sbac.edu/mybenefits

Alachua County Public Schools

2024 EMPLOYEE BENEFITS GUIDE

Proud to Offer a Comprehensive Health Care Package to Eligible Employees

Alachua County Public Schools (ACPS) is proud to offer a comprehensive health care program to eligible employees. This guide will provide detailed information about each benefit. During benefits enrollment you have the opportunity to review your coverage needs, consider the benefits plans available to you, and select those that will provide the most value to you and your family.

This guide also provides tips on how you can save on health care expenses. Be sure to compare the plans in this guide to ensure you enroll in the ones that best meet your needs and financial goals.

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Eligibility

EMPLOYEES
Employees must be a regular, full-time employee currently working .50 FTE or higher. Eligible employees must be actively at work when their benefits become effective.

DEPENDENT ELIGIBILTY REQUIREMENTS

Eligible Dependents are:

- Your legal spouse or your domestic partner.
- Your child(ren), children whom you have been appointed legal guardianship of, stepchildren, and legally adopted children.

Children will be covered from birth, adoption, or time of guardianship until:

- Health Insurance – End of calendar year they turn 26.
- Dental and Vision - End of calendar year they turn 25
- Your dependent child(ren) must be unmarried to be covered.
- Critical Illness, Accident, and Life – To age 26.

Disabled Child(ren)

Dependents who become disabled before age 26 and rely on you for support may be eligible.

DEPENDENT ELIGIBILTY DOCUMENTS

All dependent eligibility documents must be uploaded into PlanSource. Paper documents or emailed documents are not accepted. The following documents must be uploaded during your enrollment period before coverage is approved**:**

Spouse – BOTH (2) documents must be provided as one attachment.

- A copy of your court-filed marriage certificate (filed in public records, church documents are not accepted) **AND** one of the following:
    - Copy of the front page of the current year's Federal Tax Return showing "Married filing jointly" or "Married filing separately".
    - A household statement dated within the last 60 days with both you and your spouse's names listed. (For example: bank statement, mortgage statement, property tax, electricity, or cable).

Domestic Partner – Affidavit of Domestic Partnership (provided by Benefits Office upon request.) Domestic partners may only be covered on the medical plan.

Children – Birth certificate, hospital birth record, adoption certificate naming you or your spouse as the child's parent, or a copy of the court order naming you or your spouse and the child's legal guardian, legal custodian, or foster parent.

Disabled Child(ren) – Birth certificate, hospital birth record, adoption certificate naming you or your spouse as the child's parent, or a copy of the court order naming you or your spouse and the child's legal guardian, legal custodian, or foster parent **AND** a copy of the Social Security Administration letter awarding disability benefits or letter form physician confirming disabled status.

Benefits Enrollment

ACTIVELY AT WORK

- Eligible employees must be actively at work on the plan effective date for new benefits to be effective, meaning you are physically capable of performing the functions of your job on the first day of work concurrent with the plan effective date. For example, if your 2024 Medical Flexible Spending Account becomes effective on January 1, 2024, you must be actively at work on January 1, 2024, to be eligible for your new benefits. If you are not actively at work but return to active work status within ten working days from the plan effective date, your benefits will cover you on the first of the month following your return-to-work date.

- For employees on leave who experience a lapse in coverage, your benefits may be reinstated on the 1st of the month following 30 days of continuous work, if you request reinstatement. If not requested upon returning to work, you must wait until Open Enrollment and enroll in coverage to be effective in the new plan year.

BENEFITS EFFECTIVE DATE

- Your benefits will be effective the 1st of the month following 30 days of employment and will be effective through December 31, 2024 as long as you continue working for ACPS.

Start Date	Effective Date
August	October 1
September	November 1
October	December 1
November	January 1

Start Date	Effective Date
December	February 1
January	March 1
February	April 1
March	May 1

Start Date	Effective Date
April	June 1
*May	July 1
June	August 1
July	September 1

*10-month employees hired May 1st or after, benefits will be effective October 1st.

MEMBER ID CARDS

- ID Cards are issued for some benefits - Please refer to back cover for the list of carriers.

- Your ID card contains important information about you, your employer group, and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.

- Replacement Cards – Contact the carrier directly - See back cover for contact information.

NEW HIRE ENROLLMENT

- New hire enrollment must be completed within 14 days from your start date. *(exception: 10-month employees with a start date of May 1st or later will not have access to New Hire Enrollment until the first 14 days of their start date in the new school year).*

- **You will default into the Opt-Out package and waive all voluntary benefits if you fail to complete your new hire benefits enrollment within the 14-day new hire window.** If you choose not to enroll, or miss the deadline, you will have to wait until the next Open Enrollment period to enroll unless you experience a Qualified Life Event.

OPEN ENROLLMENT – Annually October 1st through October 25th

- Make changes to current enrollment: add new coverage, drop coverage, add new dependents, or drop dependents. **NOTE: You must re enroll in voluntary Flexible Spending Accounts/Dependent Care Flexible Spending Accounts (FSA/DCFSA) each year if you wish to continue participation.**

HOW TO ENROLL WITH PLANSOURCE

Benefits enrollment is completed online via PlanSource – the self-service, online portal for employees. Once logged in, you will be able to see benefits offered to you and compare costs. This system is available year-round to check current coverage or make changes. A tutorial of the New Hire Enrollment process is available on the Benefits Launchpad for your reference. Access the Benefits Launchpad at https://sbac.edu/mybenefitslaunchpad.

To start your enrollment:

From an ACPS Device
ACPS Launch Pad
myPortal
Productivity
Benefits
Log into PlanSource

From cell phone, tablet, or laptop
mybenfits.sbac.edu
Log into myPortal

This will bring you to the "*Welcome Page.*" Click "*Get Started*" OR "*Shop New Hire Enrollment*" to begin.

Step 1: Review Profile

- Verify your personal information; if there are changes to your address or name, contact your Human Resources representative via email. The * indicates a required field.
- After reviewing personal information, select ***"Next: Review My Family".*** There you can ***"Add Family Member",*** even if you are not enrolling them in coverage. Adding dependents to your family profile will prompt dependent coverage options. Please double check spelling of names and verify dates of birth and social security numbers.
- If not adding family members, click **"Next – Shop for Benefits".**

Step 2: Shop Benefits

- Start by clicking on **"Shop Plans"** in the Medical Section. Then click **"View Plan"** and **"Update Cart"** to select the Medical Plan you wish to enroll in. The system will automatically prompt the next benefit for you to review once you make your selection. Continue this process as you respond to each benefit offered.
- When you reach the Optional Life and Dependent Life benefits, you must click on **"Select Amount"** and choose the benefit amount and then **"Update Cart"** to enroll in these benefits.
- If you are not interested in the benefit you must click **"Decline Coverage"** then **"Confirm Decline"** to continue.
- After you have entered a response to all benefits, review your selections. If no changes are needed, click **"Next: Review Beneficiaries".**

Step 3: Review Beneficiaries

- Click **"+"** to open your life insurance benefit(s), then click **"+ADD BENEFICIARY".**
- Select a beneficiary from **"Choose existing beneficiary"** OR complete bottom section to enter a person, charity, or trust. You must enter a number in the allocation box to designate the percentage of the benefit payable to that beneficiary (any whole number 1-100.) Your total allocation must equal 100 to proceed.
- Please ensure both a primary and secondary beneficiary are designated.
- Click **"Review & Checkout."**

Step 4: Checkout

- Once you have responded to each benefit you will be taken to the page that says **"*You're almost done!*"** Review your selections for accuracy and click **"*CHECKOUT*"** at the bottom of the page.
    - If ***"CHECKOUT"*** is grayed out, you must go back and review any benefit where a ***"SHOP PLANS"*** button appears.
    - Your benefit selections will not be saved until you click ***"CHECKOUT"*** and the *"Congratulations you have completed your enrollment"* page appears.

Step 5: Documents

- **Review *"Your To-Do-List".*** Upload the required documents **before your enrollment period closes** if you added any new family members to your coverage.

MID-YEAR CHANGES

PLANSOURCE

You may not change your pre-tax benefits during the plan year unless you experience a Qualified Life Event. The changes you make must be the result of, and consistent with, the Qualified Life Event that occurred. A tutorial of the Life Event process is available on the Benefits Launchpad for your reference. Access the Benefits Launchpad at https://sbac.edu/mybenefitslaunchpad.

Mid-year change requests and supporting documentation must be submitted online via PlanSource within 30-days of the date of the event, and must be completed within 14 days from the start of the process.

QUALIFIED LIFE EVENTS AND REQUIRED DOCUMENATION

- Marriage – A copy of your court-filed marriage certificate (is filed in public records, church documents are not accepted) AND a copy of the front page of the current year's Federal Tax Return showing "Married filing jointly" or "Married filing separately," or a household statement dated within the last 60 days with both you and your spouse's names listed. (For example, bank or mortgage statements, property tax notices, electricity or cable bills, etc.)
- Divorce – Divorce Decree
- Birth of a Child – Birth Certificate
- Adoption – Adoption Certificate/Court Order
- Loss of Coverage – Document which indicates the benefit enrolled, the termination date, and covered dependents (this may be from the prior benefit carrier or employer.) Dependent eligibility documents may also be required in addition to the proof of loss of coverage.
- Gain of Creditable Coverage – Confirmation statement of NEW coverage (must include type of coverage, covered members, and effective date. Date must be 30 days before or after the start of the new coverage.)

Step by Step Instructions

- Log in to mybenefit.sbac.edu or navigate to the ACPS launchpad sbac.edu/mybenefitslaunchpad.
- Click "Update Benefits."
- Select the type of life event.
- Enter effective date of the life event.
- Click "Continue."
- Select plans/make changes to your benefits.
- Click "Checkout."
- Upload required documents using the *Document Request* links.
- Before coverage becomes active, payment may be required when new coverage or new dependents are added. The Benefits Department will contact via email for payment.
- **If you do not request the change, provide the necessary documentation, and pay any premium due within 30 days, you will have to wait until the next Open Enrollment to make the change.**

Key Terms to Know

Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Annual Maximum

Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Brand Formulary Drugs

The brand formulary is an approved, recommended list of brand-name medications. Drugs on this list are available to you at a lower cost than drugs that do not appear on this preferred list.

Coinsurance

A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible.

Copayment

A set dollar amount you pay for network doctors' office visits, emergency room services, and prescription drugs.

Contingent Beneficiary

The individual or organization that receives proceeds of your life insurance policy if the primary beneficiary is unable to do so. It is recommended beneficiaries are 18 years and older.

Deductible

Total dollar amount, based on the allowed amount, you must pay out-of-pocket for covered medical expenses each calendar year before the plan pays for most services. The deductible does not apply to network preventive care if any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services

Generic Drugs

These drugs are usually the most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase formulary or non- formulary brand name drugs.

Maintenance Drugs

Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma, and diabetes.

Network

A group of health care providers, including dentists, physicians, hospitals, and other health care providers that agree to accept pre-determined rates when servicing members.

Non-Formulary Drugs

These drugs are not on the recommended formulary list. These drugs are usually more expensive than drugs found on the formulary. You may purchase brand-name medications that do not appear on the recommended list, but at a significantly higher out-of-pocket cost.

Out-of-Pocket Maximum

The maximum amount of coinsurance a Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of-pocket maximum.

Primary Beneficiary

The individual or organization designated to receive the proceeds of your life insurance policy upon the policy holders death. It is recommended they are 18 years or older.

Primary Care Physician (PCP)

The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Portability

An employee carries or 'ports' his/her current Group Life coverage after employment ends, without having to answer any medical questions. Portability is for an employee who is leaving their job and still wants to maintain the protection that life insurance provides.

Qualifying Event

An occurrence that qualifies the subscriber to make an insurance coverage change outside of Open Enrollment.

Specialty Drugs

Prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic, and often costly conditions.

MEDICAL PLANS

Your medical coverage is administered through **Florida Blue**. You'll have access to a nationwide network* of doctors and hospitals, providing you with quality care and significant savings in comparison to receiving services out-of-network.

Florida Blue
In the pursuit of health®

MEDICAL BENEFITS	BlueOptions $750 DED Plan In-Network	BlueOptions $1,500 DED Plan ($500 HRA) In-Network	BlueOptions $2,500 DED Plan ($500, $1,000, OR $1,500 HRA) In-Network	MEDICAL OPT OUT PACKAGE *Does not include Medical Coverage*
Calendar Year Deductible				
Per Individual	$750	$1,500	$2,500	If you have health coverage elsewhere, the School Board offers Hospital Indemnity and Short Term Disability Plans, at no cost to you. This package includes flexible benefit dollars in the form of a $250 medical FSA. To be eligible for this benefit, you must have other medical insurance and decline all of Alachua County Public School's offered medical plans.
Family Aggregate	$2,250	$4,500	$7,500	
Out-of-Pocket Maximum				
Per Individual Family	$5,000	$5,000	$4,000	
Aggregate	$10,000	$10,000	$8,000	
Coinsurance (% the plan pays)	80%	80%	80%	
Preventive Services	No Charge	No Charge	No Charge	
Office Visits				
Virtual Visits	$15	$15	$15	
Primary Care Physician	$30	$25	$20	
Specialist	DED + 20%	DED + 20%	DED + 20%	
Urgent Care	$40	$35	$35	
Mental Health	DED + 20%	DED + 20%	DED + 20%	
Emergency Room	DED + $100 + 20%	DED + $100 + 20%	DED + $100 + 20%	
Inpatient Hospital	DED + 20%	DED + 20%	DED + 20%	
Outpatient Procedures				
Hospital	DED + 20%	DED + 20%	DED + 20%	
Ambulatory Surgery Center	$100	DED + 20%	DED + 20%	
Outpatient Diagnostic Tests				
Independent Clinical Lab	No Charge	No Charge	No Charge	
Independent Testing Center	$50	DED + 20%	DED + 20%	
Advanced Imaging				
MRI, CT, PET, etc.	$200	DED + 20%	DED + 20%	
COST PER PAYCHECK (20)				
Employee Only	$27.95	$0.00	$0.00	No Cost
Employee + Spouse	$488.36	$407.78	$374.52	
Employee + Child(ren)	$406.09	$339.10	$308.58	
Employee + Family	$603.06	$503.56	$466.48	
Dual Spouse	$222.75	$123.25	$86.16	

Short-term Disability
Benefit amount is $100 per week. Benefit begins on the 15th day of accidental disability or the 15th day of sickness disability. Coverage is for non-work related disability. Normal pregnancy is included. Benefit terminates at age 70. Maximum benefit period is 26 weeks.

Hospital Indemnity
Benefit amount pays $90 per day for each day you are hospital confined, up to 91 continuous days of confinement.

*For complete details, exclusions and limitations, and out-of-network benefits, please review The Summary of Benefits & Coverage document posted at www.sbac.edu/mybenefits. It is also available in paper form, free of charge from the Benefits office.

Health Reimbursement Arrangement

A Health Reimbursement Arrangement (HRA) is an employer-funded benefit that is designed to pay or reimburse you for qualified medical expenses that are paid for out-of-pocket. Employees enrolled in the BlueOptions $1,500 or $2,500 deductible medical plans will receive a prorated employer funded HRA, based on the chart below. You and your enrolled dependents on your medical plan are eligible to access these funds. If you separate employment your HRA will be prorated using the chart below.

You will receive a WEX debit card that gives you direct access to your HRA funds. Due to IRS regulations, debit card transactions may need to be substantiated.

Keep all itemized receipts and provider documentation for your medical, dental, or vision expenses, in case the WEX requests documentation to substantiate one or more of your transactions. If you fail to substantiate the transactions, your debit card may be deactivated, and the funds may be added to your taxable income on your W-2.

FAQs

- HRA is 100% funded by ACPS (no cost to the employee.)
- You can use your HRA to pay for qualified medical expenses such as deductibles, co-pays, coinsurance, prescriptions, dental, and vision expenses.
- HRA funds rollover at the end of each plan year, allowing you to build the funds for future expenses. The rollover maximum is $5,000 from prior years. Total balance not to exceed $5,500. Any amount over the rollover amount will be forfeited.
- If you separate from ACPS, you will retain any unused funds if you are vested. You are considered vested after you have been enrolled in an HRA eligible medical plan after six or more consecutive years. If you are not vested, earned and unused funds must be utilized by the last day of the month in which you last physically worked.
- If you are also enrolled in a Medical FSA, claims will be paid from your FSA first.

Number of Months Covered	$1,500 or $2,500 Plan Employee Only	$2,500 Plan Employee +1 (Spouse or Child)	$2,500 Plan Employee + 2 or more (Children or Full Family)
12	$500.00	$1,000	$1,500.00
11	$458.33	$916.67	$1,375.00
10	$416.66	$833.33	$1,250.00
9	$374.99	$750.00	$1,125.00
8	$333.32	$666.67	$1,000.00
7	$291.65	$583.33	$875.00
6	$249.98	$500.00	$750.00
5	$208.31	$416.67	$625.00
4	$166.64	$333.33	$500.00
3	$124.97	$250.00	$375.00
2	$83.30	$166.67	$250.00
1	$41.63	$83.33	$125.00

Prescription Drugs

Your pharmacy benefits are provided through **Express Scripts, Inc (ESI)**. You may purchase up to a 30-day supply of covered drugs when you fill your prescription at a participating retail pharmacy. You can use the mail order pharmacy program if you use a maintenance medication, such as those for blood pressure or cholesterol. The mail order pharmacy program offers up to a 90-day supply at a reduced cost to you.

MEMBER ID CARD

- Members will receive a separate pharmacy (Express Scripts) card. Use this card for all prescriptions.
- Immunizations/vaccinations for Shingles, Pneumonia, and Flu are covered under adult wellness (preventative) or the members can go to the pharmacy and have a pharmacist administer at no cost, just present your ESI card.

PRESCRIPTION BENEFITS		
Plan	**$750 DED Plan**	**$1,500 & $2,500 DED Plan**
Deductible	**$200 Brand Only**	**$100 Brand Only**
Retail Pharmacy Generic / Preferred Brand / Non-Preferred Brand / Specialty	20% / 40% / 40%	20% / 40% / 40%
Mail Order (90-day supply) Generic / Preferred Brand / Non-Preferred Brand	$20 / $50 / $80	$20 / $50 / $80

Ensure you don't pay more than you have to for your prescriptions with these tips:

1. *Ask your doctor or pharmacist if a generic alternative is available.*
2. *Compare medication prices in your Express Scripts online account with GoodRx before you fill at the pharmacy.*
3. *Fill maintenance prescriptions by using the mail order option.*

Create an account on express-scripts.com or the Express Scripts mobile app and access your prescription plan anytime and anywhere.

- Visit express-scripts.com and select REGISTER or download the mobile app for free and select REGISTER.
- Enter the requested information, including your member ID or Social Security Number, and create your username and password.
- Click or tap REGISTER NOW.

Once your account is created, you can:

- Check the cost of your prescriptions before you go to the pharmacy.
- Check your order status.
- Refill and renew prescriptions.
- Find your nearest preferred pharmacy.
- View and print member ID Cards.
- Enroll eligible prescriptions in automatic refill.
- Set reminders to take your medication.
- Enroll in home delivery.

Get your 90-day prescriptions shipped right to your door with mail order.

- Log into express-scripts.com

If enrolling a new prescription:

- Contact your doctor and ask them to e-prescribe a 90-day prescription directly to ESI.
- OR send in a request by selection "Form" or "Forms & Cards" from the "Benefits" menu, print a mail order form and follow the mailing instructions.
- OR call ESI at the Member Services number on your card and they will contact your doctor for you!

If enrolling current prescriptions:

- Transfer retail prescriptions to home delivery by clicking "Add Cart" for eligible prescriptions and check out.
- You can also refill and renew prescriptions.
- Check Order Status to track shipping of your prescriptions. After ESI receives our prescription from your doctor you will receive your medication in 7 days.

Florida Blue
In the pursuit of health®

HOW TO USE AND ACCESS FLORIDA BLUE'S MEMBER PORTAL

Create an account on floridablue.com or the Florida Blue mobile app and manage your plan anytime and anywhere with an online account.

- Visit floridablue.com and select LOGIN and select NEW MEMBER REGISTRATION.
- Enter your member number, name, date of birth, and zip code.

Once your account is created, you can:

- View and print member ID cards.
- Find providers.
- View plan documents.
- Access Claim information.

TELADOC®

If you have a cold, sore throat, sinus problem, or other benign condition, you may be able to skip the doctor's office and receive expert care from the comfort of home. This virtual visit benefit allows you to have a phone consult or video conference with a doctor using either your mobile device or computer. If a prescription is needed, your doctor will send the script to the pharmacy of your choice.

TALK TO A DOCTOR ANYTIME FOR $15 per visit!

To learn more and register:

- Download the mobile app.
- visit teladoc.com.
- Or call 1-800-Teladoc.

Create account

Use your phone, the app, or the website to create an account and complete your medical history.

Talk to a doctor

Request a time and Teladoc doctor with contact you.

Feel better

The doctor will diagnose symptoms and send a prescription if necessary.

Dental Benefits

Humana

	Advantage	PPO	Traditional Preferred
	In-Network Only	In-Network Fee Schedule	Coverage based on Usual , Customary, and Reasonable Fees
IN-NETWORK			
Calendar Year Deductible Individual Family	No DED	$50 $100	$50 $100
Preventive Services	Covered at 100%		
Basic Services			
Restoration (One Surface)	$24	20%	20%
Restoration (Two Surfaces)	$31		
Extraction	$26		
Major Services			
Crown	$445	No Benefit	50%
Complete Denture	$642	No Benefit	
Partial Denture	$709	No Benefit	
Root Canal	$497	20%	
Surgical Extraction	$108		
Orthodontic Services			
Evaluation	$35	N/A	50% $1,000 Lifetime Max (under age 19)
Treatment	$250		
Retention	$450		
Therapy	$2,100 (Under age 19) $2,300 (Over age 19) For 24-month full banded cases		
Annual Benefit Maximum	**Unlimited**	**$750**	**$1,000 (excludes ortho)**
OUT-OF-NETWORK YOU MAY BE BALANCE BILLED IF YOU USE AN OUT-OF-NETWORK PROVIDER			
Diagnostic & Preventive	N/A	100%	100%
Basic Services	N/A	40%	20%
Major Services	N/A	40%	50%
Orthodontic Services	N/A	N/A	50% $1,000 Lifetime Max (under age 19)
EMPLOYEE COST PER-PAY-PERIOD (20)			
Employee Only	**$11.83**	**$10.58**	**$19.48**
Employee & 1 Dependent	**$23.26**	**$20.09**	**$37.97**
Employee & 2 or More Dependents	**$31.80**	**$36.82**	**$67.62**

You may view your benefits, print an ID card, and locate in-network dental providers by visiting **humana.com**.

Vision Benefits

Your vision coverage is provided through **Aetna**. When you utilize a provider that participates in the network, discounts will be greater and there are no claim forms necessary. Plan participants also have access to discounted lens upgrade options and Lasik eye surgery.

You may view benefits, print an ID card, and search for in-network vision providers at **aetna.com**.

IN-NETWORK	
Eye Exams* Routine Eye Exam Contact Lens Fitting/Follow-up	$10 copay Standard: $40 allowance Premium: 10% discount
Frames**	$130 allowance 20% off balance
Lens Single Vision Bifocal Trifocal Lenticular	 $15 Copay $15 Copay $15 Copay
Contacts*	$130 allowance 15% off balance
Diabetes Benefit Office Service Visit (Medical Follow Up Exam) Retinal Imaging & Extended Ophthalmoscopy [1] Gonioscopy [2] Scanning Laser [2]	$0 copay
OUT-OF-NETWORK	
Eye Exams* Routine Eye Exam Contact Lens Fitting/Follow-up	$30 Reimbursement Not Covered
Frames**	$65 Reimbursement
Lens Single Vision Bifocal Bifocal Trifocal Lenticular	 $25 $40 $60 $100
Contacts	$104 Reimbursement
Diabetes Benefit Office Service Visit (Medical Follow Up Exam) Retinal Imaging & Extended Ophthalmoscopy[1] Gonioscopy [2] Scanning Laser [2]	 $77 $50 $15 $33

Frequently asked questions

What is a benefit allowance?

A benefit allowance gives you a certain dollar amount to use towards contacts and glasses (lenses and frames). When you choose materials that are within that dollar amount or allowance, they are covered at 100%. If you choose a frame exceeding your plan allowance, you'll be responsible for paying the overage, in addition to any applicable copays at the time of your visit.

Can I get contacts AND glasses in the same calendar year?

No. You can only get contacts OR glasses in the same calendar year, not both.

EMPLOYEE COST PER-PAY-PERIOD (20)	
Employee Only	$2.75
Employee & Family	$7.69

* Benefits may be redeemed every 12 months

** Benefits may be redeemed every 24 months

[1] One per 6 months

[2] Up to two services per year for Type 1 & Type 2 diabetics

Flexible Spending Accounts (FSAs)

ACPS offers the choice of two Flexible Spending Accounts (FSAs) administered by **WEX**, which allow you to pay for eligible expenses with pre-tax dollars. *(Enrollment in a voluntary Medical FSA is in addition to the Medical Opt Out FSA if you declined medical coverage.)*

MEDICAL FLEXIBLE SPENDING ACOUNT (FSA)

A Medical FSA is an account in which you contribute pre-tax dollars that may be used to pay for eligible medical, prescription, dental, and vision expenses not fully covered by your insurance plans for you and your tax eligible dependents.

Funds cannot be carried over from year to year. However, your may incur new expenses until the end of the grace period (March 15) and submit reimbursement requests until the end of the run-out period (April 15.) If you separate from ACPS, you must utilize your remaining balance by the end of the month of separation. Any unused funds after the run-out period or separation will be forfeited.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DCFSA)

A Dependent Care FSA is an account in which you contribute pre-tax dollars that may be used to pay for eligible expenses related to the care and supervision of your child (**to age 13**) or adult dependent (spouse or dependent who is incapable of self-care) on your tax return. Eligible expenses include child or adult daycare, after school care, nursery school, nannies or babysitters. You must accumulate the funds in your Dependent Care FSA before you can be reimbursed. Private School Tuition is not an eligible expense.

A full list of qualified expenses can be found in IRS Publication 502, at www.irs.gov/pub/irs-pdf/p502.pdf.

	ANNUAL CONTRIBUTION LIMITS	
	MINIMUM	**MAXIMUM**
Health Care FSA	$250	$1,500
Dependent Care FSA	$250	$5,000 (or $2,500 if married and filing separately)

Basic Life and AD&D

Alachua County Public Schools provides all benefit eligible employees with Basic Life and Accidental Death and Dismemberment (AD&D) coverage at no cost. Coverage is provided through our Group Term Life policy with **The Standard**.

Group Term Life has no cash value; benefits are paid to the designated beneficiary upon death of the covered employee. If your death is due to an accident, Accidental Death and Dismemberment (AD&D) pays your designated beneficiary an additional amount equal to your coverage amount. AD&D may also pay a benefit to you if you lose a limb in an accident.

- Administrators receive **$20,000**.
- All other employees receive **$10,000**.

FREQUENTY ASKED QUESTIONS	
DOES THE COVERAGE AMOUNT CHANGE BASED ON MY AGE?	The amount of coverage will reduce to 65% of the original amount at age 65 and 50% of the original amount at age 70.
CAN I CONTINUE THIS COVERAGE IF MY EMPLOYMENT ENDS?	Coverage may be continued through Portability or Conversion after separation if certain criteria is met. If you would like to continue coverage after your employment ends with us, please reach out to The Standard.
CAN I CONTINUE THIS COVERAGE WHEN I RETIRE?	Coverage may continue for the basic life benefit. However, the premium will not be paid by ACPS and will be the retiree's responsibility. The maximum amount of life insurance a retiree may continue is $20,000 (before any age reduction.)
WHAT IS PORTABILITY?	Employees may "port" (or buy) group life insurance coverage when they are losing coverage because their employment is being voluntarily or involuntarily terminated. You must: • Be under the age of 65. • Have been insured for at least 12 consecutive months. • Be able to perform the material duties of at least one gainful occupation.
WHAT IS CONVERSION?	Conversion allows eligible insured employees to convert some, or all, of their group life coverage to an individual whole life insurance policy when their coverage is reduced or terminated for any reason, other than non-payment of premiums, without submitting proof of good health.
HOW DO I CHANGE MY BENEFICIARY?	You can change your beneficiaries at any time at mybenefits.sbac.edu. Review your policies regularly and do not forget to make changes when you have a life event such as marriage, birth, adoption, or dependent death.

Optional Life

Employees have the option to purchase additional life insurance coverage through **The Standard**.

EMPLOYEE COVERAGE

You may elect to purchase up to a maximum of $300,000 in Option Life Insurance.

You may elect up to the guaranteed issue amount of $300,000 without submitting evidence of insurability only at **New Hire Enrollment.**

Those currently enrolled can increase current volume by $10k during open enrollment without submitting evidence of insurability up to the $300k maximum.

Age < 40		Age 40+		Age 65-69 (65% of original amount)		Age 70+ (50% of original amount)	
Amount	Per Pay (20)	Amount	Per Pay (20)	Amount	Per Pay (20)	Amount	Per Pay (20)
$10,000	$0.42	$10,000	$2.22	$6,500	$1.44	$5,000	$1.11
$50,000	$2.10	$50,000	$11.10	$32,500	$7.22	$25,000	$5.55
$100,000	$4.20	$100,000	$22.20	$65,000	$14.43	$50,000	$11.10
$150,000	$6.30	$150,000	$33.30	$97,500	$21.65	$75,000	$16.65
$200,000	$8.40	$200,000	$44.40	$130,000	$28.86	$100,000	$22.20
$250,000	$10.50	$250,000	$55.50	$162,500	$36.08	$125,000	$27.75
$300,000	$12.60	$300,000	$66.60	$195,000	$43.29	$150,000	$33.30

SPOUSE COVERAGE

You may elect life insurance in the amount of $10,000 for your eligible spouse when you are first eligible for the plan, without submitting evidence of insurability. Your spouse is not eligible if they are also an ACPS employee or are a full-time member of the armed forces.

Spouse Amount	Per Pay (20)
$10,000	$3.00

CHILD COVERAGE

You may elect life insurance in the amount of $5,000 for your eligible child(ren.) All child life amounts are guarantee issue and no evidence of insurability is required. Your child(ren) cannot be covered by more than one employee. Your child(ren) cannot be covered if they are a full-time member of the armed forces.

Child(ren) Amount	Per Pay (20)
$5,000	$0.45

*Individual employee voluntary life premiums are calculated in PlanSource.

IMPORTANT DISCLOSURES

Does the coverage amount change based on my age?

The amount of coverage will reduce to 65% at age 65 and to 50% at age 70.

Your amount of spouse or dependent optional life insurance cannot exceed 100% of your total life amount.

Do I have to fill out a medical questionnaire?

Late enrollees must complete evidence of insurability. Coverage will be effective on the first day of the month following the date your medical questionnaire is approved by the insurance company.

Can I keep the same amount of optional life coverage that I'm currently enrolled in when I retire?

Employees may keep a maximum of $20,000 in life benefits as a retiree of Alachua County Public Schools. However, the retiree is responsible for the full premium based on their age and benefit amount.

Optional Life is part of our group term life insurance and has no cash value, and does not refund premiums if coverage is dropped, terminated, or if you separate employment. The benefit amount will be paid only to the designated beneficiary upon death of the insured.

Long-Term Disability

Employee have the option to purchase Long-Term Disability through **The Standard**. LTD is an income replacement program that protects you and your family in the event you become disabled and are unable to perform the material and substantial duties of your job.

LTD benefits replace up to 60% of your monthly earnings if you have become disabled as it is defined by the plan and meet the 90-day elimination period. Disability benefits will continue until your disability ends or you reach your normal retirement age under Social Security, which ever comes first. See a brief summary of benefits below.

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IMPORTANT TO KNOW

Why disability coverage is important

We understand that for most of us our income is the most important financial resource. To be without income for an extended period of time would most likely be devastating for you and your family. We recognize the importance of protecting your income in the event you are unable to work due to an injury or illness.

LONG-TERM DISABILITY	CLASS 1	CLASS 2	CLASS 3
Salary	Over $40k	$40k or less	$30k or less
Elimination Period The amount of time you must wait between an illness or disability begins and when you can start receiving benefits	90 Days	90 Days	90 Days
Benefits Payable Duration	End of disability or you reach retirement under Social Security		
	Year of Birth	Full Retirement Age	
	1943-1954	66	
	1955	66 and 2 months	
	1956	66 and 4 months	
	1957	66 and 6 months	
	1958	66 and 8 months	
	1959	66 and 10 months	
	1960	67	
% of Income Replaced	60%	60%	60%
Maximum Monthly Benefit	$3,000	$2,000	$1,500

Example:
Suppose your annual income is $35,000 or $2,917 per month ($35k divided by 12 months.) If you qualify for LTD, 60% of your monthly income would be $1,750. Based on this possible benefit, your benefit option would be Class 2 or 3, with Class 2 optimizing your benefit the most. See table below.

Benefit Option	Max Monthly Benefit	Benefit Payable (60% of income)	Option Evaluation
Class 1	$3,000	$1,750	Maximum Benefit is $1,750 (You pay a higher rate without a high benefit)
Class 2	$2,000	$1,750	Maximum Benefit is $1,750 (You receive max amount)
Class 3	$1,000	$1,750	Maximum Benefit is $1,500 (you don't receive your full 60% benefit)

Premium is individualized and based on salary. It will be calculated through PlanSource during your enrollment and is automatically updated each plan year.

Group Critical Illness

Group Critical Illness is offered through **The Standard** and provides compensation paid directly to you regardless of any other insurance if you are diagnosed with a covered illness. You may be eligible to receive a lump sum benefit that can help pay out-of-pocket medical expenses such as copays and deductibles, or spend how ever you'd like.

Employees, spouses, and children enrolled in Critical Illness are eligible for a $50 Health Maintenance Screening Benefit with the completion of a screening test.

CRITICAL ILLNESS

- Heart Attack or Stroke.
- Major Organ Failure.
- End-Kidney Failure.
- Severe Coronary Artery Disease (25%).

PROGRESSIVE DISEASES

- Amyotrophic Lateral Sclerosis.
- Advanced Alzheimer's Disease.
- Advanced Multiple Sclerosis.
- Advanced Parkinson's Disease.

CANCER

- Invasive Cancer.
- Non-Invasive Cancer.

SUPPLEMENTAL CONDITIONS

- Loss of sight, hearing, or speech.
- Benign brain tumor.
- Coma.
- Occupational HIV.
- Hepatitis B, C, or D.
- Infectious Diseases (25%).
- Permanent Paralysis.

EMPLOYEE COVERAGE: $15,000
SPOUSE COVERAGE: $7,500

Age	Employee Only (20 pay)	Employee + Spouse (20 pay)
Under 25	$2.51	$3.77
25-29	$3.23	$4.85
30-34	$4.22	$6.34
35-39	$5.75	$8.63
40-44	$8.09	$12.14
45-49	$10.34	$15.52
50-54	$13.31	$19.97
55-59	$18.08	$27.13
60-64	$24.11	$36.17
65-69	$36.89	$55.34
70 +	$57.32	$85.99

Children from birth to age 26 are automatically covered at no extra cost. Coverage amount for children is $7,500.

Group Accident

Group Accident is offered through **The Standard** and provides compensation paid directly to you regardless of any other insurance you may have. A set benefit amount is paid based on the type of injury and treatment needed.

COVERED INJURIES	
Concussion	$600
Coma	$15,000
Ruptured Disc	$1,000
Fractures Dislocations Burns	varies based on location of injury
Eye Injury	$300
Laceration	$100-$800
Dental Work (Emergency) • Extraction. • Crown.	 $150 $350
EMERGENCY & HOSPITILIZATION	
Ambulance (ground, one per accident)	$600
Air Ambulance	$1,500
Emergency Room Benefit	$300
Hospital Admission	$2,500
Hospital Confinement (per day up to 365 days)	$700/day
X-Ray	$400
TREATMENT & SERVICE	
Occupational Therapy Speech Therapy Physical Therapy	$200
Therapy maximum is 6 per accident	
Prosthetic Device • One. • More than one.	 $1,000 $2,000

Health Maintenance Screening Benefit

If you are enrolled in Group Accident **and/or** Critical Illness, you are eligible for a $50 Screening Benefit upon the completion of a screening test such as the following:

- Biopsies for cancer.
- Bone Density screening.
- Breast Ultrasound.
- Cancer antigen 125 & 1503.
- Colonoscopy.
- Complete blood count (CBD.)
- Comprehensive Metabolic Panel (CMP.)
- Electrocardiogram (EKG.)
- Lipid Panel.
- Mammogram.
- Pap smears/test.
- Stress test using bicycle or treadmill.
- Mental health assessment.

Every year, each covered family member can receive the benefit. **If you are enrolled in both Critical Illness and Group Accident, you are eligible for a Screening Benefit for both coverages.**

Tier	Cost per pay period (20)
Employee Only	$5.74
Employee + Spouse	$9.27
Employee + Child(ren)	$11.30
Full Family	$17.69

Pet Discount Program

With Pet Assure's veterinary core discount plan, you will save on all in-house medical services at local participating veterinarians. Simply present your ID card at all well, sick or emergency visits, and the vet will discount your bill right at the time of service. All pets are eligible. There are no exclusions for breed, age, or pre-existing health conditions.

How do I use Pet Assure?

- When you visit a participating vet, present your Pet Assure member ID card from the Pet Assure app at checkout, and the veterinary staff will apply a 25% discount to all in-house medical services. There is no paperwork or forms to fill out. You can use your savings immediately on your benefit start date.

What procedures are discounted?

- Participating veterinarians discount all in-house medical services. This includes the office visit, vaccinations, surgery, dental cleaning, spay and neuter surgery, x-rays, and any other procedures the vet performs. Even procedures related to pre-existing conditions are discounted.

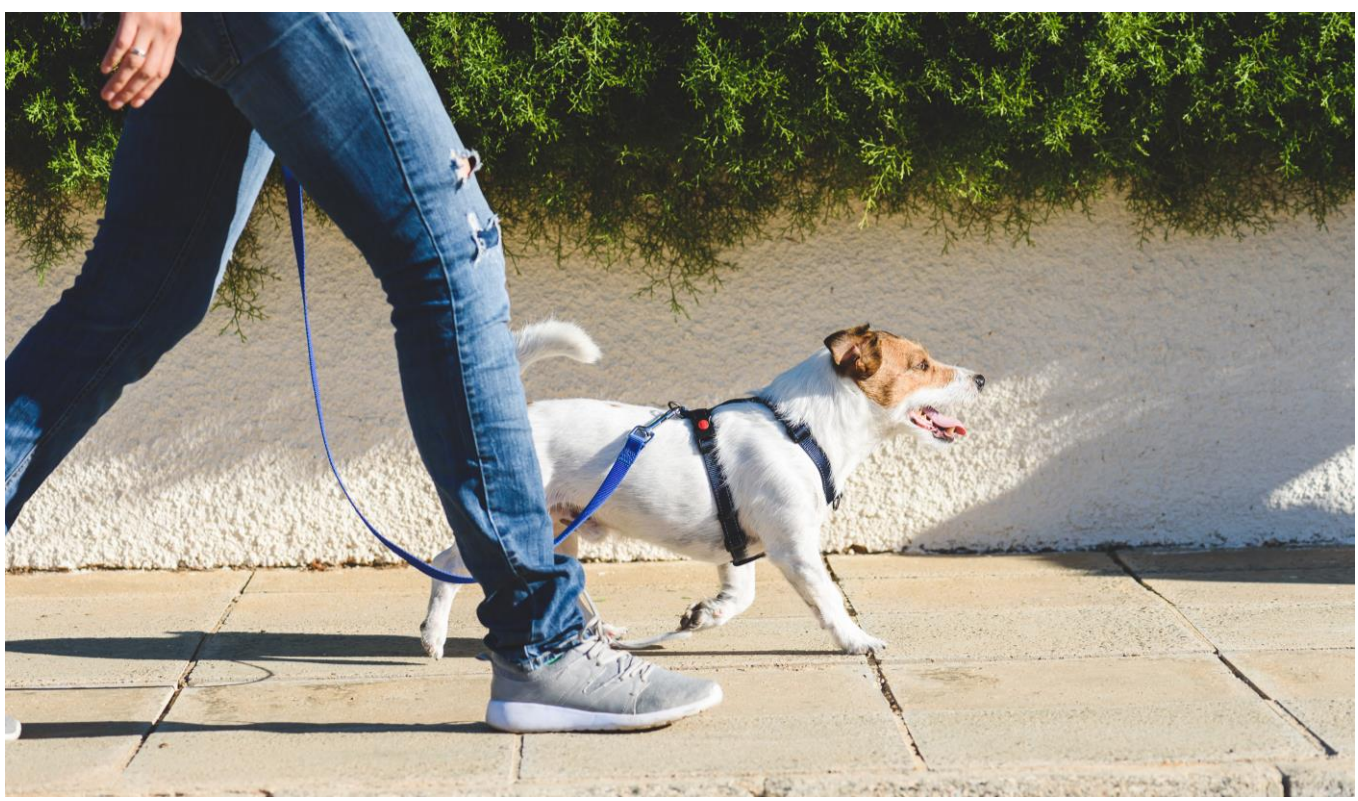
Where can I find a list of participating vets in my area?

- You can search for participating practices by visiting www.petbenefits.com/search. Mention that you're a Pet Assure member when you call to make an appointment.
- If a veterinarian you would like to visit does not participate, you can invite them to join by clicking the "Invite to Pet Assure" button. With a few details, you'll have a custom-generated email to send to your vet inviting them to join and providing instructions for them to contact Pet Assure for further details

Visit https://www.petbenefits.com/land/acps to learn more!

Pet Assure
SINCE 1995

Tier	Cost per pay period (20)
One Pet	$7.05
Two or More Pets	$11.10



A helping hand when you need it.

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

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, which includes WorkLife Services and is available to you and your family in connection with your group insurance from The Standard Company. It's confidential – information will be released only with your permission or as required by law.

Connect to Resources, Support and Guidance

You, your dependents (including children to age 26), and all household members can contact the program's master-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, over the phone, by video, or via 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

(TTYL Services: 711)

24 hours a day

7 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.

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

Federal Notices

IMPORTANT NOTICE FROM ALACHUA COUNTY PUBLIC SCHOOLS 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 Alachua County Public Schools 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Alachua Count Public Schools has determined that the prescription drug coverage offered by ACPS 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.

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 decide to drop your current coverage with Alachua Count Public Schools, since it is employer/union 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 (Alachua Count Public Schools Self-Funded Group Plan.)

Since you are losing creditable prescription drug coverage under the (Alachua Count Public Schools Self-Funded Group Plan), you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When will you pay a higher premium (penalty) to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current coverage with Alachua County Public Schools will not be affected. Your current coverage pays for health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits. [See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current Alachua Count Public School coverage, be aware that you and your dependents will be able to get this coverage back only during a qualified life event or during the annual enrollment period.

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 coverage with Alachua Count Public Schools will not be affected. Your current coverage pays for health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all your current health and prescription drug benefits. [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Alachua Count Public Schools coverage, be aware that you and your dependents will be able to get this coverage back only during a qualified life event or during the annual enrollment period.

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 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 limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778.)

NOTICE OF PATIENT PROTECTIONS AND SELECTIONS OF PROVIDERS

Alachua County Public School Health Plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your covered dependents. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Florida Blue at 800-352-2583. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization Florida Blue or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Florida Blue at 800-352-2583.

HIPAA PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices is available on sbac.edu/mybenefits and from

the benefits department.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

To request special enrollment or obtain more information, visit mybenefits.sbac.edu or contact the Benefits Department.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable.) In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours.)

MICHELLE'S LAW

Michelle's Law protects a postsecondary student from losing full-time student status under an employer's medical coverage if the student is (i) a dependent child of a participant or beneficiary under the terms of the plan; and (ii) enrolled in a plan on the basis of being a student at a postsecondary educational institution immediately before the first day of a medically necessary leave of absence from school. A dependent covered under the law is entitled to the same benefits as if the dependent continued to be enrolled as a full-time student. The law also recognizes that changes in coverage (whether
due to plan design or a subsequent annual enrollment election) pass through to the dependent for the remainder of the medically necessary leave of absence.

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998 (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA.) For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator 352-955-7577.

CHIPRA - 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, 2023. Contact your State for more information on eligibility –

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

To see if any other states have added a premium assistance program since July 31, 2023, 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

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Benefits Contact List

CONTACT	PHONE	EMAIL	WEBSITE
Accident & Critical Illness The Standard Group #760841	(800) 634 -1743	standard.com	
Dental Humana Group #789160	(800) 233-4013	humana.com	
Employee Assistance Program The Standard	(888) 293-6948	heathadvocate.com/standard3	
HRA, FSA, & DCFSA WEX	(866) 451-3399	wexinc.com	
Life and Disability The Standard Group #760841	Life: (800) 628-8600 Disability: (800) 368-1135	standard.com	
Medical Florida Blue Group #78129	(800) 352-2583	floridablue.com	
Pet Discount Program Pet Assure Group #7534	(800) 891-2565	petbenefits.com/land/acps	
Pharmacy Express Scripts Group #78129	(866) 581-5255	express-scripts.com	
Vision Aetna Group #1052100-101	(877) 973-3238	aetna.com	
Benefits Department Kyle Stout – Insurance Specialist New Hires & Employees on Leave	(352) 955-7577	benefits@gm.sbac.edu	sbac.edu/mybenefits
Benefits Department Tara Culkin – Program Services Specialist Active Employees, Health & Wellness	(352) 955-7577	benefits@gm.sbac.edu	sbac.edu/mybenefits
Benefits Department Lori Bolte – Benefits Coordinator Separations & Retirees	(352) 955-7577	benefits@gm.sbac.edu	sbac.edu/mybenefits
Florida Division of Retirement (FRS) FRS Member Inquires FRS Financial Guidance Line	(844) 377-1888 (866) 446-9377	frs.fl.gov	
Retirement Ashley Darby Personnel Specialist	(352) 955-7705	darbyan@gm.sbac.edu	www.sbac.edu/retirement
The Bailey Group Katti Allen Account Manager	(904) 671-0527	kallen@mbaileygroup.com	mbaileygroup.com