2024-2025
Wakulla County School Board

WAKULLA
SCHOOL DISTRICT

WAKULLA COUNTY SCHOOL BOARD

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

Robert Pearce
Superintendent

Edward Hand
District I

Melisa Taylor
District II

Cale Langston
District III

Joshua Brown
District IV

Laura Lawhon
District V

Dear Employee,

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

Your open enrollment will be for all core (Medical/Dental/Vision) plus supplementary benefits. For 2024, we are proud to continue our partnership with American Fidelity and other existing companies for the following supplementary benefits:

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

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

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

Sincerely,

Bobby Pearce,
Superintendent of Schools

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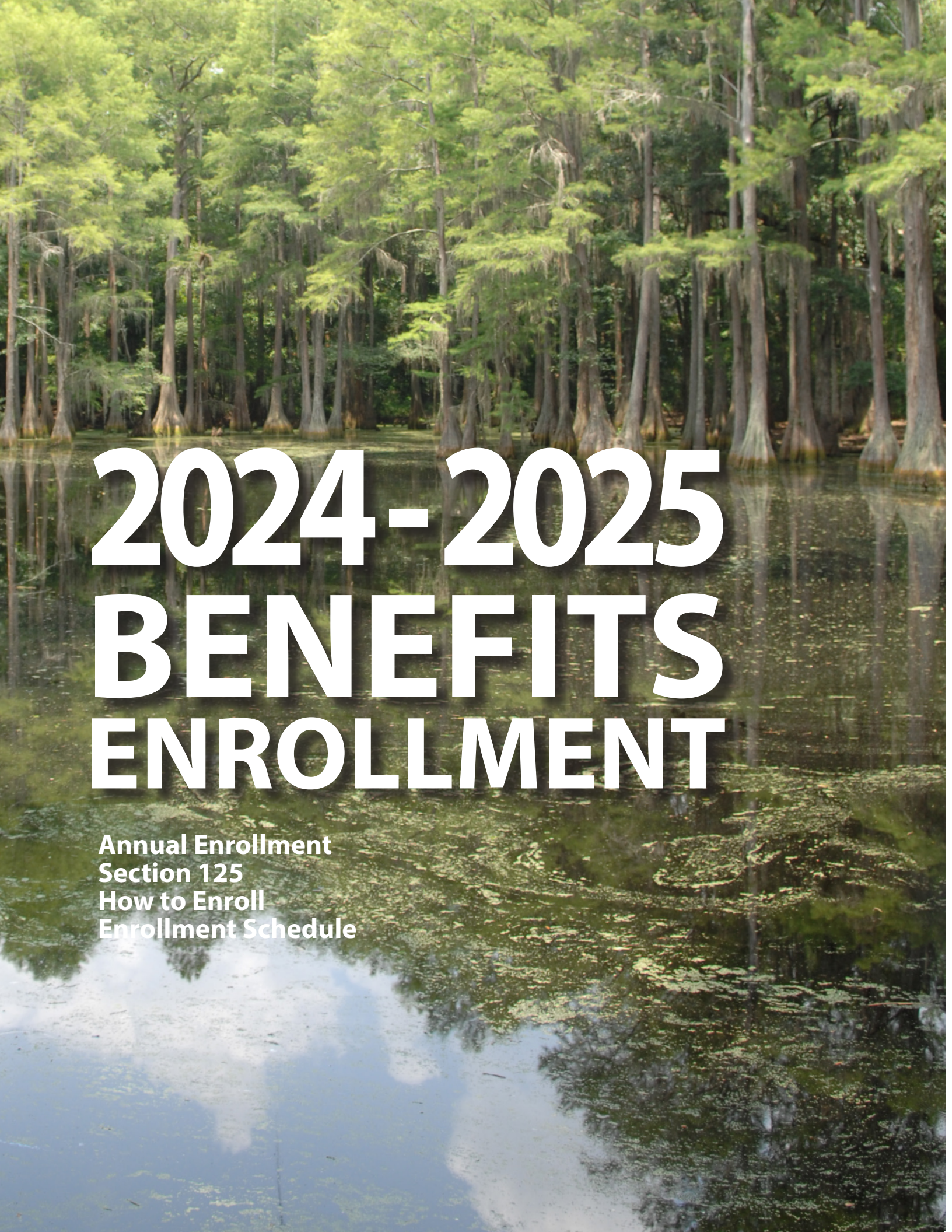

2024-2025 BENEFITS ENROLLMENT

Annual Enrollment
Section 125
How to Enroll
Enrollment Schedule

Your Annual Enrollment

Important Dates to Remember

Your Open Enrollment Dates are:

August 5, 2024 - August 23, 2024

Your Plan Year is:

October 1, 2024 - September 30, 2025

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

Annual Open Enrollment

Each year Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Your election deductions begin in September and will remain in effect through the plan year (October 1, 2024 - September 30, 2025) for your Voluntary benefits.

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

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

Important Points To Consider

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

Your Section 125 Plan

Save Money With Section 125

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

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

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

Benefits Eligible For The Section 125

Group Medical and Dental Insurance

- Accident Insurance
- Cancer Insurance
- Flexible Spending Accounts

How Can This Plan Help Me?

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

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

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

How to Enroll

Wakulla County School Board makes it easy for you to enroll in your 2024 benefits.

Point your smart phone camera at the QR code to schedule your appointment or copy in your browser https://enroll.americanfidelity.com/D48B8588:

You can enroll in:	
• Dental Insurance	• Accident Only Insurance
• Vision Insurance	• Life Insurance
• Group Life Insurance	• Health Flex Spending Account
• Disability Income Insurance	• Dependent Care FSA
• Cancer Insurance	

What To Bring To Your Appointment

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

**Please keep in mind that you may be subject to an audit – which would require you to bring all of the above required documents in order to complete your enrollment.*

Don't Miss It!

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

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

Enrollment Schedule

Wakulla County School District Enrollment Schedule

Location	2024 Dates
District Office- Admin	Aug 12 - Aug 15
Maintenance	Aug 14
Riversprings Middle School	Aug 12 - Aug 14
Crawfordsville Elementary School	Aug 19 - Aug 21
Medart Elementary	Aug 14 - Aug 16
Wakulla High School	Aug 5 - Aug 7; Aug 12
Adult Education- Wakulla Institute	Aug 14
Shadeville Elementary	Aug 15 - Aug 16; Aug 21
Wakulla Educational/ Pre-K	Aug 19 - Aug 20
Riversink Elementary	Aug 14 - Aug 16
Wakulla Middle School	Aug 12 - Aug 13
School Board	Aug 19
Transportation	Aug 8 - Aug 9
Wakulla Institute- Pathways	Aug 13
Wrap Up - District Office	Aug 22 -Aug 23

If you need to schedule a time that's not listed please call our Branch Office to make an appointment 850-425-1100 or email us AFES-FL@americanfidelity.com.

INSURANCE PLANS

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

Accident Insurance
Cancer Insurance
Critical Illness Insurance
Hospital GAP Insurance
Hospital Indemnity

Medical Insurance

Capital Health Plan

Wakulla County School Board
Medical Rates

CAPITAL HEALTH PLAN Quality Choice			
Plan Type	Total Premium (10)	Board (ER contribution)	Employee Cost
Employee Only	$975.36	$553.69	$421.67
Family	$2,926.08	$1,619.22	$1,306.86
Employee / Spouse	$1,950.72	$793.86	$1,156.86
Employee / Child	$1,658.11	$551.25	$1,106.86

CAPITAL HEALTH PLAN Value Choice			
Plan Type	Total Premium (10)	Board (ER contribution)	Employee Cost
Employee Only	$833.26	$553.69	$279.57
Family	$2,499.76	$1,619.22	$880.54
Employee / Spouse	$1,666.50	$793.86	$872.64
Employee / Child	$1,416.53	$551.25	$865.28

Rates

The Wakulla County School Board contributes $5,536.90 per year for single coverage and $16,192.20 per year for family coverage to our health care plan for each regular employee working twenty (20) or more hours per week.
(Exception: Based on our Health Benefit Measurement Period Policy found on page 32 a temporary employee working more than 30 hours/week may become eligible for such contributions.) If an employee works less than twenty (20) hours a week (part-time employees), he/she has the option to enroll in the health care plan provided they pay the total premium.

Cancelling a Pre-Tax Deduction

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

All changes or cancellations must be in the Payroll Office by the date listed in the "Due in County Office" section of the Payroll Reporting Salary Schedule (see page 57) for that particular paycheck date. If a change or cancellation is made after the pre-taxed deduction is deducted from your paycheck, the school board will not refund your deduction. It will be your responsibility to seek a refund from the appropriate company.

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

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

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

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

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

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

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: $15 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
	Specialist visit	Office: $75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$250 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://capitalhealth.com/members/about-your-medications	Tier 1 – Preferred Generic Tier 2 – Non-Preferred Generic	$15 / 30-day supply	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied. Retail or mail order, one copay per 30 day supply up to 90 days.
	Tier 3 – Preferred Brand	$50 / 30-day supply	Not Covered	
	Tier 4 – Non-Preferred Brand	$100 / 30-day supply	Not Covered	

	Specialty drugs Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty	$100 / 30-day supply	Not Covered	Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $250 / visit Hospital: $500 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$75 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$750 / visit $500 / observation	$750 / visit $500 / observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status an additional copayment may apply based on services rendered.
	Emergency medical transportation	$250 / transport	$250 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 / visit	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 / visit	Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission $500 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted $75 / provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	$75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	Childbirth/delivery professional services	No Charge	Not Covered	————none————

	Childbirth/delivery facility services	$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$75 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic care
- Annual routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those

agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

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

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

About these Coverage Examples:

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

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

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

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$960**

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

- The plan's overall deductible $0
- Specialist copayment $75
- Hospital (facility) copayment $500
- Other copayment $100

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

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

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

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

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

Important Questions	Answers	Why This Matters:
see a specialist?	referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth	have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: $15 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth–Services provided by network providers through remote access technology including web and mobile devices.
	Specialist visit	Office: $75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth–Services provided by network providers through remote access technology including web and mobile devices.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$250 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition	Tier 1 – Preferred Generic Tier 2 – Non-Preferred Generic	$15 / 30-day supply	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or

More information about **prescription drug coverage** is available at https://capitalhealth.com/members/about-your-medications	Tier 3 – Preferred Brand	$50 / 30-day supply	Not Covered	quantity limits may apply. Your benefits/services may be denied. Retail or mail order, one copay per 30 day supply up to 90 days.
	Tier 4 – Non-Preferred Brand	$100 / 30-day supply	Not Covered	
	Specialty drugs Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty	$100 / 30-day supply	Not Covered	Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $250 / visit Hospital: $500 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$75 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$500 / visit $500 / observation	$500 / visit $500 / observation	Copayment is waived if inpatient admission occurs; however if moved to observation status an additional copayment may apply based on services rendered. .
	Emergency medical transportation	$250 / transport	$250 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 / visit	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 / visit	Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission $500 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted $75 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance	Outpatient services	$75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.

abuse services	Inpatient services	$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	$75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$75 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Glasses
- Habilitation services
- Hearing aids
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Dental care (Adult) • Dental care (Child)	• Infertility treatment • Long-term care	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic care	• Annual routine eye care (Adult)

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

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

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$2,500
Specialist copayment	$75
Hospital (facility) copayment	$500
Other copayment	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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

The plan's overall deductible	$2,500
Specialist copayment	$75
Hospital (facility) copayment	$500
Other copayment	$100

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,320**

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

The plan's overall deductible	$2,500
Specialist copayment	$75
Hospital (facility) copayment	$500
Other copayment	$0

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos Unterstützung zu erhalten. 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

آیا ناتوانی خاصی دارید؟ به زبانی بجز انگلیسی صحبت می کنید؟ برای دریافت کمک رایگان با این شماره ها تماس بگیرید. 1-877-247-6512، TTY/TDD 850-383-3534 یا 1-877-870-8943

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

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis? 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 1-877-247-6512, TTY/TDD 850-383-3534 lub 1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону: 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是残障人士吗？您不会说英语吗？请拨打电话以免费获取帮助。电话号码：1-877-247-6512；TTY/TDD（听障人士）：850-383-3534 或 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士? 您是否不會講英語? 請撥打電話以取得免費協助。
1-877-247-6512，聽障者請使用 TTY/TDD 850-383-3534 或 1-877-870-8943

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

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

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8 am – 5 pm at 850-383-3311 or 1-877-247-6512. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - February 14; 8:00 a.m. - 8:00 p.m., Monday - Friday, February 15 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 8:00 p.m.

Capital Health Plan contact information is located on our website: http://www.capitalhealth.com/Capital-Health-Plan/Contact-Us

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

amwell

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

DOWNLOAD NOW!

Search the App store or Google Play for Amwell

Step 1: Enroll to create your account
Step 2: Enter Service Key **CHP**
Step 3: Select the doctor you'd like to see

App Store | Google play

capitalhealth.com/amwell

amwell

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

You can use Amwell when:

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

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

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

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

Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

2018.03.003

Health Plan Benefits

Health Plans Contact Directory

Vendor	Member Services	Website
Capital Health Plan	850-383-3311	www.capitalhealth.com
Standard Insurance Company - Vision	800-877-7195	www.standard.com/services
Standard Insurance Company - Dental	800-547-9515	www.standard.com/services
USAble Life	800-333-3256	_

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

Dental Plan

Standard Insurance Company

Wakulla County School Board
Dental/Vision Rates
2024-2025

Rates
(10 pay/year)

	Dental High Plan	Dental Low Plan	Vision plan
Employee	$41.62	$28.99	$8.28
Employee/Spouse	$82.03	$57.12	$16.68
Employee/Child(ren)	$83.95	$65.57	$17.88
Family	$124.46	$94.66	$25.09

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

Your Dental Benefits Portal

How to log in and manage your benefits from any device

Access your Dental benefits from The Standard‡ using our secure member portal. It's designed to work on any web-enabled device. So you can check your Dental benefits, show your ID card or find a dentist anytime. **We're here to help make things easy. Let's get started.**

Log In or Register in 3 Simple Steps

1. **Go to standard.com/dental:**

   Choose where you receive your benefits.

   - Select "**Log In For Benefits,**" unless your employer is in New York.
   - Select "**Log In For Benefits (In NY)**" if your employer is in New York.

2. **Log in or register for a new account:**

   - Existing members: Choose "**Members**" and log in with your user ID and password, if you already have an account.
   - New members: Choose "**Members**," then "**New Users**" and register to create a user ID and password.

3. **If prompted, complete the 2-step verification process for security:**

   - Request a one-time security passcode by selecting your preferred contact method — text or a phone call.
   - Enter the code to verify your identity and complete your registration. You're all set!

Review Your Benefits or Select a Dentist

Once you're logged in, you can:

- Print an ID card
- Review your benefits summary or certificate
- Check the status of claims
- Review your Explanation of Benefits
- Find or suggest a dental provider

Need help logging in?

Please contact your HR department. Or call The Standard's Dental customer service team at **800.547.9515.** If your employer is based in New York, call **888.396.8641.** You can count on us for fast answers and support.

‡ The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of 1100 SW Sixth Avenue of Portland, Oregon, in all states except New York, where insurance products are offered by The Standard Life Insurance Company of New York of 333 Westchester Avenue, West Building, Suite 300, White Plains, New York. Product features and availability vary by state and company, and are solely the responsibility of each subsidiary. Each company is solely responsible for its own financial condition. Standard Insurance Company is licensed to solicit insurance business in all states except New York. The Standard Life Insurance Company of New York is licensed to solicit insurance business in only the state of New York.

19615

Dental Portal Login Flyer
(1/19) SI/SNY

Wakulla County School Board

Group Dental Insurance

Help protect your oral health with regular dental exams and procedures.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered dental care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Low Plan 1: Dental Plan Summary **Effective Date: 10/1/2024**

Plan Benefit	In Network	Out of Network
Type 1 (Preventive)	100%	100%
Type 2 (Basic)	80%	80%
Type 3 (Major)	50%	50%
Waiting Period	None	None
Deductible	$50/Calendar Year	$50/Calendar Year
	Type 1,2,3	Type 1,2,3
	No Family Maximum	No Family Maximum
Maximum *(per person)*	$750 per calendar year	$750 per calendar year
Max Keeper	Included	Included
Allowance	90% usual and customary	90% usual and customary
Max Builder℠	Included	Included
Annual Eye Exam	None	None
Annual Open Enrollment	Included	Included

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 in 6 months) • Sealants (age 13 and under)	• Periapical X-rays • Space Maintainers • Restorative Amalgams • Restorative Composites (anterior and posterior teeth) • Denture Repair • Simple Extractions • Complex Extractions	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) • Anesthesia

Tenthly Rates	
Employee Only (EE)	$28.99
EE + Spouse	$57.12
EE + Children	$65.57
EE + Spouse & Children	$94.66

WAKULLA COUNTY SCHOOL BOARD

Max Builder℠

This dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. A participant must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount. Earns an extra reward, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards will be lost; but he or she can begin earning rewards again the very next year.

Benefit Threshold	$250	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$125	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$50	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$500	Maximum possible accumulation for Max Builder and PPO Bonus combined

Max Keeper

With this plan option, benefits for Type 1/Preventive procedures are not deducted from the plan participant's annual maximum benefit. This saves the entire annual maximum for the Type 2/Basic and Type 3/Major procedures that are covered by your plan.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member provider are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit **http://www.standard.com/services** and click on "Find a Dentist."

Your provider network is Classic Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1. If you do not enroll during your company's open enrollment period, then you will be subject to the Late Entrant Provision.

Submitting a claim

Your policy requires all claims be received by The Standard within 90 days of the date of service. You may submit a claim, or your Dentist can file your claim on your behalf and you can assign payment to your Dentist. If the 90 day deadline is missed, you will be responsible for covering the cost of the service. *Requirements for claims submission vary by state, please consult your group certificate for details.

WAKULLA COUNTY SCHOOL BOARD

Prior Extraction Limitation

Your policy has a prior extraction limitation, also known as the "missing tooth clause". This means that if you had a tooth extracted prior to enrolling in your plan with The Standard, we may or may not pay for any benefits towards replacing that tooth. Please review your policy or contact Customer Service for details.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Customer Service

Customer service is available to plan participants through our well-trained and helpful service representatives. Call or go online to locate the nearest network provider, view plan benefit information and more.

Call Center: 800.547.9515

- Service representative hours:
  5 a.m. to 10 p.m. Pacific Monday through Thursday
  5 a.m. to 4:30 p.m. Pacific Friday
- Interactive Voice Response available 24/7

View plan benefit information at:
www.standard.com/services.

About The Standard

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

Standard Insurance Company

WAKULLA COUNTY SCHOOL BOARD

Group Dental Insurance

Help protect your oral health with regular dental exams and procedures.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered dental care services. NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 2: HIGH Dental Plan Summary **Effective Date: 10/1/2024**

Plan Benefit	In Network	Out of Network
Type 1 (Preventive)	100%	100%*
Type 2 (Basic)	90%	80%*
Type 3 (Major)	60%	50%*
Waiting Period	None	
Deductible	$0/Calendar Year Type 2,3	$0/Calendar Year Type 2,3
	Waived Type 1	Waived Type 1
	No Family Maximum	No Family Maximum
Maximum *(per person)***	$1,000 per calendar year	$1,000 per calendar year
Max Keeper	Included	Included
Allowance	Discounted Fee	90% usual and customary
Max Builder℠	Included	Included
Annual Eye Exam	None	None
Annual Open Enrollment	Included	Included

**If you go to an out of network Dentist, you will be responsible for paying the difference between what the Dentist submits for payment and the amount we pay.*

***Maximum is per calendar year for both in network and out of network.*

HIGH PLAN

Employee	$41.62
Employee and Spouse	$82.03
Employee and Child(ren)	$83.95
Family	$124.46

Standard Insurance Company

WAKULLA COUNTY SCHOOL BOARD

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

In Network		
Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 in 6 months) • Sealants (age 13 and under)	• Periapical X-rays • Space Maintainers • Fillings for Cavities • Restorative Composites (anterior and posterior teeth) • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) • Anesthesia
Out of Network		
Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 in 6 months) • Sealants (age 13 and under)	• Periapical X-rays • Space Maintainers • Fillings for Cavities • Restorative Composites (anterior and posterior teeth) • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) • Anesthesia

Max Builder℠

This dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. A participant must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount. Earns an extra reward, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards will be lost; but he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

Max Keeper

With this plan option, benefits for Type 1/Preventive procedures are not deducted from the plan participant's annual maximum benefit. This saves the entire annual maximum for the Type 2/Basic and Type 3/Major procedures that are covered by your plan.

Wakulla County School Board

Max Keeper

With this plan option, benefits for Type 1/Preventive procedures are not deducted from the plan participant's annual maximum benefit. This saves the entire annual maximum for the Type 2/Basic and Type 3/Major procedures that are covered by your plan.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member provider are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit **http://www.standard.com/services** and click on "Find a Dentist."

Your provider network is Classic Network.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on October 1. If you do not enroll during your company's open enrollment period, then you will be subject to the Late Entrant Provision.

Submitting a claim

Your policy requires all claims be received by The Standard within 90 days of the date of service. You may submit a claim, or your Dentist can file your claim on your behalf and you can assign payment to your Dentist. If the 90 day deadline is missed, you will be responsible for covering the cost of the service. *Requirements for claims submission vary by state, please consult your group certificate for details.

Prior Extraction Limitation

Your policy has a prior extraction limitation, also known as the "missing tooth clause". This means that if you had a tooth extracted prior to enrolling in your plan with The Standard, we may or may not pay for any benefits towards replacing that tooth. Please review your policy or contact Customer Service for details.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Wakulla County School Board

Customer Service

Customer service is available to plan participants through our well-trained and helpful service representatives. Call or go online to locate the nearest network provider, view plan benefit information and more.

Call Center: 800.547.9515

- Service representative hours:
  5 a.m. to 10 p.m. Pacific Monday through Thursday
  5 a.m. to 4:30 p.m. Pacific Friday
- Interactive Voice Response available 24/7

View plan benefit information at:
www.standard.com/services.

About The Standard

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

Standard Insurance Company

WAKULLA COUNTY SCHOOL BOARD

Group Vision Insurance

Help protect your eye health with coverage for exams, glasses and contacts.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered vision care services. NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 1: Balanced Care Vision I Plan Summary **Effective Date: 10/1/2024**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to $60	Not covered
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$130**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/12	12/12/12
	Based on date of service	Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

Lens Options (participant cost)*

	VSP Choice Network + Affiliates	Out of Network
	(Other than Costco)	
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	Not covered
Solid Plastic Dye	$15 (except Pink I & II)	Not covered
Plastic Gradient Dye	$17	Not covered
Photochromatic Lenses (Glass & Plastic)	$31-$82	Not covered
Scratch Resistant Coating	$17-$33	Not covered
Anti-Reflective Coating	$43-$85	Not covered
Ultraviolet Coating	$16	Not covered

**Lens Option participant costs vary by prescription, option chosen and retail locations.*

WAKULLA COUNTY SCHOOL BOARD

Additional Balanced Care Vision I Choice Network Features	
Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Vision Plan Participant Service

Balanced Care Vision I from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 800.877.7195

- Service representative hours: 5 a.m. to 7 p.m. Pacific Monday through Friday, 6 a.m. to 2:30 p.m. Pacific Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at:
www.standard.com/services

Wakulla County School Board

About The Standard

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The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

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

FOR ALL ACTIVE FULL TIME EMPLOYEES

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

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

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

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

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

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

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

DEPENDENT LIFE	EMPLOYER CONTRIBUTION: 0%

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

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

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

Employee $6.12 (10-Month Rate)

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

USAble Life

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

FOR ALL RETIREES

GROUP TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT	**EMPLOYER CONTRIBUTION:** 0%

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

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

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

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

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

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

DEPENDENT LIFE	**EMPLOYER CONTRIBUTION: 0%**

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

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

Benefits terminate when you are no longer eligible.

RETIREES $38.40 (Annual) *DEPENDENT $34.80 (Annual)*

Important Note

This benefit summary provides a very brief description of USAble Life's insurance products. This is not an insurance policy and only the actual provisions of an issued policy control. USAble Life's policies set forth the rights and obligations of covered persons and USAble Life. Please be aware that certain limitations and exclusions may apply, and certain coverage may reduce or terminate due to age or lack of eligibility. If you enroll and are approved for coverage, you will be furnished with a certificate of insurance. Please read your insurance documents carefully.

This benefit summary was generated by USAble Life on 7/16/2019 at 1:40 PM and may not reflect changes recently submitted to USAble Life.

Long-Term Disability Income Insurance

American Fidelity Assurance Company

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

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

How the Plan Works

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

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

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

Learn more at americanfidelity.com/info/disability

Universal Life Insurance

Texas Life Insurance Company

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

Universal Life Insurance

(PureLife-Plus)

A voluntary permanent[1] life insurance product that guarantees life insurance to age 121. *(Underwritten by Texas Life Insurance Company)*

Did You Know?

More than 100 million individuals in the United States don't have sufficient coverage to provide their families with financial security in case of a tragedy.[2]

Voluntary permanent life insurance can be an ideal complement to the Group Life Insurance coverage provided by your employer. Ask your AFES or AWD representative about the benefits of owning voluntary permanent life, the coverage you can keep after your employment ends.

Consider a PureLife-Plus Contract!

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

- Guaranteed death benefit to age 121.[1]
- Minimal cash value – premiums dedicated primarily to the purchase of life insurance.
- Long premium guarantees.[3]
- Limited right to partial refund of premium if future premium required to continue coverage increases.[3] (Conditions apply)
- Take it with you when you leave employment.
- Coverage available for employee, spouse, children and grandchildren.[4]

Coverage Feature	What It Means To You
Several Product Options	Choose the coverage to meet your financial needs.
Guaranteed Premium[3]	Your premiums are guaranteed for each applicable period.
Guaranteed Death Benefit[5]	Your death benefit is guaranteed for the life of the contract provided premiums are paid when due.
Interim Coverage[6]	Coverage normally begins when you complete the application and the authorization for your employer to deduct premiums from your paycheck. Two year suicide and contestability provisions apply. (one year in ND).
Enhance Your Coverage	Additional riders may be available on certain products to expand your policy.
Easy Application	No medical exams and minimal health questions.[7]
Portable	You own the policy. Take the coverage with you if you choose to leave your current job.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

This product is not available in NY and is not generally qualified under Section 125 Plans. Underwritten by Texas Life Insurance Company. Not affiliated with American Fidelity Assurance Company.

[1]Provided required premiums are paid timely.
[2]Insurance Barometer Study, 2021. Life Happens & LIMRA, p8.
[3]After the guaranteed period, premiums may go down, stay the same or go up.
[4]Coverage not available in WA on children or on grandchildren in WA or MD. In MD, child must reside with the applicant to be eligible for coverage.
[5]Some limitations apply. See brochure for details.
[6]Conditions apply. In Kansas, Temporary Insurance applies. Form 16M050.
[7]Issuance of this policy may depend on the answer to these questions.

As with most life insurance products, Texas Life contracts and riders contain certain exclusions, limitations, exceptions, reductions of benefits, waiting periods and terms for keeping them in force. Please see product summaries for costs and complete details. Flexible Premium Adjustable Life Insurance to age 121. PureLife-plus is underwritten and issued by Texas Life Insurance Company, 900 Washington Avenue, Waco, Texas 76701. Texas Life is licensed to do business in the District of Columbia and every state but NY. See the PureLife-plus brochure for details. Form ICC18-PRFNG-NI-18, Form Series PRFNG-NI-18 or PRFNG-NI-20-OHIO.

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Accident Only Insurance

Limited Benefit Accident Only Insurance

American Fidelity Assurance Company

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

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

How the Plan Works

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

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

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

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details, AO-03 series with AMDI258 rider. **This product is inappropriate for people who are eligible for Medicaid coverage.** The premium and amount of benefits provided vary dependent upon the plan selected. The company has the right to change premiums by class. The Wellness Benefit is not available in all states.

Cancer Insurance

Limited Benefit Cancer Insurance Policy

American Fidelity Assurance Company

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

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

How the Plans Work

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

Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider**
  May include option to choose lump sum benefit for diagnosis of internal cancer only, heart attack/stroke (first to occur) only or both.
- **Hospital Intensive Care Unit Rider**

Learn more at americanfidelity.com/info/cancer.

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

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected. Availability of riders may vary by state. Diagnostic and Prevention Benefit is not available in all states.

Hospital GAP PLAN® Insurance

Hospital Limited Benefit Medical Expense Insurance

American Fidelity Assurance Company

Limited Benefit Hospital GAP PLAN® Insurance from American Fidelity Assurance Company can help policyholders pay for their out-of-pocket expenses. Supplementing their major medical insurance with gap insurance can help cover their expenses so they can focus on getting well.

Three Primary Benefits

- **In-Hospital****
- **Outpatient**
- **Physician Outpatient Treatment**

**"Hospital" shall not include any institution used as a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long term nursing unit or geriatrics ward, or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Learn more at americanfidelity.com/info/gap-insurance.

Coverage Feature	What It Means for the Policyholder
In-Hospital Benefit	This is payable for covered for out-of-pocket expenses up to the maximum benefit selected per confinement.
Outpatient Benefit	This is payable for the difference between the actual outpatient expenses incurred and the amount paid by the primary medical plan for out-of-pocket Covered Charges up to a maximum outpatient benefit of $200.00 for outpatient treatment in a Hospital emergency room, outpatient surgery in a Hospital outpatient facility or free-standing outpatient surgery center, and diagnostic testing in a Hospital outpatient facility or MRI facility. All benefits for the same or related conditions will be subject to the maximum outpatient benefit, unless such conditions are separated by 90 consecutive days, then a new maximum outpatient benefit will apply.
Physician Outpatient Treatment Benefit	This is payable for Physician visits. This benefit pays up to $25.00 per visit, for up to five visits ($125.00) per family per calendar year, for outpatient treatment due to Sickness, or outpatient emergency care for an injury due to an Accident, provided the Covered Person is covered by Another Medical Plan when such charges are incurred, at a Hospital outpatient clinic, free-standing emergency care clinic, or Physician office for out-of-pocket Covered Charges.

THIS IS A LIMITED POLICY. This highlights the important features of the policy. Limitations, exclusions, and waiting periods apply. Refer to the policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. If the policyholder resides in a state other than their employer's state of domicile, where required by law, policy provisions and benefits may vary.

Group Hospital Indemnity Insurance

Limited Benefit Group Hospital Indemnity Insurance ***American Fidelity Assurance Company***

If you experienced a medical emergency, would you be prepared to cover the out-of-pocket medical expenses? And, what about everything else that adds up—like bills, groceries, and housing?

Major medical insurance plans are designed to pay a large portion of your medical costs. But with a high deductible plan, you must pay out of your own pocket until you meet your deductible and plan maximum. That's where AF Hospital Assist™ can help.

How the Plan Works

Limited Benefit Group Hospital Indemnity Insurance, or AF Hospital Assist™, is a Health Savings Account (HSA)-qualified plan designed to help pay for out-of-pocket expenses, like a hospital stay, while also allowing the tax benefit and potential savings from an HSA.

This plan provides benefits paid directly to you if you're hospitalized or suffer injuries resulting from an accident.

Hospital shall not include an institution used by you as a place for rehabilitation; a place for rest or for the aged; a nursing or convalescent home; a long-term nursing unit or geriatric ward; or an extended care facility for the care of convalescent, rehabilitative, or ambulatory patients.

Learn more at americanfidelity.com/info/hospital-indemnity

Coverage Feature	What It Means For You
Simplified underwriting	No medical exams or health questions are required to apply
Health Savings Account compatible	Help offset your high deductible while allowing your HSA savings to grow
Multiple plan options: Basic, Enhanced, Enhanced Plus	Choose the plan to meet your financial needs
Three choices of coverage: You, your spouse, and your children	Choose the coverage that best fits your lifestyle
Benefits paid directly to you	Use the money however best fits your needs
Guaranteed renewable	Keep the policy as long as premiums are paid
Portable	Take the policy with you even if you change employers

This product may contain limitations, exclusions and waiting periods. **This product is inappropriate for people who are eligible for Medicaid coverage.** The insurer has the right to increase premiums.

Group Critical Illness Insurance

Limited Benefit Group Critical Illness Insurance Policy

American Fidelity Assurance Company

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

American Fidelity Assurance Company's Limited Benefit Critical Illness Insurance can be the solution that helps you and your family focus on recovery, and may help you with paying bills. Our plan can assist with the expenses that may not be covered by major medical insurance. You may also have the option to add an infectious disease rider to this policy in select states.

How the Plan Works

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

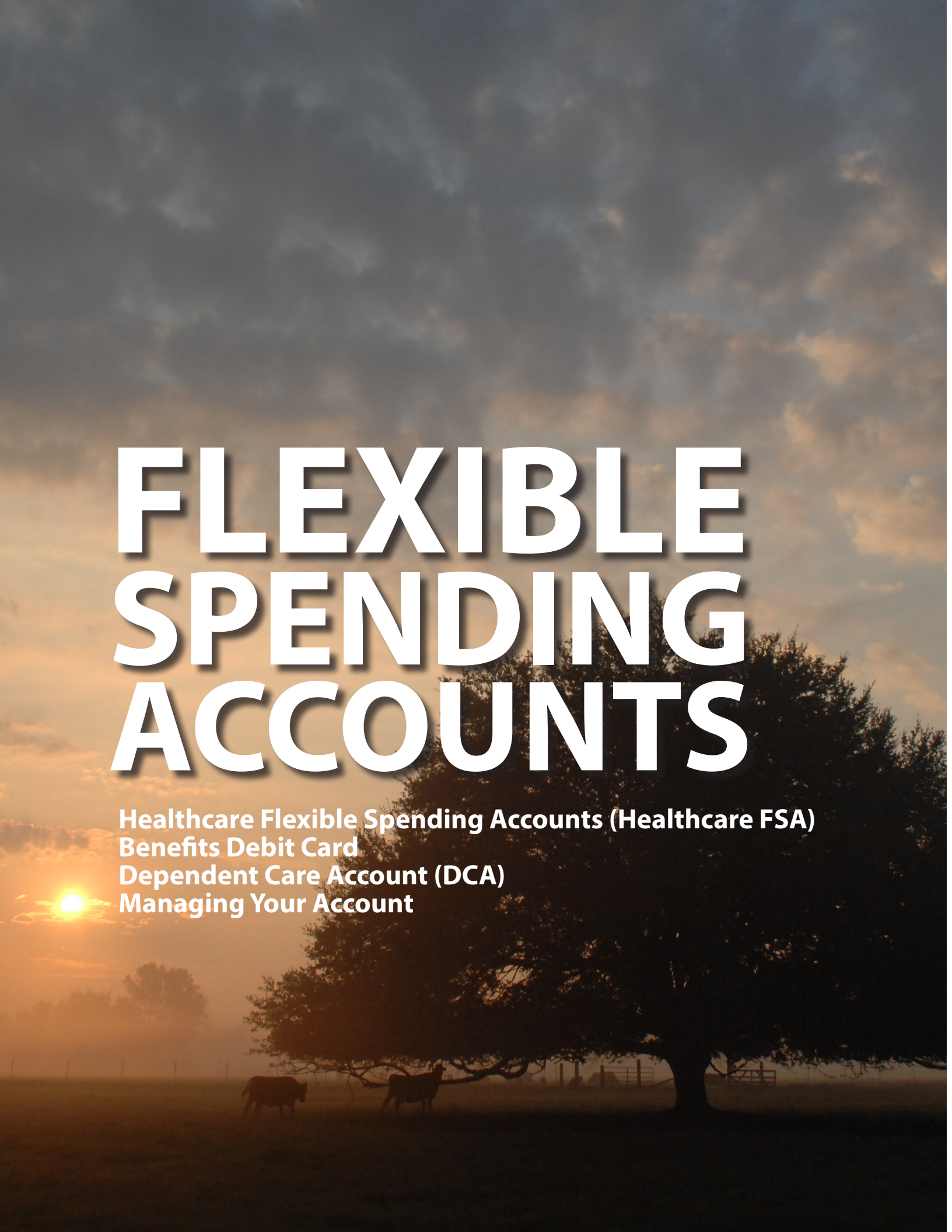
Guaranteed Renewable

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

Learn more at americanfidelity.com/info/critical-illness.

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

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**.



FLEXIBLE SPENDING ACCOUNTS

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

Flexible Spending Accounts

American Fidelity Assurance Company

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

Flexible Spending Account Savings Example

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

* Estimated state 5% and federal 15%.

Grace Period

When an employer has chosen to include a Grace Period (GP) for their Healthcare FSA (HCFSA) and/or Limited Purpose FSA (LPFSA), participants have 2 months and 15 days after the end of the current plan year to continue to incur eligible expenses for reimbursement.

In addition to the GP, employers' Section 125 Plans also have a Run-Off Period of 3 months after the end of the plan year, and it applies to the HCFSA and LPFSA. The Run-Off is to allow participants to submit claims incurred in both the current plan year and the Grace Period. For a calendar year, a GP would end on 3/15 and the Run-Off would end on 3/31. So, a participant would have until 3/15 to "incur" and until 3/31 to "submit" their eligible expenses for reimbursement. After 3/31, any remaining FSA funds from the plan year that ended on 12/31 would be forfeited by the participant. The forfeitures are not retained by AF. After year-end reconciliation, any plan forfeitures returned to the employer are handled in accordance with IRS guidelines.

Healthcare Flexible Spending Account (Healthcare FSA)

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

Minimum Annual Election: $300.

Maximum Annual Election: Internal Revenue Code allows up to $3,200 per plan year, the employer may set the maximum equal to or lower than this amount.

Examples of Eligible Expenses for Healthcare FSA

Copays/coinsurance

Deductibles

Dental treatments

Diabetic supplies

Prescription drugs and medicines

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

Flu shots

Immunizations

Lab fees

Laser/Lasik/RK surgery

Medical exams

Orthodontia

Psychiatric care

Wheelchair

X-rays

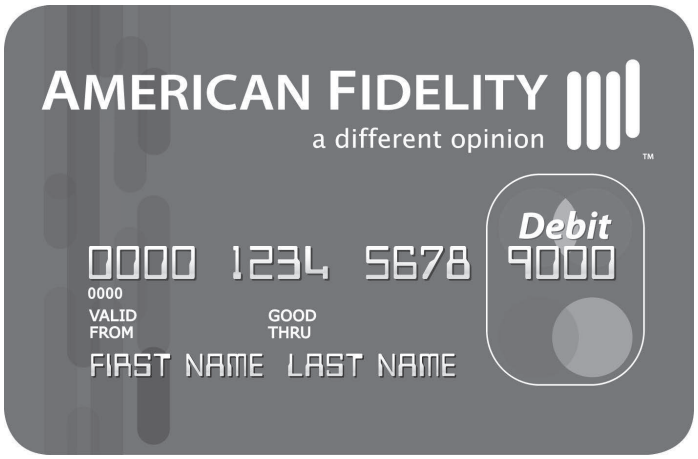
Link- americanfidelity.com

For a complete list of eligible expenses, please visit: https://americanfidelity.com/claims/fsa-hsa-eligibility-list/

Flexible Spending Accounts

Benefits Debit Card

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



Using Your Benefits Debit Card

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

Cards for Healthcare FSAs can be used at:

- Health care related facilities which include: hospitals, physician offices, dental offices, vision offices; and,
- Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.

Snap. Submit. And Go!

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

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

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

Activating Your Card

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

Flexible Spending Accounts

American Fidelity Assurance Company

Dependent Care Account (DCA)

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

Minimum Annual Election: $300.

Maximum Annual Election: While the IRC allows a maximum of $5,000 per year, the employer may set the maximum equal to or lower than this amount.

Examples of Eligible Dependent Care Expenses

After-school care or extended day programs

Nanny expenses

Baby-sitter inside or outside participant's household

Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household

Dependent Day Care center* expenses/pre-kindergarten/nursery school expense

Expenses paid to a non-dependent relative of participant to care for the child

Summer day camp if the primary purpose of the expense is custodial in nature and not educational

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

**A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.*

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

FSA Funds Availability

Healthcare FSA

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

Dependent Care Account

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

Important FSA Notes:

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

Flexible Spending Accounts

File a Claim

Three Easy Ways

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

Use AFmobile to manage your reimbursement accounts and insurance benefits.

2. **Online at americanfidelity.com**

3. **By mail or fax**

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

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

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

Manage Your Reimbursement Account With AFmobile®

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

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

Getting Started:

Download AFmobile. To register, you will need:

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

Using Our Online Portal

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

Getting started:

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

Direct Deposit

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

Three ways to sign up for direct deposit:

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

Other Information

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

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

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

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

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

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

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

Other Information

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

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

☐ **Yes** (Continue)

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

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

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

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

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

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

Date of change (mm/dd/yyyy):

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

Other Information

Health Benefit Measurement Period Policy

A. **Measurement Period**

a. Initial Measurement Period

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

b. Standard Measurement Period

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

B. **Administrative Period**

a. Initial Administrative Period

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

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

b. Standard Administrative Period

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

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

C. **Stability Period**

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

a. Initial Stability Period

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

b. Standard Stability Period

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

Example:

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

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

Other Information

Payroll Deduction Directory

AIG/Valic*	800-633-8960
American Century Investment/Aspire-IPX*	888-684-6653
American Fidelity Assurance Co	800-323-3748
AXA Equitable*	800-628-6673
Capital Health Plan	850-383-3311
Financial Resources/Security Benefit Group*	800-747-5164
Florida Retirement System	850-907-6500
ING/Voya*	877-884-5050
Mid-America	855-329-0097
National Life Group	877-603-4032
Nationwide/Fiduciary Trust Co.*	800-548-6463
Oppenheimer Funds/Invesco*	800-835-7305
Plan Member Services*	800-874-6910
Standard Insurance Company-Dental	800-547-9515
Standard Insurance Company-Vision	800-877-7195
Texas Life Insurance	800-283-9233
USAble Life	800-333-3256
United Way	850-414-0844
Valery Insurance Agency	800-330-8845
Wakulla Insurance Agency HUB Florida	850-926-7900
Wakulla Senior Citizens Center	850-926-7145
Washington National Insurance	800-541-2254

403(b) Tax Sheltered Annuities (TSA)

Meaningful Notice

Wakulla County School District, FL

MEANINGFUL NOTICE / PLAN SUMMARY INFORMATION 2024

403(b) PLAN

The 403(b) Plan is a valuable retirement savings option. This notice provides a brief explanation of the provisions, policies and rules that govern the 403(b) Plan offered.

Plan administration services for the 403(b) plan are provided by U.S. OMNI & TSACG Compliance Services. Visit the U.S. OMNI & TSACG Compliance Services' website *(https://www.tsacg.com)* for information about enrollment in the plan, investment product providers available, distributions, enrollment, exchanges or transfers, 403(b) loans, and rollovers.

ELIGIBILITY
Most employees, with the exception of private contractors, appointed/elected trustees and/or school board members are eligible to participate in the 403(b) plan immediately upon employment. Please verify if your employer allows student workers to participate in the 403(b) plan. Eligible employees may make voluntary elective deferrals to the 403(b) plan. Participants are fully vested in their contributions and earnings at all times.

EMPLOYEE CONTRIBUTIONS
Traditional 403(b)
Upon enrollment, participants designate a portion of their salary that they wish to contribute to their traditional 403(b) account up to their maximum annual contribution amount on a pre-tax basis, thus reducing the participant's taxable income. Salary deferral contributions to the participant's 403(b) account are made from income paid through the employer's payroll system. Taxes on contributions and any earnings are deferred until the participant withdraws their funds.

Roth 403(b)
Contributions made to a Roth 403(b) account are after-tax deductions from your paycheck. Income taxes are not reduced by contributions you make to your account. All qualified distributions from Roth 403(b) accounts are tax-free. Any earnings on your deposits are not taxed as long as they remain in your account for five years from the date that your first Roth contribution was made. Distributions may be taken if you are 59½ (subject to plan document provisions) or at separation from service.

The Internal Revenue Service regulations limit the amount participants may contribute annually to tax-advantaged retirement plans and imposes substantial penalties for violating contribution limits. U.S. OMNI & TSACG Compliance Services monitors 403(b) plan contributions and notifies the employer in the event of an excess contribution.

THE BASIC CONTRIBUTION LIMIT FOR 2024 IS $23,000.
Additional provisions allowed:

AGE-BASED ADDITIONAL AMOUNT
Participants who are age 50 or older any time during the year qualify to make an additional contribution of up to $7,500.

THE SERVICE-BASED CATCH UP AMOUNT
The special catch-up provision allows participants to make additional contributions of up to $3,000 if, as of the preceding calendar year, the participant has completed 15 or more full years of employment with the current employer, not averaged over $5,000 per year in annual contributions, and has not utilized catch-up contributions in excess of the aggregate of $15,000. For a detailed explanation of this provision, please visit *https://www.tsacg.com*.

ENROLLMENT
Employees who wish to enroll in the 403(b) plan must first select the provider and investment product best suited for their 403(b) account. Upon establishment of the account with the selected provider, a "Salary Reduction Agreement" (SRA) form and any disclosure forms must be completed and submitted to the employer. This form authorizes the employer to withhold 403(b) contributions from the employee's pay and send those funds to the Investment Provider on their behalf. A SRA must be completed to start, stop or modify contributions to a 403(b) account. Unless otherwise notified by your employer, you may enroll and/or make changes to your current contributions anytime throughout the year.

Please note: The total annual amount of a participant's contributions must not exceed the Maximum Allowable Contribution (MAC) calculation. For convenience, a MAC calculator is available at https://www.tsacg.com.

Meaningful Notice

INVESTMENT PROVIDER INFORMATION
A current list of authorized 403(b) Investment Providers and current employer forms are available on the employer's specific Web page at *https://www.tsacg.com*.

PLAN DISTRIBUTION TRANSACTIONS
Distribution transactions may include any of the following depending on the employer's Plan Document: loans, transfers, rollovers, exchanges, hardships, withdrawals or distributions. Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. All completed forms should be submitted to the plan administrator for processing. Prior to taking a loan, participants should consult a tax advisor.

PLAN-TO-PLAN TRANSFERS
A plan-to-plan transfer is defined as the movement of a 403(b) account from a previous plan sponsor's plan and retaining the same account with the authorized investment provider under the new plan sponsor's plan.

ROLLOVERS
Participants may move funds from one qualified plan account, i.e. 403(b) account, 401(k) account or an IRA, to another qualified plan account at age 59½ or when separated from service. Rollovers do not create a taxable event.

DISTRIBUTIONS
Retirement plan distributions are restricted by IRS regulations. A participant may not take a distribution of 403(b) plan accumulations unless they have attained age 59½ or separated from service. In most cases, any withdrawals made from a 403(b) account are taxable in full as ordinary income.

EXCHANGES
Participants may exchange account accumulations from one 403(b) investment provider to another 403(b) investment provider that is authorized under the plan; however, there may be limitations affecting exchanges, and participants should be aware of any charges or penalties that may exist in individual investment contracts prior to exchange.

403(b) PLAN LOANS
Participants may be eligible to borrow their 403(b) plan accumulations depending on the provisions of their 403(b) account contract and provisions of the employer plan. If loans are available, they are generally granted for a term of five years or less (general-purpose loans). Loans taken to purchase a principal residence can extend the term beyond five years depending on the provisions of their 403(b) account contract and provisions of the employer. Details and terms of the loan are established by the provider. Participants must repay their loans through monthly payments as directed by the provider.

HARDSHIP WITHDRAWALS
Participants may be able to take a hardship withdrawal in the event of an immediate and heavy financial need. To be eligible for a hardship withdrawal according to IRS Safe Harbor regulations, you must certify and may be asked to provide evidence that the distribution is being taken for specific reasons. These eligibility requirements to receive a Hardship withdrawal are provided on the Hardship Withdrawal Disclosure form at *https://www.tsacg.com*.

EMPLOYEE INFORMATION STATEMENT
Participants in defined contribution plans are responsible for determining which, if any, investment vehicles best serve their retirement objectives. The 403(b) plan assets are invested solely in accordance with the participant's instructions. The participant should periodically review whether his/her objectives are being met, and if the objectives have changed, the participant should make the appropriate changes. Careful planning with a tax advisor or financial planner may help to ensure that the supplemental retirement savings plan meets the participant's objectives.

Other Information

Direct Deposit

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

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

All bank changes must be in writing. If your bank account is closed after Payroll has processed paychecks, it will take 3 to 5 business days for the funds to be returned to the School Board account and a check to be issued to you. Please make all changes by the date listed in the "Due in County Office" section of the Payroll Reporting Salary Schedule (on page 55) for that particular paycheck date.

Twelve (12) Check Proration

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

The two (2) "summer checks" do not contain salary supplements that may have been received during the School Year. Additionally, no payroll deductions are made from these checks other than required taxes , retirement and court orders. These checks are usually ready by mid-June. Please see the Payroll Reporting Salary Schedule (on page 57) for those exact dates.

Certified personnel and all 12 month personnel automatically receive twelve (12) checks. These checks are paid on the last working day of each month. Please see the Payroll Reporting Salary Schedule on page 57 for the exact dates.

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

Salary Schedule

OPEN ENROLLMENT ENDS AUGUST 23, 2024

PAYROLL BEGINS	PAYROLL ENDS	DAYS IN PERIOD	DUE IN COUNTY OFFICE	DATE EMPLOYEES RECEIVE CHECKS
		10 MONTH EMPLOYEES		
08-05-24	08-29-24	19	08-15-24	08-30-24
08-30-24	09-25-24	19	09-16-24	09-30-24
09-26-24	10-22-24	19	10-16-24	10-31-24
10-23-24	11-19-24	20	11-07-24	11-22-24
11-20-24	12-25-24	20	12-05-24	12-20-24
01-01-25	01-28-25	18	01-15-25	01-31-25
01-29-25	02-25-25	18	02-11-25	02-28-25
02-26-25	03-31-25	19	03-07-25	03-31-25
04-01-25	04-28-25	19	04-14-25	04-30-25
04-29-25	05-27-25	20	05-08-25	05-30-25

All absentees of 10 month employees during May 8th thru May 27, 2025, will be reported June 3, 2025.
10 month employees will receive their June and July checks direct deposited on June 26 and June 30, 2025.

		9 1/2 MONTH EMPLOYEES		
*Advance Request			08-23-24	08-30-24
08-05-24	08-28-24	18	08-29-24	09-13-24
08-29-24	09-24-24	18	09-30-24	10-15-24
09-25-24	10-21-24	19	10-25-24	11-15-24
10-22-24	11-18-24	19	11-18-24	12-13-24
11-19-24	12-20-24	19	12-18-24	01-15-25
01-06-25	01-30-25	18	01-31-25	02-13-25
01-31-25	02-27-25	18	02-28-25	03-14-25
02-28-25	04-01-25	18	04-01-25	04-15-25
04-02-25	04-29-25	19	04-30-25	05-15-25
04-30-25	05-27-25	19	05-15-25	06-02-25

All absentees of 9 1/2 month employees during May 15 thru May 27, 2025, will be reported by email.
Any remaining substitute hours will be due May 29, 2025.
Employees requesting 12 checks will have their July and August checks direct deposited on June 12 and June 13, 2025.

		9 MONTH EMPLOYEES		
*Advance Request			08-23-24	08-30-24
08-12-24	09-03-24	16	08-30-24	09-13-24
09-04-24	09-27-24	17	10-01-24	10-15-24
09-30-24	10-23-24	17	10-29-24	11-15-24
10-24-24	11-19-24	18	11-20-24	12-13-24
11-20-24	12-20-24	18	12-18-24	01-15-25
01-07-25	01-31-25	17	01-31-25	02-13-25
02-03-25	02-28-25	18	02-28-25	03-14-25
03-03-25	04-02-25	18	04-02-25	04-15-25
04-03-25	04-29-25	18	04-30-25	05-15-25
04-30-25	05-23-25	18	05-15-25	06-02-25

All absentees of 9 month employees during May 15 thru May 23, 2025, will be reported by email.
Any remaining substitute hours will be due May 29, 2025.
Employees requesting 12 checks will have their July and August checks direct deposited on June 12 and June 13, 2025.

		12 MONTH EMPLOYEES		
07-01-24	07-31-24	23	07-17-24	07-31-24
08-01-24	08-30-24	22	08-19-24	08-30-24
09-02-24	09-30-24	21	09-18-24	09-30-24
10-01-24	10-31-24	23	10-18-24	10-31-24
11-01-24	11-29-24	21	11-12-24	11-22-24
12-02-24	12-31-24	22	12-09-24	12-20-24
01-01-25	01-31-25	23	01-17-25	01-31-25
02-03-25	02-28-25	20	02-18-25	02-28-25
03-03-25	03-31-25	21	03-12-25	03-31-25
04-01-25	04-30-25	22	04-16-25	04-30-25
05-01-25	05-30-25	22	05-12-25	05-30-25
06-02-25	06-30-25	21	06-12-25	06-30-25

*The Superintendent is authorized to issue salary payments on August 30, 2024 as requested, not to exceed 1/2 the first monthly payroll.

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

Wakulla County Schools Employee 2024-2025 Benefits Enrollment

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

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

Wakulla Insurance Agency

68-C Feli Way
Crawfordville, Florida 32327
(850) 926-7900

HUB
Division of HUB FLORIDA.

Benefits Directory

Medical Benefits

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

Dental Insurance

Standard Insurance Company
800-547-9515
www.standard.com/services

Vision Insurance

Standard Insurance Company
800-877-7195
www.standard.com/services

Voluntary Insurance Benefits

American Fidelity Assurance Company
Disability Income, Cancer, Accident, Term & Whole Life, Critical Illness, Hospital GAP and Hospital Indemnity
9000 Cameron Parkway
Oklahoma City, Oklahoma 73114
800-662-1113
www.americanfidelity.com

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

Section 125 Services & Flexible Spending Accounts

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