TALLAHASSEE

COMMUNITY COLLEGE

Retiree
Open Enrollment 2024
November 1st – November 25th, 2023

444 Appleyard Drive
Tallahassee, Florida 32304-2895
850.201.6200 | www.tcc.fl.edu

Retiree

It is time for our Annual Open Enrollment; your yearly opportunity to make changes to your health and welfare benefits. Open Enrollment provides you with the chance to review your current health care choices and decide if they are still right for you and your eligible dependents in 2024. Elections will be effective January 1, 2024.

Enclosed in this packet is our summary plan guides for health insurance; Capital Health Plan and Blue Cross Blue Shield, as well as The Standard Dental, Vision and Life. Please review the packet and complete any forms needed for a change of benefits or new enrollment.

Information for 2024

- BCBS Blue Options, and CHP had rate increases.
- Life Insurance – Cannot increase current election amount; only decrease or drop the coverage.
- As a reminder, you can not elect health insurance if you currently do not have it with TCC. If you need advice or guidance please reach out to us, we would gladly assist you.
- If you are nearing 65, please contact HR. You will become eligible for Medicare plans and other options that are a lower premium cost to you.

All forms should be returned to HR via, email, fax, or mail.

- Retiree Update Form – Please complete if there were any changes and return to HR. This helps us keep updated contact information.
- Insurance Enrollment Forms – If you are changing your current health election for Capital Health Plan or Florida Blue, please contact Human Resources for enrollment forms.
- Medicare Eligible over age 65 Plans: If you are nearing age 65, please contact the benefit team for forms and options that may have a lower premium cost.

Please send all forms to:
Email: Waseem Kofar-Naisa waseem.kofarnaisa@tcc.fl.edu
Mail: 444 Appleyard Dr., Tallahassee Fl 32304 Attn: HR Waseem Kofar-Naisa
Tel: 850-201-8568 Fax: 850-201-8489

Deadline for forms: November 24th, 2023

If you have any questions regarding your benefits, please contact Human Resources and speak with any of our Benefit Team, or contact Waseem Kofar- Naisa directly at 850-201-8568.

Sandy Martin

Sandy Martin
Human Resources Manager
Email: sandy.martin@tcc.fl.edu
Phone: 850-201-8021

Retiree
Insurance Rates 2024

Retiree (Under 65)

Provider	Retiree	Retiree + 1	Retiree + Family
Capital Health Plan	$777.89	$1,587.00	$2,023.19
Blue Options PPO 03559 Plan (2024)	$1,158.43	$2,757.10	$3,614.34
Blue Options PPO 05905 Plan (2024)	$724.96	$1,726.10	$2,262.85

Retiree Medicare Eligible (65 and older)

Provider	Retiree	Retiree + 1 (Both on Medicare)	Retiree + 1 (1 With Medicare + 1 Without)	Retiree + Family (Retiree w/Medicare & Family)
Capital Health Plan Medicare Advantage	$243.44	$486.88	$1,021.33	$1,488.74
Blue Medicare PPO Elite - Retiree	$300.92	Not Applicable	Not Applicable	Not Applicable
Blue Medicare PPO Elite - Spouse	$300.92	Not Applicable	Not Applicable	Not Applicable

Dental – The Standard (2024)

Plan Type	Retiree	Retiree + 1	Retiree + Family
Low Option	$23.26	$44.54	$81.17
High Option	$33.84	$65.13	$110.96

Vision – The Standard VSP Network (2024)

	Retiree	Retiree + Spouse	Retiree + Child(ren)	Retiree + Family
Rate	$5.60	$9.44	$9.60	$15.20

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Plan: Capital Selection $15/$30/$50

Capital Health Plan Member Services: 850-383-3333

Website: https://capitalhealth.com

Capital Health Plan **Capital Selection $15/$30/$50**

Coverage for: Employee or Family | **Plan Type:** HMO

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: $15 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth–Services provided by network providers through remote access technology including web and mobile devices.
	Specialist visit	Office: $40 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth–Services provided by network providers through remote access technology including 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)	$100 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://capitalhealth.com/	Tier 1 – Preferred Generic Tier 2 – Non-Preferred Generic	$15 / 30-day supply	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. Retail or mail order, one copay per 30 day supply up to 90 days.
	Tier 3 – Preferred Brand	$30 / 30-day supply	Not Covered	
	Tier 4 – Non-Preferred Brand	$50 / 30-day supply	Not Covered	

members/about-your-medications	Specialty drugs Tier 5 – Preferred Specialty Tier 6 – Non-Preferred Specialty	$50 / 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: $100 / visit Hospital: $250 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$40 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$300 / visit $250 / observation	$300 / visit $250 / observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status, an additional copayment may apply based on services rendered.
	Emergency medical transportation	$100 / transport	$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: $25 / visit Telehealth: $25 / visit Amwell: $15 / visit	Urgent care center: $25 / visit Telehealth: $25 / visit 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)	$250 / admission $250 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted $40 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	$40 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility	$250 / admission	Not Covered	Prior authorization required. Your benefits

	services			/services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	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
- Annual routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or

www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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.

About these Coverage Examples:

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

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

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

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other copayment	**$50**

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	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

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

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

Florida Blue

Plan 1: Blue Options 03559 Rx $15/$60/$100

Plan 2: Blue Options 05905 Rx $10/$60/$100

1-800-352-2583

Website: www.floridablue.com

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$600** Per Person/**$1,800** Family. Out-of-Network: **Combined with In-Network.**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$6,000** Per Person/**$12,000** Family. Out-Of-Network: **Combined with In-Network.**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, Deductible does not apply/ Primary Care Visits: $30 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 30% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $50 Copay per Visit/ Virtual Visits: $40 Copay per Visit	Deductible + 30% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share.. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	30% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Physician Office: $50 Copay per Visit/ Independent Diagnostic Testing Center: Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	$15 Copay per Prescription at retail, $30 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$60 Copay per Prescription at retail, $120 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$100 Copay per Prescription at retail, $200 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $75 Copay per Visit/ Hospital Option 1: $150 Copay per Visit	Deductible + 30% Coinsurance	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 30% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	$100 Copay per Visit + 20% Coinsurance	$100 Copay per Visit + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2; $45 Copay per remaining Visit/ Urgent Care Visits: $50 Copay per Visit	Deductible + $50 Copay per Visit	————none————

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital: $750 Copay per Admission	$2,500 Copay per Admission	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply/ Specialist Virtual Visits: No Charge, Deductible does not apply/ Hospital: No Charge, Deductible does not apply	30% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge/ Hospital: $2,500 Copay per Admission	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$50 Copay on initial Visit	Deductible + 30% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital: $750 Copay per Admission	$2,500 Copay per Admission	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	$50 Copay per Visit	Physician Office: Deductible + 30% Coinsurance/ Outpatient Rehab Center: Deductible + 30% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 60 days.

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

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)	
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

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

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

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

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

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

department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

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.

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

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

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	$600
Specialist Copayment	$50
Hospital (facility) Copayment	$750
Other No Charge	$0

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$600
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,660**

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

The plan's overall deductible	$600
Specialist Copayment	$50
Hospital (facility) Copayment	$750
Other Coinsurance	20%

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	$600
Specialist Copayment	$50
Hospital (facility) Copayment	$750
Other Copayment	$100

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	$600
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$7,000** Per Person/**$14,000** Family. Out-of-Network: **$14,000** Per Person/**$28,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$7,350** Per Person/**$14,700** Family. Out-Of-Network: **$15,500** Per Person/**$30,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge, Deductible does not apply/ Primary Care Visits: $50 Copay per Visit/ Virtual Visits: No Charge, Deductible does not apply	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $75 Copay per Visit/ Virtual Visits: $75 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge, Deductible does not apply	50% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge, Deductible does not apply/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.floridablue.com/members/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $20 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$60 Copay per Prescription at retail, $100 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$100 Copay per Prescription at retail, $120 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Up to 30 day supply for retail. Not covered through Mail Order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge, Deductible does not apply - Visits 1-2; Deductible + 30% Coinsurance per remaining Visit/ Urgent Care Visits: Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	————none————

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge, Deductible does not apply/ Specialist Virtual Visits: No Charge, Deductible does not apply/ Hospital: No Charge, Deductible does not apply	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge, Deductible does not apply	Physician Services: No Charge, Deductible does not apply/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$75 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 35 visits.
	Rehabilitation services	$75 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.

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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)	
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

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

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$7,000
Specialist Copayment	$75
Hospital (facility) Coinsurance	30%
Other No Charge	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$7,000
Copayments	$80
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,440**

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

The plan's overall deductible	$7,000
Specialist Copayment	$75
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

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	$2,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	$7,000
Specialist Copayment	$75
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

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	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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

Section 1557 Notification: Discrimination is Against the Law

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide:

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

If you need these services, contact:

- Health and vision coverage: 1-800-352-2583
- Dental, life, and disability coverage: 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

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

Dental, life, and disability coverage:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

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

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

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-3852 (رقم هاتف الصم والبكم: 1-800-559-0778.
اتصل برقم 1-800-333-7222.

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

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

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

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.
ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

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

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

Dental High Plan

Dental Low Plan

Retiree Vision Plan

Retiree Life Insurance Plan (Information only, can not elect if you did not elect when you first retired)

Retiree Enrollment Forms (Must be returned if electing any Standard coverage) Website:

www.standard.com

1-800.547.9515

Standard Insurance Company
Tallahassee Community College
Group Policy #169468

Group Life Insurance

Help protect your loved ones from financial hardship.

This coverage is designed to help provide financial support and stability to your family should you pass away. Life insurance is an easy, responsible way to help protect your family from financial hardship during a difficult time — and into the future.

This plan offers:

- Competitive group rates
- The convenience of payroll deduction
- Benefits if you become terminally ill or die

About This Coverage

How Much Can I Apply For?	For You:	**$5,000, $10,000, $15,000, $20,000** or **$25,000**

See the Important Details section for more information, including requirements, exclusions, limitations and definitions.

Additional Features

Your coverage comes with some added features:

Travel Assistance[1]	Available 24 hours a day, this service connects you to resources when you're traveling at least 100 miles from home or in a foreign country for up to 180 days.
Life Services Toolkit[2]	This service allows you and your beneficiaries access to online content for will preparation, identity theft support and other tools and calculators, and provides your beneficiaries with services for grief, and legal and financial matters.

1 This service is provided through an arrangement with a service provider who is not affiliated with The Standard. Travel Assistance is not an insurance product. For more information, visit **www.standard.com/travel-info**.

2 The Life Services Toolkit is offered through an arrangement with a service provider that is not affiliated with The Standard. For more information, visit **www.standard.com/mytoolkit-info**.

How Much Life Insurance Do You Need?

After a death in the family, there are many unexpected expenses. Your benefits could help your family pay for:

- Outstanding debt
- Burial expenses
- Medical bills
- Your children's education
- Daily expenses

To estimate your insurance needs, you'll need to consider your unique circumstances. Use our online calculator at **www.standard.com/life/needs**.

How Much Your Coverage Costs

Because this insurance is offered through Tallahassee Community College, you'll have access to competitive group rates, which may be more affordable than those available through individual insurance. You'll also have the convenience of having your premium deducted directly from your paycheck.

If you elect coverage, your monthly premiums are shown below:

$5,000 = $11.80
$10,000 = $23.60
$15,000 = $35.40
$20,000 = $47.20
$25,000 = $59.00

Important Details

Here's where you'll find the details about the plan.

Eligibility Requirements

To be eligible for coverage, you must be an employee of Tallahassee Community College who retired under the employer's retirement program.

Medical Underwriting Approval

Required for:

- All late applications (applying 31 days after becoming eligible)
- Requests for coverage increases
- Reinstatements, if required
- Employees eligible but not insured under the prior life insurance plan

Visit **https://myeoi.standard.com/169468** to complete and submit a medical history statement online.

Coverage Effective Date

To become insured, you must:

- Meet the eligibility requirements listed in the previous sections,
- Serve an eligibility waiting period*,
- Receive medical underwriting approval (if applicable),
- Apply for coverage and agree to pay premium, and
- Be actively at work (able to perform all normal duties of your job) on the day before the insurance is scheduled to be effective.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Contact your human resources representative or plan administrator for further information about the applicable coverage effective date for your insurance.

*Defined as the date you retire

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage from The Standard.

Conversion

If your insurance reduces or ends, you may be eligible to convert your existing Life insurance to an individual life insurance policy without submitting proof of good health.

Exclusions

Subject to state variations, you are not covered for death resulting from suicide or other intentionally self-inflicted injury, while sane or insane. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death.

When Your Insurance Ends

Your insurance ends automatically when any of the following occur:

- The date the last period ends for which a premium was paid
- The date your employment terminates
- The date you cease to meet the eligibility requirements (insurance may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy

For more details on when your insurance ends, contact your human resources representative or plan administrator.

Group Insurance Certificate

If coverage becomes effective and you become insured, you may receive a group insurance certificate containing a detailed description of the insurance coverage, including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. The information present in this summary does not modify the group policy, certificate or the insurance coverage in any way.

About Standard Insurance Company

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**.

GP190-LIFE/S399, GP399-LIFE/TRUST, GP899-LIFE, GP190-LIFE/A997/S399, GP411-LIFE

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 12505-D-VL-FL-169468 (9/23)
7429919-1059084

Tallahassee Community College

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: 1/1/2024**

	VSP Choice Network + Affiliates	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.*
***The Costco and Walmart allowance will be the wholesale equivalent.*

Lens Options (participant cost)*

	VSP Choice Network + Affiliates	Out of Network
	(Other than Costco)	
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.*

Tallahassee Community College

Monthly Rates	
Employee Only (EE)	$4.99
EE + Spouse	$8.40
EE + Children	$8.57
EE + Spouse & Children	$13.56

Additional Balanced Care Vision I Choice Network Features	
Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Retail Chain Affiliate Providers Available With Balanced Care Vision I Plans

Retail chain affiliate providers, which include Costco® Optical and Visionworks, give participants added convenience and additional retail choices. Costco Optical has 400 locations across the country, while Visionworks manages nearly 400 optical stores in 37 states and DC, including well-known stores such as EyeMasters, Visionworks, Dr. Bizer's VisionWorld, Eye DRx, and Hour Eyes, to name a few. Participants enjoy a covered-in-full benefit experience with equivalent frame benefit at any of these retail chain locations.

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.

Vision Plan Participant Service

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

VSP Call Center: 800.877.7195

- Service representative hours: 5 a.m. to 7 p.m. Pacific Monday through Friday, 6 a.m. to 2:30 p.m. Pacific Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at:
www.standard.com/services

TALLAHASSEE COMMUNITY COLLEGE

Retiree Dental Insurance High Plan

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: 1/1/2024**

Plan Benefit	In Network	Out of Network
Type 1 (Preventive)	100%	80%*
Type 2 (Basic)	80%	70%*
Type 3 (Major)	50%	40%*
Waiting Period	None	
Deductible	$50/Calendar Year Type 2 & 3	$50/Calendar Year Type 2 & 3
	Waived Type 1	Waived Type 1
	$150/family	$150/family
Maximum *(per person)***	$1,750 per calendar year	$1,000 per calendar year
Allowance	Discounted Fee	90% usual and customary
Max Builder℠	Included	Included
Annual Eye Exam	None	None
Annual Open Enrollment	Included	Included

**If you go to an out of network Dentist, you will be responsible for paying the difference between what the Dentist submits for payment and the amount we pay.*
***Maximum is per calendar year for both in network and out of network.*

Orthodontia Summary - Adult and Child Coverage

	In Network	Out of Network
Allowance	Discounted Fee	Usual and customary
Plan Benefit	50%	50%
Lifetime Maximum *(per person)***	$1,000	$1,000
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network.*

TALLAHASSEE COMMUNITY COLLEGE

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

In Network		
Type 1	**Type 2**	**Type 3**
• Routine Exam (2 in 12 months) • Bitewing X-rays (2 in 12 months) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (4 in 12 months) • Fluoride for Children 16 and under (1 in 12 months) • Sealants (age 16 and under) • Space Maintainers	• Fillings for Cavities • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
Out of Network		
Type 1	**Type 2**	**Type 3**
• Routine Exam (2 in 12 months) • Bitewing X-rays (2 in 12 months) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (4 in 12 months) • Fluoride for Children 16 and under (1 in 12 months) • Sealants (age 16 and under) • Space Maintainers	• Fillings for Cavities • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Monthly Rates	
Employee Only (EE)	$33.84
EE + 1 Dept	$65.13
EE + 2+ Depts	$110.96

Max Builder℠

This dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. A participant must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount. Earns an extra reward, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards will be lost; but he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

TALLAHASSEE COMMUNITY COLLEGE

Retiree Dental Insurance Low Plan

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: 1/1/2024**

Plan Benefit	In Network	Out of Network
Type 1 (Preventive)	100%	70%*
Type 2 (Basic)	80%	50%*
Type 3 (Major)	50%	30%*
Waiting Period	None	
Deductible	$100/Calendar Year Type 2 & 3	$100/Calendar Year Type 2 & 3
	Waived Type 1	Waived Type 1
	$300/family	$300/family
Maximum *(per person)***	$1,000 per calendar year	$1,000 per calendar year
Allowance	Discounted Fee	90% usual and customary
Max Builder℠	Included	Included
Annual Eye Exam	None	None
Annual Open Enrollment	Included	Included

**If you go to an out of network Dentist, you will be responsible for paying the difference between what the Dentist submits for payment and the amount we pay.*
***Maximum is per calendar year for both in network and out of network.*

Orthodontia Summary - Adult and Child Coverage

	In Network	Out of Network
Allowance	Discounted Fee	Usual and customary
Plan Benefit	50%	50%
Lifetime Maximum *(per person)***	$1,000	$1,000
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network.*

TALLAHASSEE COMMUNITY COLLEGE

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

In Network		
Type 1	**Type 2**	**Type 3**
• Routine Exam (2 in 12 months) • Bitewing X-rays (2 in 12 months) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (4 in 12 months) • Fluoride for Children 16 and under (1 in 12 months) • Sealants (age 16 and under) • Space Maintainers	• Fillings for Cavities • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)
Out of Network		
Type 1	**Type 2**	**Type 3**
• Routine Exam (2 in 12 months) • Bitewing X-rays (2 in 12 months) • Full Mouth/Panoramic X-rays (1 in 3 years) • Periapical X-rays • Cleaning (4 in 12 months) • Fluoride for Children 16 and under (1 in 12 months) • Sealants (age 16 and under) • Space Maintainers	• Fillings for Cavities • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Monthly Rates	
Employee Only (EE)	$23.26
EE + 1 Dept	$44.54
EE + 2+ Depts	$81.17

Max Builder℠

This dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. A participant must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount. Earns an extra reward, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards will be lost; but he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

TALLAHASSEE COMMUNITY COLLEGE

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."

Your provider network is Classic Network.

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 January 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.

TALLAHASSEE COMMUNITY COLLEGE

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.

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.

Standard Insurance Company
Tallahassee Community College
Group Policy #169468

Retiree Enrollment and Change Form

Group Number	Divison
169468	Retirees

Please check below type of coverage or change:

Apply for Coverage ☐ Name Change ☐ Former Name: ☐

Add Dependent ☐ Delete Dependent ☐ Effective Date for Add/Delete: ☐

Beneficiary Change ☐ (Must Complete Beneficiary Section)

Last Name	First Name	Social Security Number	Birth Date	Female/Male

Address	City	State	Zip Code

Phone Number	Email Address	Employer Name

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence of Insurability requirements.

Last Name, First Name:

Dental Insurance (Standard – Administered by Ameritas Corp)

	Retiree Only	Retiree +1 Dependent	Retiree +2 (or more)
Option 1: Low Plan	$17.50 ☐	$33.50 ☐	$61.50 ☐
Option 2: High Plan	$24.90 ☐	$47.90 ☐	$81.90 ☐

Vision Insurance (Standard – VSP Network)

Retiree	Retiree + Spouse	Retiree + Children	Retiree + Family
$4.99 ☐	$8.40 ☐	$8.57 ☐	$13.56 ☐

List dependents to enroll or drop for Dental and/or Vision Care.

Last Name, First Name	Spouse or Child	Dental		Vision		Gender		Date of Birth
		Add	Drop	Add	Drop	F	M	
		☐	☐	☐	☐			
		☐	☐	☐	☐			
		☐	☐	☐	☐			
		☐	☐	☐	☐			

Beneficiary Designation:

This designation applies to your Life. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary Full Name	Address	DOB	Phone No.	SSN (if known)	Relationship	% of Benefit

Contingent Full Name	Address	DOB	Phone No.	SSN (if known)	Relationship	% of Benefit

Last Name, First Name:

Signature

I wish to make the choices indicated on this form. If electing coverage, I understand that all premium payments are my responsibility and will be paid timely each month. I understand that my premium amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies).

Signature of Applicant (Member/Employee)	Date

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  - ❖ Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  - ❖ If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  - ❖ If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- 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, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Medicare Part D Credible Coverage Notice

Medicare Part D Creditable Coverage Notice

Important Notice from Tallahassee Community College About Your Prescription Drug Coverage and Medicare

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

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

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

(2) The Plan Sponsor has determined that the prescription drug coverage offered by the Sample Company Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you 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.

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 Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription 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 coverage with the Plan Sponsor 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.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below 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 the Plan Sponsor 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).

Date:	10/1/2023
Name of Entity/Sender:	Tallahassee Community College
Contact-Position/Office:	Human Resources Manager
Address:	444 Appleyard Drive, Tallahassee, FL 32304
Phone Number:	850-201-8510

For questions or concerns regarding your Benefit options
please contact one of the Human Resource representatives
below.

Sandy Martin
Human Resources Manager

Office: (850) 201-8021
Fax: (850) 201-8489
sandy.martin@tcc.fl.edu

Samantha Monroe
Human Resources Specialist II

Office: (850) 201-6034
Fax: (850) 201-8489
samantha.monroe@tcc.fl.edu

Waseem Kofar-Naisa
Human Resource specialist I

Office: (850) 201-8564
Fax: (850) 201-8489