Hamilton County School District

Employee Benefits Guide

Effective Date:
10/01/2023 – 09/30/2024

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Eligibility & Enrollment

Who Is Eligible?

All full-time employee who work 30 or more hours per week on average are eligible to enroll in benefits. Benefits will begin first of the month following 60 days of full-time employment. In addition, the following family members are eligible for medical, dental and vision coverage:

- Legal Spouse
- Dependent Children (to age 26 for dental vision, and to age 20 for life insurance or at age 24 if full-time student).

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When Can You Enroll?

- During your initial new hire enrollment period
- During your employer's annual open enrollment period
- Within 30 days of when you experience a qualifying life event

How to Make Changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Example of qualifying life events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Please Note: *The Internal Revenue Service (IRS) does not consider financial hardship a qualifying life event to drop or make changes to coverages mid-year.*

Enrollment Instructions

Group Benefits Enrollment
INSTRUCTIONS

Hamilton County School District is now conducting benefit enrollment online at
https://enroll.benefitsconnect.net/hamiltonfl

For Online Enrollment Technical Assistance – Please call GIS Benefits – 866-400-7771. Our office is open Monday through Friday from 8:30 am to 5:00 pm EST. If you are prompted to leave a message, someone will return your call within one business day.

Online enrollment with Benefits Connect is simple, secure and can be done in a few minutes from any computer with internet access. After enrolling online, you will have access to your benefit information 24 hours a day, from any computer. For your security Benefits Connect is 128-bit encrypted and password protected. Follow the steps below to learn how to access the system and enroll.

1 TO GET STARTED, YOU WILL NEED

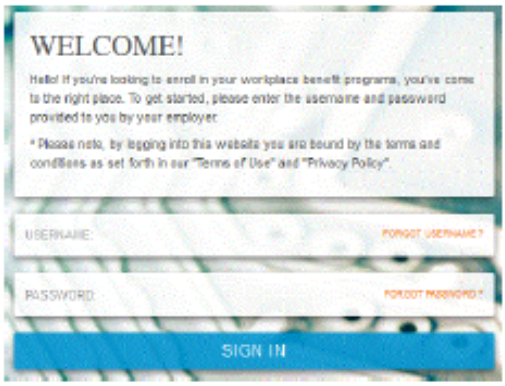
During the enrollment process you will be asked to provide some basic information that you should have available.

- Your social security number
- Your dependent's social security numbers and birth dates

2 USER NAME AND PASSWORD

Initially your user name and password are defaulted to a standard format. Upon completing your first login you will be prompted to enter and complete three security questions. From there you will be asked to change your password. Let's walk through a sample login.

Your **user name** is made up of the **first six letters of your last name**, followed by your **first initial** and **the last four numbers of your social security number**. The **initial password** for the system is your **social security number** (without dashes).
Note: If your last name is not six letters please use your entire last name, first initial and last four of our social security number as your username.



3 PERSONAL PROFILE

After your initial login, the system will take you to the PERSONAL INFORMATION section. Please complete all fields. Fields in RED are required, and must be completed. When you have completed all of the fields, click *NEXT* to proceed to the next screen.

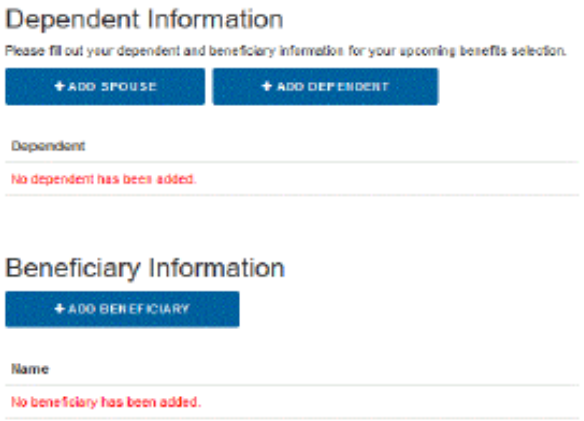
Enrollment Instructions continued…

4 DEPENDENT PROFILE & BENEFICIARIES

The system will now take you to the DEPENDENT INFORMATION section:

- To enter a spouse, click the "+ Add Spouse" icon, enter information, and click *Save*.
- To enter a child, click the "+ Add Dependent icon, enter information, and click *Save*.
- To enter a Beneficiary, click the "+ Add Beneficiary" icon, enter information, and click *Save*.

Note: You only need to add dependents that you would like to enroll for coverage. You will choose which dependents to enroll for each plan when you reach the election screens.

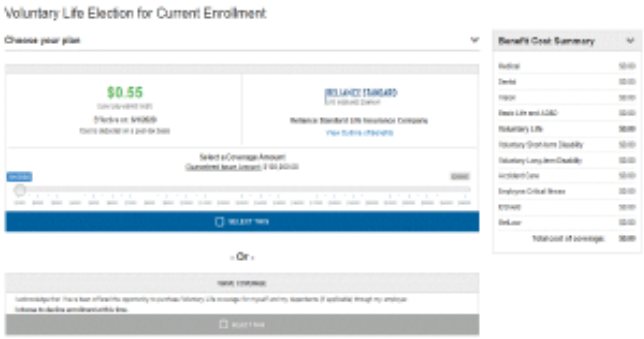


5 BENEFIT PLAN ELECTIONS

Next, the system will take you to the BENEFIT PLAN ENROLLMENT Section. Each benefit and your options will be displayed one by one.

- To enroll in a plan, check "Select This" below the option you'd like, and check any dependents you want to cover. If applicable, indicate the amount for which you would like to enroll.
- To waive coverage, check *Select This* under *Waive Coverage* below the electable benefits.
- For information about a plan, click *View Plan Outline of Benefits*.
- For plans provided by your company at no cost to you, enrollment is already checked.

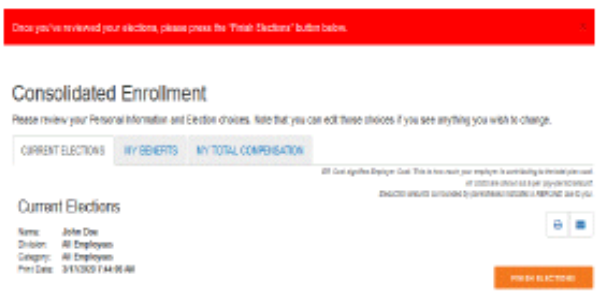
Click *Save & Continue* after each benefit selection.



6 COMPLETING YOUR ENROLLMENT

Once you have gone through enrollment for each plan available, the system will take you to the CONSOLIDATED ENROLLMENT FORM page. This screen will show you a summary of the information you entered and the benefit elections you made.

- **To complete the enrollment process: Please Click "Finished."**
- If you need to log off before completing enrollment, any data you entered will be saved. The next time you log on, you will be taken directly to the last saved screen.
- **Always make sure to log out upon completing any action on the system.**



Medical Insurance

Florida Blue; Policy #78162

Overview of Benefits				
Plan Name	05907	05302	05192/05193 HSA	05771
Network	BlueOptions	BlueOptions	BlueOptions	BlueOptions
Plan Type	PPO	PPO	PPO	PPO
In-Network:				
Individual Deductible	$7,500	$5,000	$2,500	$1,500
Family Deductible	$15,000	$10,000	$5,000	$4,500
Coinsurance %	20%	30%	20%	20%
Individual Out of Pocket Maximum	$8,200	$6,350	$5,800	$4,500
Family Out of Pocket Maximum	$16,400	$12,700	$11,600 ($6,850 max per person)	$9,000
Preventive Care	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Primary Care Office Visit	Visits 1-3: $0; 4+:$30	$30	20% after Deductible	$30
Specialist Office Visit	$60	$55	20% after Deductible	$55
Virtual/Phone Visit	$30	$30	20% after Deductible	$30
Urgent Care	$100	$60	20% after Deductible	$60
Emergency Room	20% after Deductible	$300	20% after Deductible	$250
Diagnostic (X-ray, blood work) Free standing Lab	Lab: $0; X-Ray: $60	Lab: $0; X-Ray: Deductible then 30%	20% after Deductible	Lab: $0; X-Ray: $50
Major Diagnostic Independent Test Center (MRI, CT, PET)	20% after Deductible	30% after Deductible	20% after Deductible	$250
Outpatient Surgery	20% after Deductible	30% after Deductible	20% after Deductible	20% after Deductible
Inpatient Hospitalization	20% after Deductible	30% after Deductible	20% after Deductible	20% after Deductible
Prescription Deductible	N/A	N/A	Same as Medical	N/A
Generic Prescriptions	$10	$10	$10	$10
Formulary Brand Name Prescriptions	20%	20%	$50	$60
Non-Formulary Brand Name Prescriptions	Not Covered	Not Covered	$80	$100
Specialty Medications	Not Covered	Not Covered	Not Covered	$100
Out of Network (OON)				
OON Deductibles Individual/Family	$15,000 / $30,000	$10,000 / $30,000	$5,000 / $10,000	$4,500 / $13,500
OON Coinsurance %	50%	50%	40%	50%
OON Out of Pocket Maximums Family/Individual	$16,400 / $32,800	$20,000 / $40,000	$11,600 / $23,200	$9,000 / $18,000
Coverage Tier	**Employee's Semi-Monthly (24) Payroll Deductions**			
Employee Only	$61.40	$101.73	$154.39	$279.25
Employee + Spouse	$544.66	$610.91	$471.78	$1,057.22
Employee + Child(ren)	$364.36	$415.57	$308.01	$760.63
Employee + Family	$791.74	$878.58	$696.20	$1,463.67

*Medical Waiver Credit: If you choose not to enroll in medical insurance through HCSD, you may enroll in Employee Only Dental & Long-Term Disability Insurance at no cost to you.

*Dependent Age Limits: Age 26

Virtual Healthcare by Teladoc

Florida Blue; Policy #78162

How to set up your Teladoc account

Simply download the Teladoc app and follow the four steps you see below.

1 Confirm benefits

Provide some information about yourself to confirm your eligibility.

2 Benefit confirmation

We'll confirm that we found your benefits so you can finish creating your account.

3 Create account

Provide your contact information and preferred language.

4 Complete account

Create a username, password and pick security questions to ensure your account is secure.

Set up your Teladoc account today

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

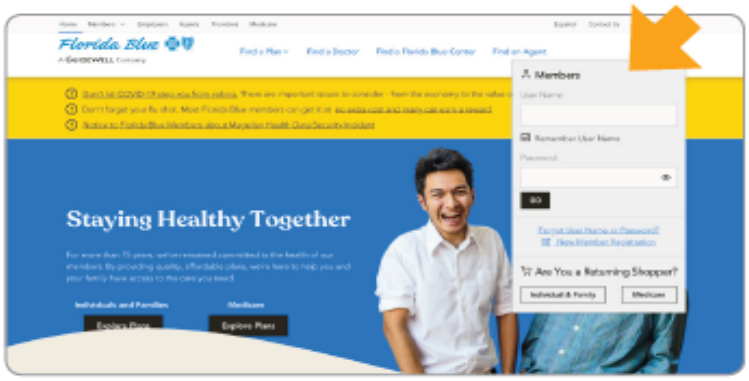
Register for FL Blue Portal

Florida Blue; Policy #78162

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

Florida Blue
Your local Blue Cross Blue Shield

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



To register:

Click **Log in**, then **New Member Registration**.

If you have trouble logging in, call 800-352-2583 for help.

New Member Registration Steps

To get started, click on **Manage my plan**.

Step 1: Fill in your personal information and click **Continue**.

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

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

Step 4: Choose a **User Name** and **Password**. The **Password** must be typed in twice for security purposes. If you'd like to receive communications electronically, click the **Yes** box and then click **Continue**.

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

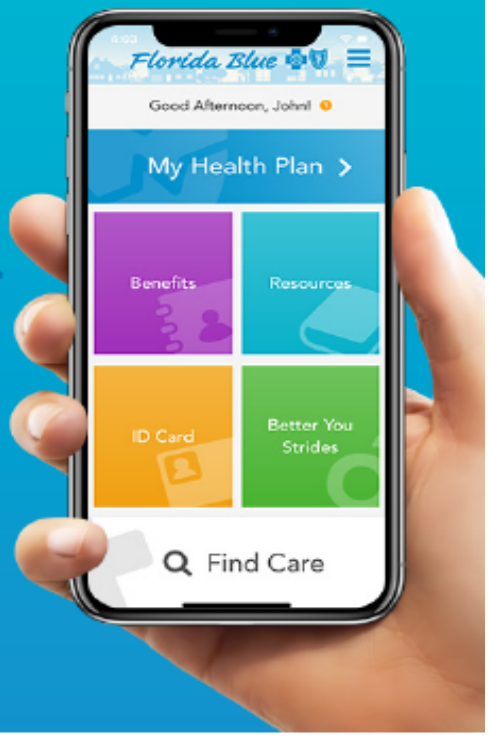
***Note:** The security questions will be used if you forget your **User Name** or **Password**.*

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

Mobile App
Florida Blue; Policy #78162

Florida Blue
In the pursuit of health

Download the Florida Blue Mobile App today!



Save Time. Save Money. Stay Healthy.

- Check plan benefits and see the status of your claims
- Find the nearest in-network doctor, Urgent Care Center or pharmacy
- Compare medical costs
- View your member ID card

As Easy as 1, 2, 3…

1. **Download the app** – available through the Apple App Store or Google Play
2. **Get Registered** – log in using your Florida Blue member account User ID and Password
3. **Get Started** – anytime, anywhere with Touch ID*

Stay informed and in control ***24 hours a day, 7 days a week!***

GET IT ON Google Play Download on the App Store

*If available on your mobile device.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an HMO affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).

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Know Before You Go
Florida Blue; Policy #78162

Remember, where you go matters!

Choosing the right treatment option can help you avoid needless worry, higher out-of-pocket costs and hours of unnecessary waiting. Use this simple guide to help you make the right decisions when you can't see your PCP.

Virtual Visits

Virtual visits let you speak securely by online video with your network or Teladoc family doctor, mental health provider or specialist. Use virtual visits for conditions like:

- Rash
- Sinus infection
- Urinary tract infection
- Common cold
- Cough
- Flu

Call your doctor and ask if they offer virtual visits, or register with Teladoc at teladoc.com.

Convenient Care Centers

Convenient care centers may be a good option. They usually have a similar copay to a PCP and treat things like:

- Cold and flu-like symptoms
- Sinus infection
- Urinary tract infection
- Rash/skin conditions

Be sure to check to see if convenient care centers are in your plan's network.

Urgent Care Centers

Urgent care centers are **less expensive than ERs** and often have **shorter wait times**. Visit an urgent care center for conditions like:

- Cold, flu and fever
- Strains, sprains and/or breaks
- Infections
- Mild burns

To find an urgent care center near you visit floridablue.com and select **Find a Doctor**.

Emergency Room

Going to an ER for an issue that is not life-threatening often results in long wait times and high medical bills. Examples of symptoms that require emergency room care:

- Severe chest pain (a possible heart attack)
- Signs of a possible stroke
- Severe or sudden shortness of breath
- Sudden or unexplained loss of consciousness

If you have a life-threatening emergency, call 911 right away.

For more information on care options visit us online at **floridablue.com**.

Health Savings Account (HSA)
Administered by HealthEquity; Policy #78162

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money**—HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable**—The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver**—HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

The maximum amount that you can contribute to an HSA in 2023 is $3,850 for individual coverage and $7,750 for family coverage.

Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

For a detailed listing of eligible and ineligible medical expenses, please visit Publication 502 on the IRS website: https://www.irs.gov/publications/p502#en_US_2022_publink1000178851

HSA CASE STUDY

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. (This example only includes HSA contribution amounts and does not reflect any investment earnings).

Year 1	
HSA Balance	$1,000
Total Expenses: - Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$850
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

➔

Year 2	
HSA Balance	$1,850
Total Expenses: - Office visits: $100 - Prescription drugs: $200 - Preventive care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 3	$1,550
Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Health Savings Account (HSA)

Administered by HealthEquity; Policy #78162

HealthEquity | HSA

Health Savings Account

An HSA lets you put money away for future healthcare costs while saving on taxes. How? HSAs are never taxed at a federal income tax level when used for qualified medical expenses. Contributions can come straight out of your paycheck, and your HSA can grow tax-free too.

- ☑ No 'use-it-or-lose-it,' keep your HSA forever
- ☑ Create a healthcare emergency safety net
- ☑ Invest[1] your HSA tax-free, like a 401(k)

Annual tax saving potential[2]

$1,550 Family plan

$770 Individual plan

2023 IRS Contribution Limits	
$7,750 Family plan	**$3,850** Individual plan
Members 55+ can contribute an extra $1,000	

See how much you can save

HealthEquity.com/Learn/HSA

Common qualified medical expenses:

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

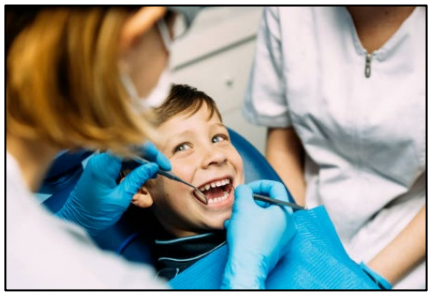
[1]Investments made available to HSA members are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, or guaranteed by HealthEquity, Inc. | [2]Estimated savings are based on an assumed combined federal and state income tax rate of 20%. Actual savings will depend on your taxable income and tax status. | HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

Dental Insurance

The Standard; Policy #160-156603

Overview of Benefits	Classic Network	
Annual Deductible (Individual/Family)	$50 / $150	
Annual Benefit Maximum	$2,500 (In-Network & Out-of-Network total)	
Child Orthodontia Lifetime Maximum	$1,000	
Maximum Rollover	Included	
	In-Network	Out-of-Network
Preventive Services		
Routine Exam (2 per benefit period) Cleanings (2 per benefit period) Bitewing/Full Mouth X-Rays Fluoride Treatments (children age 14 & under) Sealants (children age 14 & under)	Covered 100% (Deductible Waived)	*Covered 100%* *(Deductible Waived)* **Subject to balance billing*
Basic Services		
Restorative Amalgams & Composites Endodontics (Surgical & Non-Surgical) Periodontics (Surgical & Non-Surgical) Simple & Complex Extractions Anesthesia Space Maintainers	Covered 80% after Deductible	Covered 80% after Deductible **Subject to balance billing*
Major Services		
Onlyas Crowns (1 in 5 years per tooth) Crown & Denture Repair Implants Prosthodontics (fixed bridge; removable complete/partial dentures)	Covered 50% after Deductible	Covered 50% after Deductible **Subject to balance billing*
Child Orthodontia Services (under age 19)		
Consultation & Services	50%	50%
Employee's Semi-Monthly (24) Payroll Deductions	**If Enrolling in HCSD Medical Insurance**	**If Waiving HCSD Medical Insurance**
Employee Only	$25.84	$0.00
Employee + Spouse	$41.68	$15.84
Employee + Child(ren)	$39.72	$13.88
Employee + Family	$51.64	$25.80

*Dependent Age Limits: Age 26



Your Dental Benefits Portal
The Standard; Policy #160-156603

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

Vision Insurance

The Standard; Policy #160-156603

Overview of Benefits	Balanced Care Vision II		
	In Network	Out of Network (after copay, you pay)	Frequency
Eye Examination	$0 Copay	Up to $35	Every 12 Months
Materials Copay	$15 Copay	N/A	N/A
Eyeglass Frames	$130 Allowance	Up to $65	Every 24 Months
Eyeglass Lenses			
Single Vision Lenses	$0 Copay after $15 Materials Copay	Up to $25	Every 12 Months
Lined Bifocal Lenses		Up to $40	
Lined Trifocal Lenses		Up to $55	
Lenticular Lenses	20% Discount	Not Covered	
Elective Contact Lenses (in lieu of eyeglasses)			
Contact Lenses	$130 Allowance; 10% discount on amount over allowance	Up to $104	Every 12 Months
Evaluation & Fitting	Up to $40	N/A	N/A
Medically Necessary Contact Lenses			
Contact Lenses	$0 Copay	Up to $200	Every 12 Months
Employee's Semi-Monthly (24) Payroll Deductions			
Employee Only	$0.00		
Employee + Spouse	$2.68		
Employee + Child(ren)	$2.41		
Employee + Family	$5.33		

*Dependent Age Limits: Age 26

Life/AD&D Insurance

The Standard; Policy #156603

Employer Paid Basic Life/AD&D - Overview of Benefits	
Life Benefit	
Life Amount	$20,000
Accidental Death & Dismemberment (AD&D)	
AD&D Amount	$20,000
Benefit Reduction Schedule	
Benefits are reduced by a certain percentage as an employee ages.	50% at age 70
Other Basic Life Features & Services	
Please refer to your certificate of benefits for more information	• Portability of Insurance • Right to Convert Provision • Accelerated Benefit • Waiver of Premiums • Repatriation Benefit • Life Services Toolkit • Travel Assistance • Standard Secure Access account payment option

Voluntary Life/AD&D - Overview of Benefits			
Benefits	**Employee**	**Spouse**	**Child(ren)**
Benefit Minimum	$10,000	$5,000	$10,000
Benefit Maximum	$300,000	$150,000 (not to exceed 100% of employee's amount)	$10,000 (not to exceed 100% of employee's amount)
Benefit Increments	$10,000	$5,000	$10,000
Guarantee Issue	$150,000	$30,000	$10,000
Benefit Reduction	50% at age 70		Coverage terminates at age 20, or age 24 if full-time student
Additional Features	• Portability of Insurance • Right to Convert Provision • Accelerated Benefit • Waiver of Premium		

Disability Insurance
The Standard; Policy #156603

For working individuals, a disability is a medical condition that reduces your ability to perform your job duties, usually an injury or illness. While some disabilities are work-related, nearly 75% of disabling injuries to workers occur off the job.

Disability insurance is coverage that provides you with income protection, should you lose time on the job due to an injury or illness. With disability coverage, you are compensated for a portion of your lost income.

Why Is Disability Insurance So Important?
The risk of disability is greater than most employees realize. When you become disabled and lose time at work, your source of income is eliminated. Nearly one-third of employees will miss more than one month of pay due to injury or illness. In addition to lost income, you are most likely experiencing an increase in medical expenses due to your disabling injury or illness.

Traditional medical insurance doesn't cover every expense related to an injury or illness. Bills and expenses can continue to add up, especially if you have to stop working for a period of time and lose your income. Disability insurance is additional coverage that can help you pay deductibles or copayments and other increasing medical costs not covered by your employer-sponsored medical plan.

Voluntary Short-Term Disability (STD) - Overview of Benefits	
Elimination Period for Accident	**14 Days**
Elimination Period for Illness	**14 Days**
Benefit Duration	**180 Days**
Benefit Percentage	**60% of pre-disability earnings up to $1,500 maximum**
Benefit Maximum	**$15 up to a maximum of $1,500, not to exceed 60% of pre-disability weekly earnings.**

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

Long-Term Disability (LTD) - Overview of Benefits	
Elimination Period for Accident	**181 Days**
Elimination Period for Illness	**181 Days**
Benefit Duration	**Until age 65**
Benefit Percentage	**60% of pre-disability earnings up to $6,000 maximum**
Benefit Maximum	**$100 up to a maximum of $6,000, not to exceed 60% of pre-disability monthly earnings.**

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

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

If you declined medical insurance with HCSD, LTD insurance is included at no cost to you.

Supplemental Insurance

The Standard; Policy #156603

Accident Insurance: ***Keep your finances on track when an accident happens.***

Here's How Accident Insurance Works

1 You have an accident.

Your health insurance covers some costs, after you meet your deductible. But you still may have copays and a lot of out-of-pocket expenses.

2 We send you a check.

The Standard will send a check directly to you — not to your medical providers — upon approval of your claim. You decide how you spend the money.

3 You focus on getting better.

With The Standard helping you handle the unexpected expenses, you get to pay attention to what matters most — your health.

Here's what it does:

- **Pays you directly**, so you can choose how to spend the money.
- **Pays you for what happens**, regardless of your other coverage.
- **Goes with you** if you leave your employer.
- **Provides coverage without answering any medical questions.**
- Gives you the option to **cover your spouse and children**.
- **Pays an additional 25 percent benefit** if your child, 18 or under, is injured playing organized sports.
- **You pay the same premium** for as long as you have your coverage.
- Provides the convenience of having your **premium payments deducted directly from your paycheck**.

Critical Illness Insurance: ***Plan for the costs of a serious illness so you can focus on getting well.***

1 You get a critical illness diagnosis

Your health insurance covers many of your treatment costs, but you still have a lot of expenses that your finances aren't ready for.

2 The Standard is there for you

The Standard helps shield your finances by paying benefits directly to you. And you get to decide how you spend that money.

3 Focus on getting better

With The Standard helping cover your out-of-pocket or everyday expenses, you get to concentrate on what's most important to you, getting better.

Here's what it does:

- **Pays you directly**, so you can choose how to spend the money
- **Goes with you** if you leave your employer
- **Covers children** at a 25% of your benefit amount at no additional cost
- Gives you the option to **cover your spouse**

Hospital Indemnity Insurance: ***Keep your finances on track when you're in the hospital.***

1 You're admitted to the hospital.

Your health insurance covers many costs of your stay and treatment. But you still have a lot of expenses, including deductibles, copays, and other costs you couldn't predict.

2 We send you a check.

The Standard will send a check directly to you - not to your medical providers - upon approval of your claim. You decide how you spend the money.

3 You focus on recovering.

With The Standard helping you handle the costs of your hospital stay, you get to concentrate on what matters most - your health.

Here's what it does:

- **Pays you directly**, so you can choose how to spend the money
- **Goes with you** if you leave your employer
- **Provides coverage** without answering any medical questions
- Gives you the option to **cover your spouse and children**
- **Protects your HSA Account**
- Provides the convenience of having your **premium payments deducted directly from your paycheck**

Employee Assistance Program (EAP)
The Standard; Policy #156603

A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,[1] which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three counseling sessions per issue. Sessions can be done in person, on the phone, by video or text.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

Contact **EAP**

888.293.6948
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **healthadvocate.com/standard3** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

1 The EAP service is provided through an arrangement with Health Advocate℠, which is not affiliated with The Standard. Health Advocate℠ is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

SI **17201**

Employee Assistance Program-3 EE
(8/21)

The Life Services Toolkit
The Standard; Policy #156603

Life Insurance

The Life Services Toolkit

Resources and Tools to Support You and Your Beneficiary

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Health Advocate℠ to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard.

Services to Help You Now

Visit the Life Services Toolkit website at **standard.com/mytoolkit** and enter user name "assurance" for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and advance directives.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website for guidance on how to begin, to educate yourself on funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Death Benefit,[1] you may access the services for beneficiaries outlined on the next page.

continued on reverse

The Life Services Toolkit is provided through an arrangement with Health Advocate℠ and is not affiliated with The Standard. Health Advocate is solely responsible for providing and administering the included service. This service is not an insurance product.

1 An Accelerated Death Benefit or Accelerated Benefit allows a covered individual who becomes terminally ill to receive a portion of the Life insurance proceeds while living, if all other eligibility requirements are met.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

SI **17526**

Life Services EE
(8/21)

The Life Services Toolkit (continued)

The Standard; Policy #156603

Services for Your Beneficiary

Life insurance beneficiaries[2] can access services for 12 months after the beneficiary receives the Life claim letter from The Standard. Recipients of an Accelerated Death Benefit can access services for 12 months after the date of payment.

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Care Managers with advanced training are on call to provide confidential grief sessions by phone or in person. Your beneficiaries are eligible for up to six face-to-face sessions.

  Our Care Managers may offer your beneficiaries additional grief support through support kits sent to their home, based on each individual's needs. As part of this program, age-appropriate books can be sent for children and teens.

- **Legal Services:** In addition to online estate planning tools, your beneficiaries can obtain legal assistance from experienced attorneys. They can schedule an initial office visit or a telephone consultation for up to 30 minutes with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25% rate reduction from the attorney's normal hourly or fixed-fee rates.

- **Financial Assistance:** Your beneficiaries can schedule up to 30-minute telephone sessions with financial counselors who can help with issues such as budgeting strategies, and credit and debt management.

- **Support Services:** During an emotional time, your beneficiaries can receive help planning a funeral or memorial service. WorkLife advisors can guide them to resources to help manage household repairs and chores, find child care and elder care providers or organize a move or relocation.

- **Online Resources:** Your beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources about funeral costs, find funeral-related services and make decisions about funeral arrangements.

Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

For beneficiary services, visit **standard.com/mytoolkit (user name: support)** or call the assistance line at **800.378.5742**

2 The Life Services Toolkit is not available to Life insurance beneficiaries who are minors or to non-individual entities such as trusts, estates, charities.

Travel Assistance Program

The Standard; Policy #156603

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Reference Number:
01-AA-STD-5201

Download on the App Store | GET IT ON Google Play

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

1 Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

2 Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

3 Participants are responsible for arranging transportation from the point of injury or illness to the initial point of medical care or assessment and the cost related to this transportation. Any emergency evacuation services provided by Assist America, Inc. must be arranged by Assist America, Inc.

SI 14684

Travel Assistance EE
(4/23)

Glossary
Commonly Used Terms

Allowed Amount: This is the maximum payment the plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Claim: A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe.

Copay: A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing: Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn’t cover usually aren’t considered cost sharing.

Deductible: A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

In-network: Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient: A person who is treated as a registered patient in a hospital or other health care facility.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Out-of-network (OON): Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket Maximum (OOPM): The highest out-of-pocket amount paid for covered services during a benefit period.

Prescription Drug Coverage: Coverage under a plan that helps pay for prescription drugs. If the plan’s formulary uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each “tier” of covered prescription drugs.

Preventive Care: Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician (PCP): A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Referral: A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don’t get a referral first, the plan may not pay for the services.

Specialist: A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Notice to Employees of Coverage Options

New Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

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

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

Notice to Employees of Coverage Options

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name	4. Employer Identification Number (EIN)	
Hamilton County School District	59-3316429	
5. Employer address	6. Employer phone number	
5686 US Highway 129 South, Suite 1	386-792-7800	
7. City	8. State	9. ZIP code
Jasper	FL	32052
10. Who can we contact about employee health coverage at this job?		
Carrie Black		
11. Phone number (if different from above)	12. Email address	
386-792-7837	Carrie.Black@hamiltonfl.com	

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

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

- **With respect to dependents:**
  - **We do offer coverage. Eligible dependents are your legal spouse, and your natural, step, or adopted children until they reach age 26.**

**** 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.

Medicare Part D Notice of Creditable & Non-Creditable Coverage

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

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

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

2. **Hamilton County School District has determined that the prescription drug coverage offered by the BlueOptions 05192/05193 HSA and BlueOptions 05771 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

3. **Hamilton County School District has determined that the prescription drug coverage offered by the BlueOptions 05907 and BlueOptions 05302 is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the BlueOptions 05907 and BlueOptions 05302 This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

4. **You can keep your current coverage from BlueOptions 05907 and BlueOptions 05302. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you decide to drop your current coverage with Hamilton County School District since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under BlueOptions 05907 and BlueOptions 05302.

Mandatory Benefit Notices

Benefit Notice	Applicability	Description
SBC	Group health plans and health insurance issuers	Group health plans and health insurance issuers are required to provide an SBC to applicants and enrollees each year at open enrollment or renewal time. Federal agencies have provided a template for the SBC, which health plans and issuers are required to use. The issuer for fully insured plans usually prepares the SBC. If the issuer prepares the SBC, an employer is not also required to prepare an SBC for the health plan, although the employer may need to distribute the SBC prepared by the issuer.
Medicare Part D notice of creditable or non-creditable coverage	Employers with group health plans that provide prescription drug coverage	Employers must notify Medicare Part D-eligible individuals before Oct. 15 each year about whether the drug coverage is at least as good as the Medicare Part D coverage (in other words, whether the prescription drug coverage is "creditable" or "non-creditable"). Because employers may not be able to identify which individuals are eligible for Medicare Part D, they often provide the Medicare Part D disclosure to all plan participants. Employers will satisfy the timing requirements for this notice if it is provided to all plan participants annually, prior to Oct. 15 of each year. CMS has provided model notices for employers to use.
WHCRA notice	Group health plans that provide medical and surgical benefits for mastectomies	Group health plans must provide a notice about the WHCRA's coverage requirements at the time of enrollment and on an annual basis after enrollment. The annual WHCRA notice can be provided at any time during the year. Employers often include the annual notice with their open enrollment materials. Employers that redistribute their SPDs each year can satisfy the annual notice requirement by including the WHCRA notice in their SPDs. Model language is available in the DOL's model notice guide.
Children's Health Insurance Program (CHIP) notice	Group health plans that cover residents in a state that provides a premium assistance subsidy under a Medicaid plan or CHIP	If an employer's group health plan covers residents in a state that provides a premium subsidy under a Medicaid plan or CHIP, the employer must send an annual notice about the available assistance to all employees residing in that state. The annual CHIP notice can be provided at any time during the year. Employers often provide the CHIP notice with their open enrollment materials. The DOL has a model notice that employers may use.

Mandatory Benefit Notices

Benefit Notice	Applicability	Description
SPD	Group health plans subject to ERISA	An SPD must be provided to new health plan participants within 90 days of the date their plan coverage begins. Employers may include the SPD in their open enrollment materials to make sure employees who newly enroll receive the SPD on a timely basis. Also, an employer should include the SPD with its enrollment materials if it includes notices that are required to be provided at the time of enrollment, such as the WHCRA notice. In addition, an updated SPD must be provided to participants at least every five years, if material modifications have been made during that period. If no material modifications have been made, an updated SPD must be provided at least every 10 years.
COBRA General Notice	Group health plans subject to COBRA	Group health plans must provide a written General Notice of COBRA Rights to covered employees within 90 days after their health plan coverage begins. Employers may include the General Notice in their open enrollment materials to ensure that employees who newly enroll during open enrollment receive the notice on a timely basis. The DOL has a COBRA Model General Notice that can be used by group health plans to meet their notice obligations.
Grandfathered plan notice	Health plans that have grandfathered status under the Affordable Care Act (ACA)	To maintain a plan's grandfathered status, the plan sponsor must include a statement of the plan's grandfathered status in plan materials provided to participants describing the plan's benefits (such as the SPD, insurance certificate and open enrollment materials). The DOL has provided a model notice for grandfathered plans.
Notice of patient protections	Non-grandfathered group health plans that require designation of a participating primary care provider	If a non-grandfathered plan requires participants to designate a participating primary care provider, the plan or issuer must provide a notice of patient protections whenever the SPD or similar description of benefits is provided to a participant. This notice is often included in the SPD or insurance certificate provided by the issuer (or otherwise provided with enrollment materials). The DOL has provided a model notice of patient protections for plans and issuers to use.

Mandatory Benefit Notices

Benefit Notice	Applicability	Description
HIPAA privacy notice	Self-insured group health plans	The HIPAA Privacy Rule requires self-insured health plans to maintain and provide their own privacy notices. Special rules, however, apply for fully insured plans. Under these rules, the health insurance issuer, and not the health plan itself, is primarily responsible for the privacy notice. Self-insured health plans are required to send the privacy notice at certain times, including to new enrollees at the time of enrollment. Thus, the privacy notice should be provided with the plan's open enrollment materials. Also, at least once every three years, health plans must either redistribute the privacy notice or notify participants that the privacy notice is available and explain how to obtain a copy. The Department of Health and Human Services has model privacy notices for health plans to choose from.
HIPAA special enrollment notice	All group health plans	At or prior to the time of enrollment, a group health plan must provide each eligible employee with a notice of his or her special enrollment rights under HIPAA. This notice should be included with the plan's enrollment materials. It is often included in the health plan's SPD or insurance booklet.
Wellness notice – HIPAA	Group health plans with health-contingent wellness programs	Employers with health-contingent wellness programs must provide a notice that informs employees that there is an alternative way to qualify for the program's reward. This notice must be included in all plan materials that describe the terms of the wellness program. If wellness program materials are being distributed at open enrollment (or renewal time), this notice should be included with those materials. Sample language is available in the DOL's model notice guide.
Wellness notice – ADA	Wellness programs that collect health information or include medical exams	To comply with the Americans with Disabilities Act (ADA), wellness plans that collect health information or involve medical exams must provide a notice to employees that explains how the information will be used, collected and kept confidential. Employees must receive this notice before providing any health information and with enough time to decide whether to participate in the program. Employers that are implementing a wellness program for the upcoming plan year should include this notice in their open enrollment materials. The Equal Employment Opportunity Commission has provided a sample notice for employers to use.
Individual coverage HRA (ICHRA) notice	Employers that sponsor ICHRAs for specific classes of employees (or all employees)	Beginning in 2020, employers of all sizes may implement an ICHRA to reimburse their eligible employees for insurance policies purchased in the individual market, or for Medicare premiums. Employers with ICHRAs must provide a notice to eligible participants about the ICHRA and its interaction with the ACA's premium tax credit. In general, this notice must be provided at least 90 days before the beginning of each plan year. Employers may provide this notice at open enrollment time if it is at least 90 days prior to the beginning of the plan year. A model notice is available for employers to use to satisfy this notice requirement.

Mandatory Benefit Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Mandatory Benefit Notices

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

Mandatory Benefit Notices

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Notes

Contact Information

Benefit Coverage	Carrier	Customer Service	Website
Medical	FL Blue	800.352.2583	www.FloridaBlue.com
Virtual Healthcare	Teladoc	800.835.2362	www.Teladoc.com
Health Savings Account	HealthEquity	866.735.8195	www.HealthEquity.com
Dental	The Standard	800.547.9515	www.Standard.com
Vision	The Standard	800.289.0614	www.Standard.com
Employer Paid Basic Life/AD&D	The Standard	800.628.8600	www.Standard.com
Voluntary Life/AD&D	The Standard	800.628.8600	www.Standard.com
Short-Term Disability	The Standard	800.368.2859	www.Standard.com
Long-Term Disability	The Standard	800.368.1135	www.Standard.com
Accident Critical Illness Hospital Indemnity	The Standard	866.851.2429	www.Standard.com
Employee Assistance Program (EAP)	The Standard	888.293.6948	www.HealthAdvocate.comStandard3
The Life Services Toolkit	The Standard	800.378.5742	www.Standard.com/MyToolkit (Username: support)
Travel Assistance Program	The Standard	800.872.1414	www.MedServices@AssistAmerica.com

HCSD Contact Information:

Carrie Black, Employee Benefits Specialist
386.792.7837
Carrie.Black@hamiltonfl.com

For assistance with benefit questions, membership card issues, claims, & billing inquiries please contact your Acentria service contact:

Rebecca Peavey & Kishrondra Petruska
Benefits Account Executive
Direct: 386.362.4724
Email: HCSD@acentria.com

www.Acentria.com

Hamilton County School District

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10/01/2023 – 09/30/2024

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