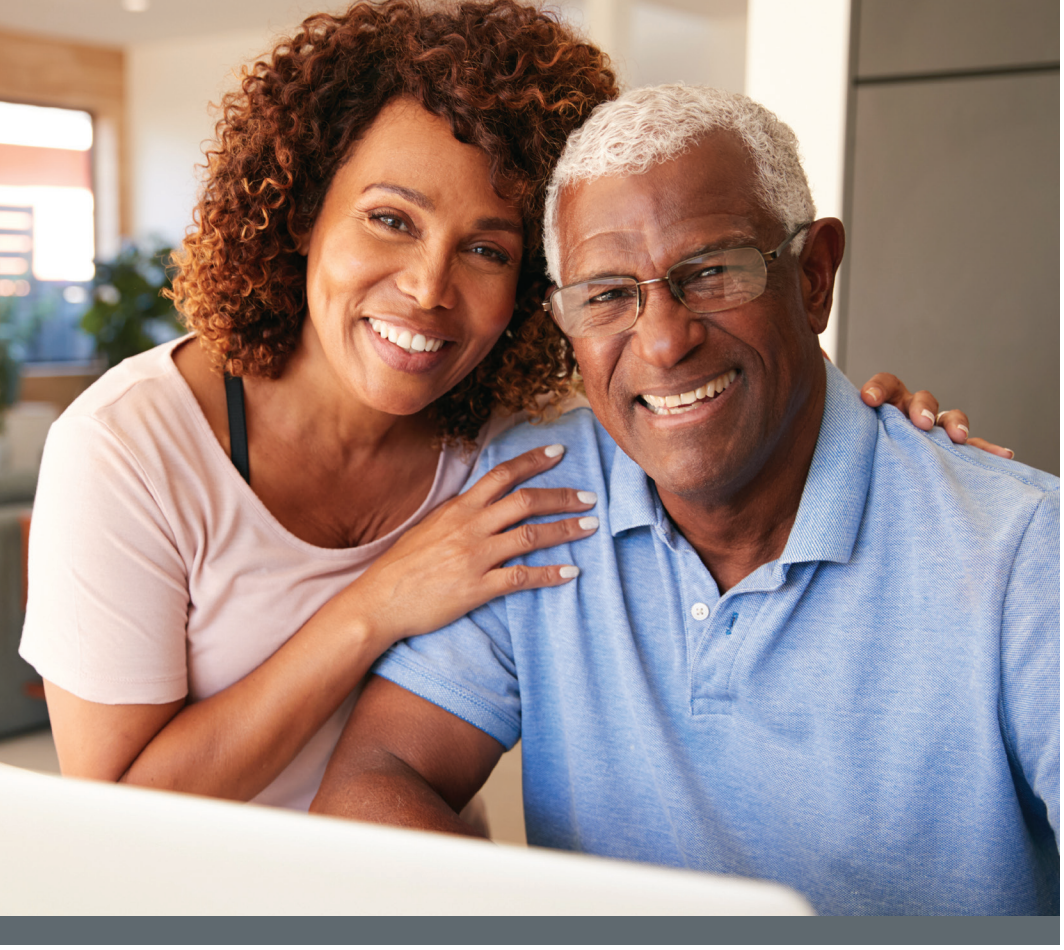

BCSD

For Your Benefit

October 2021 - September 2022

Retiree Guide

At Bradford County School District,

your health and happiness are important to us

That's why we're so committed to making sure you get the benefits package that's right for both you and your family. Our package combines the peace of mind that comes with excellent medical care with competitive prices.

Annual Enrollment is your chance to ensure that your benefits package is right for you. Our program is built around you and created to keep you in great shape, physically and financially.

Please take the time to read through this booklet and understand all the options available to you. Taken together, we think we've created a benefit package that gives you outstanding support, whether you're at work, at home or even on vacation.

What's Here

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/ Benefits Department.

Enrollment Guidelines

Know when you can change your coverage

Juan and his wife just had a baby!

Having a baby is a **qualifying life event,** so Juan must contact Payroll Specialist/ Department within **30 days** of birth to add his baby.

During Annual Enrollment

Each Annual Enrollment, coverage changes will be in effect **October 1 through September 30**.

Other qualifying events include marriage or divorce, adopting a child, custody status change of a child, a change in Medicare or Medicaid eligibility, or a change in your or your spouse's work affecting benefits eligibility.

It is once again time for you to complete your annual review of the insurance plans you maintain through the District. Open enrollment, or the annual sign-up period, is August 16 - September 3. Now is the time for you to review your options and make the selection that is best for you to continue for the upcoming year. Remember, all changes made during open enrollment are effective October 1, 2021. If you are not currently enrolled in Medical, Dental, Vision or Life Insurance, you are not eligible to enroll after retirement.

Know who you can add to your plans

You may cover:

- Your legal spouse
- Your natural, adopted, foster, step children and children in your custody due to a court order until:
  - **MEDICAL:** the end of the calendar year when they reach age 26. Extended coverage to age 30 may be available, please contact Payroll Specialist/Department for details.
  - **CHILD LIFE INSURANCE:** from live birth through age 19 (through age 23 if a registered student in full-time attendance at an accredited educational institution)

If you have an adult child who became disabled before age 26, please contact Payroll Specialist/Department for information on adding them to medical insurance.

What Open Enrollment Means:

Open Enrollment provides us an opportunity to familiarize ourselves with the many benefits offered. This is also your once-a-year opportunity to make changes to core benefit plans for Medical, Dental and Vision in addition to life insurance coverage (if applicable). Once the annual enrollment period ends, you will not have any further opportunities to make changes for the benefit plan year unless you experience a Qualifying Life Event (QLE).

For 2021, Florida Blue will continue to be the provider for medical coverage. There is a rate increase for the 10/1/2021-9/30/2022 plan year. Please note: BlueCare Plan 132/133 has been added to the selection of plans. There are now five Florida Blue plans available for selection. The Florida Blue plan matrix is listed on page 5. The Dental is now available through Florida Combined Life and the Vision plans are now available through The Standard using the Ameritas Network. The $5,000 or $10,000 Life Insurance opitons are now available through The Standard. The rates are listed on page 18.

Please remember also, if you are eligible for Medicare benefits and are currently enrolled in the District's group health plan, the Florida Blue – BlueMedicare Group PPO Medicare Advantage health plan is still available to you. If you currently cover your spouse and they are not Medicare eligible, you may still consider the BlueMedicare Group PPO as an option. Your spouse, who is not Medicare eligible, will have the option to switch to one of the Florida Blue HMO or PPO plans. Many Medicare eligible retirees may find that a private Medicare plan is a suitable option for their needs. For more information on these plans, or to enroll in the BlueMedicare Group PPO Medicare Advantage plan, please contact Amy Johnson at Gallagher Benefit Services **(386) 269.3374**.

When researching which health plan you should consider, please remember there is a different network of doctors / providers for some of the plans. All of the networks can be researched on-line by visiting **www.FloridaBlue.com**. From the Home page, choose "Find a Doctor" on the top of the page. Be sure to select the applicable network. The chart below lists the network associated with each plan:

Plan Name	Provider Network
BlueOptions Plans: 03160/03161 | 05901 | 05182/05183	Florida Blue BlueOptions PPO Network
BlueCare Plans 132/133 | 128/129	Florida Blue BlueCare HMO Network

Medical Insurance Made Simple

What happens when you need healthcare?

All five plans cover in-network preventive care 100%. Beyond that, your responsibility depends on the plan you choose, the services you need, and where you receive your care.

YOUR PLANS AT-A-GLANCE	BlueOptions 03160/61 HSA compatible	BlueOptions 05901	BlueOptions 05182/83 HSA compatible	BlueCare 132/133	BlueCare 128/129 HSA compatible
Networks	**In- and out-of-network coverage available**	**In- and out-of-network coverage available**	**In- and out-of-network coverage available**	**In-network coverage only (BlueCare network)**	**In-network coverage only (BlueCare network)**
Deductible $	$	$$$	$$$	$$$	$$$
Out-of-Pocket Maximum	$$	$$	$$	$$$	$$
How you pay for care	Deductible then coinsurance	Mix of copays and deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance	Deductible then coinsurance

Monthly rates

We do our very best to get the most competitive prices while getting you the best possible coverage.

	BlueOptions 03160/61	BlueOptions 05901	BlueOptions 05182/83	BlueCare 132/133	BlueCare 128/129
Monthly					
Employee Only	$507.71	$638.57	$712.46	$734.60	$449.50
Employee + Family	$1,144.71	$1,439.07	$1,604.90	$1,654.77	$1,013.46

Know your terms!

Copay – a flat fee you pay whenever you use certain medical services, like a doctor visit.

Deductible – the dollar amount you pay before your medical insurance begins paying deductible-eligible claims.

Coinsurance – the percentage of covered medical expenses you continue to pay after you've met your deductible and before you reach your out-of-pocket maximum.

Out-of-pocket maximum – the most you will pay during the calendar year for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Balance billing – the amount you are billed to make up the difference between what your out-of-network provider charges and what insurance reimburses. This amount is in addition to, and does not count toward your out-of-pocket maximum.

Your Medical Coverage

IN-NETWORK COVERAGE					
	BlueOptions 03160/61 HSA compatible	**BlueOptions 05901**	**BlueOptions 05182/83 HSA compatible**	**BlueCare 132/133 HSA compatible**	**BlueCare 128/129 HSA compatible**
DEDUCTIBLE	$1,400 single coverage $2,800 family coverage	$2,000 per person	$2,500 single coverage $5,000 family coverage	$3,000 single coverage $6,000 family coverage	$2,500 single coverage $5,000 family coverage
COINSURANCE (your share)	20% after DED	50% after DED	10% after DED	30% after DED	20% after DED
OUT-OF-POCKET MAXIMUM	$5,000 single coverage $5,000 family coverage	$6,350 per person $12,700 family maximum	$5,000 single coverage $10,000 family coverage	$6,550 | $13,100 ($6,850 Max per person)	$5,000 | $10,000 ($6,850 max per person)
PREVENTIVE CARE	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
PRIMARY CARE VISIT	DED then 20%	$35	DED then 10%	DED then 30%	DED then 20%
SPECIALIST VISIT	DED then 20%	$75	DED then 10%	DED then 30%	DED then 20%
INDEPENDENT LAB	DED	100% covered	DED	DED then 30%	DED
X-RAY	DED then 20%	$50	DED	DED then 30%	DED then 20%
IMAGING (MRI / CT)	DED then 20%	$200	DED then 10%	DED then 30%	DED then 20%
URGENT CARE CENTER	DED then 20%	DED then 50%	DED then 10%	DED then 30%	DED then 20%
EMERGENCY ROOM	DED then 20%	DED then 50%	DED then 10%	DED then 30%	DED then 20%
INPATIENT HOSPITAL	DED then 20%	Opt 1: $2,000 Opt 2: $3,000	DED then 10%	DED then 30%	DED then 20%
OUTPATIENT HOSPITAL	DED then 20%	Opt 1: $300 Opt 2: $400	DED then 10%	DED then 30%	DED then 20%
PRESCRIPTION DRUG COVERAGE					
RETAIL	DED then: $10 / $50 / $80	$10 / $50 / $80	DED then: $10 / $50 / $80	DED then: $10/20%/NC	DED then: $10 / $50 / $80
MAIL ORDER	DED then $25/$125/$200	$25/$125/$200	DED then $25/$125/$200	DED then $25/20%/NC	DED then $25/$125/$200
OUT-OF-NETWORK COVERAGE subject to balance billing (see page 4)					
DEDUCTIBLE	$2,500 | $5,000	$6,000	$5,000 | $10,000	Not covered	Not covered
COINSURANCE (your share)	40% after DED	50% after DED	40% after DED	Not covered	Not covered
OUT-OF-POCKET MAX	$10,000 | $10,000	$30,000 | $30,000	$10,000 | $20,000	Not covered	Not covered

Florida Blue

Group Number: 60479
Website: **www.floridablue.com**
Phone: **800.352.2583**

Download Florida Blue's mobile app for claims information, to access your ID card, find a doctor, and more!

GET IT ON Google Play
Available on the App Store

Florida BlueMedicare PPO

Monthly Premium, Deductible and Limits

Monthly Plan Premium	▪ **$374.79 for Elite PPO** You must continue to pay your Medicare Part B premium.
Deductible	▪ In-Network: **$0** ▪ Out-of-Network: **$1,000** ▪ **$0** per year for Part D prescription drugs
Maximum Out-of-Pocket Responsibility	▪ **$1,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$3,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in- and out-of-network providers combined.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Care ◊	▪ **$200** copay per day, days 1-5 ▪ **$0** copay per day, after day 5	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Outpatient Hospital Care	▪ **$75** copay per visit for Medicare-covered observation services ▪ **$200** copay for all other services ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulatory Surgical Center	▪ **$150** copay in an ambulatory surgical center	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Doctor's Office Visits	▪ **$10** copay per primary care visit ▪ **$25** copay per specialist visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Preventive Care	▪ **$0** copay ▪ Abdominal aortic aneurysm screening ▪ Alcohol misuse screening and counseling ▪ Annual Wellness Visit ▪ Bone mass measurements ▪ Breast cancer screening (mammograms) ▪ Cardiovascular disease screening and intensive behavioral therapy ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screening ▪ Depression screening ▪ Diabetes screening and self-management training ▪ Glaucoma screening ▪ Hepatitis B and C screening ▪ HIV screening ▪ Intensive Behavioral Therapy for Obesity	▪ **20%** of the Medicare-allowed amount

	In-Network	Out-of-Network
	▪ Lung cancer screening ▪ Medical nutrition therapy ▪ Prostate cancer screening ▪ Sexually transmitted infections - screening and high-intensity behavioral counseling to prevent them ▪ Smoking and tobacco use cessation counseling ▪ Vaccines for influenza, pneumonia and Hepatitis B ▪ Welcome to Medicare preventive visit Any additional preventive services approved by Medicare during the contract year will be covered.	
Emergency Care	**Medicare Covered Emergency Care** ▪ **$75** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$75** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	
Urgently Needed Services	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$25** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$25** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$75** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	

	In-Network	Out-of-Network
Diagnostic Services/ Labs/Imaging◊	**Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$15** copay at an outpatient hospital facility **X-Rays** ▪ **$25** copay at an Independent Diagnostic Testing Facility (IDTF) ▪ **$100** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$50** copay at a physician's office ▪ **$75** copay at an IDTF ▪ **$100** copay at an outpatient hospital facility **Radiation Therapy** ▪ **20%** of the Medicare-allowed amount	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Hearing Services	**Medicare-Covered Hearing Services** ▪ **$25** copay for exams to diagnose and treat hearing and balance issues	**Medicare-Covered Hearing Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Dental Services	**Medicare-Covered Dental Services ◊** ▪ **$25** copay for non-routine dental care	**Medicare-Covered Dental Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for non-routine dental
Vision Services	**Medicare-Covered Vision Services** ▪ **$25** copay for physician services to diagnose and treat eye diseases and conditions ▪ **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) ▪ **$0** copay for one diabetic retinal exam per year ▪ **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery	**Medicare-Covered Vision Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Mental Health Care ◊	**Inpatient Mental Health Services** ▪ **$200** copay per day, days 1-7 ▪ **$0** copay per day, days 8-90 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **$30** copay	**Inpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible 190-day lifetime benefit maximum in a psychiatric hospital **Outpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Skilled Nursing Facility (SNF) ◊	▪ **$0** copay per day, days 1-20 ▪ **$100** copay per day, days 21-100 Our plan covers up to 100 days in a SNF per benefit period.	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Physical Therapy ◊	▪ **$25** copay per visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulance ◊	▪ **$150** copay for each Medicare-covered trip (one-way)	▪ **$150** copay for each Medicare-covered trip (one-way)
Transportation	▪ Not covered	▪ Not covered
Medicare Part B Drugs ◊	▪ **$5** copay for allergy injections ▪ **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

Part D Prescription Drug Benefits

Deductible Stage

This plan does not have a prescription drug deductible.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **$4,130**. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost sharing below applies to a one-month (31-day) supply.

	Preferred Retail	Standard Retail	Mail Order
Tier 1 - Preferred Generic	**$0** copay	**$8** copay	**$0** copay
Tier 2 - Generic	**$3** copay	**$15** copay	**$3** copay
Tier 3 - Preferred Brand	**$30** copay	**$40** copay	**$30** copay
Tier 4 - Non- Preferred Drug	**$60** copay	**$70** copay	**$60** copay
Tier 5 - Specialty Tier	**33%** of the cost	**33%** of the cost	**33%** of the cost

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including what any Part D plan has paid and what you have paid) reaches **$4,130**.

You stay in this stage until your year-to-date “out-of-pocket” costs reach a total of **$6,550**.

During the Coverage Gap Stage:

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs, throughout the coverage gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the *greater* of:

- **$3.70** copay for generic (including brand drugs treated as generic) and **$9.20** copay for all other drugs, or **5%** of the cost.

Additional Drug Coverage

- Please call us or see the plan’s “Evidence of Coverage” on our website (**www.floridablue.com/medicare**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 cost sharing.
- Your cost-sharing may be different if you use a Long-Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Additional Benefits

	In-Network	Out-of-Network
Diabetic Supplies ◊	▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medicare Diabetes Prevention Program	▪ **$0** copay for Medicare-covered services	▪ **20%** of the Medicare-allowed amount
Podiatry	▪ **$25** copay for each Medicare-covered podiatry visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Chiropractic	▪ **$20** copay for each Medicare-covered chiropractic visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medical Equipment and Supplies ◊	▪ **20%** of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Occupational and Speech Therapy ◊	▪ **$25** copay per visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Telehealth	▪ $25 copay for Urgently Needed Services ▪ $10 copay for Primary Care Services ▪ $25 copay for Occupational Therapy/Physical Therapy/Speech Therapy at a freestanding location ▪ $25 copay Occupational Therapy/Physical Therapy/Speech Therapy at an outpatient hospital ▪ $25 copay for Dermatology Services ▪ $30 copay for individual sessions for outpatient Mental Health Specialty Services ▪ $30 copay for individual sessions for outpatient Psychiatry Specialty Services ▪ $30 copay for Opioid Treatment Program Services ▪ $30 copay for individual sessions for outpatient Substance Abuse Specialty Services ▪ $0 copay for Diabetes Self-Management Training ▪ $0 copay for Dietician Services	▪ 20% of the Medicare-allowed amount after $1,000 out-of-network deductible

You Get More with BlueMedicare

	In-Network	Out-of-Network
HealthyBlue Rewards 	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.	
SilverSneakers® Fitness Program 	▪ Gym membership and classes available at fitness locations across the country, including national chains and local gyms ▪ Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more	

Disclaimers

Florida Blue is a PPO and Rx (PDP) plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Florida Blue members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

If you have any questions, please contact our Member Services number at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Our hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

Health coverage is offered by Blue Cross and Blue Shield of Florida, Inc., dba Florida Blue, an Independent Licensee of the Blue Cross and Blue Shield Association.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You may also view the "Evidence of Coverage" for this plan on our website, **www.floridablue.com/medicare**.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

You and your dependent(s) can join this plan if you are a retired employee of the group and the following conditions are met:

- You and your dependent(s) are entitled to Medicare Part A and enrolled in Medicare Part B
- You and your dependent(s) live in the plan service area, and
- You are identified as an eligible participant by your former employer.

Neither you nor your dependent(s) are eligible for this plan if:

- You are an active employee of the group, or
- You are a retired employee of the group with a dependent who is an active employee of the group and has coverage through the group's plan for active employees.

Our service area includes all 50 states and the District of Columbia

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Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network to receive medical services, you may pay more for these services. If you use pharmacies that are not in our network to fill your covered Part D drugs, the plan will generally not cover your drugs.

- You can see our plan's provider and pharmacy directory at our website (**www.floridablue.com/medicare**). Or call us and we will send you a copy of the provider and pharmacy directories.

Have Questions? Call Us

- If you have questions about this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
  - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
  - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- Or visit our website at **www.floridablue.com/medicare.**

Important Information

Through this document you will see the "◊" symbol. Services with this symbol may require prior authorization from the plan before you receive the services from network providers. If you do not get a prior authorization when required, you may have to pay out-of-network cost-sharing, even though you received services from a network provider. Please contact your doctor or refer to the Evidence of Coverage (EOC) for more information about services that require a prior authorization from the plan.

Dental Insurance

Our Florida Combined Life Insurance Company dental plan allows you to visit any licensed dentist you like – but you make the most of your plan when you choose an in-network dentist. To locate an in-network provider, visit **floridabluedental.com/find-a-dentist** | when searching the directory, be sure to enter your dental plan name as indicated on your ID card (Blue Dental Choice True Group)

In-network dentists provide:

Quality Assurance
Network dentists are monitored for proper licensing, cleanliness, and safety.

No pre-payment
You'll pay only your portion of the bill. Insurance pays your dentist directly.

No balance billing
You won't be charged more than the contracted rate.

Lower prices
Through reduced fees

	BlueDental Choice True Group Dentist	Plus Balance Billing
	In-Network Coverage	Out-of-Network Coverage
Annual Deductible DED	$50 individual; $150 family	$50 individual; $150 family
Annual Maximum Benefit	$1,500 per person	$1,500 per person
Preventive Services (Exam, cleaning, x-rays)	100% covered Deductible does not apply	100% covered, plus balance billing Deductible does not apply
Basic Services (Root Canal, Extractions, Fillings)	DED then 20%	DED then 50%, plus balance billing
Major Services (Inlays, Onlays, Crowns, Dentures)	DED then 50%	DED then 50%, plus balance billing
Child Orthodontics (to age 19)	50%, $1,000 lifetime maximum coverage	50%, $1,000 lifetime maximum coverage

Your dental benefits go further with Maximum Rollover

How to qualify for Maximum Rollover:
For active BlueDental PPO members, the rollover amount is applied automatically. All you need to do is visit the dentist and receive at least one covered service during the calendar year. Routine clearings qualify, as we encourage you to take advantage of your preventive benefits.

Here's an example of how it works:
If you use less than $500 of the annual maximum, then the $350 rollover amount is applied to the next year. In year two, your total benefit is the annual maximum + the $350 in rollover dollars. You can continue adding rollover dollars up the rollover maximum as long as you qualify.

You can check your Maximum Rollover balance online:
Log in or create an account at **FloridaBlue.com**; once logged in, click the drop down menu in the top right corner and select 'Dental'. Here you can find a dentist, print or order a new ID card, and get answers to questions. Click "Learn More" in the benefits section to access the benefits portal.

Florida Combined Life

Group Number: 60479
Website: **floridabluedental.com**

BlueDental plans are offered through Florida Combined Life Insurance Company (FCL), an affiliate of Blue Cross and Blue Shield of Florida, Inc., DBA Florida Blue.

Vision Insurance

Keep your eyes healthy and your vision sharp with comprehensive vision coverage offered through **Standard.** All services except frames are available once every 12 months; **frames are available once every 24 months. Based on date of service.**

Visit **www.Standard.com** and select **Find an Eye Doctor** to locate a participating provider. **Your network is VSP.**

Balanced Care Vision | VSP Choice Network		
	In-Network	**Out-of-Network**
Eye Examination	$10 copay	$10 copay
Prescription Glasses Lenses and/or frames	In network $25	Out of Network $25
Glasses		
Lenses - Single	100% covered after copay	Up to $30 reimbursement
Lenses - Lined Bifocal	100% covered after copay	Up to $50 reimbursement
Lenses - Lined Trifocal	100% covered after copay	Up to $65 reimbursement
Frames	$130 allowance after copay	Up to $100 reimbursement
Contacts		
Elective Contact Lenses	$130 allowance	Up to $105 reimbursement
Medically Necessary Contacts	Covered 100%	Up to $210 reimbursement

Elective contact lenses are in lieu of glasses (lenses & frames). You are not eligible for glasses under our plan until 12 months after you receive contacts and vice-versa.

The Standard

Group Number: 169306
Website: **www.standard.com**
Phone: **800.877.7195**

ID cards are not provided for vision care. In-network providers can confirm your coverage details using your name.

Life Insurance

Life Insurance

If you're a Retiree you have the opportunity to elect and purchase life insurance in the amount of $5,000 and $10,000 through The Standard.

Feature	Option 1	Option 2
Available Increments	$5,000	$10,000
Monthly Premium	$11.50 Monthly	$23.00 Monthly

The Standard

Group Number: 169306
Website: **www.standard.com**
Phone: **800.547.9515**

Your Cost for Coverage

Your monthly cost for coverage

Medical Insurance

Coverage Level	BlueCare 128/129	BlueOptions 05182/05183	BlueOptions 05901	BlueOptions 03160/03161	BlueCare 132/133
EE Only	$507.71	$638.57	$712.46	$734.60	$449.50
FAMILY	$1,144.71	$1,439.07	$1,604.90	$1,654.77	$1,013.46

Dental and Vision Bundle

Florida Combined Life Dental/Standard Vision

Coverage Level	Dental/Vision Bundle
EE Only	$37.34
EE + SP	$75.44
EE + CH	$89.39
FAMILY	$131.01

Life Insurance

Coverage Level	Per Month
$5,000	$11.50
$10,000	$23.00

Annual Notices and Disclosures

This section contains important information about your benefits and rights. Please read the following pages carefully and contact Payroll Specialist/Department with any questions you have.

HIPAA Special Enrollment Rights

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

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

To request special enrollment or obtain more information, contact your Benefits or HR Administrator.

Section 111

Effective January 1, 2009 Group Health Plans are required by the Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. This mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help to establish who pays first. The mandate requires Group Health Plans to collect additional information such as social security numbers for all enrollees, including dependents aged six months or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses; and treatment of physical complications of the mastectomy, including lymphedema.

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

Newborns' and Mothers' Health Act

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

Patient Protection

If your group health plan requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the group health plan will make one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre- approved treatment plan, or procedures for making referrals.

For a list of participating healthcare professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate

and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **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 **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 July 31, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium-assistance-pa 800.862.4840
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2023)

MEDICARE D NOTICE

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE:

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

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

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

2. Bradford County School District has determined that the prescription drug coverage offered by Florida Blue for the plans 03160/61, 05901, 05182/83, and 128/129 is, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Bradford County School District prescription coverage will be affected. You can not keep your coverage with Bradford County School District if you elect Part D coverage. If you decide to join a Medicare drug plan and drop your current coverage under the Bradford County School District Medical Plan, be aware that you and your dependents will not be able to get this coverage back.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage/**), which outlines the prescription drug plan provisions/ options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Bradford County School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have the coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact your Personnel Department. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage with Prime Therapeutics changes. You also may request a copy of this notice at any time.

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

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

For More Information About Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **800.MEDICARE (800.633.4227)**. TTY users should call **877.486.2048**.
- For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov,** or call them at **800.772.1213** (TTY **800.325.0778**).

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

Date:	October 1, 2021
Name of Entity/Sender:	Bradford County School District
Address:	501 West Washington Street Starke, FL 32091
Phone Number:	(904) 966.6008

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting