Employee Benefits
Services Group

Retiree Benefits Overview 2020-2021

Franklin County School District 2019-2020

		Monthly
Capital Health Plan	**Retiree Only**	**$748.39**
	Retiree & Family	**$1567.34**
Florida Blue	**Retiree Only**	**$748.39**
	Retiree & Family	**$1567.34**
CAPITAL HEALTH Plan MEDICARE	**Retiree**	**$260.74**
Standard - Dental Low Plan	**Retiree Only**	**$29.59**
	Retiree & Family	**$91.26**
Standard - Dental High Plan	**Retiree Only**	**$37.18**
	Retiree & Family	**$106.46**
Lincoln Life Insurance	$10,000	$25.00
Lincoln Life Insurance	$20,000	$50,000

Lincoln Financial Group®

Franklin County School District

Retirees electing $20,000 benefit

Life Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings.

AT A GLANCE:

- A cash benefit of $20,000 to your loved ones in the event of your death
- *LifeKeys*® services, which provide access to counseling, financial, and legal support
- *TravelConnect*℠ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 70 and benefits terminate at employee age 99. See the plan certificate for details.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

Lincoln Financial Group®

Franklin County School District

Retirees electing $10,000 benefit

Life Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings.

AT A GLANCE:

- A cash benefit of $10,000 to your loved ones in the event of your death
- *LifeKeys*® services, which provide access to counseling, financial, and legal support
- *TravelConnect*℠ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

ADDITIONAL DETAILS

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Franklin County School District
Dental Highlight Sheet

Low Plan 1: Dental Plan Summary **Effective Date: 1/1/2018**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	$150/family
Maximum *(per person)*	$1,000 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK Assist℠	None
Annual Open Enrollment	None

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

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

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

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

Franklin County School District
Dental Highlight Sheet

We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515.** Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Dental Network Information

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

Pretreatment

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

Late Entrant Provision

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

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

Franklin County School District
Dental Highlight Sheet

High Plan 1: Dental Plan Summary **Effective Date: 1/1/2018**

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	$150/family
Maximum *(per person)*	$1,500 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK Assist℠	None
Annual Open Enrollment	Included

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum *(per person)*	$1,000
Waiting Period	None

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

Type 1	Type 2	Type 3
• Routine Exam (1 in 6 months)	• Full Mouth/Panoramic X-rays (1 in 5 years)	• Onlays
• Bitewing X-rays (1 in 12 months)	• Restorative Amalgams	• Crowns (1 in 10 years per tooth)
• Periapical X-rays	• Restorative Composites	• Crown Repair
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• Sealants (age 13 and under)	• Periodontics (nonsurgical)	
• Space Maintainers	• Periodontics (surgical)	
	• Simple Extractions	
	• Complex Extractions	
	• Anesthesia	

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Franklin County School District
Dental Highlight Sheet

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Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

Late Entrant Provision

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

Section 125

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

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

Franklin County School Board
Eye Care Highlight Sheet

Plan 1: Balanced Care Vision I Plan Summary **Effective Date: 1/1/2015**

	VSP Network	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$10 Eye Glass Lenses or Frames*	$10 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $52
Lenses (per pair)		
Single Vision	Covered in full	Up to $55
Bifocal	Covered in full	Up to $75
Trifocal	Covered in full	Up to $95
Lenticular	Covered in full	Up to $125
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to $60	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frames	$130	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/24 Based on date of service	12/12/24 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*

Lens Options (participant cost)*

	VSP Network	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $25 adults	No benefit
Solid Plastic Dye	$13 (except Pink I & II)	No benefit
Plastic Gradient Dye	$15	No benefit
Photochromatic Lenses (Glass & Plastic)	$27-$76	No benefit
Scratch Resistant Coating	$15-$29	No benefit
Anti-Reflective Coating	$39-$75	No benefit
Ultraviolet Coating	$14	No benefit

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

Monthly Rates

Employee Only (EE)	$7.78
EE + Spouse	$15.36
EE + Children	$17.24
EE + Spouse & Children	$25.22

Franklin County School Board
Eye Care Highlight Sheet

Additional Balanced Care Vision I Features

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

Eye Care Plan Participant Service

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

VSP Call Center: 1-800-877-7195
- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: standard.com/services
View plan benefit information at: vsp.com

Section 125

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

This form is a benefit highlight, not a certificate of insurance.

Capital Selection $15/$30/$50 Rx

Coverage Period: Plans beginning on or after 10/01/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Employee or Family | Plan Type: HMO

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $2,000 single coverage / $4,500 family coverage. Pharmacy: $4,600 single coverage / $8,700 family coverage.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers.	Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not Covered	————none————
	Specialist visit	$40 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$100 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown.
	Tier 2 drugs	$30/30-day supply $60/60-day supply $90/90-day supply (retail & mail order)	Not Covered	Prior authorization and/or quantity limit may apply. Your benefits/services may be denied.
	Tier 3 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and/or quantity limit may apply. Your benefits/services may be denied.
	Specialty drugs	$50 /30-day supply	Not Covered	Limited to 30 day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limit may apply. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $100 / visit Hospital: $250 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$40 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$300 / visit $250 / observation	$300 / visit $250 / observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status, an additional copayment may apply based on services rendered.
	Emergency medical transportation	$100 / transport	$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care: $25 / visit Telehealth: $15 / visit	Urgent care: $25 / visit Telehealth: $15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission $250 / observation	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Physician/surgeon fees	No Charge if admitted $40 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / visit	Not Covered	————none————
	Inpatient services	$250 / admission	Not Covered	Prior authorization required. Your benefits/ services may be denied.
If you are pregnant	Office visits	$40 / visit	Not Covered	————none————
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$250 / admission	Not Covered	Prior authorization required. Your benefits/ services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	Not Covered	Not Covered	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic care
- Routine eye care (Adult)

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

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

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$250
Other *copayment*	$0

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

Total Example Cost	$13,400

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,060

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

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$250
Other *copayment*	$15

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

Total Example Cost	$7,500

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,160

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

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$250
Other *copayment*	$0

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

Total Example Cost	$2,000

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$700

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

Capital Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association

Nondiscrimination and Accessibility Notice (ACA §1557)

Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Capital Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
Capital Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at one of the numbers listed below.

If you believe that Capital Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: memberservices@chp.org. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:
U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–368–1019, 800–537–7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Have a disability? Speak a language other than English? Call to get help for free.
1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

Vous souffrez d'un handicap ? Vous parlez une autre langue que l'anglais ? Appelez pour obtenir une aide gratuite. 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita:
1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

هل تعاني من إعاقة؟ هل تتحدث لغة غير اللغة الإنجليزية؟ اتصل للحصول على المساعدة المجانية.
أو 1-877-870-8943، (TDD/TTY) 850-383-3534، جهاز الاتصال الهاتفي للصم/الهاتف النصي، 1-877-247-6512

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8:00 am – 5:00 pm at 850-383-3311 or 1-877-247-6512. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m. Capital Health Plan contact information is located on our website: https://capitalhealth.com/contact

Approved by Compliance Committee: 8/23/2016; Revised 5/3/17; Revised 11/14/17; Revised 8/21/18; Revised 7/17/19

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$2,500** Per Person. Out-of-Network: **$5,000** Per Person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$5,800** Per Person. Out-Of-Network: **$11,600** Per Person.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visits: Deductible + 20% Coinsurance/ Virtual Visits (Telemedicine): Deductible + 20% Coinsurance	Primary Care Visits: Deductible + 40% Coinsurance/ Virtual Visits (Telemedicine): Not Covered	Physician administered drugs may have higher cost shares.
	Specialist visit	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 20%	Per Admission Deductible + Deductible + 40%	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Coinsurance	Coinsurance	share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Inpatient services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 20% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Hearing aids	• Pediatric glasses
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine eye care (Adult)
• Dental care (Adult)	• Pediatric dental check-up	• Routine foot care unless for treatment of diabetes
• Habilitation services	• Pediatric eye exam	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care - Limited to 35 visits	• Most coverage provided outside the United States. See www.floridablue.com.	• Non-emergency care when traveling outside the U.S.

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

About these Coverage Examples:

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

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

The plan's overall deductible	**$2,500**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$0**

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

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$30
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,390**

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

The plan's overall deductible	**$2,500**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$1,500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,160**

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

The plan's overall deductible	**$2,500**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

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

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

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توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
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The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$5,000** Family. Out-of-Network: **$10,000** Per Person/**$10,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,850** Per Person/**$11,600** Family. Out-Of-Network: **$23,200** Per Person/**$23,200** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visits: Deductible + 20% Coinsurance/ Virtual Visits (Telemedicine): Deductible + 20% Coinsurance	Primary Care Visits: Deductible + 40% Coinsurance/ Virtual Visits (Telemedicine): Not Covered	Physician administered drugs may have higher cost shares.
	Specialist visit	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 20%	Per Admission Deductible + Deductible + 40%	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Coinsurance	Coinsurance	share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Inpatient services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 20% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Hearing aids	• Pediatric glasses
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine eye care (Adult)
• Dental care (Adult)	• Pediatric dental check-up	• Routine foot care unless for treatment of diabetes
• Habilitation services	• Pediatric eye exam	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care - Limited to 35 visits	• Most coverage provided outside the United States. See www.floridablue.com.	• Non-emergency care when traveling outside the U.S.

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html .

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

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

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About these Coverage Examples:

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

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$0**

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

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$30
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,590**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,880**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

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

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

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Rev. 3/06

INS DOC

FLORIDA RETIREMENT SYSTEM PENSION PLAN

Insurance Payroll Deduction Authorization Form

FRANKLIN CO SCHOOL BOARD

Approved Deduction Name

SHANNON VENABLE
Retiree Contact Person

(850) 670-2810 Ext 4105
Retiree Contact Person's Telephone No

The payee must authorize new insurance deductions OR the restart of a previously closed deduction. The payee is the person receiving the FRS pension payment.

PAYEE SSN: _____ **DEDUCTION CODE : 416**

PAYEE NAME: _____ **DEDUCTION CODE : 417**

I hereby authorize the Division of Retirement to deduct my insurance premiums from my monthly Florida Retirement System (FRS) benefit check and make any subsequent premium changes as directed by my insurance provider. I understand that my insurance provider is responsible for notifying me of premium changes as they occur and for any refunds (if applicable). If I am changing insurance companies I will notify the existing company of the cancellation or changes.

Payee's Signature: _____
Signature required if no premium deduction (for above deduction code) from previous month's pension payment.

Address: _____

Date: _____ Telephone No: _____

Date of Birth: _____ Date Member Retired: _____

Insurance office use only. The Division of Retirement will not use this information.

Insurance provider staff must fax or mail a completed authorization form for all new deductions (or restarted deductions) to the Division of Retirement. MAIL: Division of Retirement, Retired Payroll Section, PO Box 3090, Tallahassee, FL 32315-3090; **FAX: 850-410-2010**

Standard Insurance Company **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
158971	**Retirees**		

To Be Completed By Applicant ☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ Name Change

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female

Your Address	City	State	ZIP

Former Name (Last, First, Middle) *Complete only if name change*	Phone Number

Employer Name	Job Title/Occupation
FRANKLIN COUNTY SCHOOL DISTRICT	

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

Life Insurance

You may choose one of the following options:

☐ Voluntary Life $10,000

☐ Voluntary Life $20,000

Beneficiary ***This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form to your Human Resources Department.