BENEFITS GUIDE

School District of DeSoto County

2024
2025

School District of DeSoto County

DC

Arcadia, Florida

Table of Contents

Important Dates to Remember:

Your open enrollment dates are:
July 22, 2024 through **Aug. 23, 2024**

Your plan year dates are:
Oct. 1, 2024 through Sept. **30, 2025**

ONLINE RESOURCES:

>> Click to view important information on how to enroll, the enrollment link, plan information, and more!

- DCSD Benefits Website: https://www.desotoschools.com/apps/pages/index.jsp?uREC_ID=1218907&type=d&pREC_ID=2471429
- Enroll Online: www.employeenavigator.com

IMPORTANT NOTES:

Starting October 1, 2024, the District is changing their Life and AD&D, additional Life and AD&D, Short- and Long-term disability from USAble to The Standard. For this year only:

- Employees may elect additional Life coverage in $10,000 increments, up to $200,000, without providing proof of health.
- Spouse Life coverage may be elected in $2,500 increments, up to $50,000, without providing proof of health.
- Children Life coverage may be elected (through age 25) with a choice of $5,000 or $10,000 in coverage.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. ***Please see page 32 for more details.***

Key Things To Know

2024 Benefit Options

The School District of DeSoto County (DSCD) offers a wide range of benefits to eligible employees. During Open Enrollment, you may make changes to your current elections or add new coverages. To make changes for the plan year, you **MUST** complete your enrollment elections online at www.employeenavigator.com .

- **Medical Insurance -** Florida Blue , the District Health Plan Administrator, will continue to offer two (2) health plans for the 2024-2025 plan year. Employees have the option to enroll in coverage for themselves, their spouses and/or their dependents. To find a physician, see your claims, check your deductible, and out of pocket maximum balances, visit www.bcbsfl.com.
- **Excepted Benefit Health Reimbursement Arrangement (EBHRA) –** The EBHRA is an alternative to the medical plan that provides $750 per year to help cover out-of-pocket medical expenses for employees that **do not choose health insurance coverage**.
- **Healthcare Reimbursement Account (HRA) -** The District automatically funds an HRA with $600 for single coverage and $1,200 for Employee + Dependent Tiers for employees enrolled on the medical plans. This money is available October 1, 2024. If you enroll in a district medical plan no action is required.
- **Dental Insurance** – Florida Combined Life BlueDental Choice Plus PPO will continue as the district's dental carrier for 2024-2025. To find a list of providers, visit www.bcbsfl.com.
- **Vision** – Davis Vision will continue as the district's vision insurance provider for the 2024-2025 plan year. You have two (2) plan options, a low plan or high plan, to choose from.
- **Flexible Spending Accounts** - To utilize an FSA for healthcare reimbursement, ***you MUST enroll each year*****.** Your FSA may be used to fund your authorized out-of-pocket medical, prescription, dental, or vision expenses with pretax dollars. The maximum annual FSA contribution is $3,200 for 2024 and 2025.
- **Dependent Care Reimbursement - To utilize an FSA for dependent care reimbursement, *you MUST enroll each year*.** The annual amount you can contribute is $5,000 per household, per plan year for 2024 and 2025. Dependent Care FSA may be used for both eligible children and eligible adults.
- **Group Life and AD&D Insurance** – The District provides $20,000 of Basic Term Life and AD&D insurance to all benefit eligible employees. Additional Life and AD&D coverage is available for employees to purchase for themselves and eligible dependents.
- **Short-Term Disability (STD) -** All benefit eligible employees may elect to participate in the voluntary, employee paid, Short-Term Disability insurance program. STD replaces a portion of your pay when you miss work because of a covered disability and pays you directly to help cover costs during recovery, like housing, food and childcare.
- **Long-Term Disability (LTD)** - All benefit eligible employees may elect to participate in the voluntary, employee paid, Long-Term Disability insurance program.

Benefits Eligibility

New Hires - Newly elected employee benefits become effective on the first of the month following a 45-day waiting period, from the day you begin employment.

Is your dependent a valid dependent?

If any of the dependents you currently cover do not meet the eligible dependent definition requirements, Open Enrollment is an opportunity to remove them from your coverage without question.

The School District reserves the right to audit employee benefit enrollments at any time. You must enter a valid Social Security number in your Employee Navigator Benefit's profile for every dependent. This is mandatory and required by the IRS. Please log into your account and ensure all the Social Security numbers associated with your family members are listed correctly.

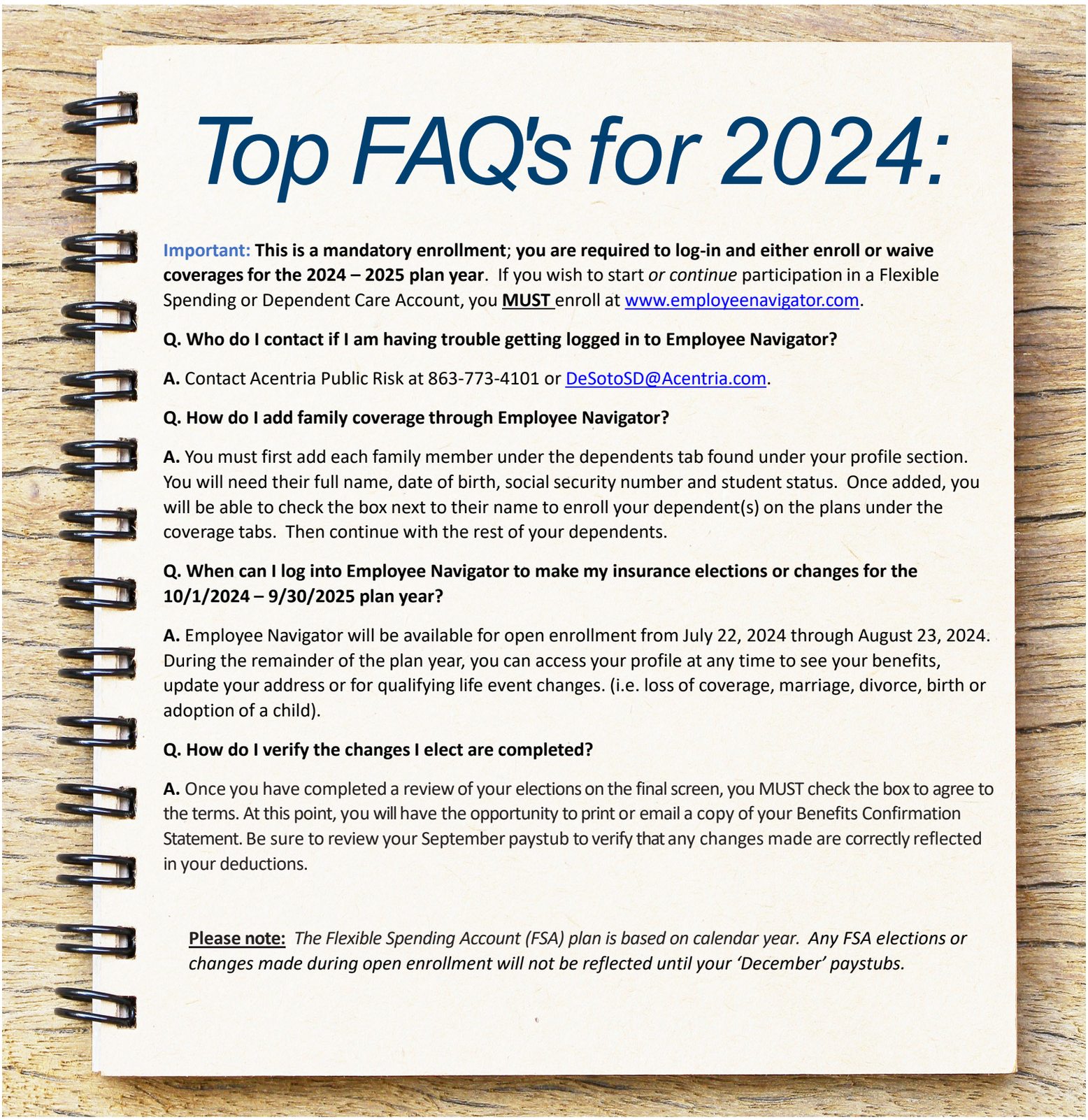
Eligible Dependents include:

- *Spouse*
- *Children*
- *Newborn Children*
- *Disabled Children*
- *Stepchildren*
- *Legally Adopted Children*
- *Child whom the Covered Employee has been court-appointed as Legal Guardian or Legal Custodian*
- *Dependent of a Dependent, up to 18 months of age*

Please note: You will be asked to provide dependent documentation for every dependent enrolled on the plans. Dependent Documentation includes:

- Copy of Marriage License when enrolling a Spouse
- Copy of Birth Certificate when enrolling a child
- Court Order for dependent whom you have custody

Frequently Asked Questions



Top FAQ's for 2024:

Important: This is a mandatory enrollment; you are required to log-in and either enroll or waive coverages for the 2024 – 2025 plan year. If you wish to start *or continue* participation in a Flexible Spending or Dependent Care Account, you **MUST** enroll at www.employeenavigator.com.

Q. Who do I contact if I am having trouble getting logged in to Employee Navigator?

A. Contact Acentria Public Risk at 863-773-4101 or DeSotoSD@Acentria.com.

Q. How do I add family coverage through Employee Navigator?

A. You must first add each family member under the dependents tab found under your profile section. You will need their full name, date of birth, social security number and student status. Once added, you will be able to check the box next to their name to enroll your dependent(s) on the plans under the coverage tabs. Then continue with the rest of your dependents.

Q. When can I log into Employee Navigator to make my insurance elections or changes for the 10/1/2024 – 9/30/2025 plan year?

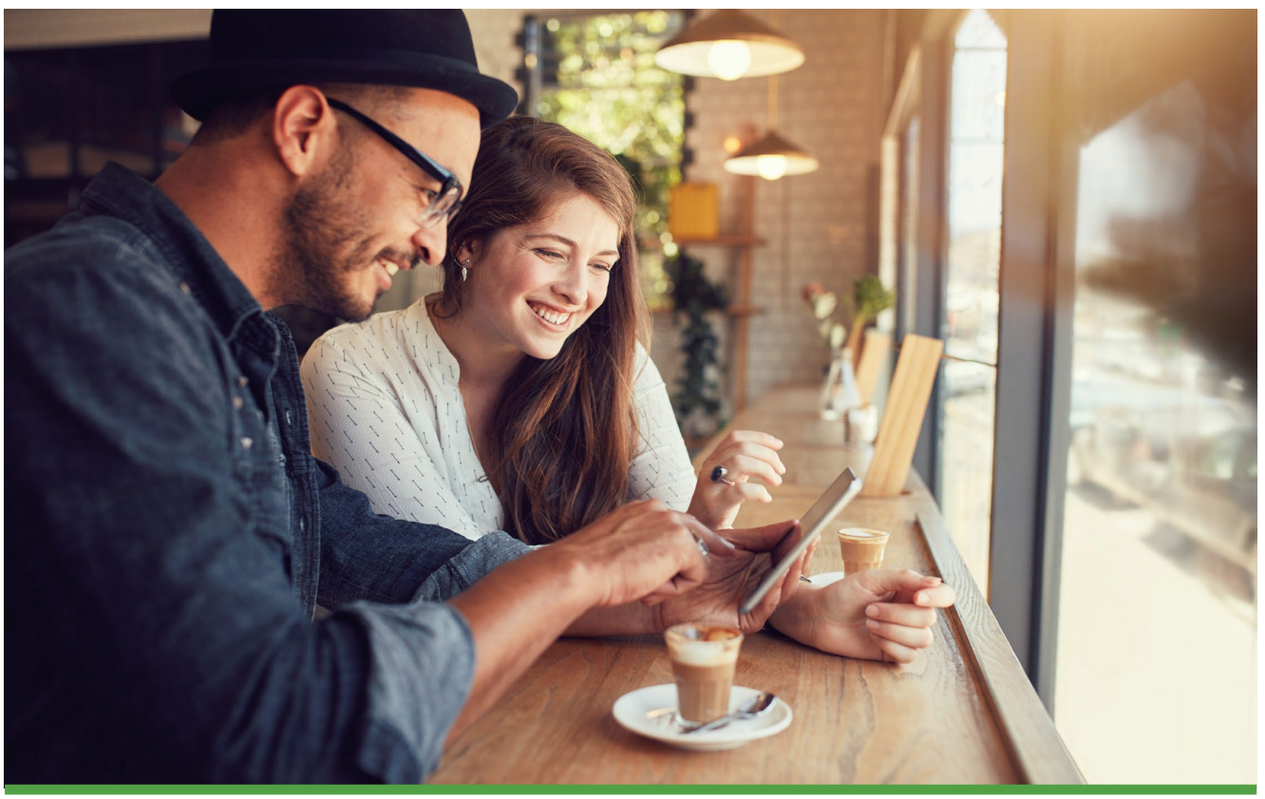
A. Employee Navigator will be available for open enrollment from July 22, 2024 through August 23, 2024. During the remainder of the plan year, you can access your profile at any time to see your benefits, update your address or for qualifying life event changes. (i.e. loss of coverage, marriage, divorce, birth or adoption of a child).

Q. How do I verify the changes I elect are completed?

A. Once you have completed a review of your elections on the final screen, you MUST check the box to agree to the terms. At this point, you will have the opportunity to print or email a copy of your Benefits Confirmation Statement. Be sure to review your September paystub to verify that any changes made are correctly reflected in your deductions.

Please note: *The Flexible Spending Account (FSA) plan is based on calendar year. Any FSA elections or changes made during open enrollment will not be reflected until your 'December' paystubs.*

How to Enroll
www.employeenavigator.com



Before You Start Your Web Enrollment

Thoroughly review your benefit options. Be sure to gather the following information before you begin the enrollment process:

For All Your Dependents:

- Full Legal Name
- Date of Birth
- Social Security Numbers
- Marriage License, Birth Certificate, Court Documents

For Beneficiary:

- Full Legal Name
- Date of Birth
- Social Security Number
- Relationship
- Address
- Telephone Number

When you have all the information together, and are ready to make your elections,

log into www.employeenavigator.com to begin the online enrollment process.

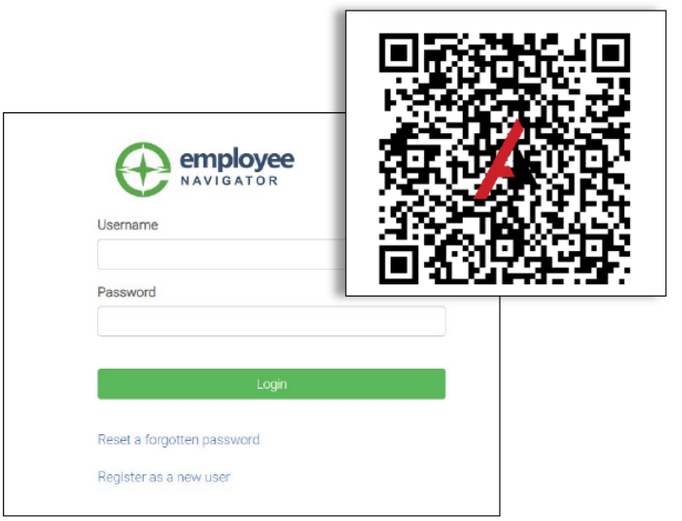
How to Enroll

1 Create an Account/Log in

Go to www.employeenavigator.com and click **Login** to register or scan the QR code.

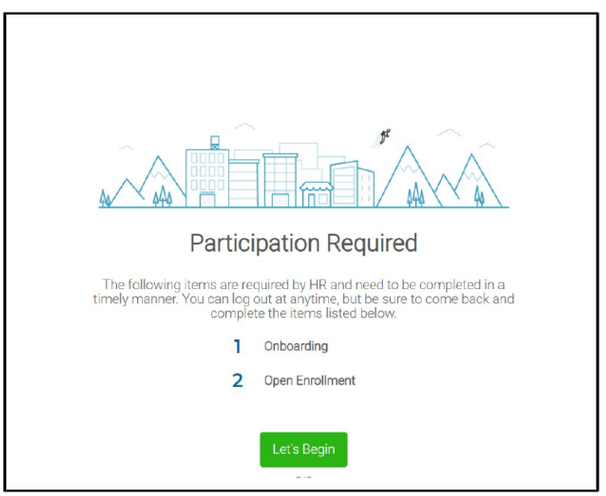
- First time users: Click Register as a new user, enter your personal information, and **company identifier**.
- Returning Users: Log in with your username and password.
- **Forgot your password or username?** Click Reset a forgotten password to reset both password and username, if needed.

COMPANY IDENTIFIER: **DESOTOSCHOOLS**



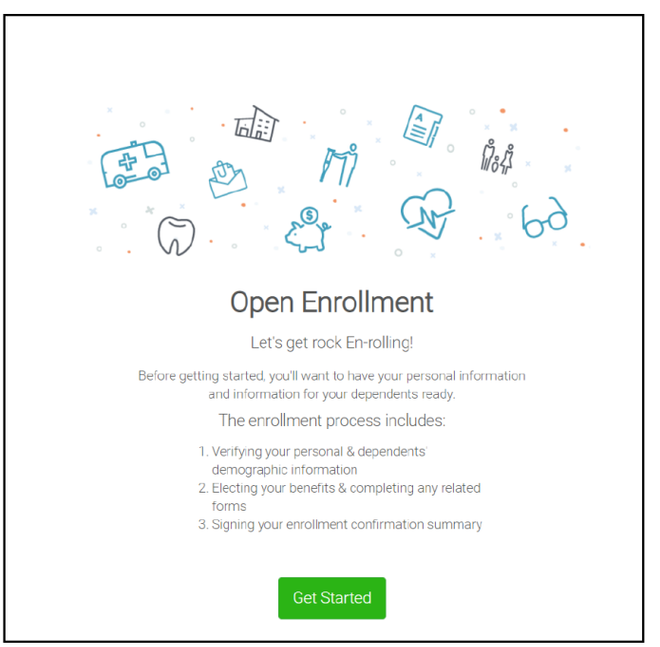
2 Welcome

After you login click **Let's Begin** to complete your required tasks.



3 Onboarding

Complete any assigned onboarding task before enrolling in your benefits. Once you've completed your tasks, click **Begin Enrollment**. **If you logout now, you can come back later and start from where you left off.**



4 Start Enrollment

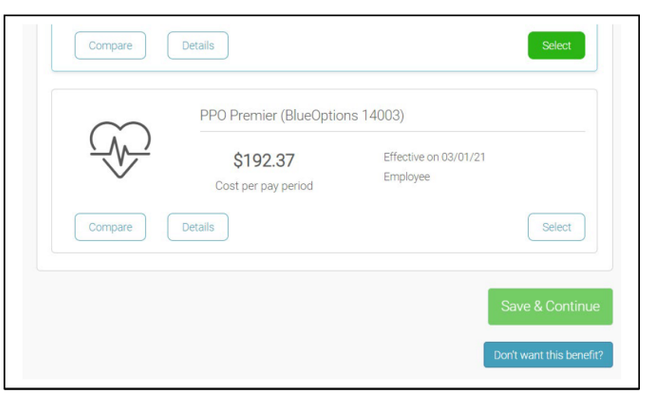
After clicking **Get Started**, you will need to complete some personal & **dependent information** before moving to your benefit elections.

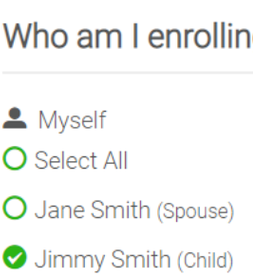
TIP Have dependent details available. To enroll dependents in coverage you will need their dates of birth and social security numbers.

How to Enroll

5 Elect your Benefits

- To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**
- Below your dependents, you can view your available plans and the cost per pay period. To elect a benefit, click **Select** below the plan cost.
- **Click Save & Continue at the bottom of each screen to save your elections.**
- If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select the reason why from the drop-down menu.
- If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

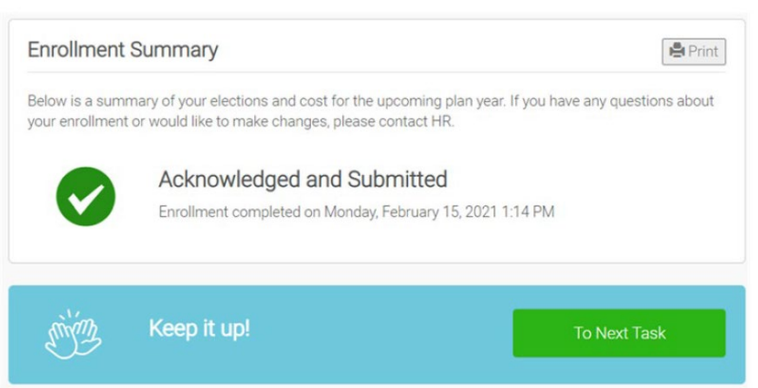




T I P If you miss a step, you will see **Enrollment Not Complete!** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

6 Review and Confirm

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records, or login at any point during the year to view your summary online.



7 Congratulations!

You have successfully completed your enrollment! You will have the remainder for your Open Enrollment Window to come back and make updates to plans or dependents if needed.

You can login to review your benefits 24/7

Medical Rates | Florida Blue

This is what YOU PAY:

October 1, 2024 - September 30, 2025			
Benefit	Monthly Premium	Employee Per Pay Period	Employer Cost Per Pay Period
BlueCare 48 - HMO			
Individual	$1,102.12	$49.60	$501.46
Child	$1,675.29	$284.80	$552.84
Spouse	$2,043.73	$347.43	$674.43
Family	$2,548.67	$433.27	$841.06
2 Employees - Family	$2,548.67	$203.89	$1,070.44
(Per employee)		$101.95	$535.22
Blue Options - PPO 05301			
Individual	$1,195.65	$95.65	$502.17
Child	$1,817.47	$354.41	$554.33
Spouse	$2,217.22	$432.36	$676.25
Family	$2,765.02	$539.18	$843.33
2 Employees - Family	$2,765.02	$317.98	$1,064.53
(Per employee)		$158.99	$532.27

USING AN OUT-OF NETWORK PROVIDER WILL INCUR ADDITONAL OUT-OF-POCKET COST.

2024 - 2025 MEDICAL PLAN OPTIONS IN-NETWORK COMPARISON CHARTS

UNDERSTANDING YOUR MEDICAL OPTIONS

*Both medical plans provide the same benefit coverage for In-Network. The difference between the plans is your monthly premium cost and network coverage. Employees pay a higher cost share for the PPO plan. The PPO plan also includes Out-of-Network coverage, whereas the HMO plan does not. **Referrals are not required on either Plan.**

BENEFIT CATEGORY	Florida Blue BlueCare 48 HMO In Network	Florida Blue Blue Options 05301 PPO In Network	 Out-of-Network
Deductible (DED) (Per Person/Family)	$1,500 / $3,000	$1,500 / $3,000	$6,000 / $12,000
Coinsurance (Member Responsibility)	20%	20%	50%
Out-of-Pocket Maximum (Per Person/Family)	$6,000 / $12,000	$6,000 / $12,000	$24,000 / 48,000
PREVENTIVE CARE			
Adult Preventive Care	Covered in Full	Covered in Full	Covered in Full
Adult annual Physical Exam	Covered in Full	Covered in Full	Covered in Full
Well-Child Care	Covered in Full	Covered in Full	Covered in Full
Physician Office Visits			
Value Choice PCP	Covered in Full	Covered in Full	Not Covered
Primary Care Visit	20% Coinsurance	20% Coinsurance	50% Coinsurance
Value Choice Specialist	$20 Copay	$20 Copay	Not Covered
Specialist Visit	20% Coinsurance	20% Coinsurance	50% Coinsurance
Virtual Visit (Teladoc)	Covered in Full	Covered in Full	Not Covered
Virtual Visit - Specialist	20% Coinsurance	20% Coinsurance	Not Covered
Outpatient Labs, X-Rays & Imaging			
Value Choice PCP	Covered in Full	Covered in Full	Not Covered
Value Choice Specialist	$20 Copay	$20 Copay	Not Covered
Independent Clinical Laboratory	Covered in Full	Covered in Full	50% Coinsurance
Physician or Specialist Office	20% Coinsurance	20% Coinsurance	50% Coinsurance
Independent Diagnostic Testing Center	20% Coinsurance	20% Coinsurance	50% Coinsurance
Hospital Services			
Inpatient Facility Care	20% Coinsurance	20% Coinsurance	50% Coinsurance
Outpatient Facility Surgery	20% Coinsurance	20% Coinsurance	50% Coinsurance
Physician InPatient / Outpatient	20% Coinsurance	20% Coinsurance	50% Coinsurance
Emergency Care			
Emergency Room	20% Coinsurance	20% Coinsurance	20% Coinsurance
Urgent Care	20% Coinsurance	20% Coinsurance	20% Coinsurance
Value Choice Urgent Care	Covered in full/Visits 1-2 PBP, 20% coinsurance for remaining visits	Covered in full/Visits 1-2 PBP, 20% coinsurance for remaining visits	Not Covered
Emergency Medical Transportation	20% Coinsurance	20% Coinsurance	20% Coinsurance
Maternity Care			
Office Visits	20% Coinsurance	20% Coinsurance	50% Coinsurance
Childbirth/Delivery Professional	20% Coinsurance	20% Coinsurance	20% Coinsurance
Childbirth/Delivery Facility	20% Coinsurance	20% Coinsurance	50% Coinsurance
Mental Health			
Inpatient Physician Services	20% Coinsurance	20% Coinsurance	20% Coinsurance
Inpatient Hospital	20% Coinsurance	20% Coinsurance	50% Coinsurance
Outpatient	20% Coinsurance	20% Coinsurance	50% Coinsurance
Virtual Visit - Specialist	Covered in Full	Covered in Full	Not Covered
Prescription Drugs (Deductible does not apply)	Up to 31 days / Up to 90 days	Up to 31 days / Up to 90 days	
Generic Preferred / Non-Preferred Brand	$15 / $40	$15 / $40	50% Coinsurance
Preferred Brand	$40 / $100	$40 / $100	50% Coinsurance
Non-Preferred Brand	$60 / $150	$60 / $150	50% Coinsurance
Specialty Preferred Brand / Non-Preferred Brand	Cost Share	Cost Share	Cost Share

Virtual Visits | Florida Blue

You Don't Have to Leave Home to See the Doctor

Virtual Visits Deliver Care Anytime, Anywhere

Sometimes it's not easy to get to the doctor's office when a health issue pops up. Try a virtual visit, and see the doctor anytime, from anywhere.

Virtual visits let you speak securely by online video with your family doctor, specialist or mental health therapist. Your cost share is as little as $0[1]!

Many Florida Blue doctors and therapists now offer virtual visits. If yours doesn't or if they aren't available, you can schedule a virtual visit using Teladoc, the nation's largest virtual health care company. Just sign up on the Teladoc website or app and speak with a U.S. board-certified doctor within minutes. Or schedule an appointment with one of Teladoc's licensed behavioral health therapists. Your cost share is still as little as $0[1]!

Medical

Primary Care		Specialists	
Try a virtual visit with a primary care doctor when you have a non-emergency illness like:		Consider a virtual visit for follow-up care from your:	
Flu	Cough	Cardiologist	Endocrinologist
Rashes	Sore throat	Dermatologist	Neurologist
Sinus infections	Other minor issues	Gastroenterologist	Or other specialists

It's easy

- Call your in-network doctor and ask if they offer virtual visits. They already know you and have access to your medical records.
- If your primary care doctor doesn't offer virtual visits or if you need care after hours, Teladoc offers primary care 24/7. Teladoc also offers specialist care for dermatology and mental health.
  - Register by downloading the Teladoc mobile app, visit Teladoc.com or call 800-TELADOC (835-2362).
  - Fill out your medical history.
  - Request a visit. State the reason for your visit and your preferred time.
  - Enter the virtual waiting room for your appointment.

During a virtual visit, you can be diagnosed, treated and prescribed medication. If you use Teladoc, details of your visit can be shared with your family doctor at your request.

Florida Blue
Your local Blue Cross Blue Shield

TELADOC.

Lucet | Employee Assistance Program

Personalized care and resources, *when you need them.*

Whether its planning for your financial future or beginning to seek mental health resources, your Employee Assistance Program (EAP) is here to help. Available to you and your household members, Lucet's EAP is your first step to resources, counseling and so much more to support your wellbeing.

We're here to help

Stress, relationships, work and money. These are the most common reasons people reach out to EAP every year. No matter what issues you're facing, the resources you access are confidential so feel safe knowing you can begin addressing any of your personal challenges today.

EAP Services & Resources

Help for every day life

Counseling
Call us or go online to access no-cost sessions with a provider.

Legal & Financial
Navigating finances and the legal system with a no-cost 30-minute telephonic consultation per issue.

Work/Life
Referrals and resources for family, career, caregiving, health and wellness needs.

Coaching
Sessions with a life coach designed to promote self-awareness and clarify goals.

Your well-being is our priority.

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

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

Your company code: **desoto**

6 counseling/coaching sessions, per topic, per year.

Scan to learn more at eap.lucethealth.com

Log in. It's so easy!

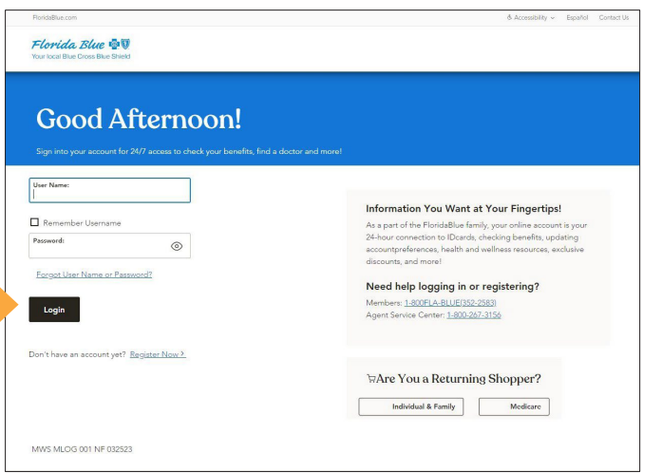
Register at **FloridaBlue.com**

Florida Blue
Your Health Solutions Partner

We are here to help you get the most out of your benefits. With your personalized member account—ID cards, benefits, doctors, cost-saving tools, and more—are all at your fingertips! Simply log in at FloridaBlue.com or the Florida Blue mobile app.

To register:

Scan the code, go to **Log in**, then **Register Now**.



New Member Registration Steps

To get started, click on **New Member Registration**

Step 1: Choose **Manage Your Plan** or **Care for a Friend or Loved One**.

Step 2: Enter your email address and click **Continue**. Check your email for a confirmation code.

Step 3: Once you have the confirmation code from your email, enter the code and click **Continue**.

Step 4: Choose a **User Name** and **Password**. The **Password** must be typed in twice for security purposes.

Step 5: Create three different security questions and type an answer below each. Click **Continue**.

***Note**: The security questions will be used if you forget your **User Name** or **Password**.*

Step 6: Success! Click **Go** to log in to your account and start exploring.

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Log in. It's so easy!
Register at **FloridaBlue.com**

Florida Blue
Your Health Solutions Partner

Florida Blue
Your Health Solutions Partner

Need care and don't know where to go?

No matter where you are, a doctor, urgent care center, or hospital is right at your fingertips.

Find care in Florida Online

Step 1. Log in to **FloridaBlue.com**.

Step 2. At the top of the screen, click **Find & Get Care** and select **Find A Doctor & More**.

Step 3. Simply enter the name of a provider, facility, or condition, and click the **Search** button, or select from one of the suggested results. At the bottom of the screen, you can also search by the type of provider.

Step 4. If your plan includes **Virtual Visits**, scroll down and click **Find Virtual Care**.

Outside Florida?
Find care from anywhere!

(For members who have out-of-state benefits.*)

1. Log in to **bcbs.com/find-a-doctor** or call **1-800-810-2583**.
2. Click on **In the United States**.
3. Enter a **Location** and **Plan** to find care anywhere in the U.S.

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HRA THE EASY WAY

Take advantage of your employer-funded Health Reimbursement Arrangement (HRA)

FREE MONEY? YES, PLEASE

HRAs require no payroll deductions and you don't need to contribute any money. Your organization will fund the entire account. Plus, all reimbursements for qualified medical expenses are tax-free too.

BRIDGE THE GAP ON ELIGIBLE HEALTHCARE EXPENSES

Your organization sets your annual healthcare reimbursement limit and determines which expenses are eligible. Although it varies by plan design, common eligible expenses include deductibles, coinsurance and copays.

Ask your benefits team for a full list of your eligible expenses.

SAY GOODBYE TO HASSLE

Log in and manage everything via our intuitive mobile app.[1] Check your balance, review claims status, and manage payments. Want to initiate a claim? Easy. Just snap a photo of the receipt and you're on your way.

Enroll today. Talk to your benefits team.

866.735.8195 | HealthEquity.com/Learn

[1]Accounts must be activated via the HealthEquity website in order to use the mobile app.

HealthEquity | Excepted Benefit Health Reimbursement Arrangement (EBHRA)

QUICKSTART GUIDE

Your Health Reimbursement Arrangement

At-a-Glance

Your HRA:
The Essentials

Managing Your Account

Using Your HRA Dollars

Register online now!

If you haven't registered online yet, please do so today. To register, just visit **www.healthequity.com/wageworks**, select "LOG IN/REGISTER" and then "Employee Registration." You'll need to answer a few simple questions and create a username and password.

Questions?

If you have any questions or concerns, you can talk to a trained expert to learn more about the program. Just call 877.924.3967.

Download the EZ Receipts® mobile app!

Use your mobile device to file claims and take care of your account paperwork from anywhere. Go to **www.healthequity.com/wageworks** to learn more.

PE-303-HRA-QS-NC

Welcome to HealthEquity. Start Saving. Here's How.

Welcome to your health reimbursement arrangement (HRA) program sponsored by your employer and brought to you by HealthEquity. Your HRA is funded by contributions from your employer or plan sponsor. Through this program, your employer puts pre-tax money into your HRA to help you pay for eligible healthcare expenses.

Ready to get started? This short guide will show you how.

Your HRA: The Essentials

Your HRA is governed by IRS regulations that detail who is eligible to use the account and where and how the money in it is to be used. Your HRA was designed to be simple. To keep it that way, it's important to comply with the IRS regulations that govern the program. The following guidelines will help you avoid any inconvenience.

- **Make sure account funds are only spent on expenses for those who are eligible.** Typically, those eligible are you, your spouse and your eligible dependents.
- **Know what expenses are eligible.** Log in to your account at **www.healthequity.com/wageworks** for a complete list of your employer's eligible healthcare expenses. Generally, eligible healthcare expenses include services and products that are medically necessary to treat a specific condition.
- **Over-the-counter (OTC) medications, drugs and menstrual care products.** You can pay for items out of pocket and use Pay Me Back to submit your claim to HealthEquity for reimbursement. Pay Me Back claims can be submitted online, or with your smartphone or mobile device. (HRA plans vary by employer, and these changes do not necessarily change the benefits under your employer's plan.)
- **Keep an eye on your HRA.** Log in to your account at **www.healthequity.com/wageworks** to view your transactions and keep track of your balance.
- **Register for an online account at www.healthequity.com/wageworks.** When you register online and provide a current email, you ensure that you will have 24/7 access to your account and will be automatically signed up to receive important updates and alerts. You also must have an account to use the mobile app and take advantage of features like Upload Receipts for online claims.
- **Keep your receipts.** Save receipts that describe exactly what you paid for. Make sure the amount and the service date – not the payment date – are included.

WageWorks
everyone benefits

QUICKSTART GUIDE

Managing Your Account

You can manage and check up on your account through HealthEquity online or over the phone. The "Claims and Activity" page online details all your account activity.

For the latest information, visit **www.healthequity.com/wageworks** and log in to your account 24/7. In addition to reviewing your most recent HRA activity, you can:

- Update your account preferences and personal information.
- Schedule payments to healthcare providers.
- Check the complete list of eligible expenses for your HRA program.
- Manage your account while on the go via the HealthEquity mobile website.
- Download the EZ Receipts app to file claims.

Using Your HRA Dollars

When you pay for an eligible healthcare expense, you want to put your account to work right away. HealthEquity gives you several options to use your money the way you choose.

Using your Mobile Device

With the EZ Receipts mobile app, you can file and manage your reimbursement claims on the spot, with a click of your mobile device camera, from anywhere.

To use EZ Receipts:

- Download at **www.healthequity.com/wageworks/employees/go-mobile**.
- Log in to your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim.
- Use your mobile device camera to capture the documentation.
- Submit the image and details to HealthEquity.

Paying online

You can pay many of your eligible healthcare expenses directly from your HRA account with no need to fill out paper forms.* It's quick, easy, secure and available online at any time.

To pay a provider:

- Log in to your HRA at **www.healthequity.com/wageworks**.
- Select "Submit Receipt or Claim."
- Request "Pay My Provider" from the menu and follow the instructions.
- Make sure to provide an invoice or appropriate documentation. When you're done, HealthEquity will schedule the checks to be sent in accordance with the payment guidelines. If you pay for eligible, recurring expenses, follow the online instructions to set up automatic payments.

* You must, however, provide documentation. For more information about the documentation requirements and payment guidelines, visit **www.healthequity.com/wageworks**.

Filing a claim

You also can file a claim online to request reimbursement for your eligible expenses.

- Go to **www.healthequity.com/wageworks**, log in to your account and select "Submit Receipt or Claim."
- Select "Pay Me Back."
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
  - Date of service or purchase
  - Detailed description
  - Provider or merchant name
  - Patient name
  - Patient portion or amount owed

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

If you prefer to submit a paper claim by fax or mail, download a Pay Me Back claim form at **www.healthequity.com/wageworks** and follow the instructions for submission.

HealthEquity

WageWorks everyone benefits

Flexible Spending Account

A healthcare FSA lets you use tax-free money to pay for eligible medical expenses.[1] FSAs help members realize significant savings on healthcare costs. Don't think of it as money deducted from your paycheck – think of it as money added to your wallet.

- ☑ Access annual contribution amount on day one
- ☑ Fast, hassle-free payments and reimbursement
- ☑ Pay for your spouse and dependents too

Annual tax saving potential[2]

$640

IRS Contribution Limit[3]
$3,200

See how much you can save

HealthEquity.com/Learn/FSA

[1]FSAs are never taxed at a federal income tax level when used appropriately for qualified medi expenses. Also, most states recognize FSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | [2]The example is for illustrati purposes only. Estimated savings are based on a maximum annual contribution and an assume combined federal and state income tax bracket of 20%. Actual savings will depend on your contribution amount and taxable income and tax status. | [3]Contribution limit is accurate as of 11/09/23. Each fall the IRS updates the FSA contribution limits. For the latest information, pleas visit: HealthEquity.com/Learn | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

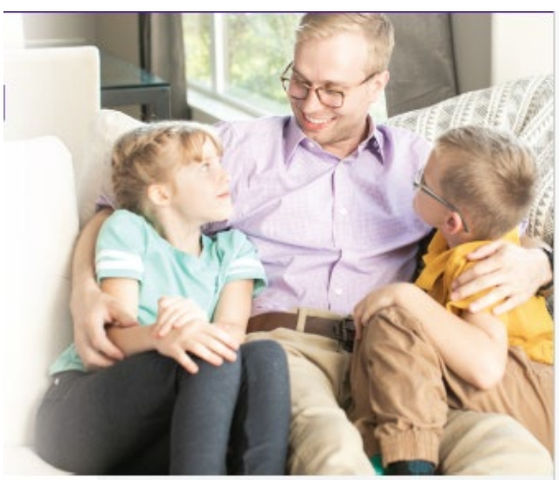
Did you know?

You MUST enroll in the FSA benefit <u>each</u> year.

If you do not enroll each year, your FSA will end on the last day of the plan year..

The FSA plan year runs January 1st thru December 31st.

All FSA election or changes made during open enrollment will not be reflected until your December paystubs.



Common eligible medical expenses:

- Pain relievers
- Doctor visits
- Dental cleaning
- Sleep aids
- Eyeglasses/contacts
- Cold/cough medicine
- Chiropractic care
- Insulin testing supplies

Dependent Care Flexible Spending Account

A DCFSA lets you use tax-free money to pay for eligible dependent care expenses.[1] A qualifying 'dependent' may be a child under age 13, a disabled spouse, or an older parent in eldercare.

- ☑ Pre-tax payroll contributions
- ☑ Fast, hassle-free payments and reimbursement
- ☑ Enjoy a full year to spend your account funds

Annual tax saving potential[2]

$1,000

IRS Contribution Limit[3]
$5,000

See how much you can save

HealthEquity.com/Learn/DCFSA

Common eligible dependent care expenses:

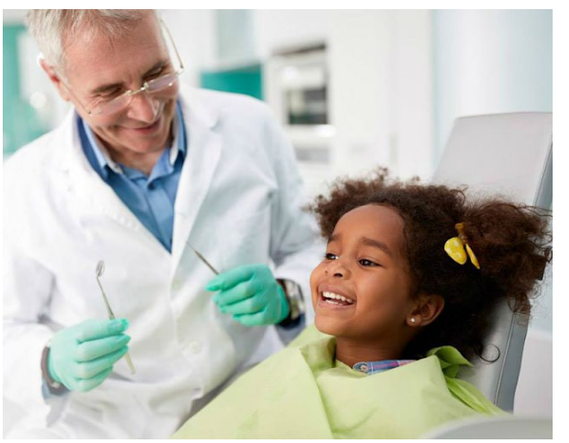
- Daycare
- Nursery school
- Babysitter
- Preschool
- Summer day camp
- Before/after school programs
- Elder daycare

[1]DCFSAs are never taxed at a federal income tax level when used appropriately for eligible dependent care expenses. Also, most states recognize DCFSA funds as tax deductible with very few exceptions. Please consult a tax advisor regarding your state's specific rules. | [2]The example is for illustrative purposes only. Estimated savings are based on a maximum annual contribution and an assumed combined federal and state income tax bracket of 20%. Actual savings will depend on your contribution amount and taxable income and tax status. | [3]Contribution limit is accurate as of 11/09/2023. Each fall the IRS updates the DCFSA contribution limits. For the latest information, please visit: HealthEquity.com/Learn | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

Dental | Florida Combined Life

Dental insurance pays for preventive care that can protect you and your family from the high cost of dental disease. It also helps pay for more extensive, costly and unexpected expenses such as fillings, crowns and root canals. You can visit any dentist, but to receive the most out of your benefits, from the negotiated discounts on coverage services, choose an in-network dentist. For specific plan information please refer to the Florida Combined Life Dental benefit summary.

BLUEDENTAL CHOICE PLUS PPO		
BENEFIT	**IN-NETWORK**	**OUT-OF-NETWORK**
Network	**Choice Plus**	
***Annual Deductible**	**Individual:** $50 **Family:** $100	**Individual:** $50 **Family:** $100
Annual Benefit Maximum	$2,000	
Lifetime Ortho Max	N/A	
Diagnostic & Preventive Services	100%	100%
Oral Evaluations; Office Visits; Bitewing X-rays; Cleanings; Fluoride Treatments Child; Space Maintainers		
Basic Services	80%	80%
Sealant—per tooth; Amalgam Restorations; Resin-Based Restorations; Extractions-Routine & Surgical; Root Canal Molar; Periodontal Scaling & Root Planing		
Major Services	50%	50%
Crowns-Porcelain; Complete & Partial Dentures; Pontic; Implants		
Orthodontic Services	Not Covered	Not Covered
Per Pay Period Contributions		
Employee Only	$19.53	
Family	$57.19	
*No deductible for Preventive Services		



How to find a Florida Combined Life Dental provider:

Step 1: Go to www.floridabluedental.com

Step 2: Click **Find a Dentist**

Step 3: Enter the **name of the Dentist**

Step 4: Under Select Plan choose **"BlueDental Choice Plus"** from the drop-down menu

Step 5: Enter your Zip code and other search preferences

Step 6: Click Search

Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

Dental members who have access to the Advantage Plus Network:

- BlueDental Choice℠
- BlueDental Choice Plus℠
- BlueDental Choice Copayment℠

Florida Blue's comprehensive and affordable Dental plans are backed by strong network options.

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

Advantage Plus National Network

- No authorizations or referrals are needed
- Flexibility for any family member to change dentists at any time
- No forms to complete

Oral Health for Overall Health

Florida Blue understands that oral health is related to overall health. We combine our medical + dental expertise to protect and promote the health of our customers. That means it's more important than ever to get regular preventive dental care that will help you maintain not only your good oral health, but your good health in general.

Here's how it works:

- Delivering oral health education to members, providers and employers
- Targeted outreach provides courtesy contact by direct mail, e-mail and telephone with members to encourage a dental visit and improve overall health
- Enhanced benefits improve overall health through specialized care programs

To Find a Provider

in or out of your area, visit us at www.floridabluedental.com or call customer service at 1-888-223-4892.

An Expanded National Dental Network to Better Serve You!

Florida Blue is continuing to work on your behalf to provide Dental coverage and support services needed to protect you and your family. Our robust network gives you a variety of choices in your local area, as well as providing access to more than 170,000 dentists across the U.S., including Hawaii and Alaska.

Florida Blue's plans ensure members get quality Dental care from skilled professionals, plus courteous and efficient care services. Our approach promotes preventative care that encourages overall health and well-being. All backed by an expanded statewide and national network that makes it easy to find a dentist.

Florida Blue
In the pursuit of health®

Vision Plan | Davis Vision

DavisVision		
BENEFIT	**DESIGNER**	**FASHION**
Client Code	**3719**	**3718**
Exam Frequency	**Once per Calendar Year**	
Exam Benefit	$10 Copay	$10 Copay
Lenses Frequency	**Once per Calendar Year**	
LENSES		
Single Vision	$20 Copay	$20 Copay
Lined Bi-Focal	$20 Copay	$20 Copay
Lined Tri-Focal	$20 Copay	$20 Copay
Lenticular	$20 Copay	$20 Copay
Frame Frequency	**Once Every Other Calendar Year**	
Frame Benefit - Davis Vision Collection		
Fashion	Covered in Full	Covered in Full
Designer	Covered in Full	$15 Copay
Premier	$25 Copay	$40 Copay
Non-Collection	$130 Allowance	$100 Allowance
Standard Scratch-Resistant Coating	Covered in Full	Covered in Full
UV Coating	$12 Copay	$15 Copay
Tint (Solid & Gradient)	Covered in Full	$15 Copay
Photochromatic	$65 Copay	$70 Copay
Standard Polycarbonate		
Child (up to age 18)	Covered in Full	Covered in Full
*Adult	$30 Copay	$35 Copay
Contact Lense Frequency	**Once Every Other Calendar Year**	
Elective Contact Lenses		
Davis Vision Collection	Covered in Full	N/A
Non-Collection	$130 Allowance	$100 Allowance
Necessary Contact Lenses	Covered in Full	Covered in Full
Per Pay Period Contributions	**DESIGNER PLAN**	**FASHION PLAN**
Employee Only	$3.28	$2.24
Employee + Spouse	$6.57	$4.49
Employee + Child(ren)	$6.89	$4.71
Family	$9.52	$6.50

*Covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

Our eyes are constantly changing so it is important to have an annual eye examination. Vision insurance provides benefits for examinations and discounts on frames, lenses, and lens accessories. You can use any provider, but you will benefit from the negotiated discounts using an in-network provider and a higher coinsurance paid by Davis Vision. For specific plan information, please refer to the Davis Vision benefit summary.

Vision Plan | Davis Vision

You may choose from the following vision plans:

- Davis Vision Fashion Plan Client Code 3718
- Davis Vision Designer Plan Client Code 3719

Davis Vision Plan

Davis Vision is dedicated to helping you see clearly, and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, plans are designed to be easy to use and help you access the care you need. An annual eye exam is about much more than healthy vision. It can help you manage your overall health and well-being, too. An eye exam can spot the early signs of serious health conditions like diabetes and high blood pressure, so you can be treated sooner, rather than later.

Davis Vision offers two (2) plans, the Fashion and Designer plans, for your selection. Both plans offer an eye exam once a year, with your choice of lenses or contacts. Frames are offered once every two years.

Frequency of Visits

- **Examination** - Once every 12 Months
- **Lenses or Contact Lenses** - Once every 12 Months
- **Frames** - Once every 24 Months

How to find a Davis Vision Provider:

*Step 1: visit **davisvision.com***

Step 2: In the upper right-hand corner, CLICK Member Log In

Step 3: Enter your Plan Client Code

Step 4: Click on Find a Provider

***For more details about your plan**, visit davisvision.com/member and enter the Client Code or call 1 (877)923-2847 and enter the Client Code when prompted. For Lasik information, visit davisvision.com.*

Group Life/AD&D Insurance | The Standard

Life insurance provides your surviving family members with the funds to meet existing financial obligations, such as: unpaid medical bills, funeral expenses, mortgage payments and other debts (credit cards, car loans, etc.).

Employee Basic Life and AD&D Insurance – Paid by the School District

The School District will continue to pay for a $20,000 in Group Term Life and AD&D coverage for all benefit eligible employees. Your Basic Group Term Life insurance will be reduced by 65% at age 65 and by 50% at age 70.

Optional – Employee Additional Life Insurance – Paid by Employee

All eligible employees can select coverage amounts up to five times their annual salary, not to exceed $500,000*.

*Subject to medical underwriting and approval.

Eligible employees can purchase up to a maximum of $500,000 in coverage with $200,000 on a guarantee issue-basis (no medical questions asked) during open enrollment. Anything over this amount requires Evidence of Insurability (EOI).

If you are currently eligible for Additional Life insurance, but not enrolled, or if you are currently enrolled in Additional Life insurance and wish to increase your coverage level, the amount you are applying for is subject to medical EOI.

If you have been turned down in the past for Additional Life insurance, then you will not be eligible.

Optional - Dependent Life Insurance – Paid by Employee

All eligible employees have the option to purchase life insurance for eligible dependents, subject to medical underwriting and approval.

A Dependent Life Insurance policy will provide a maximum of $250,000 in coverage with $50,000 in guarantee issue basis (no medical questions asked) for your spouse. Coverage for children (through age 25) is available with an option of $5,000 or $10,000 per dependent child. The employee will automatically be the beneficiary of the policy. Dependents are eligible through age 25.

Child Life Rates

AGE	PREMIUM
0-25	$0.200/$1,000

Optional Group Life Insurance Employee Life Rates

AGE	PREMIUM
0-19	$0.046/$1,000
20-24	$0.046/$1,000
25-29	$0.46/$1,000
30-34	$0.055/$1,000
35-39	$0.074/$1,000
40-44	$0.092/$1,000
45-49	$0.150/$1,000
50-54	$0.212/$1,000
55-59	$0.340/$1,000
60-64	$0.524/$1,000
65-69	$.911/$1,000
70-74	$1.500/$1,000
75-999	$2.060/$1,000

Spouse Life Rates

AGE	PREMIUM
0-19	$0.046/$1,000
20-24	$0.046/$1,000
25-29	$0.46/$1,000
30-34	$0.055/$1,000
35-39	$0.074/$1,000
40-44	$0.092/$1,000
45-49	$0.150/$1,000
50-54	$0.212/$1,000
55-59	$0.340/$1,000
60-64	$0.524/$1,000
65-69	$.911/$1,000
70-74	$1.500/$1,000
75-999	$2.060/$1,000

Group AD&D Insurance | The Standard

Voluntary Accidental Death & Dismemberment coverage provides support after an accidental death or severe injury with much-needed financial assistance through a difficult time. Our AD&D insurance includes a Family Benefits Package designed to help surviving family members maintain their standard of living and pursue their dreams.

	Voluntary AD&D Insurance		
	Employee	Spouse	Child
Benefit Schedule	Increments of $5,000	Increments of $2,500	Increments of $5,000
Maximum Benefit	$500,000	$250,000	$10,000
Minimum Benefit	$5,000	$2,500	$5,000
Age Reduction Schedule	To 65% at age 65	To 65% at age 65	None
	To 50% at age 70	To 50% at age 70	

	Voluntary AD&D Rates		
	Employee	Spouse	Child
Rate: Per $1,000	0.04	0.020	0.010

This plan provides 24-hour coverage for accidents and dismemberments occurring on or off the job. Commissions are not included in a member's annual earnings. The Family Benefits Package includes:

- The Higher Education Benefit reimburses tuition expenses up to $5,000 per child per year towards a 4-year college education for the deceased's children - not to exceed a cumulative total of $20,000 or 25% of the AD&D benefit per child, whichever is less.
- Career Adjustment Benefit reimburses tuition expenses up to $5,000 per year to help a spouse to return to the workforce after the death of their spouse - not to exceed the cumulative total or $10,000 or 25% of the AD&D benefit, whichever is less.
- Child Care Benefit reimburses a family's child-care expenses up to $5,000 per year - not to exceed $10,000 or 25% of the AD&D benefit, whichever is less.
- AD&D insurance for dependents continues automatically, without premium payment, for five months after the death of the insured member.
- Dependents coverage includes child(ren) from live birth through age 25.
- The AD&D Occupational Assistance service is included and provides access to a Workplace Possibilities (SM) Consultant who helps those with a specified accidental dismemberment return to productive work and life.

An Accelerated Death Benefit is included.
Terminally ill members may withdraw up to 80% of their Life benefit to a maximum of $500,000 (when Basic Life and any Additional Life are combined).

- **The Family Benefits Package includes:**
  - **The Higher Education Benefit** reimburses tuition expenses up to $5,000 per child per year towards a 4-year college education for the deceased's children - not to exceed a cumulative total of $20,000 or 25% of the AD&D benefit per child, whichever is less.
  - **Career Adjustment Benefit** reimburses tuition expenses up to $5,000 per year to help a spouse to return to the workforce after the death of their spouse - not to exceed the cumulative total of $10,000 or 25% of the AD&D benefit, whichever is less.
  - **Child Care Benefit** reimburses a family's childcare expenses up to $5,000 per year - not to exceed $10,000 or 25% of the AD&D benefit, whichever is less.

- **The Helmet Benefit** pays a benefit for a loss of life due to an accident that occurs when riding a bicycle or a motorcycle and wearing a helmet.

- **A hand and/or foot** that is lost and later surgically reattached will still be considered a loss.

- **Payment for AD&D losses**, including any coma benefit payment, for the same accident cannot exceed 100% of the AD&D Insurance Benefit.

- **An Assault Benefit** is included and provides an additional benefit if a member suffers death or dismemberment as a result of an act of physical violence at work that is punishable by law.

- **The AD&D Occupational Assistance** service is included and provides access to a Workplace Possibilities (SM) Consultant who helps those with a specified accidental dismemberment return to productive work and life.

Travel Assistance is included and provides assistance with pre-trip planning, medical assistance services, emergency transportation services, travel and technical assistance services and legal referral.

- **The Life Services Toolkit** is included and helps beneficiaries cope with grief and loss, get answers to legal questions, plan a memorial or a funeral, and address financial concerns. Additionally, all covered employees will have access to online will preparation and other estate planning documents as well as articles to help deal with identity theft, improve wellness and more.

Additional Plan Design Details
On the policy effective date, all members (enrolled or eligible) may increase their benefit amount up to the guarantee issue amount without providing evidence of insurability.

- **On the policy effective date**, all members (enrolled or eligible) may increase their spouse's benefit amount up to the guarantee issue amount without providing evidence of insurability.
- **During the Annual Enrollment Period**, all members (enrolled or eligible) may increase their benefit amount up to $20,000, not to exceed the guarantee issue amount, without providing evidence of insurability.
- **During the Annual Enrollment Period**, all members (enrolled or eligible) may increase their spouse's benefit amount up to $10,000, not to exceed the guarantee issue amount, without providing evidence of insurability.
- **During a Family Status Change**, members who are currently enrolled, as well as those eligible but not currently enrolled, may increase their benefit amount, as well as their spouse's and child's benefit amounts (if included in the proposal), up to the guarantee issue amount without providing evidence of insurability.
- **No evidence of insurability is required for child coverage**.

Voluntary Short-Term Disability Insurance | The Standard

What Is Short-Term Disability Insurance (STD)?

STD is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work. STD coverage begins after the elimination period of the event causing your disability. The coverage allows you to continue to receive pay at a fixed weekly amount or a set percentage of your income.

Voluntary Short-Term Disability Plan

Voluntary Short Term Disability Benefit	
Benefit Schedule	60%
Insured Predisability Earnings	$1,667
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	$15
Benefit Waiting Period Accident	7 Days
Benefit Waiting Period Sickness	7 Days
Maximum Benefit Period	90 Days
Guarantee Issue Benefit Amount	Full Benefit
Partial/Residual Disability	80%
Temporary Recovery	90 Days
Maternity	Covered the same as any other illness

What happens to your income if an injury or illness keeps you from working?

Group Short-Term Disability Insurance from Standard Insurance Company (The Standard) can replace part of your paycheck if you're disabled and can't work for a short time.

What It Does

- Replaces a portion of your pay when you miss work because of a covered disability
- Pays you directly to help cover costs during recovery, like housing, food and childcare
- Can resume paying benefits with no waiting period, if your disability returns within a specified amount of time

Voluntary Short-Term Disability Rates

Voluntary Short Term Disability Rates	
Age	Rate is Percent of Earnings
0-24	0.820
25-29	0.861
30-34	0.787
35-39	0.664
40-44	0.689
45-49	0.689
50-54	0.820
55-59	1.123
60-64	1.369
65 - 999	1.484

Voluntary Long-Term Disability Insurance | The Standard

The School District of DeSoto County offers Voluntary Long-Term Disability insurance through The Standard. This insurance is designed to replace a portion of your income should you become unable to work in the event you are injured or sick for an extended period.

Voluntary Long Term Disability Benefit	
Benefit Schedule	60%
Insured Predisability Earnings	$15,000
Maximum Monthly Benefit	$9,000
Minimum Monthly Benefit	$100 or 10%
Benefit Waiting Period	90 Days
Maximum Benefit Period	to age 65
Guarantee Issue Benefit Amount	Full Benefit
Own Occupation Period	24 Months
Partial/Residual Disability	Included
Preexisting Condition Period	3/12
Mental & Nervous Limitation	24 Months
Substance Abuse Limitation	24 Months
Other Limited Conditions	24 Months
Musculoskeletal/Connective	24 Months
Return to Work Incentive	12 Months

Voluntary Long Term Disability Rates	
Age	Rate Per $10 Benefit
0-24	0.138
25-29	0.198
30-34	0.294
35-39	0.336
40-44	0.444
45-49	0.600
50-54	0.798
55-59	0.870
60 - 999	0.924

What Is Long-Term Disability Insurance (LTD)?
LTD is a type of disability insurance coverage that pays employees a set percentage of their regular income after a specified waiting period. For example, if a worker is covered under short-term disability (STD) insurance as well, the LTD insurance would kick in once the STD policy is exhausted after six months.

LTD insurance protects workers in the event they become disabled for a prolonged period prior to retirement. The length of LTD plan continues paying out until age 65.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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.

Notice to Employees of Coverage Options

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 Desoto County School District		4. Employer Identification Number (EIN) 59-6000580
5. Employer address 530 LaSolono Ave		6. Employer phone number 863-494-4222
7. City Arcadia	8. State Florida	9. ZIP code 34266
10. Who can we contact about employee health coverage at this job? Dr. Gina Stafford, Director of Human Resources		
11. Phone number (if different from above) 863-494-4222	12. Email address Gina.Stafford@desotoschools.com	

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

- **As your employer, we offer a health plan to some employees. Eligible employees are those who work 30 hours or more on average each week.**

- **With respect to dependents, we do offer coverage. Eligible dependents are your:**
  - *Spouse*
  - *Children**
  - *Newborn Children**
  - *Disabled Children**
  - *Stepchildren**
  - *Legally Adopted Children**
  - *Child whom the Covered Employee has been court-appointed as Legal Guardian or Legal Custodian**

***FS. 627.6562 A policy must** offer the policyholder or certificate holder the option to insure a child of the policyholder or certificate holder at least until the end of the calendar year in which the child reaches the age of 30, if the child:

(a) Is unmarried and does not have a dependent of his or her own;
(b) Is a resident of this state or a full-time or part-time student; and
(c) Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

**** 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.

Notice to Employees of Coverage Options

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? $0.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☒ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

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

_____

• 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)

Medicare Part D Notice of Creditable & Non-Creditable Coverage

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide a minimum standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The School District of DeSoto County has determined that the prescription drug coverage for their plans administered by Florida Blue is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Mandatory Benefit Notices

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.
The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:
1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Mandatory Benefit Notices

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:
The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible.
The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website:
https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaida-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment
Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email:
masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website:
http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website:
https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP)
(pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
WWebsite: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP)
Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website:
https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
| Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select
https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-andeligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Benefits Directory

Benefit Coverage	Carrier	Customer Service	Website
Medical / Pharmacy	Florida Blue	800-352-2583	www.Floridablue.com
Virtual Visits	Teladoc	800-835-2362	www.Teladoc.com
Dental	Florida Combined Life	888-223-4892	www.Floridabluedental.com
Vision	Davis Vision	800-999-5431	www.Davisvision.com
Life and Accidental Death & Dismemberment (AD&D), Short and Long-term Disability	The Standard Insurance Company	800-628-8600	www.Standard.com
Employee Assistance Program	Lucet	800-624-5544	www.eap.lucethealth.com

For assisstance with benefit quesitons, enrollment, eligibility, membership card issues, claims & billing inquiries please contact your Acentria service team:

Office: 863-773-4101

Samantha Gonzalez	Crystal McMullen	Erica Striker	Michael Watkins
Account Manager	Account Manager	Wellness Account Manager	Local Representative
Samantha.Gonzalez@Acentria.com	Crystal.McMullin@Acentria.com	Erica.Striker@Acentria.com	Michael.Watkins@Acentria.com
863-773-4103	850-295-8042	850-407-7793	813-763-3332