2020/2021

**NEW EMPLOYEE INSURANCE PACKET:**

**Please complete, sign and return necessary forms within this packet for your desired plans.**

**Employees Signature**_____

***PLEASE SIGN AND RETURN TO STEPHANIE HOLLEY FINANCE DEPARTMENT PH#643-2275 EXT.11222 OR EMAIL: stephanie.holley@lcsb.org***

**CAPITAL HEALTH PLAN**
**Need Enrollment Form completed and supporting documentation based on plan chosen.**

**Employees Amounts After Board Pays $386.39**

| | | |
|---|---|---|
| EMPL ONLY | 238.67 | |
| EMPL/SPOUSE | 863.73 | |
| EMPL/CHILDREN | 676.22 | |
| EMPL/FAMILY | 1,488.79 | |

**STANDARD:**

NEEDED FOR THESE PLANS: SSN#_____, DOB_____, ADDRESS_____
ALSO IF ADDING CHILDREN OR SPOUSE NEED THEIR: SSN#_____, DOB_____

**DENTAL**

| | LOW PLAN | | HIGH PLAN | |
|---|---|---|---|---|
| EMPL ONLY | 18.83 | | 35.32 | |
| EMPL/SPOUSE | 45.17 | | 70.05 | |
| EMPL/CHILDREN | 46.62 | | 82.44 | |
| EMPL/FAMILY | 72.52 | | 109.31 | |

**VISION**

| | | |
|---|---|---|
| EMPL ONLY | 6.72 | |
| EMPL/SPOUSE | 13.47 | |
| EMPL/CHILDREN | 14.41 | |
| EMPL/FAMILY | 21.78 | |

**Standard Basic Life Ins $10,000.00 Free to employee, board pays this monthly amount. (FORM ATTACHED TO COMPLETE AND SIGN)**

**STANDARD LTD AND OPT'L LIFE PLANS: PLEASE EMAIL ME IF YOU WANT TO PURCHASE PLAN/PLANS STEPHANIE.HOLLEY@LCSB.ORG AND I WILL HAVE FORM SENT TO YOU TO COMPLETE.**

**TSIC** **Monthly Amount**_____

**UNITED WAY:** **Monthly Amount**_____

**OTHER SUPPLEMENTAL INSURANCE OFFERED:**
I MUST HAVE A FORM COMPLETED BY THESE REPRESENTATIVES FOR THEIR PLANS OFFERED.

**AFLAC:** CONTACT AFLAC REPRESENTATIVE: JERRY ALFORD 850-899-6565 OR CHRISTEN CHASON 850-556-2921

**VOYA:** CONTACT VOYA Annuity Plans REPRESENTATIVE: Greg Parsons 850-298-4322

**TASC Benefits Enrollment Form must be completed if you choose to Enroll in the Flexible Spending Account: (FSA) Healthcare Flexible spending Account or Dependent Care FSA:**

Capital Health PLAN

An independent Licensee of the Blue Cross and Blue Shield Association

# ENROLLMENT APPLICATION

| 1. Election Type | Initial Enrollment (New Hire): ☐ | Open Enrollment: ☐ | Retiree: ☐ Retirement Date: | Surviving Spouse: ☐ | Special Enrollment: ☐ * Please list the Qualifying Event and provide supporting documentation: |
|---|---|---|---|---|---|

| 2. SSN: | 3. Last Name: | 4. First Name: | 5. M.I.: |
|---|---|---|---|

6. Physical Address:

Street City State Zip Code County

7. Mailing Address: (If different from above)

Street City State Zip Code County

| 8. Date of Birth: | 9. Sex: ☐ Female ☐ Male | 10. Marital Status: ☐ Married ☐ Single ☐ Legally Widowed ☐ Divorced Separated | 11. Primary PH #: | 12. Work PH #: | 13. Other #: |
|---|---|---|---|---|---|

| 14. Name of Employer: | 15. Part-Time Hire Date: | 16. Full-Time Hire Date: | 17. Type of Employment: ☐ Full-Time ☐ Part-Time: ____ Hours per week |
|---|---|---|---|

18. LIST ELIGIBLE FAMILY MEMBERS TO BE COVERED (PLEASE PRINT)
A certified copy of the court order must be attached for dependents in court-ordered custody or guardianship of the certificate holder. If more space is required, attach a separate page with additional information. Please provide (on the reverse side of this form) an alternate address for any dependent not living with you.

Applicant's Primary Care Physician Selection: | Current Patient? ☐ Yes ☐ No

| 19. Relationship To You | 20. Sex | 21. Last Name, First Name MI | 22. SSN | 23. Date of Birth | 24. Disabled | 25. Dependent Primary Care Physician Selection(s): | 26. Current Patient? |
|---|---|---|---|---|---|---|---|
| Spouse | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Dependent 1 ☐ Child ☐ Stepchild ☐ Other # | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Dependent 2 ☐ Child ☐ Stepchild ☐ Other # | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |
| Dependent 3 ☐ Child ☐ Stepchild ☐ Other # | ☐ Male ☐ Female | | | | ☐ Yes ☐ No | | ☐ Yes ☐ No |

# Supporting documentation required.

27. Race/Ethnicity – Optional (This information is designed for the purpose of data collection and will not be used for determining eligibility, rating or claim payment.)

Employee: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Spouse: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 1: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 2: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other
Dependent 3: ☐ African American ☐ American Indian/Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other

28. Are you or any member of your family (listed on this application) covered by any other health plan or health insurance that will be in effect concurrently with the coverage you are applying for? ☐ Yes ☐ No
If yes, complete the appropriate section(s) below. If more space is needed, attach a separate sheet with additional information.

| OTHER HEALTH PLAN INSURANCE | MEDICARE | |
|---|---|---|
| Insured Member's Name: Date of Birth: | Beneficiary Name: | Beneficiary Name: |
| Employment Status: ☐ Active ☐ Retired Name of Employer: Type of coverage: ☐ Single ☐ Family | Entitlement Reason: ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability | Entitlement Reason: ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability |
| Policy #: Effective Date: | Medicare HIC#/MBI: | Medicare HIC#/MBI: |
| Name of Insurance Company: Phone: | Part A Effective Date: | Part A Effective Date: |
| Does the above insurance cover "all" family members including yourself? ☐ Yes ☐ No If no, please list dependents not covered on a separate sheet. | Part B Effective Date: | Part B Effective Date: |

29. ACCEPTANCE OF COVERAGE/MEMBERSHIP:
I have read and understand the Acceptance of Any Coverage/Membership on the reverse side of this form.

Signature of Applicant/Employee: Date:

| Authorized Group Administrator's Signature: | Date: | Group ID: | Employee's Proposed Coverage Effective Date: |
|---|---|---|---|
| Authorized Group Administrator's Printed Name: | Group Administrator's Contact Phone #: | | Group Administrator Email Address: |

Please return this completed form by:

Mail: Capital Health Plan • Attn: Enrollment • PO Box 15349 • Tallahassee FL 32317 • Fax: 850-523-7369 OR Email: Enrollment@chp.org

2017.042.EnrollApp

**Principal Choice $15/$50/$100**

**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: $4,850 single coverage $9,200 family coverage. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers. | Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Office: $15 / visit<br>Telehealth: $15 / visit | Not Covered | Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices. |
| | Specialist visit | Office: $50 / visit<br>Telehealth: $50 / visit | Not Covered | Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices. |
| | Preventive care/screening/ immunization | No Charge for covered services | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | Diagnostic tests other than x-ray or blood work may incur a cost share. |
| | Imaging (CT/PET scans, MRIs) | $150 / 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**<br>More information about **prescription drug coverage** is available at www.capitalhealth.com/MedCenter | Tier 1 drugs | $15/30-day supply<br>$30/60-day supply<br>$45/90-day supply<br>(retail & mail order) | Not Covered | The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied. |
| | Tier 2 drugs | $50/30-day supply<br>$100/60-day supply<br>$150/90-day supply<br>(retail & mail order) | Not Covered | |
| | Tier 3 drugs | $100/30-day supply<br>$200/60-day supply<br>$300/90-day supply<br>(retail & mail order) | Not Covered | |

| | | | | |
|---|---|---|---|---|
| | Specialty drugs | $100 /30-day supply | Not Covered | Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory Surgical Center: $200 / visit<br>Hospital; $350 / visit | Not Covered | Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services. |
| | Physician/surgeon fees | $50 / provider | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | $500 / visit<br>$350 / observation | $500 / visit<br>$350 / 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 | $200 / transport | $200 / transport | Covered if medically necessary. |
| | Urgent care | Urgent care center: $50 / visit<br>Telehealth: $50 / visit<br>Amwell: $15 / visit | Urgent care center: $50 / visit<br>Telehealth: $50 / visit<br>Amwell: $15 / visit | Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $350 / admission<br>$350 / observation | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| | Physician/surgeon fees | No Charge if admitted<br>$50 / provider for observation | Not Covered | ——none—— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 / visit | Not Covered | ——none—— |
| | Inpatient services | $350 / admission | Not Covered | Prior authorization required. Your benefits /services may be denied. |
| **If you are pregnant** | Office visits | $50 / visit | Not Covered | ——none—— |
| | Childbirth/delivery professional services | No Charge | Not Covered | ——none—— |
| | Childbirth/delivery facility services | $350 / 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 require ed. Your benefits/ services may be denied. |
| | Rehabilitation services | $50 / visit | Not Covered | Limited to the consecutive 62-day period immediately following the first service date. |
| | Habilitation services | Not Covered | Not Covered | ————none———— |
| | Skilled nursing care | No Charge | Not Covered | Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission. |
| | Durable medical equipment | No Charge | Not Covered | Prior authorization required for certain devices. Your benefits/services may be denied. |
| | Hospice services | No Charge | Not Covered | Prior authorization required for inpatient services. Your benefits/services may be denied. |
| **If your child needs dental or eye care** | Children's eye exam | $15 / visit | Not Covered | ————none———— |
| | Children's glasses | Not Covered | Not Covered | ————none———— |
| | Children's dental check-up | Not Covered | Not Covered | ————none———— |

**Excluded Services & Other Covered Services:**

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

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

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

- Chiropractic care
- 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: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

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

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

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

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**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** | **$50** |
| ■ **Hospital (facility) copayment** | **$350** |
| ■ **Other copayment** | **$0** |

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

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$760** |

## 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** | **$50** |
| ■ **Hospital (facility) copayment** | **$350** |
| ■ **Other copayment** | **$100** |

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

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

## Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---|
| ■ **The plan's overall deductible** | **$0** |
| ■ **Specialist copayment** | **$50** |
| ■ **Hospital (facility) copayment** | **$350** |
| ■ **Other copayment** | **$0** |

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

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $0 |
| Copayments | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,200** |

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

# LIBERTY COUNTY SCHOOL BOARD

# Group Dental Insurance

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

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

**Plan 1: Dental Plan Summary** **Effective Date: 10/1/2020**

| Plan Benefit | |
|---|---|
| Type 1 (Preventive) | 100% |
| Type 2 (Basic) | 80% |
| Type 3 (Major) | 50% |
| Waiting Period | None |
| Deductible | $15/visit |
| | Type 1,2,3 |
| | No Family Maximum |
| Maximum *(per person)* | $750 per calendar year |
| Allowance | Discounted Fee |
| Annual Eye Exam | None |
| Annual Open Enrollment | Included |

**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) | • Periapical X-rays | • Crowns (1 in 10 years per tooth) |
| • Cleaning (1 in 6 months) | • Space Maintainers | • Crown Repair |
| • Fluoride for Children 13 and under (1 in 12 months) | • Restorative Amalgams | • Endodontics (nonsurgical) |
| • Sealants (age 13 and under) | • Restorative Composites | • Endodontics (surgical) |
| | • Simple Extractions | • Periodontics (nonsurgical) |
| | | • Periodontics (surgical) |
| | | • Denture Repair |
| | | • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) |
| | | • Complex Extractions |
| | | • Anesthesia |

## Dental Network Information

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

## 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.

# LIBERTY COUNTY SCHOOL BOARD

# Group Dental Insurance

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

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

**Plan 2: Dental Plan Summary** **Effective Date: 10/1/2020**

| Plan Benefit | |
|---|---|
| Type 1 (Preventive) | 100% |
| Type 2 (Basic) | 80% |
| Type 3 (Major) | 50% |
| Waiting Period | None |
| Deductible | $50/Calendar Year Type 2 & 3 |
| | Waived Type 1 |
| | $150/family |
| Maximum *(per person)* | $1,000 per calendar year |
| Allowance | 90% usual and customary |
| Annual Eye Exam | None |
| Annual Open Enrollment | Included |

**Orthodontia Summary - Child Only Coverage**

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

## Dental Network Information

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

# LIBERTY COUNTY SCHOOL BOARD

## Open Enrollment

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

## Submitting a claim

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

## Prior Extraction Limitation

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

## Late Entrant Provision

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

## Section 125

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

## Customer Service

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

**Call Center: 800.547.9515**

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

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

# LIBERTY COUNTY SCHOOL BOARD

## About The Standard

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

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

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

# LIBERTY COUNTY SCHOOL BOARD

## Pretreatment

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

## Open Enrollment

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

## Submitting a claim

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

## Prior Extraction Limitation

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

## Late Entrant Provision

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

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# LIBERTY COUNTY SCHOOL BOARD

# Group Vision Insurance

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

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

**Plan 1: Balanced Care Vision I Plan Summary** **Effective Date: 10/1/2020**

| | VSP Choice Network | Out of Network |
|---|---|---|
| Deductibles | | |
| | $10 Exam | $10 Exam |
| | $25 Eye Glass Lenses or Frames* | $25 Eye Glass Lenses or Frames |
| Annual Eye Exam | Covered in full | Up to $45 |
| Lenses (per pair) | | |
| Single Vision | Covered in full | Up to $30 |
| Bifocal | Covered in full | Up to $50 |
| Trifocal | Covered in full | Up to $65 |
| Lenticular | Covered in full | Up to $100 |
| Progressive | See lens options | NA |
| Contacts | | |
| Fit & Follow Up Exams | Participant cost up to $60 | Not covered |
| | | |
| Elective | Up to $130 | Up to $105 |
| Medically Necessary | Covered in full | Up to $210 |
| Frame Allowance | $130 | Up to $70 |
| Frequencies (months) | | |
| Exam/Lens/Frame | 12/12/24 | 12/12/24 |
| | Based on date of service | Based on date of service |

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

**Lens Options (participant cost)***

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

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

| Monthly Rates | |
|---|---|
| Employee Only (EE) | $6.72 |
| EE + Spouse | $13.47 |
| EE + Children | $14.41 |
| EE + Spouse & Children | $21.78 |

$10,000.00 Basic Life Paid By The Board

Standard Insurance Company **Beneficiary Designation/Change**

This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance, Life with Accidental Death & Dismemberment (AD&D) Insurance, AD&D Insurance and, unless specified otherwise on a separate signed sheet of paper, Supplemental Life Insurance.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to your Employer during your lifetime. Return the completed form to your Human Resources Department.

**MEMBER/EMPLOYEE INFORMATION**

| Your Name (Last, First, Middle) | | Date of Birth |
|---|---|---|
| Your Address | | |
| City | State | Zip |
| Group Name | Group No. | |

**BENEFICIARY INFORMATION**

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
- If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%."

| Primary – Full Name | Address | Birth Date | Phone No. | Soc. Sec. No. *if known* | Relationship | % of Benefit *Total must equal 100%* |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

| Contingent – Full Name | Address | Birth Date | Phone No. | Soc. Sec. No. *if known* | Relationship | % of Benefit *Total must equal 100%* |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

Signature of Member/Employee _____ Date _____

*Human Resources Department – Retain for your records.*

# BENEFITS ENROLLMENT FORM

For enrollment assistance, please call Customer Care at (877) 933-3539. Have your enrollment form, Client TASC ID, and company name available. **Please print this form, sign, and return to your employer for processing.**

| EMPLOYEE INFORMATION | | | | | |
|---|---|---|---|---|---|
| **Employee Name:** | *Last Name* | *First Name* | | | *Middle Initial* |
| **Social Security Number:** | | **Date of Birth:** | | **Gender:** | |
| **Home Address:** | *Street* | *City* | | *State* | *Zip Code* |
| **Email Address:** | | | **Telephone #:** | | |

| EMPLOYER/BENEFITS INFORMATION | | | |
|---|---|---|---|
| **Employer Name:** | | **Date of Hire:** | |
| **Plan Effective Date:** | | **Date of 1st Payroll Deduction:** | |
| **Insurance Carrier Name:** | | | |

| PLAN ELECTIONS | | | | | |
|---|---|---|---|---|---|
| **Plan Type** | **Annual Election ($)** | **Number of Payrolls** | **Amount per Pay Check ($)** | **Employer Contribution** *(if applicable)* | |
| | | | | **Per Month** | **Per Year** |
| ❑ **Healthcare Flexible Spending Account (FSA):** | | | | | |
| ❑ **Dependent Care FSA:** | | | | | |
| [redacted] | | | | | |
| [redacted] | | | | | |
| [redacted] | | | | | |

| **FOR DEPENDENT COVERAGE:** | **Married?** ❑ Yes ❑ No<br>**Dependent Children?** ❑ Yes ❑ No | ***If Yes*, list your spouse and dependent children below:** |
|---|---|---|

| Last Name | First Name | Social Security Number* | Relationship to Employee | Date of Birth* | Gender |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I understand that any amounts remaining in my account(s) not used for qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws.

Furthermore, I agree that the IRS regulations state four conditions: (1) any expenses I/we incur must be within the Plan Year; (2) any expenses I/we incur must not be covered by any other sources, such as insurance; (3) I/we must provide proper documentation to receive payment; (4) I/we cannot change or revoke elections during the Plan Year unless there is a specific change in status and my employer allows such changes. Please see Summary Plan Description for details.

| **Employee Signature** | **Date** |
|---|---|
| | |

** Social Security and date of birth for employees and their dependents are required for HRA reporting purposes to the Centers for Medicare and Medicaid Services as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007. Enrollment Forms without this required information will be returned for completion.*

Total Administrative Services Corporation (TASC) | P.O. Box 7511 | Madison, WI 53707-7511
Phone: 877-933-3539 | Fax: 877-231-1287