The School Board of Sarasota County (SBSC) provides a core benefits package with no contributions required to all eligible employees with coverage in:

- Medical Insurance
- Telemedicine
- Dental Insurance
- Long Term Disability Insurance
- Vision Insurance
- Group Term Life Insurance

Optional Benefits

You have the opportunity to purchase coverage in any of these optional plans:

- Dependent Medical Insurance
- Dependent Dental Insurance
- Dependent Vision Insurance
- Voluntary Term Life Insurance
- Voluntary Dependent Term Life Insurance
- Short-Term Disability Insurance
- Critical Illness Insurance
- Accident Insurance
- Whole Life Insurance

You can also make pre-tax contributions to:

- Flexible Spending Account (FSA) Medical and/or Dependent Care
- 401(k), Roth 401(k), 403(b), Roth 403(b), and 457(b) Retirement Plans

**NEW for 2019!**

- Teladoc – Value Added Benefit
- Enhancements to PPO Plans
- Enhancements to Vision Plan
- New Long Term Disability Carrier
- New Life carrier

Who’s Eligible

As a regular, full-time Board appointed employee of the SBSC who works at least 20 hours per week, you can enroll in the benefit plans offered in this guide.

You can also enroll your dependents (when eligible), including:

- Your legal spouse
- Your children who are:
  - Younger than 26 years old
  - 26 years old or older, supported primarily by you, and incapable of self-sustaining employment by reason of mental or physical handicap (proof of their condition and dependence must be submitted)
  - 26-30 year-old eligible adult dependent children (medical and dental only; not vision)*

**Dependent Verification:**

If you are adding dependent(s) to medical, dental or vision benefits, you must provide dependent eligibility documents. Please see the full list of required documents on the benefits portal or the Risk Management website [www.sarasotacountyschools.net/departments/riskmanagement](http://www.sarasotacountyschools.net/departments/riskmanagement)

*Florida law allows you to cover eligible dependent adult children ages 26 to 30 provided they meet specific criteria. For more information, contact the Risk Management Office.

If you (and/or your dependent have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 18 for more detail.
How to Enroll
New Hires & Open Enrollment

Open Enrollment: October 15 – November 5, 2018

Please follow revised instructions on how to access the Benefit Guide and enroll in benefits.

How to Access the 2019 Benefit Enrollment Guide

Step 1: Go to www.sarasotacountyschools.net and at the top click on “About Us” → “For Employees” → “Employee Corner” → “Employee Benefits and Risk Management”

Step 2: Select “Benefit Enrollment Booklet – 2019”

How to Enroll (New Hires & Open Enrollment)

Step 1: Go to www.sarasotacountyschools.net and at the top click on “About Us” → “For Employees” → “Employee Corner” → “Employee Benefits and Risk Management”

Step 2: Select “Benefit Enrollment and Changes”

Log on by using the following:

User ID: Sarasota County Schools Employee ID number including the “A” (for example A000000).

Password: Your password will be your birthdate in YYYYMMDD format (for example March 24, 1968 would be 19680324). Once you log in you will be prompted to change your password. This will be your password for the future.

NOTE: This will be your only opportunity to enroll in FSA and make changes to your benefits for 2019 (unless a qualifying event occurs). It is recommended you review your dependent coverage and beneficiary designations.

New Hire Enrollments

New Hires are eligible to enroll in benefits the later of their Board Appointment date or start date. Upon enrollment, benefits coverage will become effective the 1st of the month following enrollment. Payroll deductions begin two pay periods before the effective date of coverage.

Please see Appendix A: Frequently Asked Questions on page 16 for additional details.

Section 125 and Benefit Election Changes

Under Section 125 of the Internal Revenue Service (IRS) code, you are allowed to pay for certain group insurance premiums using pre-tax dollars. This means your premium deductions are taken before federal income and Social Security taxes are calculated. Depending on your tax bracket, your savings could be significant.

Please make your benefit elections carefully, especially if you choose to waive medical coverage, because your pre-tax elections will remain in effect until the next plan year, unless you experience a qualifying change in status. These include, but are not limited to:

- marriage or divorce (legal separation is not considered a qualified event)
- birth or adoption of a child
- death of spouse or other dependent
- a spouse’s employment begins or ends
- dependent’s eligibility status changes due to age, student status, marital status, or employment
- you or your spouse experience a change in work hours that affect benefit eligibility
- gain or loss of other group coverage

You must make the changes within 30* days of your qualified status change. Any benefit changes must be consistent with the event. For example, if you get married, you may add your spouse to your current medical coverage, but you may not switch medical plans. All benefit changes must be approved by Risk Management.

*60 days if you, your spouse, or eligible dependent child loses coverage under Medicaid or a State Children’s Health Insurance Program (S-CHIP) or becomes eligible for state-provided premium assistance.
Understanding How Low and High Plans Differ

The Low Plans offer lower payroll deductions, but have higher out-of-pocket costs for deductibles, copays and/or coinsurance. The High Plans offer higher payroll deductions but have lower out-of-pocket costs. When evaluating the plans, you should consider how often you will use the plan, plus your payroll deductions.

BlueCare HMO Plans

Enrolling in an HMO entitles you to receive care from physicians, hospitals, or other high-quality providers who participate in the plan’s network. You will need to select a primary care physician (PCP) from the network who will help you manage all aspects of your health care. A PCP can be found at www.floridablue.com under Find a Doctor. Like all HMOs, there is no coverage for services received from out-of-network providers, except for qualified emergencies.

BlueOptions PPO Plans (New Network for 2019)

A PPO is a group of providers (doctors, hospitals, and other medical facilities) who have agreed to provide services at discounted rates. A significant difference between an HMO and a PPO is that a PPO allows you to use providers who are not in the network. When you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use an out-of-network provider, you are subject to a deductible and coinsurance, as well as any charges that are higher than what is considered reasonable and customary by Florida Blue, and you could pay substantially more out-of-pocket. Accessing out-of-network services may also subject you to plan limitations that might be avoided when you receive care from in-network providers.

Reasonable and Customary Amounts

Reasonable and customary amounts are the fees the insurance carrier considers appropriate for a medical expense based on the typical rates charged by other providers for a comparable service within the provider’s zip code. If you go to an out-of-network provider who charges more than the allowable amounts established by the insurance carrier, the provider may bill you for the remaining balance.

Mail-Order Prescription. Save time and money.

Use PrimeMail, your health plan’s mail order pharmacy, for up to a 90-day supply of medication for 2x your retail copay. If you take a daily maintenance medication to treat a chronic condition such as arthritis, asthma, high cholesterol, blood pressure, heart conditions or contraceptives — it’s a great way to save time and money. Refills are easy by phone and online. Free shipping for standard delivery direct to your home or work. Please call PrimeMail for questions or speak with a pharmacist at 1-888-849-7865, available 24/7.
### Florida Blue – Low HMO (BlueCare Plan)

<table>
<thead>
<tr>
<th></th>
<th>Monthly Plan Cost</th>
<th>Employee Cost Per Month</th>
<th>Employee Cost Per Pay (24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$613.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$1,275.04</td>
<td>$613.14</td>
<td>$306.57</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$1,159.42</td>
<td>$497.52</td>
<td>$248.76</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$1,777.00</td>
<td>$1,115.10</td>
<td>$557.55</td>
</tr>
</tbody>
</table>

### Definitions

#### Copayment and Coinsurance

A **copayment (copay)** is the fixed dollar amount you pay for certain in-network services. In some cases, you may be responsible for coinsurance after a copay is made.

Coinsurance is the percentage of covered expenses shared by the employee and the plan. In some cases, coinsurance is paid after the insured meets a deductible. For example, if the plan pays 90% of an in-network covered charge, you pay 10%.

#### Annual Deductible

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. Some services, such as office visits, require copays and do not apply to the deductible. This is an annual calendar year deductible.

After you meet your deductible, the plan pays for a percentage of eligible expenses (coinsurance) until you meet your out-of-pocket maximum. If you receive services from an out-of-network provider, the plan pays a lower percentage of coinsurance. Refer to your health care plan summaries for more information.

#### Out-of-Pocket Maximum

Some plans feature an out-of-pocket maximum, which limits the amount of coinsurance you will pay for eligible health care expenses. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in- and out-of-network annual out-of-pocket maximums. Copays, deductible, and coinsurance accumulate towards your out-of-pocket maximum.
### Medical Plan Comparison

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Low HMO BlueCare HMO</th>
<th>High HMO BlueCare HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (Single/Family)</strong></td>
<td>$500 / $1,500</td>
<td>$250 / $750</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong> (Single/Family)</td>
<td>$2,000 / $4,000</td>
<td>$1,500 / $3,000</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP Office Visits</td>
<td>$25 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>$50 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td><strong>Teladoc</strong></td>
<td>$20 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Wellness, Routine ObGyn</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Mammograms</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Well Child Care</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Facility Services (including Maternity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$200 / day (days 1-5); after deductible, Max. $1,000 per admission</td>
<td>$200 per admission after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$200 copay after deductible</td>
<td>$100 copay after deductible</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>$0 after deductible</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 copay after deductible</td>
<td>$150 copay after deductible</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Clinical Lab</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Advanced Imaging/IDTF Services</td>
<td>0% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>0% after deductible</td>
<td>0% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>0% after deductible unlimited</td>
<td>0% after deductible unlimited</td>
</tr>
<tr>
<td>Prescription Drugs – Retail (30-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$20 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$60 copay</td>
<td>$60 copay</td>
</tr>
<tr>
<td>Prescription Drugs – Mail Order (90-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>2x retail copay</td>
<td>2x retail copay</td>
</tr>
<tr>
<td>Mental/Nervous and Substance Abuse Inpatient Services</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Therapy Limits</td>
<td>30 days</td>
<td>30 days</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational, Speech, Chiropractic</td>
<td>$50 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Outpatient Therapy Limits</td>
<td>Varies by service</td>
<td>Varies by service</td>
</tr>
</tbody>
</table>

1 Out-of-Pocket Maximum includes deductible, copayments, and prescription drug costs.
2 Copay waived if admitted.
3 Services performed in an Independent Diagnostic Testing Facility. Tests performed in hospitals may have higher cost share.
4 Enteral formulas limited to $2,500; all other DME covered no maximum. Diabetic supplies (lancets, strips, etc.) are covered under the Rx benefits; supplies and equipment (insulin pumps, tubing) are covered under the medical benefit as DME.

Please note: Some services, tests, or procedures may be subject to prior authorization and medical necessity requirements. Please contact Florida Blue at 1-800-664-5295 for additional information or visit [www.floridablue.com](http://www.floridablue.com) for the member handbook.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Low PPO BlueOptions PPO</th>
<th>High PPO BlueOptions PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
<tr>
<td>Deductible (Single/Family)</td>
<td>$1,500 / $4,500</td>
<td>$500 / $1,500</td>
</tr>
<tr>
<td>Coinurance</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum(^1) (Single/Family)</td>
<td>$3,500 / $10,500</td>
<td>$2,000 / $6,000</td>
</tr>
<tr>
<td>Physician Services</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>PCP Office Visits</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
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<td>$25 copay</td>
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</tr>
<tr>
<td>Teladoc</td>
<td>40%, deductible waived</td>
<td>Covered 100%</td>
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<td></td>
<td>40%, deductible waived</td>
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<td>$150 copay; then 20% after deductible</td>
<td>$300 copay; then 40% after deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>10% after deductible</td>
<td>$300 copay; then 30% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Ambulatory Surgery Center</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Emergency Room(^2)</td>
<td>$50 copay; then 20% after deductible</td>
<td>$50 copay; then 20% after deductible</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>20%, deductible waived</td>
<td>40%, deductible waived</td>
</tr>
<tr>
<td>Independent Clinical Lab</td>
<td>Covered 100%</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Advanced Imaging/IDTF Services(^3)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment(^4)</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs – Retail (30-day supply)</td>
<td>20 visit max</td>
<td>20 visit max</td>
</tr>
<tr>
<td>Generic</td>
<td>$20 copay</td>
<td>50%</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$40 copay</td>
<td>50%</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$60 copay</td>
<td>50%</td>
</tr>
<tr>
<td>Prescription Drugs – Mail Order (90-day supply)</td>
<td>2x retail copay</td>
<td>2x retail copay</td>
</tr>
<tr>
<td>Generic</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Mental/Nervous and Substance Abuse</td>
<td>Covered 100%</td>
<td>40%, deductible waived</td>
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<td>Inpatient Services</td>
<td>Covered 100%</td>
<td>30%, deductible waived</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Covered 100%</td>
<td>30%, deductible waived</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Therapy Limits</td>
<td>30 days (combined INN and OON)</td>
<td>30 days (combined INN and OON)</td>
</tr>
<tr>
<td>Outpatient Therapy</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Physical, Occupational, Speech, Chiropractic</td>
<td>10% after deductible</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Outpatient Therapy Limits</td>
<td>Varies by service</td>
<td>Varies by service</td>
</tr>
</tbody>
</table>

\(^1\) Out-of-Pocket Maximum includes deductible, copayments, and prescription drug costs.

\(^2\) Copay waived if admitted.

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\(^4\) Enteral formulas limited to $2,500; all other DME covered no maximum. Diabetic supplies (lancets, strips, etc.) are covered under the Rx benefits; supplies and equipment (insulin pumps, tubing) are covered under the medical benefit as DME.

Please note: Some services, tests, or procedures may be subject to prior authorization and medical necessity requirements. Please contact Florida Blue at 1-800-664-5295 for additional information or visit www.floridablue.com for the member handbook.
Quality care at your convenience 24/7. Speak to a licensed doctor by web, phone, or mobile app in under 10 minutes! Schedule a doctor visit, manage your medical history, or send a prescription to your nearest pharmacy.

Doctors will diagnose, treat & prescribe medication\(^1\) for a wide range of conditions such as cold & flu, sinusitis, upper respiratory infections, and more!

**Set Up Your Account**

**Online:** [Teladoc.com](https://www.teladoc.com) and click “set up account”.

**Mobile App:** Download the app and click “Activate account. Visit [teladoc.com/mobile](https://teladoc.com/mobile) to download the app.

**Call Teladoc:** Teladoc can help you register your account by calling 1-855-835-2362.

**How Teladoc Works**

**STEP 1: CONTACT TELADOC 24/7 /365**
Access to Teladoc’s nationwide network of board-certified physicians is available via phone, video or mobile app.

**STEP 2: SPEAK WITH A PHYSICIAN**
A physician will review the patient’s medical history and contact them within minutes. Copay is the same as your Primary Care Physician office visit copay.

**STEP 3: RESOLVE THE ISSUE**
A physician will diagnose and prescribe medication, if medically necessary, electronically to the pharmacy of choice.

**TELADOC PHYSICIANS ARE:**
- U.S. board-certified in internal medicine, family practice, emergency medicine, behavioral health or pediatrics
- State licensed
- U.S. residents who average 20 years of experience.

\(^1\)If medically necessary
Flexible Spending Accounts

Flexible Spending Accounts (FSAs) enable you to set aside money for important expenses and help you reduce your income taxes at the same time. SBSC offers two types of FSAs — Health Care and Dependent Care. These accounts allow you to set aside pre-tax dollars to pay for certain out-of-pocket health care or dependent care expenses.

How Flexible Spending Accounts Work

1. Each year during Open Enrollment, you decide how much to set aside for health care and/or dependent day care expenses.

2. Your contributions are deducted from your paycheck in equal installments throughout the calendar year. Your contributions are deducted before federal and Social Security taxes are withdrawn, saving you money on your taxes.

3. When you have qualified health care and/or dependent care expenses, simply submit a claim form and documentation to the FSA administrator, Discovery Benefits. A reimbursement check will be sent to you from your FSA.

Please note that these accounts are separate — you may participate in one or both, but you cannot use money from the Health Care FSA to cover expenses eligible under the Dependent Care FSA or vice versa.

You must actively re-enroll in the FSAs each year. You are not automatically enrolled.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Annual Maximum Contribution</th>
<th>Examples of Covered Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care FSA</td>
<td>$2,650</td>
<td>Copayments, coinsurance, deductibles, dental and vision expenses, etc. for yourself and qualified dependents*</td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>$5,000 (or $2,500 if married, filing separately)</td>
<td>Day Care, nursery school, elder care expenses, etc.*</td>
</tr>
</tbody>
</table>

* See IRS Publications 502 and 503 for a complete list of covered expenses. Visit www.irs.gov for more information on Section 125 regulations.

Use-It-or-Lose-It Rule

Based on IRS rules, the plan requires you to use all of the money in your account(s) by the end of the plan year, December 31, 2019, and submit claims for reimbursement by March 31, 2020, or you will lose the remainder.

Deadline for Submitting Claims

You have until March 31, 2020 to submit claims for expenses incurred in 2019. After March 31, 2020, any money remaining in your FSA(s) will be forfeited. If you terminate employment during the plan year, you may submit claims up to 90 days after your termination for expenses incurred during the portion of the plan year preceding your termination date.

For a complete list of expenses, or if you have questions regarding the FSA, contact Discovery Benefits at 1-866-451-3399 or www.discoverybenefits.com.
Dental Insurance

Dental coverage is provided through Delta Dental Insurance Company. You can visit any dentist you choose, but you may pay less out of pocket when you visit a Delta Dental PPO or Premier dentist. To find a provider, call 1-800-521-2651 or visit www.deltadentalins.com.

Expenses are reimbursed based on the Delta Dental schedule of allowances according to the procedure code submitted. The annual deductible is $50 per individual and $150 for family and does not apply to preventive care. The maximum benefit per person is $1,500 per calendar year.

The dental plan covers these types of benefits:
- Preventive and diagnostic services like routine exams and cleanings, fluoride treatments, sealants, and x-rays
- Basic services such as simple fillings and extractions, root canals, oral surgery, and gum disease treatment
- Major services such as crowns and dentures
- Orthodontic coverage up to a lifetime maximum of $1,500
- Orthodontic coverage includes children and adults

Vision Insurance

The Humana Vision Plan now offers vision benefits through the extensive Humana Insight Network. The Vision plan offers you flexibility to see any provider. When you choose a network provider, you receive services at a predetermined fee. If you select an out-of-network provider, you will pay the eye care provider, and then file the claim for reimbursement based on the plan’s reimbursement schedule.

Benefits include periodic eye exams, plus lenses and frames or contacts. Plan features include:
- Care and testing benefits for diabetics – New for 2019
- Retinal Imaging coverage with a member copay – New for 2019
- $10 exams every 12 months
- $15 materials charge for frames and/or single vision lenses
- Lenses or contact lenses every 12 months
- Frames every 24 months
- $120 contact lenses allowance is available in place of the exam and eyeglasses

Once you enroll, you will receive an ID card to present to your network Humana provider. To find a network provider, call 1-877-398-2980 or visit www.myhumana.com.

### Dental Rates Per Pay Period

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee + 1 dependent</td>
<td>$11.48</td>
</tr>
<tr>
<td>Employee + 2 or more dependents</td>
<td>$26.24</td>
</tr>
</tbody>
</table>

### Vision Rates Per Pay Period

<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee + Family</td>
<td>$5.00</td>
</tr>
</tbody>
</table>
Long-Term Disability Insurance

At no cost to you, SBSC provides long-term disability (LTD) coverage through MetLife. You are eligible to receive LTD benefits after 90 days of a qualified disability. The plan pays 60% of your basic monthly earnings, up to a monthly maximum of $10,000. The maximum benefit period is the later of your normal retirement age or a sliding scale based upon the age at which your disability began. That means you will have a steady income stream to help pay your bills during your disability.

As a MetLife member you are eligible for the following additional benefits:

- If you are approved for LTD Benefits, the Social Security Assistance Program is designed to assist you in obtaining the Social Security benefits to which you may be entitled. Your MetLife Social Security resources will guide you through the initial application and appeals processes.

Download the MetLife US App to track your disability claims every step of the way. Search “MetLife” at iTunes App Store or Google Play to download the app on your mobile device. Then, register or log in using your My Benefits log in information to access the features.

For additional information visit [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits). For questions or to obtain a claim application call [1-800-300-4296](tel:1-800-300-4296).

Basic Term Life Insurance

SBSC provides eligible employees with basic term life insurance through The Hartford, equal to $50,000 with no premium contributions required. The benefit will be reduced by 50% on the policy anniversary date (January 1) following the date you attain age 70. Please call [1-877-778-1383](tel:1-877-778-1383) or visit [www.thehartford.com/mybenefits](http://www.thehartford.com/mybenefits) for additional information.

As a Hartford member you are eligible for the following additional benefits:

- **24/7 Funeral Planning and Concierge Services through Everest:** Advisors help families understand all of their options and put them into action while staying within their budget. Available to you, your spouse/partner and children under the age of 26. Call [1-866-854-5429](tel:1-866-854-5429) for more information.

- **24/7 Beneficiary Assist Counseling Services:** Provides you, your eligible beneficiaries and immediate family members with access to help related to the death of yourself or a loved one. Up to 5 face-to-face sessions or equivalent professional time for one service or a combination. Call [1-800-411-7239](tel:1-800-411-7239) for more information.

- **Estate Guidance Will Services through ComPsych:** Helps you create a simple, legally binding will quickly and conveniently online, saving you the time and expense of a private legal consultation. For more information visit [www.estateguidance.com/wills](http://www.estateguidance.com/wills) and use code WILLHLF.

- **24/7 Travel Assistance and ID Theft Protection Services through Europ Assistance USA:** When you’re travelling for business or pleasure, Travel Assistance services are available when you’re more than 10 miles from home for 90 days or less. In addition to ID Theft Assistance at home and when you travel, the service provides prevention education, advice and help with administrative task resulting from identity theft. Call [1-800-243-6108](tel:1-800-243-6108) for more information.

- **Ability Assist Counseling Services through ComPsych:** Provides professional support for dealing with highly impactful issues like grief, loss, or a disability. Up to 3 face to face counseling sessions per year. Available to you and your family if you are an approved claim. Call [1-800-964-3577](tel:1-800-964-3577) or visit [www.guidanceresources.com](http://www.guidanceresources.com) for more information.
Voluntary Term Life Insurance

You may also purchase voluntary term life as a supplement to the basic term life benefit through The Hartford. You pay 100% of the cost for voluntary term life insurance and deductions are withheld on an after-tax basis. Coverage is available for yourself and your eligible dependents.

Employee: Increments of $10,000 up to $300,000; new hires are eligible for a guaranteed issue amount of $300,000.

Spouse: Increments of $5,000 up to $150,000, not to exceed 50% of the employee’s voluntary coverage amount; new hires are eligible for a guaranteed issue amount of $50,000.

Child: Increments of $5,000 or $10,000 covers all of your dependent children up to age 26 who are unmarried and fully dependent upon you for support; coverage is guaranteed issue for all employees. $5,000 of coverage costs $0.30 per pay and $10,000 of coverage costs $0.60 per pay.

An individual may not be covered as an employee and a dependent. If your spouse or child is a benefit-eligible employee of School Board of Sarasota County, do not elect dependent life insurance for them, as benefits would not be payable. You must be actively at work on the effective date of coverage.

Open Enrollment Opportunity 2019
Employee: During Open Enrollment, you may increase your employee term life insurance on a guaranteed issue basis by one $10,000 increment without Evidence of Insurability (EOI).

Spouse: Employees can enroll their spouse for the first time or may increase spouse coverage on a guaranteed basis by one $5,000 increment provided the resulting amount of insurance does not exceed the guarantee issue maximum of the lesser of $50,000 or 50% of the employee’s voluntary life amount. Elections in excess of the guarantee issue amount will require EOI.

Evidence of Insurability (EOI)
New hires are eligible to elect voluntary term life insurance for yourself and your spouse up to the guaranteed issue amounts shown above without submitting EOI. New hires electing voluntary spouse coverage in excess of $50,000 and current employees electing to increase voluntary term life insurance for yourself and your spouse after the initial enrollment period must complete and submit EOI for medical underwriting approval. If your election is subject to EOI, information will be mailed to your home address with instructions about how to submit your EOI directly to The Hartford.

Voluntary Term Life Rates
Use the table below to calculate your per pay period cost. The rates below apply to you and your spouse and are based on your age as of January 1, 2019.

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 29</td>
<td>$0.019</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.025</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.028</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.036</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.058</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.096</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.164</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.258</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$0.432</td>
</tr>
<tr>
<td>70+</td>
<td>$0.758</td>
</tr>
</tbody>
</table>

**Calculate Your Total Per Pay Period Cost**

Enter your Voluntary Life Insurance Volume election (Must be in an increment of $10,000 for yourself, $5,000 for spouse, and $5,000 or $10,000 for child) 

Age Reduction Applies
- Are you age 65–69? If so, multiply Volume by 0.65.
- Are you age 70 or older? If so, multiply Volume by 0.5.

Divide Volume by 1,000

Multiply by Rate based on your age as of January 1, 2019

This is your per pay period cost >
SBSC offers you a chance to purchase voluntary insurance coverage through Aflac at a group rate to help pay benefits your major medical insurance doesn't cover. All coverage is portable which means you can take it with you if you change jobs or retire (with certain stipulations). For additional information, please call 1-800-433-3036 or visit www.aflacgroupinsurance.com.

<table>
<thead>
<tr>
<th>Available Group Plans</th>
<th>Plan Features</th>
</tr>
</thead>
</table>
| Accident Insurance         | • Plan pays benefits for a variety of injuries and accident-related expenses, including hospitalization, emergency room treatment, physical therapy, transportation, lodging for family, and more.  
• Coverage options available for you, your spouse, and child(ren).  
• Benefits are paid for accidents that occur on or off the job.  
• There are no health questions or physical exams required.    |
| Critical Illness Insurance | • Plan pays a lump sum benefit directly to you (unless otherwise assigned) if you are diagnosed with a covered specified critical illness such as cancer, heart attack, stroke, and major organ transplant.  
• Coverage options available for you, your spouse, and child(ren).  
• You do not have to be terminally ill to receive benefits.  
• The cost of the benefit will vary depending on your age, the amount of coverage you choose, tobacco use, and other such factors. |
| Short-Term Disability Insurance | • Employees may elect coverage up to 50% of their salary up to a maximum of $3,000 per month during Open Enrollment on a guaranteed issue basis. Elections must be in increments of $50.  
• Covers disability due to off-the-job covered injuries on the 1st day following an injury or 7 days following a covered illness.  
• Partial disability benefits allow a transition period before returning to full-time employment.  
• Maximum benefit duration is 3 months for disabilities due to a covered illness or injury. |
| Whole Life Insurance       | • Plan is permanent and does not expire after a certain time period. This means the premium you pay today will never change.  
• Coverage is available for you, your spouse, your child(ren), and/or your grandchildren.  
• No physical exams are required to apply for coverage (although health questions may be asked).  
• The cost of the benefit will vary depending on your age, the amount of coverage you choose, and other such factors. |

This is a brief product overview only. The plans have limitations and exclusions that may affect benefits payable. Refer to the plans for complete details, limitations, and exclusions. Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands.
Employee Wellness Program

The Employee Wellness mission is to decrease the health risks of employees while empowering them to be active, involved, conscientious health care consumers. The Employee Wellness program encourages employees to take responsibility for enhancing their own well-being, decreasing their risks for acute and chronic illness and premature death, knowing when to seek appropriate care for medical problems, and acquiring knowledge tools for achieving high level wellness.

The Employee Wellness Program provides a balanced and proactive program to employees to improve their individual health through a variety of District and site-based programs throughout the year. The program address topics such as weight management, fitness, and preventative screenings.

Prevention Pays Incentive Program
Active board-appointed employees may participate in the Prevention Pays incentive program and may be eligible for up to a $100 incentive for completing a preventative wellness exam and other wellness activities. The Prevention Pays incentive form is located on the Employee SharePoint site or by visiting the Employee Wellness Website at https://www.sarasotacountyschools.net/departments/employeewellness/

Employee Wellness Screenings and Programs
- Free biometric screenings
- Free health related seminars and workshops
- Free fitness classes
- Free Flu shots
- Free dermatology exams
- Free mammograms
- Free smoking cessation classes

Employee Wellness also connects employees to programs within the community so they can be active and have a variety of options. As a Florida Blue member, employees have access to a network of gyms through the “Fitness You Way” program for the low monthly price of $29/month (plus a one-time $29 registration fee).

Get fit and stay healthy by participating in other wellness programs, such as Weight Watchers and step challenges, provided throughout the year in varying locations. Attend one of the Employee Health Fairs to meet with benefits providers, participate in health and wellness seminars, attend free screenings, and meet community partners who specialize in Wellness. The health fairs are held annually on District professional days in October and March.

For more information on Employee Wellness and to view available programs, visit the Employee Wellness website at https://www.sarasotacountyschools.net/departments/employeewellness/

EAP and Work-Life Services

Your Employee Assistance Program (EAP) and Work-Life Services help you and your household members manage everyday life issues that can affect you at home and at work. Call the toll-free number anytime to talk with an experienced consultant who can help you find solution. SBSC covers the cost of service costs.

EAP and Work-Life Services offer:
- Assistance and counseling in person or by telephone
- Assessment and assistance from a Work-Life specialist who is an expert childcare, adult care, or other everyday concerns
- Free 30-minute consultations with attorney and financial counselor
- Assistance to a website with articles, discounts, podcast, webinars, assessment, live chat and a database to help you find local resources to provide retirement planning, career development, relationship issues, adoption, nutrition, and much more!

Access is easy and confidential! 24 hours day, seven day a week. Call 1-866-440-6556 (TTY:711) or visit humana.com/eap and use username: scs and password: scs
Retirement

Florida Retirement System (FRS)

SCSB is a participant in the Florida Retirement System (FRS). All eligible employees are automatically enrolled in FRS and will contribute a required 3% of their salary to the FRS. The district also contributes to the FRS on your behalf at a rate that is dependent on your position classification. The FRS offers you two retirement plans, the Investment Plan and the Pension Plan.

New Hires that are also new to the FRS will get communications from FRS informing you that you have an 8 month election period to choose a plan to participate in, if you do not make a choice by the end your election window you will be defaulted to the Investment Plan. To help you choose the correct plan that's right for you please visit the website ChooseMyFRSplan.com or by calling the MyFRS Financial Guidance Line at 1-866-446-9377.

All FRS members will have access to an easy to use retirement planning solution through a digital advisor service, GuidedChoice. GuidedChoice is an independent advisory firm whose sole purpose is to give you tailored, unbiased investment advice to help you reach your retirement goals. Both FRS Investment Plan and Pension Plan members will be able to get professional advice on how to allocate investments through the GuidedChoice Advisor Service at no cost. You can use this service for your Investment Plan account, as well as any other supplemental retirement account you - or your spouse - may have (for example, your 457, 403(b), IRAs) to provide a complete view of your retirement savings.

GuidedChoice will provide a clear picture of what you can expect in retirement based on how you're currently invested and how much you're saving. You'll then receive a personalized, actionable recommendation on how to adjust your investments to help meet your goals. From there, the advice can easily be implemented with just a click of a button. You will even be able to run scenario modeling to answer those difficult questions like, "Do I need to save more?" and, "When can I really retire?" Start by accessing the Advisor Service directly through www.MyFRS.com or by calling the MyFRS Financial Guidance Line at 1-866-446-9377, Option 2 (or TRS 711).

Drop Program
The Deferred Retirement Option Program (DROP) is a voluntary retirement program that is available only to FRS Pension Plan members who qualify for normal retirement. As a participant of DROP, you begin accumulating your retirement benefits while delaying your termination of employment for up to 60 months from the date you first reach your normal retirement date or your eligible deferral date. If you are employed as K-12 instructional you may defer drop until a future date indefinitely and still participate for the full 60 months.

Drop Participation Requirements

**Regular Class** - retirement for employees enrolled in FRS before 7/1/2011 eligibility is 30 years of service or age 62 whichever comes first. If you were enrolled in FRS after 7/1/2011 eligibility is 33 years of service or age 65 whichever comes first.

**Special Risk Class** - retirement for employees enrolled in FRS before 7/1/2011 eligibility is 25 years of service or age 55 whichever comes first. If you were enrolled in FRS after 7/1/2011 eligibility is 30 years of service or age 60 whichever comes first.

Service Credit

Service credit with FRS is base on your employment contract period for a fiscal year (July 1-June 30). You will earn service credit for each month you work in your contracted work year. You may be able to purchase service time from another employers retirement plan, out of state service or time lost from an approved leave of absence.

For more information on Drop or Service Credit please contact the FRS at www.MyFRS.com or by calling the MyFRS Financial Guidance Line at 1-866-446-9377 or risk management at ext 32318.
Voluntary Retirement Plans

401(k) and Roth 401(k) Retirement Savings Plans
SBSC offers eligible employees a voluntary 401(k) and Roth 401(k) retirement savings plan options. You may enroll at any time during the year by contacting Prudential Retirement Services. You may contribute a minimum of $20 per pay, up to the maximum annual deferral limit (including any contributions you make to a 403(b) plan or other qualified retirement plan). Employees 50 years or older may also make catchup contributions. To enroll or get more information, contact Prudential Retirement Services at 1-877-778-2100 or www.prudential.com/online/retirement.
You may also contact the Plan Representative, Tony Madera, Benefits Consultant of Gallagher Retirement Services, Inc. at 1-570-407-3208.

403(b), Roth 403(b) and 457(b) Retirement Savings Plans
SBSC offers voluntary 403(b), Roth 403(b) and 457(b) retirement savings plans through authorized providers. Authorized providers are listed below:

- American Century Services, LLC – Plan Number 800000045
  800-345-3533
  ext. 48113
- AXA Equitable Life Insurance Company
  800-727-0276
- IPX Franklin Templeton Funds
  844-362-6844
- National Life Group
  800-543-3794
- Plan Member Services
  800-874-6910
- ReliaStar Life – Subsidiary of VOYA Financial
  877-882-5050
- Security Benefit Group
  800-888-2461
- The Legend Group – A Lincoln Investment Co.
  888-883-6710
- VALIC
  800-426-3753
- VOYA Financial
  800-584-6001

To start contributing to a plan, please go to www.tsacg.com/individual/plan-sponsor/florida/sarasota-county-schools/
To find the District authorized representative for the companies listed above, please go to www.sarasotacountyschools.net/departments/riskmanagement and go to the “Voluntary Retirement Saving Plans” tab and click on “403(b)-457(b) Provider Representative Contact List”.

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Appendix A: Frequently Asked Questions

1. **How are the payroll deductions for dependent coverage handled?**
   The premiums are deducted the month prior to the effective date of the coverage (e.g., coverage is effective September 1; premiums are deducted in August).

   If you elect to cover your eligible dependents on the group medical, 100% of the cost will be deducted from your paycheck the month prior to the effective date of the coverage.

   Typically, the payroll cut-off date is 3-5 days before your pay date. If you complete your enrollment after the designated payroll cut-off date, it will not be possible to deduct your premium prior to the effective date of the coverage. As a result, it will be necessary to retroactively deduct your premium during the next payroll cycle.

2. **Do I need to notify Risk Management on the birth of a newborn?**
   Yes, you must report the life event online within 60 days of the qualifying event (birth). The newborn will be enrolled in the same plan as the employee. This qualifying event does not allow for a plan change. If the baby is added within the first 30 days and this changes the Plan level, the first 30 days premium will not be charged.

3. **Do I have to continue the newborn coverage past 30 days?**
   Yes, you may only drop a dependent from coverage if you have a documented Qualifying Event that meets the IRS requirements.

4. **I am taking a Leave of Absence, what is going to happen to my benefits?**
   Your benefits are going to end at the end of the month following the month in which you were last in an active paid status. For example, if you take an unpaid leave of absence not covered by FMLA effective February 5th your benefits will end March 31st.

5. **I am returning to work from a leave of absence in which my benefits ended, do I need to re-enroll in benefits or will they be reinstated according to what I had previously?**
   You must re-enroll in your benefits whenever there is a break in your district provided coverages. You will re-enroll in your benefits online following the same process outlined for New Hires.

6. **I am resigning, what is going to happen to my benefits?**
   Your benefits are going to end at the end of the month in which you were last in an active paid status for your work year. For example, if you are a 10-month employee who resigns August 1st your benefits are all going to be terminated retroactively to May 31st. Any premiums deducted for voluntary coverages after that time will be refunded through a final payroll processing.
Appendix B: Required Notices

CREDIBLE COVERAGE DISCLOSURE NOTICE

Important Notice from the School Board of Sarasota County about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with School Board of Sarasota County and about your options under Medicare. Medicare prescription drug coverage may be important to you, no matter what you decide. This information can help you decide whether or not you want to join a Medicare drug plan. If you are deciding to join, you should compare your current coverage, including drug coverage, to the options you need. You can also get more information about Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. School Board of Sarasota County has determined that the prescription drug coverage offered by your health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Credible Coverage. Because your existing coverage is Credible Coverage, you can keep this coverage and not pay a higher premium for it (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current prescription drug coverage, you can also get this coverage within 60 days of losing your current coverage. If you lose your current drug coverage for any reason, you will also be eligible for two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current School Board of Sarasota County coverage will be kept. You can keep this coverage if you only elect to join a Medicare drug plan and your School Board of Sarasota County health plan will coordinate your benefits with those under the drug coverage. If you would like more information about Medicare drug plan provisions and options that Medicare eligible individuals may have when they become eligible for Medicare prescription drug coverage, see pages 7-9 of the CMS Disclosure of Credible Coverage to Medicare Part D Eligible Individuals Guidance located at http://www.cms.hhs.gov/CredibleCoverage.

If you decide to join a Medicare drug plan and drop your current School Board of Sarasota County coverage, be aware that you and your dependents will not be able to get this coverage in the future. If you later decide to join a Medicare drug plan, you will lose access to the current coverage.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with School Board of Sarasota County and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without credible prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare basic premium per month for every month you did not have that coverage. For example, if you go nineteen months without credible coverage, your premium may possibly be at least 19% higher than the Medicare basic beneficiary premium. You may have to pay more for the drug in that plan, as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact us for further information at 1-800-FLA-BLUE (TTY:711). NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through School Board of Sarasota County changes. You also may have to wait for a copy of this notice at any time.

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

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

• Visit www.medicare.gov
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the ‘Medicare & You’ handbook for their telephone number) for personalized help.
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have questions or need more time to review your options, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: 10/20/2010
Name of Entity/Sender: The School Board of Sarasota County, Florida
Contact: Risk Management
Address: 1660 Landings Blvd.
Sarasota, FL 34231
Phone Number: 941-927-9000

COBRA
If you, your spouse, or eligible dependent lose coverage under any of SBSC group medical, dental or vision plans because of a COBRA qualifying event, you may have the right to continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). For details about qualifying events, refer to the Section 125 and benefit Election Changes section of this guide. If your coverage ends due to a COBRA-qualifying event, you will receive a notice of your continuation rights. At that time, you will have up to 60 days—from the date of your event or the date you received your notice—to decide whether you want to continue your health coverage.

If you, your spouse, and/or dependent have a COBRA-qualifying event, you must notify the Risk Management Office immediately.

Newborns’ and Mothers’ Health Protection Act of 1996

Group health plans and health insurance policies under federal law, restrict benefits for any hospital length of stay in connection with birth for the mother or newborn child to less than:

• 48 hours following a normal vaginal delivery, or
• 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women’s Health and Cancer Rights Act of 1998

The Women’s Health and Cancer Rights Act of 1998 requires your health care plan to provide women’s health services. These services include surgery and reconstruction to achieve symmetry between the breasts and prostheses due to complications resulting from a mastectomy (including lymph edema).

Coverage for these benefits, or services required in consultation with the participant’s or beneficiary’s attending physician. If you are receiving, or in the future will receive, benefits under any group medical contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above if you elect breast reconstruction. Please refer to your medical plan Certificate of Coverage for the full terms of coverage, restrictions, limitations, and exclusions. Your qualified dependents are also entitled to coverage for those benefits or services on the same terms. Coverage for the mastectomy related services or benefits required under the Women’s Health law are subject to the same deductibles and coinsurance or copayment provisions that apply to other medical or surgical benefits your group medical contract provides.

HIPAA—Continuation of Coverage

The Health Insurance Portability and Accountability Act (HIPAA) helps protect your rights to medical coverage during events such as changing or losing jobs, pregnancy and childbirth, or divorce.

Depending upon your group health plan limitations, HIPAA may also make it possible for you to get and keep health coverage even if you have past or present (pre-existing) medical conditions. If you were covered under a medical plan, you will receive a certificate of creditable coverage from Florida Blue upon termination.

HIPAA—Privacy Act Legislation

SBSC and your health insurance carrier are obligated to protect confidential health information that identifies you, or could be used to identify you, and relates to a physical or mental health condition or the payment of your health care expenses. SBSC and Florida Blue are required to comply with the Privacy Act’s policies and practices to protect the confidentiality of your health information. To comply with this legislation, Florida Blue provides a detailed description of your plan’s privacy policy in the Summary Plan Descriptions.

Effects of the privacy rule:

• You must contact your insurance provider if you need help with any health care benefit claims, concerns, or questions.
• The Risk Management Office, your manager, and/or your Human Resources representative cannot help you with health care issues without specific, written authorization from you.

Health Coverage Extended for College Students on Medically Necessary Leave

Michelle’s law provides that a group health plan may not terminate a college student’s health coverage simply because the child takes a medically necessary leave of absence from school. The law:

Allows full-time college students to take up to 12 months of medical leave. Applies to students who are covered under your plan and whose universities are located in the States that medical leave can mean that the student is absent from school or reduces his/her course load to part-time. Entitles the student to the same benefits as if they had not taken a leave.

Mandates that coverage must extend for maximum of one year after the first day of the leave (or the date coverage would otherwise terminate under the plan).

The leave of absence must:

• Be medically necessary; Commence while the child is suffering from a serious illness or injury; and Cause the child to limit his/her school activities.

The date the medical leave begins is determined by a student’s physician.

To take advantage of the extension, the child must have been enrolled in the group health plan on the basis of being a student at a post-secondary educational institution immediately before the first day of the leave.

Notice Regarding Wellness Program

The Employee Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the American’s Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or “HRA” that asks a series of questions about your health-related activities and behaviors and whether you have or have certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric skin screening, which will include a blood test for total cholesterol and is tested for glucose, total cholesterol, HDL (High-Density Lipoproteins or Healthy Cholesterol) and the Total Cholesterol/HDL Ratio. Blood Pressure is also assessed and BMI is calculated through the Height and Weight either self-reported by the participant or as measured onsite by the screening vendor. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $100 for completing preventative health screening and wellness programs. Although you are not required to complete the HRA or participate in the blood testing or any biometric screening, only employees will receive the incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Risk Management at 1-941-927-9000.
Appendix B: Required Notices

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Health Coaching through the Better You Next Steps program for additional assistance in reducing identified risk factors. You also are encouraged to share your results or concerns with your own doctor.

Discrimination is Against the Law
SBSC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCBS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SBSC:
• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  – Qualified sign language interpreters
  – Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
  – Qualified interpreters
  – Information written in other languages

If you need these services, contact Risk Management at 1-841-927-9000. If you believe that SBSC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Risk Management at 1-841-927-9000. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Risk Management is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  1-800-368-1019, 800-537-7697 (TDD)

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

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

Also, if you or your dependents lose eligibility for coverage under Medicaid or the Children’s Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, contact Florida Blue at 800-545-6565 ext. 25305 or Florida Health Care Plans at 386-615-4022 or 800-352-9824.

A federal law called HIPAA requires that we notify you that enrol to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Except Medicaid or a State Children’s Health Insurance Program).
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Eligibility Under Medicaid or a State Children’s Health Insurance Program.
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children’s Health Insurance Program.
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

All enrollment changes due to special enrollment rights are subject to the approval of the plan administrator.

Protection from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and SBSC may use aggregate information it collects to design a program based on identified health risks in the workplace, The Employee Wellness Program will never disclose any of your personal information publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Summary of Benefits and Coverage (SBC) Availability Notice
As required under the Patient Protection and Affordable Care Act, insurance companies and group health plans are providing consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. The purpose of the summary of benefits and coverage document is to help you better understand the coverage you have while allowing you to easily compare different coverage options. It summarizes the key features of the plan, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

As a result of the Patient Protection and Affordable Care Act (i.e. health care reform), School Board of Sarasota County is required to make available a Summary of Benefits and Coverage (SBC), which summarizes important health plan information such as plan limits, coinsurance, and deductibles. SBSC is intended to provide this information in a standard format to help you compare across health plan options.

Please note that an SBC is not intended to be a complete listing of all of the plan provisions. For more detailed information, please refer to the SPD and the plan document, collectively known as the plan documents.

If there are any discrepancies between the SBC and the plan documents, the plan documents prevail. Plan Documents are also available by contacting Risk Management.

Protection from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and SBSC may use aggregate information it collects to design a program based on identified health risks in the workplace, The Employee Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is are Health Coach or a Registered Nurse in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Risk Management at 1-841-927-9000.
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<tr>
<th>Plan and Contact</th>
<th>Phone Number</th>
<th>Website Address</th>
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| **RISK MANAGEMENT**  
Medical and Retirement  
Dental, Vision, Life, Disability, FSA  
Workers' Comp, Aflac, 401(k), 403(b), 457(b) | 1-941-927-9000  
Jarett Curtis x32318  
Beth Baranowski x32317  
Sabine Flesch x32316  
Fax: 1-941-927-7475 | [www.sarasotacountyschools.net/departments/riskmanagement](http://www.sarasotacountyschools.net/departments/riskmanagement) |
| **DEPENDENT ELIGIBILITY DOCUMENTS** | Fax: 1-941-927-7475 | E-mail: riskmanagement@sarasotacountyschools.net |
| **EMPLOYEE WELLNESS PROGRAM** | 1-941-927-9000  
Erin Singerman x31363 | [www.sarasotacountyschools.net/departments/employeewellness](http://www.sarasotacountyschools.net/departments/employeewellness) |
| **MEDICAL**  
HMO and PPO Florida Blue  
On-site Representative Martina Olson | 1-800-664-5295  
1-941-927-9000 x32314 | [www.floridablue.com](http://www.floridablue.com) |
| **DENTAL**  
Delta Dental Insurance Company | 1-800-521-2651 | [www.deltadentalins.com](http://www.deltadentalins.com) |
| **VISION**  
Humana Insight Network | 1-877-398-2980 | [www.humana.com](http://www.humana.com) |
| **LONG TERM DISABILITY INSURANCE**  
MetLife | 1-800-300-4296 | [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits) |
| **BASIC AND SUPPLEMENTAL LIFE INSURANCE**  
| **FLEXIBLE SPENDING ACCOUNT (FSA)**  
Discovery Benefits | 1-866-451-3399 | [www.discoverybenefits.com](http://www.discoverybenefits.com) |
| **Aflac**  
Short-Term Disability Insurance  
Critical Illness Insurance  
Accident Insurance  
Whole Life Insurance | 1-800-433-3036 | [www.aflacgroupinsurance.com](http://www.aflacgroupinsurance.com) |
| **EAP and Work-Life Services**  
Humana | 1-866-440-6556  
(TTY:711) | [humana.com/eap](http://humana.com/eap) |
| **401(k) and Roth 401(k)**  
Prudential Retirement Services | 1-877-778-2100 | [www.prudential.com/online/retirement](http://www.prudential.com/online/retirement) |
| **403(b), Roth 403(b), and 457(b)**  
Authorized Providers | See provider listing on page 16 and website | [www.sarasotacountyschools.net/departments/riskmanagement](http://www.sarasotacountyschools.net/departments/riskmanagement) |

**DISCLAIMER:** This benefit guide contains only a summary of plan highlights. They are not comprehensive plan documents. Complete details are set forth in the plan documents and individual plan policies. If there are any discrepancies between this guide and the official plan documents, the plan documents and policy will govern. School Board of Sarasota County has the right to modify, amend, or terminate the plans at any time. These plans and your eligibility for coverage are not an employment contract. They do not guarantee you the right to continued employment with School Board of Sarasota County.