2024 - 2025
Benefits Guide

What's Inside

Benefits Enrollment Checklist

BEFORE ENROLLING

- Take the time to educate yourself on all of the benefit options that are available to you by reviewing this benefits guide carefully as you consider your plan choices.
- Prepare a list of your doctors and prescriptions.

DURING ENROLLMENT

- Be sure to make your elections within the Open Enrollment period. If you do not make elections, then you may not be able to enroll and/or make changes to your benefits until the next Open Enrollment.

AFTER ENROLLMENT

- Medical coverage: If you elect coverage, you will receive an ID card in the mail that you should use for all medical and prescription services.
- Your ID card contains important information about you, your employer group and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.
- Dental coverage: If you elect coverage, you can download a copy of your dental card at sunlife.com/dentalIDCard.com.
- Vision coverage: If you elect coverage, you can print an ID card via the VSP website. For vision services, coverage will be tied to the employee's social security number. Be sure to give this to your provider at the time of service.

Enrollment Basics

WHO YOU CAN COVER

In order to be eligible to enroll in the benefits we provide, you or your dependents must meet the following eligibility criteria:

Employees

Must be a regular, full-time employee currently meeting the hours worked provisions as outlined in the contractual agreements.

Spouse

The person to whom you are legally married. Under no circumstances may ex-spouses be covered by an employee.

Dependent child(ren)

Children up to age 26 (eligible through the end of the month following the child's 26th birthday).

Newborn children of covered dependent children (under the age of 26)

A newborn child of a covered dependent child (under the age of 26) is eligible for medical coverage for the first 18 months, as long as the newborn's parent also remains covered.

Disabled dependents

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

WHEN YOU CAN ENROLL

After you are hired

Your coverage begins the first day of the month, following 45 days of employment. You must submit your benefits elections and upload all required documentation within 30 days of your date of hire.

During Open Enrollment

Open Enrollment is your opportunity to evaluate your benefit options and make changes for the following year. Benefits selected during Open Enrollment are effective October 1, 2024 - September 30, 2025.

Mid-year changes

You may make changes to your benefits elections if you experience a qualified life event. The changes you make must be the result of and consistent with the qualified life event that occurred.

Mid-year change requests and supporting documentation must be submitted within 30-days of the date of the event.

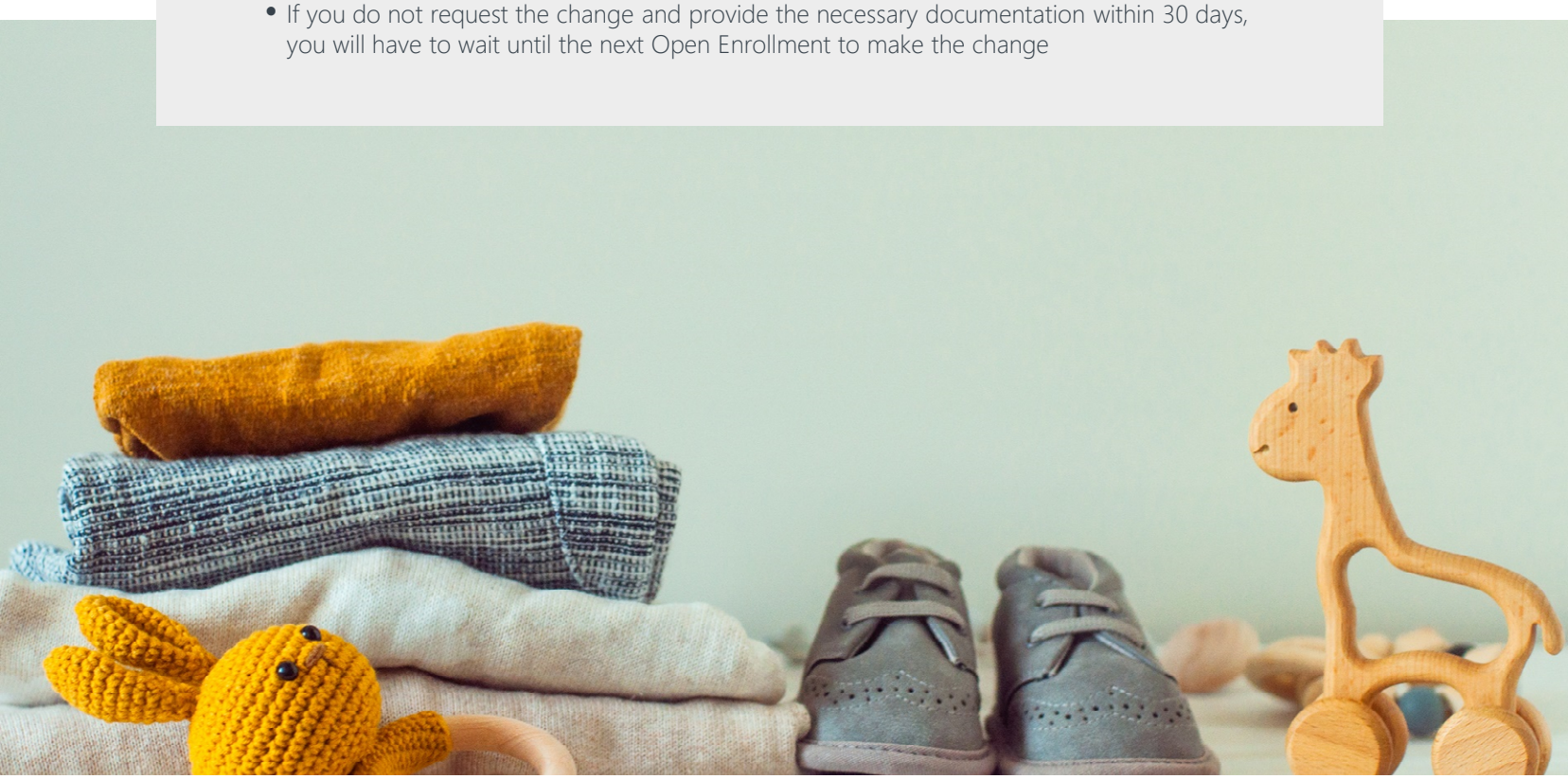
EXAMPLES OF QUALIFIED LIFE EVENTS:

- Birth, adoption, legal guardianship or placement for adoption
- Marriage, divorce or annulment
- Death of a dependent
- Gain or loss of other creditable coverage

IMPORTANT TO KNOW

How to make mid-year changes to your benefits if you've experienced a qualified life event

- Log in to https://bakercountybenefits.hrintouch.com/
- Supporting documentation should be uploaded into the enrollment portal at the time the change is requested
- If you do not request the change and provide the necessary documentation within 30 days, you will have to wait until the next Open Enrollment to make the change



HOW TO ENROLL WITH BENEFITFOCUS

All benefit elections must be submitted through Benefitfocus.

To start your enrollment

- Visit https://bakercountybenefits.hrintouch.com/
- Enter your username and password
- If you don't know your username or password, click on the "Can't access your account?" link. Follow the screen prompts
- All benefits-eligible employees will be sent an email to your BCSD email address from the Benefitfocus system that will include your system username

Benefit Resources

- The Benefitfocus Enrollment Website is your best resource!
- In Benefitfocus, you will be able to learn more about the benefits available to you, make your annual benefits elections, update dependent and beneficiary information, and much more.

Annual Enrollment "To Do" List

- Review each benefits program available and make your desired elections
- Review this booklet and detailed information on the Benefitfocus website to help make your benefit choices for the 2043-2025 plan year and enroll online
- Review the Open Enrollment Group Benefits Presentation on Benefitfocus
- Decide which Medical plan is right for you
- Review the other lines of coverage to make sure you have met all your benefit needs
- Be sure to update any beneficiaries that may have changed

IMPORTANT TO KNOW

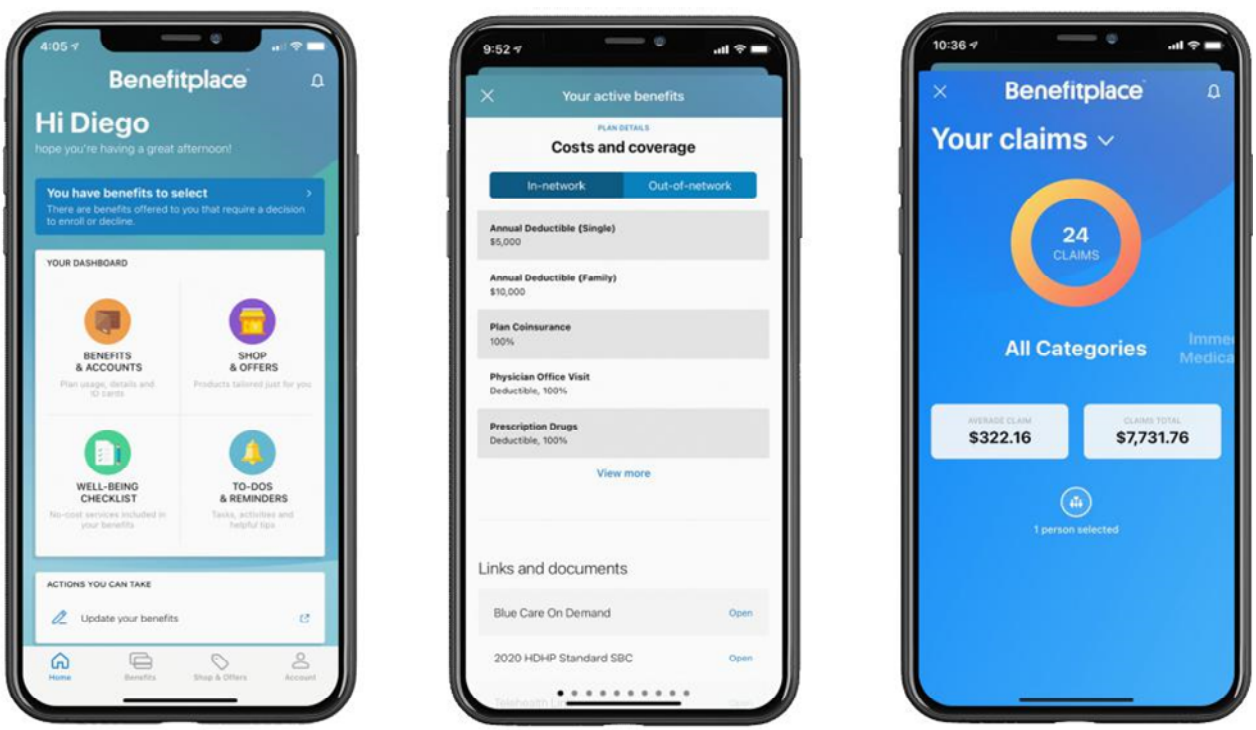
2024 – 2025 Benefit Enrollment

- Attention Employees: All benefits-eligible employees are required to complete the online enrollment process through https://bakercountybenefits.hrintouch.com. Employees are required to complete their online enrollment even if all benefits are being waived or no changes are being made to your elections.
- If the enrollment is not completed, you will not have benefits coverage for the 2024-2025 plan year.
- Instructions for completing your online enrollment are available on the https://bakercountybenefits.hrintouch.com website and will be emailed to all employees.
- Changes made during Annual Enrollment are effective October 1, 2024.

Benefitplace™ app

Your personalized benefits experience, wherever you are

Your Benefits Homepage Key Costs & Coverage Details Claims Summary Information



- One place to manage, learn and shop for affordable benefits from top brands
- A guided educational shopping experience – so you can select the best options for life.
- Get personalized, push notification communications and education on the go.
- Study up on your claims summary information, throughout the year.
- Store and share your ID cards to make forms and office visits easy
- Snap and tap to upload required documentation.

Access, learn, shop and manage all things benefits on the go. **Use your Company ID to download the app from Google Play or the Apple App Store today!**

Company ID:	**bakercountybenefits**

Questions? Contact **Dana Wood 904-259-3813** **dana.wood@bakerk12.org**

Choosing a Medical Plan

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

Choosing a Medical Plan can be overwhelming. Here are a few things to consider when choosing your plan:

- What matters most to you - keeping more of your paycheck or paying less when you receive services?
- How often do you anticipate needing medical services in the upcoming year?
- What did you spend last year on premiums AND out-of-pocket expenses?

A good way to figure out which plan is best for you and your family is to look back at last year's healthcare expenses.

- What did it cost you in annual premium?
- What were your out-of-pocket expenses?
- Were you on a plan in which you were paying more in premium and not having a lot of services or medical expenses?
- Have you taken the time to really "do the math" to determine the plan that will best meet your medical and financial needs?
- Take some time during this enrollment to really examine all the plan options available. Review the "Annual Enrollment To-Do List" on page 4.

How to Access ID Cards

Please see below for instructions on how to access your medical, dental, and vision cards through out the plan year. There is also information on how to access mobile apps and websites to view your benefits, claims, and cost-saving tools.

Medical – Florida Blue

Register at FloridaBlue.com where you can access your personalized member account, ID Cards, benefits, doctors, cost-saving tools, and more.

Where to Go

- To get started, click on New Member Registration. Choose Manage Your Plan or Care for a Friend or Loved One. Enter your email and enter the confirmation code.
- Choose a Username and Password.
- Click Go to log in and start exploring!
- You can also scan the QR code that takes you directly to the Florida Blue website!

Dental – SunLife

Check out this short video for step-by-step instructions on downloading your dental ID card at sunlife.com/dentalIDCard.com.

Online Services and the Mobile App

- Your mobile-responsive Sun Life account gives you access to everything you need to know about your dental plan, including your dental ID card.
- To complete your online registration, you will need your Social Security number or member ID, and date of birth. Register today at sunlife.com/account.
- You can easily view your dental coverage, find a dentist, access your electronic ID card, and more. For more information, please visit www.sunlife.com/mobileapps.

Vision – VSP

As a VSP member, you have access to vsp.com and the VSP Vision Care App where you can find your ID card.

Your VSP Dashboard and Vision Care App

- Visit vsp.com. Once you create an account you will receive a confirmation email.
- Once you're logged in, you'll find a quick view of your dashboard that has benefit information, access to your claim history, and you can print your Member ID Card.
- Scan the QR code below to download the VSP Vision Care App.

IMPORTANT TO KNOW

What it means to stay "in-network" and why it saves you money

Think of it this way: in-network is about getting health care from the broad range of providers who are part of your health plan. So, for in-network, that means a group of doctors, hospitals, and other health care providers have agreed to give you discounted rates because you're a FloridaBlue member.

They negotiate for you, so, you'll have less out-of-pocket costs when you get care. And they can't send you a bill for more than what has been agreed to - this is called balance billing and you're safe from it, as long as you stay in-network.

Imaging Services

If you need an X-Ray or advanced imaging service such as an MRI, CT, or PET scan, where you go for these services does have a cost impact to you. If you have these types of services in a hospital setting, the tests will be treated as an outpatient hospital service. You can typically experience a lower out-of-pocket costs by having these services performed at a free-standing imaging center that is not associated or billed through a hospital. These types of facilities are called Independent Diagnostic Testing Facilities. You can locate these facilities on the FloridaBlue provider search at www.floridablue.com

Lab Services

The in-network lab for all BCSD medical plans is Quest Diagnostics. If you have lab work performed at Baker County Medical Services, a $15 draw fee will apply.

MEDICAL PLAN PREMIUMS

Your contributions for this plan year are based on your choice of plan and coverage tier.

Listed below are per-pay-period costs for you and your dependents effective October 1, 2024 - September 30, 2025:

	BlueOptions 05774	BlueCare 62	BlueOptions 05301	BlueCare 134/35 (HSA)
	PER-PAY-PERIOD COSTS (24 times/year)			
Employee Only	$259.30	$209.90	$185.91	$66.85
Employee + Spouse	$604.74	$515.72	$472.51	$257.96
Employee + Child(ren)	$535.66	$454.60	$415.25	$219.90
Employee + Family	$851.75	$734.25	$677.20	$394.05
E/E Family	$647.29	$529.79	$472.74	$189.59
E/E Spouse	$467.22	$378.20	$334.99	$120.44

MEDICAL AND PRESCRIPTION DRUG PLANS - FloridaBlue (Group #41854)

See the summary of your medical and prescription benefits below. For complete details, exclusions and limitations, and out-of-network benefits, see the Certificates of Coverage which are available from Human Resources or your benefits website.

	BlueOptions 05774 PPO		BlueCare 62 HMO
MEDICAL BENEFITS	**In-Network**	**Out-of- Network**	**In-Network** (No out-of-Network Benefits)
Plan Year Deductible Per Individual Family Aggregate	$3,000 $9,000	$6,000 $18,000	$6,350 $12,700
Out-of-Pocket Maximum Per Individual Family Aggregate	$6,350 $12,700	$15,000 $30,000	$6,350 $12,700
Coinsurance Plan Member	80% 20%	50% 50%	100% 0%
Preventive Services	100%	50%	100%
Office Visits Primary Care Physician Specialist	$40 $100	PYD + 50% PYD + 50%	$35 $65
Urgent Care	$100	PYD + $100 copay	$100
Emergency Room	$400	$400	$300
Inpatient Hospital PAD-Per Admission Deductible Option 1 Option 2	 $500 PAD+PYD+20% $500 PAD+PYD+20%	 $500 PAD+PYD+50% $500 PAD+PYD+50%	 PYD PYD
Outpatient Procedures Option 1 Option 2	 PYD + 20% PYD + 20%	 PYD + 50% PYD + 50%	 PYD PYD
Diagnostic Tests Lab X-Ray (Independent Testing Facility)	 $0 $50	 PYD + 50% PYD + 50%	 $0 $65
Advanced Imaging MRI, CT, PET, etc.	$400	PYD + 50%	PYD
PRESCRIPTION BENEFITS			
Retail Pharmacy Tier 1 / Tier 2 / Tier 3	$10 / $60 / $100	50%	$10 / $50 / $80
Mail Order (90-day supply)	2.5x pharmacy copay	50%	2.5x pharmacy copay

MEDICAL AND PRESCRIPTION DRUG PLANS - FloridaBlue (Group #41854)

	BlueOptions 05301 PPO		BlueCare 134/35 HSA
MEDICAL BENEFITS	**In-Network**	**Out-of- Network**	**In-Network** (No out-of-Network Benefits)
Plan Year Deductible Per Individual Family aggregate	 $2,500 $7,500	 $5,000 $15,000	 $3,500 $7,000
Out-of-Pocket Maximum Per Individual Family	 $6,350 $12,700	 $13,000 $26,000	 $6,850 $7,000 pp/$14,000 max
Coinsurance Plan Member	 70% 30%	 50% 50%	 80% 20%
Preventive Services	100%	50%	100%
Office Visits Primary Care Physician Specialist	 $25 $45	 PYD + 50% PYD + 50%	 PYD + $30 PYD + $75
Urgent Care	$50	PYD + $50 copay	PYD + $100
Emergency Room	$300	$300	PYD + $350
Inpatient Hospital PAD-Per Admission Deductible Option 1 Option 2	 PYD + 30% PYD + 30%	 PYD + 50% PYD + 50%	 PYD + 20% PYD + 20%
Outpatient Procedures Option 1 Option 2	 PYD + 30% PYD + 30%	 PYD + 50% PYD + 50%	 PYD + 20% PYD + 20%
Diagnostic Tests Lab X-Ray (Independent Testing Facility)	 $0 PYD + 30%	 PYD + 50% PYD + 50%	 PYD + 20% PYD + 20%
Advanced Imaging MRI, CT, PET, etc.	 PYD + 30%	 PYD + 50%	 PYD + 20%
PRESCRIPTION BENEFITS			
Retail Pharmacy Tier 1 / Tier 2 / Tier 3	$10 / 20% / not covered	not covered	PYD then $10 / $50 / $80
Mail Order (90-day supply)	2.5x pharmacy copay (Tier 1 only)	not covered	PYD then 2.5x pharmacy copay

WHERE TO GO WHEN YOU NEED CARE

It can be hard to know where to go for medical care – especially in the heat of the moment. But, not every situation calls for a trip to the emergency room.

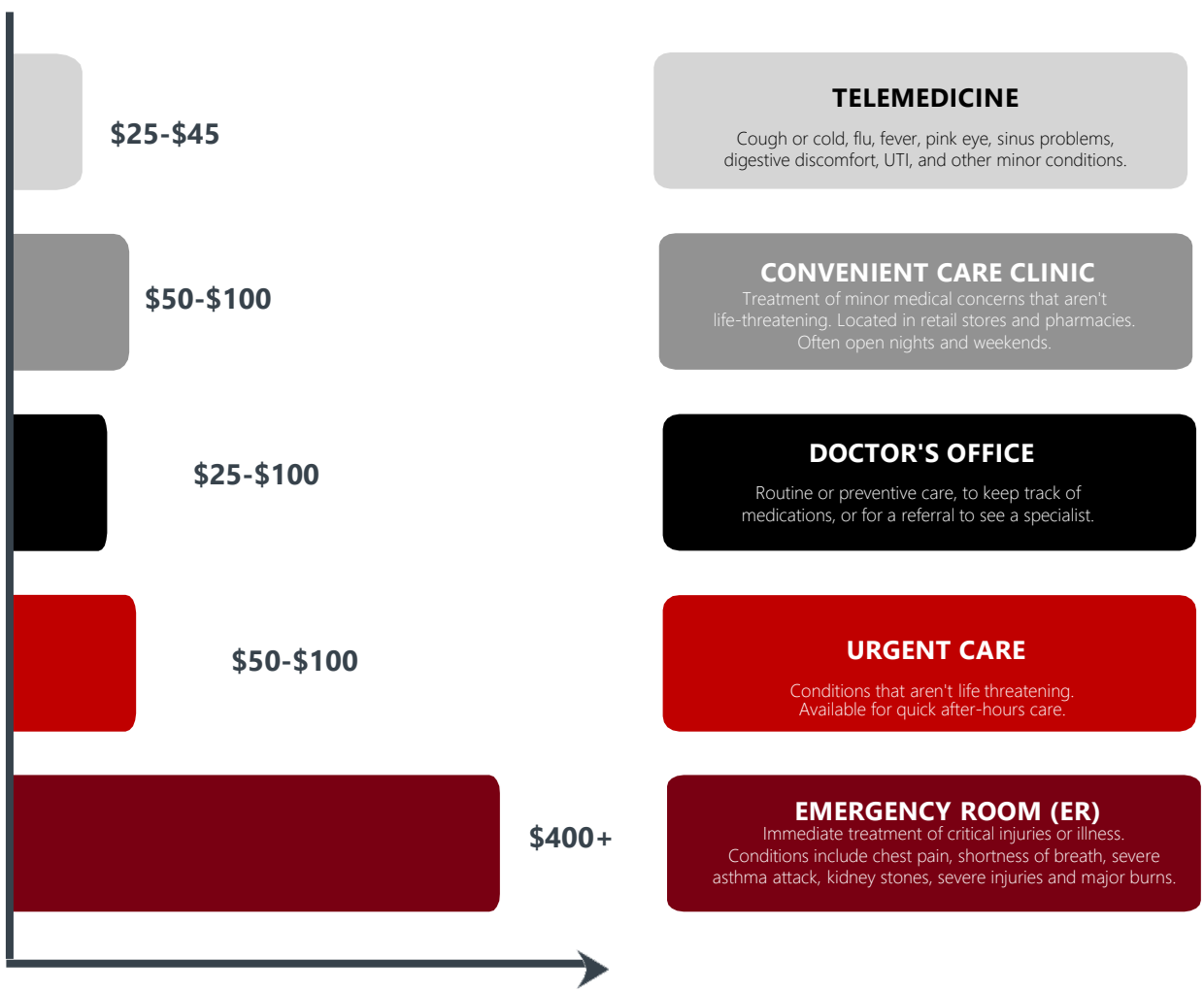
Telemedicine is a great first option

When you need care (and it isn't a true emergency like one of the conditions listed below), use your virtual visits through FloridaBlue. Their doctors can advise you on what to do next. They may even be able to help you resolve or stabilize the situation right there on the spot.

Nobody knows you better than your physician

Your physician has access to your records, knows the bigger picture of your health, and may even offer same-day appointments to meet your needs.

When seeing your physician isn't possible, however, it's important to know your options for care that fits your specific needs or situation.



Average Total Cost – Member Cost Share varies by plan

Health and Well-Being Resources

We are dedicated to helping you and your family be healthy and fit. As a covered member, you and your covered dependents have access to the following benefits and resources.

PREVENTIVE CARE

One of the best ways to stay healthy and mitigate health risks is to follow established guidelines around preventive care, including check-ups, screenings, and immunizations. Your medical, dental, and vision plans cover in-network eligible well-care visits, screenings, and immunizations at no cost for you and your covered family members.

If you use out-of-network providers, deductibles and coinsurance apply.

ONLINE AND MOBILE RESOURCES

You can stay on top of your benefits anywhere you go thanks to the mobile apps and websites our benefit carriers provide. These tools give you the ability to:

- Find a provider and care
- Download an ID card
- Check your benefits
- Review your claims
- Compare costs and access discounts
- Contact customer support

Be sure to register on www.floridablue.com and download their apps so that you can access your benefits information anytime, anywhere. All you need is your member number (located on your member ID card).

FINDING PROVIDERS

Medical in the state of Florida - www.floridablue.com

- Choose "Find a Doctor"
- Select a Plan— "BlueOptions or Blue Care (HMO)"
- Select the provider type
- Select a Location
- Enter a Provider Name or simply click "Search Now"

Medical outside the state of Florida - www.bcbs.com

Important - For BlueOptions Plans Only

- Choose "Find a Doctor"
- Select "In the United States" or "Outside the United States"
- Select your Location and Plan
- Search by Category or Provider Name
- BlueCare HMO plans do not have out-of-state benefits except for true emergencies

Health Savings Account (HSA)

If you enroll in a High Deductible Health Plan (HDHP), you should consider contributing to the Health Savings Account administered by Health Equity. With an HSA, you can gain more control over your healthcare expenses because contributions, interest, and withdrawals for qualified healthcare expenses are all tax-advantaged. This plan is not available for those enrolled in the other medical plans offered.

WHAT IS AN HSA?

A Health Savings Account is an account that you can use to pay qualified medical expenses. You own the account and benefit from the following tax advantages:

- Pre-tax contributions
- Funds accrue tax-free and withdrawals for qualified medical expenses are tax-free
- 2024 Single Coverage Max: $4,150 and 2024 Family Coverage Max: $8,300

ELIGIBILITY REQUIREMENTS

- Must be enrolled in the High Deductible Health Plan (HDHP) 134/35 (HSA) Medical Plan
- Must not be enrolled in Medicare
- Must not be covered by other medical insurance(s) such as a Health Care FSA, HRA, and other 'first dollar'coverage
- Must not have received VA medical benefits at any time in the past three months
- May not be claimed as a dependent on another individual's tax return
- Spouse not contributing to/participating in a Health Care FSA through his/her employer
- Employees over 55 years of age can elect an additional $1,000 of coverage

DEBIT CARD

All HSA participants will receive an HSA debit card from Health Equity. Your HSA card can be used to pay for qualified medical expenses billed from an insurance company, a physician's office, and pharmacies. Transactions with your HSA debit card are secure and will only work to purchase eligible and authorized items.

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

Dental Benefits

Group #954777

Your dental coverage is provided through SunLife.

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

- Choose "Find a Dentist"
- Choose the type of dentist and enter zip code
- Search by Location

IN-NETWORK	
Calendar Year Deductible Individual Family	$75 $150
Diagnostic & Preventive Cleanings, exams, x-rays (2 Dental exams and cleanings every 12 months)	Covered 100%
Basic Services Fillings (including tooth-colored fillings on posterior teeth), repairs, extractions, oral surgery, general anesthesia, endodontics and periodontics	20% after deductible
Major Services Inlays, onlays, crowns, bridges and implants	50% after deductible
Annual Benefit Maximum	$1,000

EMPLOYEE COST PER-PAY-PERIOD	
Employee Only	**$11.50**
Employee & Spouse	**$28.56**
Employee & Child(ren)	**$31.98**
Employee & Family	**$28.65**
E/E Family	**$22.30**
E/E Spouse	**$22.21**

IMPORTANT TO KNOW

Can I see my own dentist?

You are free to use the dentist or specialist of your choice.

However, when you choose a dentist in your plan's PPO network, you may save money. Using a network dentist may lower your out-of-pocket costs and may make your annual maximum go further.

If your dentist is not in-network, you can nominate your dentist to participate by calling Sun Life's Customer Service at 800-733-7879.

Vision Benefits (Group #30042721)

Your vision coverage is provided through VSP. When you utilize a provider that participates in the network, discounts will be greater and there are no claim forms necessary.

Plan participants also have access to discounted lens upgrade options and LASIK eye surgery.

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

IN-NETWORK	
Eye Exams Routine Eye Exam *Benefits may be redeemed every 12 months*	$10 copay
Frames *Benefits may be redeemed every 24 months*	$150 allowance
Lens Single Vision Bifocal Trifocal *Benefits may be redeemed every 12 months*	$10 Copay $10 Copay $10 Copay
Contacts (in lieu of glasses) Allowance Contact Lens Fitting/Follow-up *Benefits may be redeemed every 12 months*	$130 allowance Up to $60
OUT-OF-NETWORK	
Eye Exams Routine Eye Exam Contact Lens Fitting/Follow-up *Benefits may be redeemed every 12 months*	$45 Not Covered
Frames *Benefits may be redeemed every 24 months*	$70 allowance
Lens Single Vision Bifocal Trifocal *Benefits may be redeemed every 12 months*	$30 allowance $50 allowance $65 allowance
Contacts *Benefits may be redeemed every 12 months*	$105 allowance
EMPLOYEE COST PER-PAY-PERIOD	
Employee Only	**$4.02**
Employee & Spouse	**$6.44**
Employee & Child(ren)	**$6.57**
Employee & Family	**$10.99**

IMPORTANT TO KNOW

Frequently asked questions

What is a benefit allowance?

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

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

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

Life and AD&D (Group #897290)

We provide Basic Life and Accidental Death and Dismemberment (AD&D) coverage at no cost to you. Employees receive a generous benefit of $10,000 through The Hartford.

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

EMPLOYEE COVERAGE

You may elect to purchase $10,000 coverage increments, with a maximum of $500,000 up to a maximum of 5x your annual salary.

The guarantee issue amount is $100,000 and you will be able to elect up to the guaranteed issue amount when you are first eligible for the plan without having to submit evidence of insurability.

SPOUSE COVERAGE

THIS BENEFIT IS ONLY AVAILABLE IF ENROLLED IN EMPLOYEE OPTIONAL LIFE COVERAGE

Those enrolling in employee optional life coverage may also elect to purchase $5,000 increments of life insurance coverage for their spouse, up to 50% of the employee amount of coverage.

You may elect a coverage amount for your spouse up to the guarantee issue amount ($50,000) when you are first eligible for the plan, without submitting evidence of insurability.

The cost of coverage is based on the age of the employee.

CHILD COVERAGE

THIS BENEFIT IS ONLY AVAILABLE IF ENROLLED IN EMPLOYEE OPTIONAL LIFE COVERAGE

Those enrolling in employee optional life coverage may also elect to purchase $10,000 of coverage for eligible children.

All child life amounts are guarantee issue and no evidence of insurability is required. Dependents are eligible starting at 14 days-6 months at $500 and 6 months-26 years at $10,000.

IMPORTANT TO KNOW

Frequently asked questions

Does the coverage amount change based on my age?

The amount of coverage will reduce by 50% at age 70.

Do I have to fill out a medical questionnaire?

Initial elections over the guarantee issue amounts and late enrollees must complete evidence of insurability. Download the evidence of insurability form, complete it, and return it to HR. Coverage will be effective on the first day of the month following the date your medical questionnaire is approved by the insurance company.

How much does voluntary life insurance cost?

The per pay period costs for voluntary life elections will be outlined in detail in the online enrollment system. This will allow employees to see the amounts of coverage available and the corresponding cost

Short-Term Disability (Group #897290)

All full-time benefits eligible employees can purchase STD coverage through The Hartford.

This coverage is to protect you and your family in the event that a short-term disability prevents you from performing the duties of your occupation. STD coverage protects your income due to injury or sickness.

You may not be eligible for benefits if you have received treatment for a condition within the past 3 months of your plan effective date until you have been covered under this plan for 6 months. To receive benefits, your claim must be approved by the Hartford. See a brief summary of the benefits below:

SHORT-TERM DISABILITY INCOME	
Waiting Period Illness Accident	7 days, benefits begin on the 8th day 1st day
Max Benefit Duration	26 weeks
% of Income Replaced	60% of your Annual Salary
Maximum Benefit Amount	$102 weekly benefit less any other income benefit
Per Pay Period Premium	$4.69

IMPORTANT TO KNOW

Why disability coverage is important

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

Filing a STD claim

To file an STD claim, simply call The Hartford's toll-free number: 888-301-5615 from 6:00 a.m. – 6:00 p.m. PT, Monday-Friday.

Or file a claim online at www.thehartford.com/mybenefits.

Added Value from The Hartford

Life and Disability insurance from The Hartford can help you protect the financial future of your loved ones. Your coverage includes valuable services that can help. you and your family.

BENEFICIARY ASSISTANCE & COUNSELING SERVICES

The Hartford offers you Beneficiary Assist counseling that can help you or your beneficiaries (named in your policy) cope with emotional, financial, and legal issues that arise after a loss.

Includes unlimited phone contact with a counselor, attorney, or financial planner and five face-to-face sessions for up to a year from the date a claim is filed.

For more information, call: 1-800-411-7239

ESTATE GUIDANCE & WILL SERVICES

Whether your assets are few or many, it's important to have a will. Through The Hartford, you have access to EstateGuidance®. It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys.

Visit www.estateguidance.com and use code: WILLHLF

FUNERAL CONCIERGE SERVICES

The Hartford's Funeral Concierge offers a suite of online tools and life support to help guide you through key decisions. It allows for pre-planning, and documentation of wishes, and even offers cost comparisons of funeral-related expenses.

After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in significant savings.

For more information, call: 1-866-854-5429 or visit www.everestfuneral.com/Hartford.

CLAIMANT SUPPORT SERVICES (EAP)

Access up to five telephonic professional sessions per claim for legal, financial, or emotional adjustment counseling.

Contact counselors 24/7 through a dedicated, toll-free number: 888-475-3827.

TRAVEL ASSISTANCE WITH ID THEFT PROTECTION

Travel Assistance with ID Theft Protection includes pre-trip information to help you feel more secure while traveling.

It can also help you, access professionals, across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less. ID Theft services are available to you and your family at home or when traveling. In case of a serious medical emergency while traveling, please obtain emergency medical services first (contact the local "911"), and then contact Travel Assistance to alert them.

Call toll-free: 1-800-243-6108 or from other locations, call collect: 202-828-5885.

ABILITY ASSIST COUNSELING SERVICES WITH HEALTHCHAMPION HEALTH CARE SUPPORT

Ability Assist Counseling Services offers 24/7 access to master's- and Ph.D.- level clinicians. Includes three face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal, and work-life concerns.

HealthChampion offers support if you've become disabled or are diagnosed with a critical illness. You'll receive guidance on care options, helpful resources, and help with the timely and fair resolution of issues.

Call toll-free: 1-800-964-3577.

Colonial Life HIP Plan (Group #E5491055)

Employees who waive medical are eligible for this plan. The HIP Plan is offered through Colonial Life and provide benefits that pay directly to you regardless of any other insurance you may have. These plans help with the medical and personal expenses incurred when a person is undergoing treatment.

IN-NETWORK	
Emergency Room Benefit	$100/day - Maximum of two days per covered person per calendar year.
Initial Hospital Confinement	$3,000 - Maximum of one day per covered person per calendar year.
Daily Hospital Confinement	$100/day - Maximum of 365 days per covered person per confinement. *Re-confinement for the same or related condition within 90 days of discharge Is considered a continuation of previous confinement.*
Outpatient Surgery Benefit *Tiers based on surgical schedule*	Tier 1 - $500/day and Tier 2 - $1,000/day Maximum of $1,500 per covered person per calendar year for Tier 1 and 2 combined maximum of one day per outpatient surgical procedure.
Diagnostic Procedure	$250/day - Maximum of one day per covered person per calendar year.
Air Ambulance	$1,000/day - Maximum of one day per covered person per calendar year.
Ambulance	$100/day - Maximum of one day per covered person per calendar year.
Medical Appliance	$100/day - Maximum of one day per covered person per calendar year.
Doctor's Office Visit / Telemedicine	$25/day - Maximum of three days per calendar year for named insured coverage or maximum of five days per calendar year for all covered persons combined.
X-Ray	$25/day - Maximum of two days per covered person per calendar year.
EMPLOYEE COST PER-PAY-PERIOD	
Employee Only	**$2.50**
Employee & Spouse	**$12.50**
Employee & Child(ren)	**$12.50**
Employee & Family	**$12.50**

Key Terms to Know

Affordable Care Act (ACA)

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

Annual Maximum

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

Out-of-Pocket Maximum

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

Coinsurance

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

Copayment

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

Deductible

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

Brand Formulary Drugs

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

Generic Drugs

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

Maintenance Drugs

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

Non-Formulary Drugs

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

Specialty Drugs

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

Portability

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

Primary Care Physician (PCP)

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

Network

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

Qualifying Event

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

Federal Notices

IMPORTANT NOTICE FROM BCSD ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage Baker County School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. 2. BCSD has determined that the prescription drug coverage offered by the BCSD Blue Options 5301 plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the BCSD 5301 plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

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

4. 4. BCSD has determined that the prescription drug coverage offered by the FloridaBlue BlueOptions Plan 05774, BlueCare 62 and BlueCare 134/35, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

You should also know that if you drop or lose your current creditable coverage with FloridaBlue and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Since the coverage under FloridaBlue BlueOptions 5301 plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current coverage with BCSD will not be affected. Your current coverage pays for health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. [See pages 7 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you do decide to join a Medicare drug plan and drop your current coverage with BCSD, be aware that you and your dependents will be able to get this coverage back only during a qualified life event or during the annual enrollment period.

For more information about this notice or your current prescription drug coverage...

Contact your BCSD Benefits Advocate listed on the Key Contacts page of this benefit guide for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

HIPAA PRIVACY PRACTICES

Baker County Schools provides all required HIPAA privacy practices notifications via the online enrollment portal and internal communication channels.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth (60 days), adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Baker County Schools Benefits and Payroll for further information at (904)259-3813.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAE)

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Pace has elected to exempt the Pace Self-Funded Medical Plan from the following requirements:

Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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

MICHELLE'S LAW

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

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator Baker County Schools Benefits and Payroll for further information at (904)259-0401.

CHIPRA - PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov/

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+:https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
Website:
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website:
http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website:
https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website:
http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website:
https://medicaid.utah.gov/
CHIP Website:
http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website:
http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website:
https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

- U.S. Department of Labor Employee Benefits Security Administration
  www.dol.gov/agencies/ebsa
  1-866-444-EBSA (3272)
- U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
  www.cms.hhs.gov
  1-877-267-2323, Menu Option 4, Ext. 61565

Key Contacts

CONTACT	PHONE	EMAIL / WEBSITE
Medical FloridaBlue Group #41854	1.800.664.5295 1.888.476.2227 - Care Consultants	www.floridablue.com
Dental SunLife Group #954777	1.800.442.7742	www.sunlifedentalbenefits.com
Vision VSP Group #30042721	1.800.877.7195	www.vsp.com
Life and Disability The Hartford Customer Service STD Claims Life Claims Group #897290	1.800.523.2233 1.888.277.4767 1888.563.1124	www.thehartford.com
HIP Colonial Life Group #E5491055	800.325.4368	www.coloniallife.com
BCSD Human Resources Dana Wood	904.259.3813	dana.wood@bakerk12.org
The Bailey Group Benefits Consultants Monica Whitenight, Account Executive	1.904.826.1800 904.461.2106	monica.whitenight@mbaileygroup.com

Baker County Schools
2024 Benefits

The information in this Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. The benefit options selected during Open Enrollment will be binding. The terms and provisions will govern you and restrictions of the plans in which you enroll. Generally, unless you experience a qualifying life event, your elections will remain in effect for the entire plan year. By completing your enrollment, you authorize Baker County Schools to deduct contributions from your paycheck, now and in the future, as required under each of the plans. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources. Baker County Schools reserves the right to change, amend or cease these benefits at any time.