or commission of a felony
- Experimental treatment, oral hygiene, plaque control programs, and dietary instruction
- Dental care for injuries sustained as a result of war or act of war
- Charges for pulp caps
- Dental expenses incurred while coverage is not in force
- Charges for care, treatment, services, or supplies to the extent that any benefit is provided by Medicare
- Charges not customarily made when there is no insurance or charges for which there is no legal obligation to pay
- Charges for failure to keep appointments
- Replacement or repair of a lost, stolen, or damaged prosthetic or orthodontic appliance
- Additional services, such as orthodontia and/or surgical implants, are not covered unless specifically listed under covered services. Also not covered are charges for diagnostic services and treatment of jaw joint problems, such as temporomandibular joint disorders, by any method unless specifically covered under the Certificate

Sun Life Financial®

*Subject to state law variations.

GDBH-6247

SLPC 28019 12/18 (exp. 12/23)

Rate Sheet

Coverage and **10 pay** rate for Dental Insurance.
Dental coverage is contributory, meaning that you are responsible for paying for all or a portion of the cost through payroll deduction.

Basic Plan:

Coverage	10 Pay Cost*
Employee	$22.22
Employee + Spouse	$43.78
Employee + Child(ren)	$50.24
Employee + Family	$72.53

Enhanced Plan:

Coverage	10 Pay Cost*
Employee	$31.87
Employee + Spouse	$62.86
Employee + Child(ren)	$64.33
Employee + Family	$95.38

*The rate is in effect for October 1, 2019. Contact your employer to confirm the portion of the cost for which you will be responsible.

Dental Plan

Sun Life Financial

Sun Life Financial®

Thank you for selecting Sun Life Financial* for your dental product. We are pleased to provide you with the attached dental identification cards. If you have previously received cards, please replace your current ID cards with the attached cards.

Register for Online Advantage for Members on our website at www.sunlife.com/onlineadvantage. Online Advantage for Members provides you the ability to:

- Download your ID card
- View benefit and claims information
- Find a dentist

Go Mobile!
Scan the code on the right (or go to www.sunlife.com/mobileapps) to download our mobile app, **Benefit Tools**, to enjoy some of the same benefits as Online Advantage for Members.

If you have any questions, please call the toll-free number listed on your ID card.

You always have the freedom to choose any dentists with your dental plan. When using an in-network dentist, you may save on out-of-pocket costs.

*Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

Sun Life's dental networks include dentists contracted with Dental Health Alliance, L.L.C.® (D.H.A.®) and dentists under access arrangements with other dental networks.

GDOT-6749

Membership Cards

Sun Life Financial®

Group ID Number 914053

Issued to Wakulla County School Board

PRINT MEMBER NAME

Insurance products are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

Sun Life Dental Network®
(Includes Aetna Dental® Administrators)

To locate a dentist in your area – visit www.sunlife.com/findadentist. Input your Group ID and hit search.

Dental Coverage: Benefits are subject to group provisions including deductibles, coinsurance and coordination of benefits. This card is NOT a guarantee of payment. Please call to verify benefits. If services are to exceed $300, please submit a pre-determination.

For Benefit and Claim Information:
Sun Life Financial
P.O. Box 2940, Clinton, IA 52733

Electronic Claims: Payor 70408
(800) 442-7742

Sun Life Financial®

Group ID Number 914053

Issued to Wakulla County School Board

PRINT MEMBER NAME

Insurance products are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA).

Sun Life Dental Network®
(Includes Aetna Dental® Administrators)

To locate a dentist in your area – visit www.sunlife.com/findadentist. Input your Group ID and hit search.

Dental Coverage: Benefits are subject to group provisions including deductibles, coinsurance and coordination of benefits. This card is NOT a guarantee of payment. Please call to verify benefits. If services are to exceed $300, please submit a pre-determination.

For Benefit and Claim Information:
Sun Life Financial
P.O. Box 2940, Clinton, IA 52733

Electronic Claims: Payor 70408
(800) 442-7742

Vision insurance

Benefit Highlights

For all eligible employees of Wakulla County School Board, Policy # 914053

All Eligible Employees

Vision insurance[1] can help improve your eyesight—and your overall health, too.

- You will see lower out-of-pocket costs due to savings on frames, lenses, contacts, eye exams and more
- Cover your spouse[2] and your dependent children so you can help your whole family see better
  - An eligible child is defined as a child to age 26[3]
- Benefit from group rates that may be more affordable than buying vision insurance on your own

Additional plan features

- An annual comprehensive eye exam
- Doctors who offer flexible hours and office settings
- A large selection of eyewear choices we believe you will love
- Access to the largest national network[4] of private-practice eye care doctors in the industry through Vision Service Plan (VSP)
- No ID cards are needed

How Sun Life's Vision insurance can help

- Encourages routine screenings and an annual comprehensive eye exam
- Whether you just need a basic eye exam or designer frames – we have options for you
- Better eyesight can lead to a better quality of life

Vision Coverage Overview

Plan 3 Covered Expenses

Benefit	Frequency	In-Network Member Cost	Out-of-Network Benefit
Exam Services **WellVision Exam®**	1 per 12 months	$10	Up to $52
Laser Vision Correction Discount	Once per eye per lifetime	• Average 15% off the regular price or 5% off the promotional price • Discounts only available from contracted facilities	N/A
Lenses	1 per 12 months	$25 (lenses and frame)	
Single Lined **Bifocal Lined** **Trifocal** **Lenticular** **Necessary Contacts**			Up to $55 Up to $75 Up to $95 Up to $125 Up to $210
Lens Enhancements			N/A
Standard progressive **Premium progressive** **Custom progressive**		$50 copay $80-$90 copay $120-$160 copay Average savings of 35-40% on other lens enhancements	
Frames	1 per 12 months	• $130 for the frame of your choice and 20% off the amount over your allowance	Up to $57
Elective Contact Lenses *Contact lenses are in place of lenses and frames*	1 per 12 months	• 15% savings for your contact lens exam (fitting and evaluation) • $130 for contact lenses	Up to $105
Additional Glasses and Sunglasses Discounts	30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your exam. Or get 20% off from any VSP doctor within 12 months of your last exam.		N/A

Vision Q&A

How do I use my vision benefit?

Once enrolled, simply tell your VSP doctor you're a member and they will handle the rest. If you visit an in-network doctor for services and materials, you don't need an ID card or have forms to complete.

How do I locate an in-network VSP doctor?

There are three ways to find an in-network doctor:

1. Visit vsp.com and select the Signature network.
2. Call 800-877-7195.
3. Download our mobile app, Benefit Tools, and search for a doctor near you.

What happens if I use an out-of-network doctor?

You will be required to pay the full amount to the doctor at time of service. You can then submit a claim for reimbursement, which is a lesser benefit when compared to visiting a VSP doctor.

When will my coverage become effective?

Your coverage starts on the effective date specified in your group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties.

Can I enroll as a late entrant?

If you elect coverage more than 31 days after your eligibility date, your effective date will be delayed to the next plan anniversary date.

How can I get more information about my coverage?

After the effective date of your coverage, you can visit www.sunlife.com/onlineadvantage to create an account with Online Advantage. Once you're logged in, you'll be able to see your plan details and more. Or you can call Customer Service at 800-877-7195.

Please read the Important Plan Provisions section located at the end of this document for Limitations and Exclusions.

1. Administrative services for the vision insurance plan are provided by Vision Service Plan (VSP).
2. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
3. Please see your employer for more specific information.
4. Netminder as of December 2016.

Important Plan Provisions

Vision Insurance

Limitations

In no event will coverage exceed the lesser of:

- the actual cost of the examination or materials, or
- the limits of coverage shown in the Benefit Highlights section of the certificate

The allowance for lenses shown in the Benefit Highlights section is for two lenses. If only one lens is needed, coverage will be 50% of the allowance shown for two lenses.

Benefits will not be payable for replacement of lost or broken materials until the next eligible benefit period.

The plan is designed to cover visually necessary materials rather than cosmetic materials. When you or a covered dependent select any of the following extras, the plan will pay the basic cost of the allowed lenses, and you or the covered dependent will pay the additional costs for the options.

- Optional cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Progressive multifocal lenses
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2
- UV (ultraviolet) protected lenses
- Certain limitations may apply to low vision care benefits
- A frame that costs more than the plan allowance
- Contact lenses (except as noted in the Vision Insurance Schedule)

Exclusions

Covered vision benefits do not include, and we will not pay benefits for, the following:

- Orthoptic or vision training and any associated supplemental testing
- Plano lenses
- Two or more pairs of glasses, in lieu of bifocals or trifocals
- Replacement of lenses and frames furnished under the plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eye, eyes, or supporting structures, except for laser surgery as shown under the Benefit Highlights section
- Materials, services or options not shown in the Benefit Highlights section
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available
- Contact lens insurance policies or service agreements
- Refitting of contact lenses after the initial (90-day) fitting period
- Additional office visits associated with contact lens pathology
- Contact lens modification, polishing or cleaning
- Services associated with CRT or Orthokeratology

Vision Plan

Subject to state law variations.

This summary represents a general overview and is not a complete description of your plan. It is being provided before the issuance of the certificate. The actual provisions of your vision policy will be used to determine coverage for any claims submitted.

The issued policy provides vision insurance only. It does not provide basic hospital, accident or major medical coverage. Plans contain limitations, exclusions and restrictions. Plan frequencies and limitations apply. We can cancel the policy after giving the policyholder advance written notice. Contact us for costs and complete details.

This vision plan does not provide coverage for pediatric vision health services that satisfies the requirement for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act ("PPACA").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 16-VIS-C-01. In New York, group insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) under Policy Form Series 15-GP-01 and 16-VIS-C-01. Product offerings may not be available in all states and may vary depending on state laws and regulations.

GVISBH-6475

SLPC 28049 01/19 (exp. 01/24)

Rate Sheet

Coverage and **10 pay** rate for Vision Insurance.

Vision coverage is contributory, meaning that you are responsible for paying for all or a portion of the cost through payroll deduction.

Coverage	10 Pay Cost*
Employee	$8.54
Employee + Spouse	$17.10
Employee + Child(ren)	$18.82
Employee + Family	$27.36

*The rate is in effect for October 1, 2019. Contact your employer to confirm the portion of the cost for which you will be responsible.

EMPLOYEE BENEFITS SUMMARY | **50035919**
WAKULLA COUNTY SCHOOLS

FOR ALL ACTIVE FULL TIME EMPLOYEES

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT	**EMPLOYER CONTRIBUTION: 100%**

AMOUNT OF COVERAGE: Pays a benefit of $50,000 without evidence of insurability.

Benefits reduce, based on your age, to 65% at age 70, to 45% at age 75, and to 30% at age 80, and then terminate when you are no longer eligible or your retirement, whichever occurs first.

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

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Common Carrier Benefit
- Safety Equipment Benefit
- Total Loss of Use Benefit
- Dignity Planner
- *Online Employee Assistance Program (EAP) - Go to: NDBH.COM, Login: USAL903.
- *Offered through our partnership with New Directions Behavioral Health

DEPENDENT LIFE	**EMPLOYER CONTRIBUTION: 0%**

Spouse: You may purchase coverage for your eligible spouse in the amount of $10,000.

Children: You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of $2,500. Benefits are reduced to $1,000 for children from 14 days to 6 months.

Benefits terminate when you are no longer eligible or your retirement, whichever occurs first.

Important Note
If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully. This benefit summary was generated by USAble Life on 10/7/2019 at 2:17 PM and may not reflect changes recently submitted to USAble Life.

EMPLOYEE BENEFITS SUMMARY | **50035919**
WAKULLA COUNTY SCHOOLS

FOR ALL RETIREES

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT	**EMPLOYER CONTRIBUTION: 100%**

AMOUNT OF COVERAGE: Pays a benefit of $10,000 without evidence of insurability.

Benefit does not reduce, and terminates when you are no longer eligible.

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

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) is payable, if within 365 days of a covered accident, you suffer loss of life or dismemberment. AD&D provides protection for losses occurring on or off the job.

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT ALSO INCLUDES THE FOLLOWING:

- Accelerated Benefit
- Extended Life Insurance Benefit (Waiver of Premium)
- Coma Benefit
- Exposure & Disappearance Benefit
- Repatriation Benefit
- Common Carrier Benefit
- Safety Equipment Benefit
- Total Loss of Use Benefit
- Dignity Planner

DEPENDENT LIFE	**EMPLOYER CONTRIBUTION: 0%**

Spouse: You may purchase coverage for your eligible spouse in the amount of $5,000.

Children: You may purchase coverage for your eligible children between the ages of 6 months and 26 years in the amount of $2,500. Benefits are reduced to $1,000 for children from Live Birth to 6 Months.

Benefits terminate when you are no longer eligible.

Important Note
If you are not actively at work on the date your insurance or any increase in insurance is scheduled to take effect, the coverage or increase in coverage will take effect on the day you return to active work. This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully. This benefit summary was generated by USAble Life on 7/16/2019 at 1:40 PM and may not reflect changes recently submitted to USAble Life.

Long-Term Disability Income Insurance

American Fidelity Assurance Company

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?

American Fidelity Assurance Company's AF™ **Long-Term Disability Income Insurance** is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

How the Plan Works

If you become disabled due to a covered accident or sickness, Long-Term Disability Income Insurance will pay the disability benefit once you have satisfied the elimination period. Your benefit amount is dependent on your salary and the amount you select at the time of application. Disability benefits will be payable up to the benefit period stated in your policy.

Coverage Feature	What It Means To You
Accidental Injury and Sickness Coverage	You are covered in the case of a covered accident that occurs away from work or a covered sickness that causes you to be disabled.
Benefit Paid Directly to You, Regardless of Other Coverage	Use the money however best fits your financial needs, regardless of other insurance.
Waiver of Premium	Premiums are not required while you are disabled based on the length of your disability.
Age at Entry	Your premiums will be based on the date your policy becomes effective.
Accidental Death Benefit	Receive a benefit if you die as the direct result of an Accidental Injury and death occurs within 90 days after the date of the Accidental Injury.
Competitive Premiums	Your monthly premiums could be paid with only one hour of a week's paycheck.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details.

Universal Life Insurance

Texas Life Insurance Company

It is impossible for life insurance to emotionally compensate for a loss, but it may help ease the financial obligations placed on your loved ones. Individual life insurance products can help.

Universal Life Insurance

(PureLife-Plus)

A voluntary permanent[7] life insurance product that guarantees life insurance to age 121. *(Underwritten by Texas Life Insurance Company)*

Did You Know?

More Americans were relying on employer-sponsored life insurance coverage than individual coverage.[1]

Ask your employer or your AFES representative can provide you with the opportunity for Group Life Insurance — but, do you have individual life insurance you can take with you after your employment ends? Life insurance at retirement can be very costly.

Consider a PureLife-Plus Policy!

Ask Employer or American Fidelity Representative how you can secure your permanent[7] life insurance with a product that provides:

- Guaranteed death benefit to age 121.[7]
- Minimal cash value – premiums dedicated primarily to the purchase of life insurance.
- Long premium guarantees.[2]
- Limited right to partial refund of premium if future premium required to continue coverage increases.[2] (Conditions apply)
- Take it with you when you leave employment.
- Coverage available for employee, spouse, children and grandchildren.[3]

Coverage Feature	What It Means To You
Several Product Options	Choose the coverage to meet your financial needs.
Guaranteed Premium[2]	Your premiums are guaranteed for each applicable period.
Guaranteed Death Benefit[4]	Your death benefit is guaranteed for the life of the policy provided premiums are paid when due.
Interim Coverage[5]	Coverage normally begins when you complete the application and the authorization for your employer to deduct premiums from your paycheck. Two year suicide and contestability provisions apply. (one year in ND).
Enhance Your Coverage	Additional riders may be available on certain products to expand your policy.
Easy Application	No medical exams and minimal health questions.[6]
Portable	You own the policy. Take the coverage with you if you choose to leave your current job.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

This product may not be available in all states and may contain limitations. Not generally qualified benefits under Section 125 Plans. Underwritten by Texas Life Insurance Company. Not affiliated with American Fidelity Assurance Company.

[1]LIMRA: Life Ownership Focus, 2016.
[2]After the guaranteed period, premiums may go down, stay the same or go up.
[3]Coverage not available in WA on children or on grandchildren in WA or MD. In MD, child must reside with the applicant to be eligible for coverage.
[4]Some limitations apply. See brochure for details.
[5]Conditions apply. In Kansas, Temporary Insurance applies. Form 16M050.
[6]Issuance of this policy may depend on the answer to these questions.
[7]Provided required premiums are timely paid.

Flexible Premium Adjustable Life Insurance to age 121. PureLife-plus is underwritten and issued by Texas Life Insurance Company, 900 Washington Avenue, Waco, Texas 76701. Texas Life is licensed to do business in the District of Columbia and every state but NY. See the PureLife-plus brochure for details. Policy Form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18.
19M010-C 1009 (exp0121)

SB-22482-0319

Accident Only Insurance

Limited Benefit Accident Only Insurance

American Fidelity Assurance Company

Whether a weekend warrior with an active lifestyle or just a busy family, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

American Fidelity Assurance Company's AF™ **Limited Benefit Accident Only Insurance** policy can provide you with a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job.

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Limitations and Exclusions section.

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced, and Enhanced Plus	Choose the plan to meet your financial needs.
Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers many types of covered injuries.
Wellness Benefit	The plan pays an annual Wellness Benefit for one Covered Person to receive a routine physical exam, including immunizations and preventative testing.
Accident Emergency Treatment Benefit	Receive a benefit when emergency treatment in a Physician's office or emergency room occurs within 72 hours of a covered accident.
Benefit Paid Directly to You, to use as you see fit	Use the benefit however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
24-Hour Coverage	You are covered on or off the job.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details, AO-03 series with AMDI258 rider. **This product is inappropriate for people who are eligible for Medicaid coverage.** The premium and amount of benefits provided vary dependent upon the plan selected. The company has the right to change premiums by class. Availability of riders my vary by state.

SB-23288-0419

Cancer Insurance

Limited Benefit Cancer Insurance Policy

American Fidelity Assurance Company

A cancer diagnosis may be overwhelming. Even with a good major medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income, are considerable and may not be covered.

American Fidelity Assurance Company's AF™ **Limited Benefit Individual Cancer Insurance** offers a solution to help you focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

How the Plans Work

Our plans are designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, these plans can provide benefits for the treatment of cancer, transportation, hospitalization and more. We provide the benefit directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider**
  Includes a cancer benefit and a heart attack/stroke benefit
- **Hospital Intensive Care Unit Rider**

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced and Enhanced Plus	Choose the plan option to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Policy is guaranteed renewable as long as premiums are paid as required.
Diagnostic and Prevention Benefit	Receive a benefit for visiting your doctor for a cancer screening test, which helps with early detection.
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected. Availability of riders may vary by state.

SB-23287-0419

Group Critical Illness Insurance

Limited Benefit Group Critical Illness Insurance Policy

American Fidelity Assurance Company

Surviving a critical illness, such as a heart attack or stroke, can come at a high price. With advances in technology to treat these diseases, the cost of treatment rises more and more every year. Even with major medical insurance, the out-of-pocket expenses associated with a critical illness can affect anyone's finances.

American Fidelity Assurance Company's AF™ **Limited Benefit Critical Illness Insurance** can be the solution that helps you and your family focus on recovery, and may help you with paying bills. Our plan can assist with the expenses that may not be covered by major medical insurance.

How the Plan Works

If you are diagnosed with a covered Critical Illness, such as a heart attack or stroke, this plan is designed to pay a lump sum benefit amount to help cover expenses. Also, this plan offers a Recurrent Diagnosis Benefit for certain specified Critical Illnesses that provides an additional 50% of the Critical Illness benefit amount after the second occurrence date. Covered Critical Illness events include Heart Attack, Permanent Damage Due to a Stroke, and Major Organ Failure.

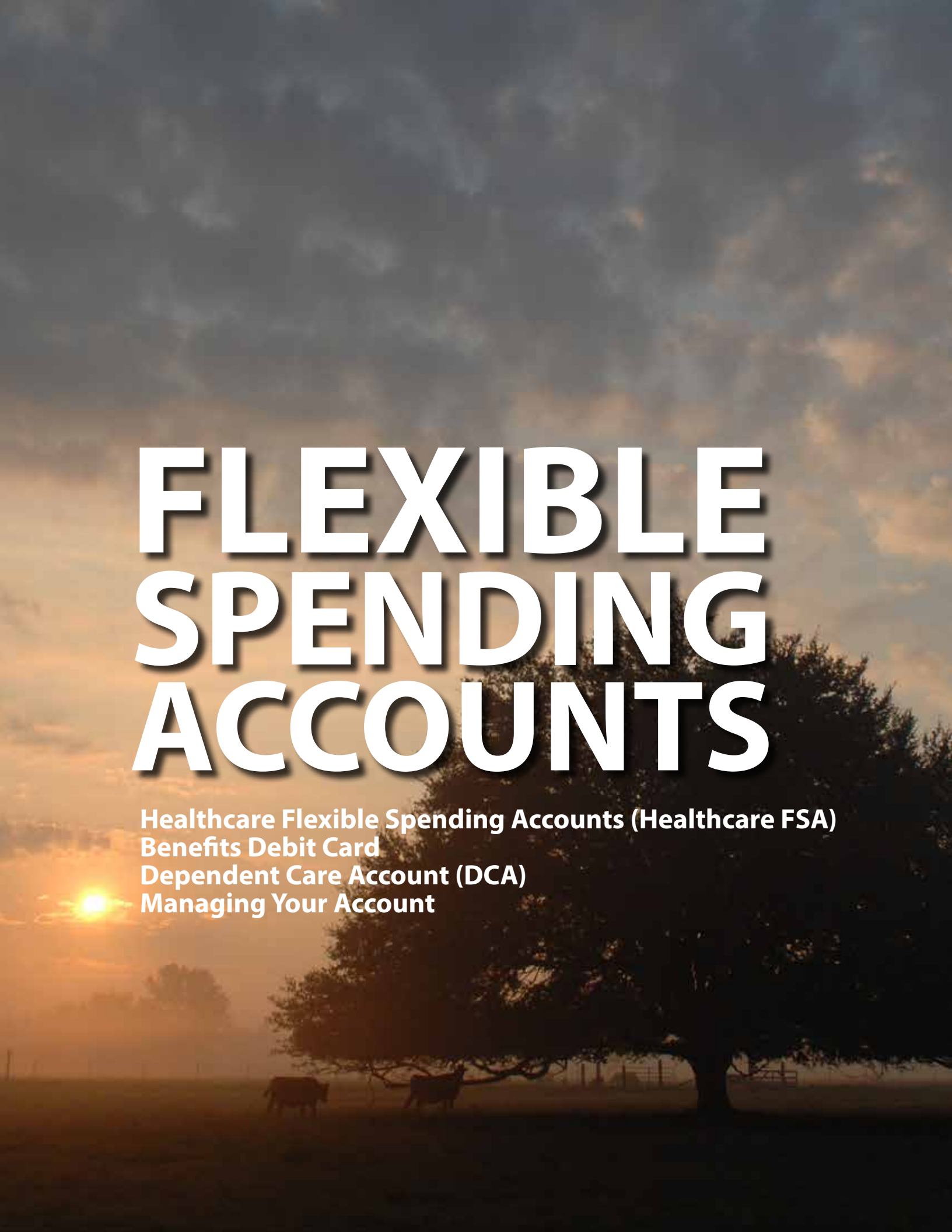
Guaranteed Renewable

You are guaranteed the right to renew your base policy until age 75 as long as you pay premiums when due or within the premium grace period. The insurer has the right to increase premium rates if the policy so provides.

Coverage Feature	What It Means For You
Plan Options	Choose from three lump sum benefit amounts: $10,000, $20,000 or $30,000.
Coverage Option	Children are automatically covered under the Employee base plan. If elected, Spousal Benefit Amounts will be 50% of the Employee Benefit Amount.
Wellness Benefit	Receive a benefit for your annual health screening test.
Benefit Paid Directly to You	Use the benefit however best fits your financial needs.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. Group Critical Illness is only offered on an after-tax basis.

SB-30543-0419



FLEXIBLE SPENDING ACCOUNTS

Healthcare Flexible Spending Accounts (Healthcare FSA)
Benefits Debit Card
Dependent Care Account (DCA)
Managing Your Account

Flexible Spending Accounts

American Fidelity Assurance Company

Flexible Spending Accounts are great cost savings tools to help with common medical expenses not covered by your major medical insurance and/or dependent care expenses. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified out-of-pocket expenses throughout the plan year.

Flexible Spending Account Savings Example

With FSA		Without FSA
$30,000	Annual Gross Income	$30,000
- $2,400	Healthcare FSA Election	$0
- $2,500	Dependent Care Account Election	$0
$25,100	Taxable Gross Income	$30,000
- $5,020	Estimated Federal Tax (20%)*	- 6,000
- $1,920.15	Estimated FICA (7.65%)	- 2,295
$18,159.85	Annual Net Income	$21,705
$0	Cost of Medical Expenses	- $2,400
$0	Cost of Dependent Care Expenses	- $2,500
$18,159.85	**Spendable Income**	**$16,805**
With an FSA, potential annual savings in this example is: $1,354.85		

By using an FSA to pay for eligible expenses, you can reduce your taxable income.

* Estimated state 5% and federal 15%.

Healthcare Flexible Spending Account (Healthcare FSA)

A Healthcare FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from co-payments, medical deductibles, prescriptions and much more.

Minimum Annual Election: $150
Maximum Annual Election: $2,700

Examples of Eligible Expenses for Healthcare FSA

Copays/coinsurance

Deductibles

Dental treatments

Diabetic supplies

Prescription drugs and medicines

Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme

Flu shots

Immunizations

Lab fees

Laser/Lasik/RK surgery

Medical exams

Orthodontia

Psychiatric care

Wheelchair

X-rays

For a more complete list of eligible expenses, please visit www.americanfidelity.com

Flexible Spending Accounts

Benefits Debit Card

American Fidelity will provide a Benefits Debit Card to all employees who elect to participate in a Healthcare FSA (where offered by your employer.) The debit card gives immediate, convenient access to Healthcare FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card can only be used for the Healthcare FSA and is not available for the DCA.

Using Your Benefits Debit Card

Simply swipe your card like you would with any other credit card. Whether at the doctor's office or the dentist, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Save ALL receipts!

Cards for Healthcare FSAs can be used at:

- Health care related facilities which include: hospitals, physician offices, dental offices, vision offices; and,
- Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a manual claim for these types of expenses.

Snap. Submit. And Go!

When using your Benefits Debit Card to pay for an eligible expense, you may need to retain documentation to verify the expense. The AFmobile® app makes this easy.

- **Snap** a photo of the itemized receipt* with your phone.
- **Submit** the photo of the itemized receipts within the app when you receive notification that a receipt is needed to verify your expense.
- **Go**! After submitting your verification and its review, you will be able to view the status of your reimbursement within the app.

*The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

Activating Your Card

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will be automatically activated when you use it for the first time for an eligible expense.

Flexible Spending Accounts

American Fidelity Assurance Company

Dependent Care Account (DCA)

A Dependent Care Account allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care expenses that allow you (and your spouse) to work. Reimbursement is permitted only after the services have been provided and the expense has been paid. As dependent care contributions are withheld from your paycheck and placed into the account, these funds become available for reimbursement requests. Submit the entire amount of your dependent care expense after the care is provided, even if it exceeds your monthly contribution amount, to maximize reimbursement opportunities. This allows you to build up a "pool" of submitted expenses, with pending amounts ready for reimbursement as soon as your next contribution is received and deposited into your account.

Minimum Annual Election: $250
Maximum Annual Election: $5,000

Examples of Eligible Dependent Care Expenses
After-school care or extended day programs
Nanny expenses
Baby-sitter inside or outside participant's household
Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household
Dependent Day Care center* expenses/pre-kindergarten/nursery school expense
Expenses paid to a non-dependent relative of participant to care for the child
Summer day camp if the primary purpose of the expense is custodial in nature and not educational
For a more complete list of eligible expenses, please visit www.americanfidelity.com.
**A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.*

Regardless of whether you participate in the Dependent Care Account under the Section 125 Plan or claim the Dependent Care credit on your income tax return, you must provide the Internal Revenue Service with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and attaching it to your annual income tax return. Be sure that you follow the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax treatment of your Dependent Day Care FSA contributions or loss of the Dependent Care Tax Credit.

FSA Fund Availability

Healthcare FSA

Your full annual election is available to you on the first day of the plan year.

Dependent Care Account

Unlike the Healthcare FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

Important FSA Notes:

- Participants are generally allowed a 90-day run-off period after the plan year ends to submit claims for expenses that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA during a plan year, reimbursement is only available for expenses and services provided after you begin your participation in the FSA.
- If you are enrolled in the Healthcare FSA and take a leave of absence during the plan year, you may (subject to your employer's plan):
  1. Prepay the contributions on a pre-tax basis, or
  2. Continue the contributions by remitting them to your employer. Pre-tax contributions may continue if you contiune to receive enough pay, or
  3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Healthcare FSAs must comply with COBRA and generally must offer COBRA continuation rights to qualified beneficiaries who lose Healthcare FSA coverage due to certain qualifying events. For most Healthcare FSAs, COBRA may be offered upon a qualifying event only if you have a balance remaining in your Healthcare FSA. The balance is generally calculated by subtracting the reimbursements made prior to the qualifying event from the annual election. If eligible, you may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or, you may choose to make a pre-tax contribution for your remaining elections for the plan year from your final pay or severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. Coverage generally may not continue beyond the current plan year. If you do not elect COBRA, only expenses incurred during the period of employment are reimbursable. Coverage under the Healthcare FSA ceases when the contributions cease.

Flexible Spending Accounts

File a Claim

Three Easy Ways

1. **On your mobile device using AFmobile®**

Use AFmobile to manage your reimbursement accounts and insurance benefits.

2. **Online at americanfidelity.com**

3. **By mail or fax**

Insurance Claim
American Fidelity Assurance Company, Attn: Benefits Department
P.O. Box 268898, Oklahoma City, OK 73125
Fax: 800-818-3453

FSA and HRA Claim
American Fidelity Assurance Company
Attn: Flex Account Administration
P.O. Box 161968, Altamonte Springs, FL 32716
Fax # 844-319-3668

*Obtain a claim form for your insurance claim at www.americanfidelity.com/fileaclaim.

Manage Your Reimbursement Account With AFmobile®

AFmobile® allows FSA and HRA participants to submit reimbursement account claims while on the go.

- Access accounts - check balances, view transaction history, and more.
- Manage claims - submit new claims, upload receipts, and check claims status.
- Receive account alerts - choose to receive account updates by text and push notifications.
- Submit documentation - tie receipts and other documentation to a pending card swipe to expedite adjudication.

Getting Started:

Download AFmobile. To register, you will need:

- Your email address - this should be the same email address provided at time of enrollment.
- Your Social Security Number.

Using Our Online Portal

Our online portal provides all the same great features as mobile, plus powerful self-service account access and education resources to help put you in the driver's seat.

Getting started:

- Register at americanfidelity.com
- Register using your email address and Social Security Number
- Once completed, access your reimbursement accounts and insurance benefits.

Direct Deposit

By enrolling in direct deposit, you can ensure a timely reimbursement! You will no longer need to worry about having to wait on checks or make any more trips to the bank.

Three ways to sign up for direct deposit:

1. Through your mobile app.
2. Online through your account at americanfidelity.com
3. By downloading a direct deposit request form

Other Information

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Randy Beach or Sharon Lewis at 850-926-0065.

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

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

Other Information

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Wakulla County School Board		4. Employer Identification Number (EIN) 59-6000892
5. Employer address 69 Arran Road		6. Employer phone number 850-926-0065
7. City Crawfordville	8. State Florida	9. ZIP code 32326
10. Who can we contact about employee health coverage at this job? Sharon Lewis		
11. Phone number (if different from above)	12. Email address sharon.lewis@wcsb.us	

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

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    All employees employed in a regular established position. Additionally, temporary employees filling a regular established position for an employee on leave of absence beyond 6 months.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    The Covered Employee's spouse; natural newborn, adopted, foster, or step child(ren) (or a child for whom the Covered Employee has been court appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 26. The newborn child of a Covered Dependent child.
  - ☐ We do not offer coverage.

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

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

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

Other Information

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

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

☐ **Yes** (Continue)

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

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

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Date of change (mm/dd/yyyy):

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Other Information

Health Benefit Measurement Period Policy

A. **Measurement Period**

a. Initial Measurement Period

The school board has established an initial Measurement Period of 12 months for all new employees hired into non-regular positions where the work schedule of the individual is either variable or unknown (e.g. substitute instructors). The average number of hours worked per week will be reviewed from the date of hire to the end of the first twelve months of employment to determine eligibility for the school board provided health benefits.

b. Standard Measurement Period

Our Standard Measurement Period will be for a 12-month period beginning on July 15 of each year and ending on July 14 of the following year. The average number of hours worked per week for each part time employee will be reviewed during this time to determine eligibility for school board provided health benefits.

B. **Administrative Period**

a. Initial Administrative Period

Our Initial Administrative Period begins immediately following the Initial Measurement Period and extends until the last day of the first month following the employee's twelve month anniversary. During this Initial Administrative Period, those part-time employees having completed the Initial Measurement Period will be notified of their eligibility for school board provided health benefits. An opportunity to enroll in the school board provided health benefits and additional information will be provided to eligible employees, including:

- Coverage options available to them under the school board's plan
- Coverage cost
- Term of such coverage or the "Initial Stability Period"
- Enrollment Documents

b. Standard Administrative Period

Our Standard Administrative Period begins on July 15 and ends on September 30 of each year. Part time employees will be notified of their new or continued eligibility for school board provided health benefits during this time. Additionally, those employees who are newly eligible for school board provided health benefits will be provided the opportunity to enroll and given additional information, including:

- Coverage options available to them under the school board's plan
- Coverage cost
- Term of such coverage of the "Standard Stability Period"
- Enrollment documents

C. **Stability Period**

If an employee chooses to enroll in the school board provide health plan, coverage is guaranteed during the Stability Period no matter how many hours are worked as long as the individual remains an employee.

a. Initial Stability Period

Our Initial Stability Period begins on the first day following the end of the Initial Administration Period and extends for the twelve consecutive calendar months. An employee whose Initial Measurement Period overlaps with the Standard Measurement Period for ongoing employees will be included in the Standard Measurement Period as well.

b. Standard Stability Period

Our Standard Stability Period is one year in length and begins on October 1 and ends on September 30

Example:

An employee beings work on December 3, 2013. The Initial Measurement Period begins on December 3, 2013 and ends on December 2, 2014. The Initial Administrative Period begins on December 3, 2014 and ends on January 31, 2015. If eligible, coverage begins on February 1, 2014 and is guaranteed through January 31, 2015.

The Standard Measurement Period begins on July 15, 2013 and ends on July 14, 2014. The new hire above whose hire date is December 3, 2013 is included in the Standard Measurement Period for the time of their employment during the Standard Measurement Period (December 3, 2013 through July 14, 2014). The Standard Measurement Period begins on July 15, 2014 and ends on September 30, 2014. If eligible, the new hire would be extended the opportunity to continue coverage on October 1, 2014 under the Standard Stability Period guaranteeing coverage through September 30, 2105 no matter how many hours are worked so long as the individual remains employed.

Other Information

Payroll Deduction Directory

American Century Investment*	800-345-3533
American Fidelity Assurance Co.	800-323-3748
AXA Equitable*	800-628-6673
Sun Life Financial Employee Benefits – Dental	888-901-6377
Sun Life Financial Employee Benefits – Vision	800-877-7195
Capital Health Plan	850-383-3311
Envision Credit Union	850-942-9000
Florida Education Association (WCTA)	850-942-0671
Florida Retirement System	850-488-6491
ING*	877-884-5050
Mid-America*	800-872-0640
Oppenheimer Funds*	800-835-7305
Plan Member Services*	800-874-6910
Pre-Paid Legal Services	850-576-7243
Professional Educators Network (PEN)	800-311-7770
Rogers, Gunter, Vaughn Insurance Co.	850-926-7900
Texas Life Insurance	800-283-9233
United Way	850-414-0844
Valery Insurance Agency	800-330-8445
Valic/AIG*	800-633-8960
Waddell & Reed/Nationwide*	800-548-6436
Washington National Insurance	800-541-2254
USAble Life	800-333-3256
Wakulla Senior Citizens Center	850-926-7145
Security Financial Resources*	800-747-5164
National Life Group*	877-603-4032

*403(b) Tax Sheltered Annuities (TSA)

Other Information

Direct Deposit

All employees will receive pay through direct deposit as a condition of employment. The Direct Deposit Agreement form is available at www.wakullaschooldistrict.org, the Payroll Department and at each school center. Please remember a **VOIDED** check **MUST** accompany the Direct Deposit Agreement or it will not be processed. If you have a savings account, please attach a deposit slip with your information on it. All completed forms must be turned into the Payroll Department.

A test run is required before your funds will be direct deposited. This may take several payroll periods before the process is complete. **Please check each payroll for verification that your check was direct deposited.**

All bank changes must be in writing. If your bank account is closed after Payroll has processed paychecks, it will take 3 to 5 business days for the funds to be returned to the School Board account and a check to be issued to you. Please make all changes by the date listed in the "Due in County Office" section of the Payroll Reporting Salary Schedule for that particular paycheck date.

Twelve (12) Check Proration

Salaried employees who work 9 or 9 ½ months may request, **BEFORE THEIR FIRST DAY OF WORK**, that their annual salary be divided into twelve (12) equal payments (hourly employees are NOT ELIGIBLE). This request continues from year-to-year and CAN NOT be terminated within a school year once the employee has started working. If an employee takes an unpaid leave of absence, they will receive all salary owed in their last paycheck. Upon their return to work, they must continue their 12 check status for the remainder of the school year.

The two (2) "summer checks" do not contain salary supplements that may have been received during the School Year. Additionally, no payroll deductions are made from these checks other than required taxes and court orders. These checks are usually ready by mid-June. Please see the Payroll Reporting Salary Schedule in your handbook for those exact dates.

Certified personnel and all 12 month personnel automatically receive twelve (12) checks. These checks are paid on the last working day of each month. Please see the Payroll Reporting Salary Schedule in your handbook for the exact dates.

If you have any questions about your payroll deductions, call the Payroll Department at 926-0065 Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

Other Information

WAKULLA COUNTY SCHOOL BOARD
SALARY SCHEDULE
2019-2020 PAYROLL REPORTING PERIODS

OPEN ENROLLMENT ENDS AUGUST 23, 2019

PAYROLL BEGINS	PAYROLL ENDS	DAYS IN PERIOD	DUE IN COUNTY OFFICE	DATE EMPLOYEES RECEIVE CHECKS
		10 MONTH EMPLOYEES		
08-01-19	08-27-19	19	08-19-19	08-30-19
08-28-19	09-24-19	20	09-13-19	09-30-19
09-25-19	10-22-19	20	10-15-19	10-31-19
10-23-19	11-19-19	20	11-07-19	11-27-19
11-20-19	12-25-19	20	12-05-19	12-20-19
01-01-20	01-29-20	19	01-16-20	01-31-20
01-30-20	02-26-20	19	02-13-20	02-28-20
02-27-20	03-31-20	19	03-11-20	03-31-20
04-01-20	04-28-20	20	04-10-20	04-30-20
04-29-20	05-27-20	20	05-11-20	05-28-20

All absentees of 10 month employees during May 11 thru May 27, 2020, will be reported June 3, 2020.
10 month employees shall receive their June check June 26, 2020 and their July check on June 30, 2020.

		9 1/2 MONTH EMPLOYEES		
*Advance Request			08-22-19	08-30-19
08-01-19	08-26-19	18	08-30-19	09-13-19
08-27-19	09-23-19	19	09-27-19	10-15-19
09-24-19	10-21-19	19	10-28-19	11-15-19
10-22-19	11-18-19	19	11-20-19	12-13-19
11-19-19	12-20-19	19	12-18-19	01-15-20
01-06-20	01-31-20	19	01-31-20	02-14-20
02-03-20	02-28-20	19	02-28-20	03-13-20
03-02-20	04-02-20	19	04-01-20	04-15-20
04-03-20	04-28-20	19	04-27-20	05-15-20
04-29-20	05-27-20	20	05-08-20	05-22-20

All absentees of 9 1/2 month employees during May 8 thru May 27, 2020, will be reported by telephone.
Employees requesting 12 checks will have their July and August checks direct deposited on June 12 and June 15, 2020
and the stubs will be mailed prior to June 12th.

		9 MONTH EMPLOYEES		
*Advance Request			08-22-19	08-30-19
08-06-19	08-29-19	18	08-30-19	09-13-19
08-30-19	09-26-19	18	09-27-19	10-15-19
09-27-19	10-23-19	18	10-25-19	11-15-19
10-24-19	11-19-19	18	11-20-19	12-13-19
11-20-19	12-20-19	18	12-17-19	01-15-20
01-07-20	02-03-20	18	01-31-20	02-14-20
02-04-20	02-28-20	18	02-28-20	03-13-20
03-02-20	04-02-20	18	03-30-20	04-15-20
04-03-20	04-28-20	18	04-27-20	05-15-20
04-29-20	05-22-20	18	05-08-20	05-22-20

All absentees of 9 month employees during May 8 thru May 22, 2020, will be reported by telephone.
Employees requesting 12 checks will have their July and August checks direct deposited on June 12 and June 15, 2020.
and the stubs will be mailed prior to June 12th.

		12 MONTH EMPLOYEES		
07-01-19	07-31-19	23	07-17-19	07-31-19
08-01-19	08-30-19	22	08-16-19	08-30-19
09-02-19	09-30-19	21	09-17-19	09-30-19
10-01-19	10-31-19	23	10-17-19	10-31-19
11-01-19	11-29-19	21	11-12-19	11-27-19
12-02-19	12-31-19	22	12-09-19	12-20-19
01-01-20	01-31-20	23	01-21-20	01-31-20
02-03-20	02-28-20	20	02-18-20	02-28-20
03-02-20	03-31-20	22	03-13-20	03-31-20
04-01-20	04-30-20	22	04-14-20	04-30-20
05-01-20	05-29-20	21	05-13-20	05-28-20
06-01-20	06-30-20	22	06-15-20	06-30-20

*The Superintendent is authorized to issue salary payments on August 30, 2020 as requested, not to exceed 1/2 the first monthly payroll.

NOTE: ALL PAYROLL REPORTS MUST BE IN THE COUNTY OFFICE NO LATER THAN NOON ON THE DATE DUE.

Other Information

Wakulla County Schools Employee 2019-2020 Benefits Enrollment

Wakulla Insurance Agency HUB Florida is proud to be part of The **Wakulla County School District's** employee benefits**.** We are here to assist you with your insurance needs year-round. If you have any questions regarding your benefits or the Affordable Care Act, please contact our office at: 850-926-7900.

New Hires & General Questions	**Kevin Vaughn**	**(850) 545-7021 kevin.vaughn@hubinternational.com**
New Hires & General Questions	**Shara Falstrom**	**(850) 205-0553 shara.falstrom@hubinternational.com**
Retirees & Medicare Questions	**Walker Cutts**	**(850) 205-0497 walker.cutts@hubinternational.com**

Wakulla Insurance Agency

2190 Crawfordville Hwy.
Crawfordville, Florida 32327
(850) 926-7900

HUB
Division of HUB FLORIDA.

Benefits Directory

Medical Benefits

Capital Health Plan
850-383-3311
www.capitalhealth.com

Dental Insurance

Sun Life Financial
1-888-901-6377
www.sunlife.com

Vision Insurance

Sun Life Financial
1-800-877-7195
www.vsp.com

Voluntary Insurance Benefits

American Fidelity Assurance Company
Disability Income, Cancer, and Accident
9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
800-662-1113
www.americanfidelity.com

TexasLife Insurance Company
800-283-9233
www.texaslife.com

Section 125 Services & Flexible Spending Accounts

American Fidelity Assurance Company
9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
800-662-1113
www.americanfidelity.com