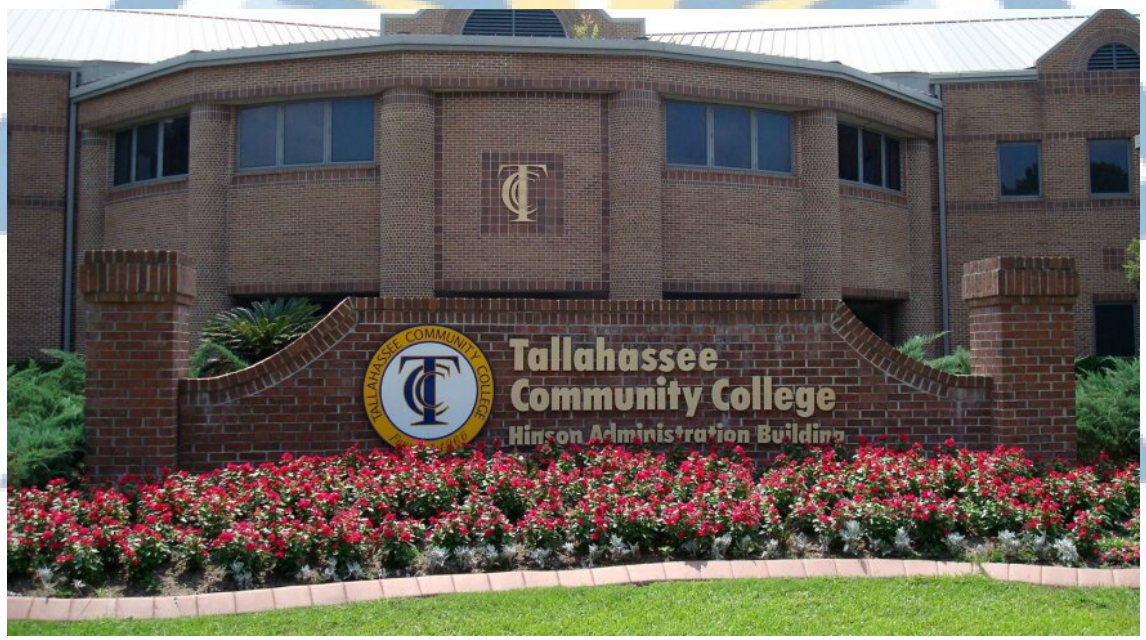
TALLAHASSEE

COMMUNITY COLLEGE

Retiree Medicare
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 over 65; Capital Health Plan Retiree Advantage and Blue Medicare, 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

Plan: Retiree Advantage Plan (Over 65)

Capital Health Plan Member Services: 850-383-3333

Website: https://capitalhealth.com

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

Capital Selection 15/30/50 Retiree Advantage (HMO)

Schedule of Copayments

Covered Service	Unit	Your Cost (Copayment)
Physician Services (including maternity care)		
Primary Care: Office visit/telehealth for services provided by your primary care physician during regular office hours	Per Visit	$15
Specialty Care: Office visit/telehealth for services provided by a participating provider when authorized by your primary care	Per Visit	$40
Urgent Care: Office Visit/Telehealth – Urgent care services provided by your primary care physician, or other Capital Health Plan personnel or participating providers including after regular office hours Telehealth – Amwell urgent care services provided by network physicians through remote access technology including the web and other mobile devices	Per Visit Per Visit	$25 $15
Preventive services covered under Original Medicare	Per Visit	$0
Acupuncture- For chronic low back pain under certain circumstances	Per Visit	$40
Chiropractic Care- if medically necessary under certain circumstances	Per Visit	$20
Mental health and Substance Use Disorder outpatient care when medically necessary and authorized by the primary care physician	Per Visit	$40
Outpatient procedures, surgical services, and other medical care provided by the primary care physician or by a participating provider when authorized by the primary care physician	Per Visit	$40
Hospital Services (including maternity care)		
Room and board in a semiprivate room, or private when medically necessary, and all services covered under this agreement	Per Admission	$250
Outpatient procedures performed in a hospital	Per Visit	$250
Mental health inpatient hospital care	Per Admission	$250
Emergency Services		
Emergency room visit	Per Visit	$120 (waived if admitted)
Medically necessary ambulance service	Per Transport	$100
Other Benefits		
Home health services	Per Occurrence	$0

Covered Service	Unit	Your Cost (Copayment)
Hospice care	Per Occurrence	$0
Skilled nursing facility services limited to 100 days of confinement per benefit period	Per Confinement	$0
Outpatient procedures performed in an ambulatory surgical center	Per Visit	$100
Durable medical equipment	Per Device	$0
Orthotic and Prosthetic medical appliances	Per Appliance	$0
Diagnostic Imaging including MRI, PET, CT, and Thallium Scans	Per Visit	$100
Routine eye exams (one every 12 months)	Per Visit	$15
Visits for physical therapy, occupational therapy, and speech language therapy	Per Visit	$40
Visits for cardiac and intensive cardiac rehabilitation services	Per Visit	$40
Visits for pulmonary rehabilitation services	Per Visit	$20
Diabetic testing supplies (Preferred Mail Order J&B Medical Supply)	Of the Cost	Preferred $0 Retail $15
Part B Drugs	Of the Cost	$0

Outpatient Prescription Drugs

		30 day supply	60 day supply	90 day supply
Retail	Tier 1	$15	$30	$45
	Tier 2	$15	$30	$45
	Tier 3	$30	$60	$90
	Tier 4	$50	$100	$150
	Tier 5	$50	N/A	N/A
	Tier 6	$0	$0	$0
Mail order	Tier 1	$15	$30	$37.50
	Tier 2	$15	$30	$37.50
	Tier 3	$30	$60	$75
	Tier 4	$50	$100	$125
*100 day supply	Tier 5	N/A	N/A	N/A
	Tier 6*	$0	$0	$0

Exclusions

Services not specifically listed in the Evidence of Coverage; service, which in our opinion was, or is, not medically necessary; hearing aids and devices; cosmetic surgery; nonprescription drugs and vitamins; and custodial care.

- You are responsible for the payment of charges for health care services that are not covered and for the payment of charges in excess of any maximum benefit limitation set forth in the Evidence of Coverage or Schedule of Copayments.
- Your maximum out-of-pocket amount for medical services in the calendar year is $3,400 per member, excluding your costs for covered Part D prescription drugs. After reaching your maximum out-of-pocket amount you generally pay nothing for covered Medicare Part A and Part B services for the remainder of the calendar year.
- Covered prescription drugs must be medically necessary, and prescribed by a qualified medical professional acting within the scope of his/her license, and dispensed by a pharmacist. Supplies other than 30, 60, or 90 days are available.
- See the Capital Health Plan Retiree Advantage Evidence of Coverage or the Capital Health Plan Retiree Advantage Summary of Benefits for additional information.
- Eyewear Benefit $200 each year/Fitness reimbursement $150 each year.

Florida Blue

Blue Medicare

Website: www.floridablue.com

Florida Blue
Your local Blue Cross Blue Shield | MEDICARE

2024 Summary of Benefits

Medicare Advantage Plan with Part D Prescription Drug Coverage

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BlueMedicare Group PPO (Employer PPO)

1/1/2024 - 12/31/2024

Elite PPO

Tallahassee Community College #78827

The plan's service area includes:
Nationwide

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." To get a complete list of the drugs we cover, call us and ask for the List of Covered Drugs ("Formulary"). You may also view the "Evidence of Coverage" and "Formulary" for this plan on our website, **www.floridablue.com/medicare**.

If you want to know more about the coverage and costs of Original Medicare, look in your current *Medicare & You* handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

You and your dependent(s) can join this plan if you are a retired employee of the group, and the following conditions are met:

- You and your dependent(s) are entitled to Medicare Part A and enrolled in Medicare Part B
- You and your dependent(s) live in the plan service area, and
- You are identified as an eligible participant by your former employer

Neither you nor your dependent(s) are eligible for this plan if:

- You are an active employee of the group, or
- You are a retired employee of the group with a dependent who is an active employee of the group and has coverage through the group's plan for active employees

Our service area is nationwide. It includes all fifty states, the District of Columbia and the United States territories.

Which doctors, hospitals, and pharmacies can I use?

We have a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network to receive medical services, you may pay more for these services. If you use pharmacies that are not in our network to fill your covered Part D drugs, the plan will generally not cover your drugs.

- You can see our plan's provider and pharmacy directory on our website (**www.floridablue.com/medicare**). Or call us and we will send you a copy of the provider and pharmacy directories.

Have Questions? Call Us

- If you are a member of this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770.
- If you are not a member of this plan, call us at 844-BLUE-MED (844-258-3633), TTY: 1-800-955-8770.
    - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas.
    - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays.
- Or visit our website at **www.floridablue.com/medicare**

Important Information

Our plans group each medication into a tier. The number of tiers may vary based on the plan you choose. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Through this document you will see the "◊" symbol. Services with this symbol may require prior authorization from the plan before you receive the services from network providers. If you do not get a prior authorization when required, you may have to pay out-of-network cost-sharing, even though you received services from a network provider. Please contact your doctor or refer to the "Evidence of Coverage (EOC)" for more information about services that require a prior authorization from the plan.

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$300.92** You must continue to pay your Medicare Part B premium.
Deductible	▪ **$0** per year for In-Network health care services ▪ **$1,000** per year for Out-of-Network health care services ▪ **$0** per year for Part D prescription drugs. There is no deductible for insulins.
Maximum Out-of-Pocket Responsibility	▪ **$1,000** is the most you pay for copays, coinsurance, and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$3,000** is the most you pay for copays, coinsurance, and other costs for Medicare-covered medical services you receive from in- and out-of-network providers.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Coverage ◊ (Authorization applies to in-network services only.)	▪ **$200** copay per day, for days 1-5 ▪ **$0** copay per day, after day 5	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Outpatient Hospital Coverage	▪ **$75** copay per visit for Medicare-covered observation services ▪ **$200** copay for all other services ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulatory Surgical Center (ASC) Services	▪ **$150** copay for surgery services provided at an Ambulatory Surgical Center ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Doctor Visits	▪ **$10** copay per provider of choice visit ▪ **$25** copay per specialist visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Preventive Care	▪ **$0** copay • Abdominal aortic aneurysm screening • Annual wellness visit • Bone mass measurement • Breast cancer screening (mammograms) • Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) • Cardiovascular disease testing • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screening • Diabetes screening • Diabetes self-management training, diabetic services and supplies • Health and wellness education programs • Hepatitis C Screening • HIV screening • Immunizations • Medical nutrition therapy • Medicare Diabetes Prevention Program (MDPP) • Obesity screening and therapy to promote sustained weight loss • Prostate cancer screening exams • Screening and counseling to reduce alcohol misuse	▪ **20%** of the Medicare-allowed amount

	In-Network	Out-of-Network
	• Screening for lung cancer with low dose computed tomography (LDCT) • Screening for sexually transmitted infections (STIs) and counseling to prevent STIs • Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) • Vision care: Glaucoma screening • "Welcome to Medicare" preventive visit	
Emergency Care	**Medicare-Covered Emergency Care** ▪ **$75** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$75** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	
Urgently Needed Services	**Medicare-Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$25** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$25** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$75** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	

	In-Network	Out-of-Network
Diagnostic Services/ Labs/Imaging ◊ (Authorization applies to in-network services only.)	**Diagnostic Procedures and Tests** ▪ **$10** copay at an Independent Diagnostic Testing Facility (IDTF) ▪ **$30** copay at an outpatient hospital facility ▪ **$0** copay for allergy testing **Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$15** copay at an outpatient hospital facility **X-Rays** ▪ **$25** copay at a physician's office or at an IDTF ▪ **$100** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$50** copay at a physician's office ▪ **$75** copay at an IDTF ▪ **$100** copay at an outpatient hospital facility **Radiation Therapy** ▪ **20%** of the Medicare-allowed amount	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Hearing Services	**Medicare-Covered Hearing Services** ▪ **$25** copay for specialist exams to diagnose and treat hearing and balance issues	**Medicare-Covered Hearing Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Dental Services	**Medicare-Covered Dental Services ◊** ▪ **$25** copay for specialist non-routine dental care	**Medicare-Covered Dental Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for non-routine dental
Vision Services	**Medicare-Covered Vision Services** ▪ **$25** copay for specialist to diagnose and treat eye diseases and conditions ▪ **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) ▪ **$0** copay for one diabetic retinal exam per year ▪ **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery	**Medicare-Covered Vision Services** ▪ **20%** of the Medicare-allowed amount for glaucoma screening ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for Medicare-covered specialist services to diagnose and treat diseases and conditions of the eye and diabetic retinal exams ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for eyeglasses or contact lenses after cataract surgery
Mental Health Services ◊ (Authorization applies to in-network services only)	**Inpatient Mental Health Services** ▪ **$200** copay per day for days 1-7 ▪ **$0** copay per day for days 8-90 190-day lifetime benefit maximum in a psychiatric hospital.	**Inpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible 190-day lifetime benefit maximum in a psychiatric hospital.
	Outpatient Mental Health Services ▪ **$30** copay	**Outpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Skilled Nursing Facility (SNF) ◊ (Authorization applies to	▪ **$0** copay per day for days 1-20 ▪ **$100** copay per day for days 21-100	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
in-network services only.)	Our plan covers up to 100 days in a SNF per benefit period.	
Physical Therapy	▪ **$25** copay per visit ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulance	▪ **$150** copay for each Medicare-covered trip (one-way) ◊	▪ **$150** for each Medicare- covered trip (one-way)
Transportation	▪ Not Covered	▪ Not Covered
Medicare Part B Drugs	▪ **$5** copay for allergy injections ▪ Up to **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊ ▪ **20% up to $35 per month** for Insulin Drugs via DME ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

Additional Benefits

	In-Network	Out-of-Network
Diabetic Supplies	▪ **$0** copay at a Florida Blue Medicare contracted network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips • Continuous Glucose Monitors (CGMs) such as Freestyle Libre and Dexcom, and supplies. ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
	Important Note: • **Insulin, insulin syringes and needles for self-administration in the home are obtained from an in-network retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.** Applicable Part D co-pays and deductibles apply. • Lifescan (OneTouch®) as well as other brands of glucose meters and test strips can also be obtained through our participating DME network. • The initial fill of a CGM when being used with an insulin pump can be obtained through our participating DME provider.	
Medicare Diabetes Prevention Program	▪ **$0** copay for Medicare-covered services	▪ **20%** of the Medicare-allowed amount
Podiatry	▪ **$25** copay for each Medicare-covered podiatry visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Chiropractic	▪ **$20** copay for each Medicare-covered chiropractic service	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medical Equipment and Supplies ◊ (Authorization applies to in-network services only.)	▪ **20%** of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

	In-Network	Out-of-Network
Occupational and Speech Therapy	▪ **$25** copay per visit ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Telehealth ◊ (Authorization applies to in-network services only)	▪ **$25** copay for Urgently Needed Services ▪ **$10** copay for Primary Care Services ▪ **$25** copay for Occupational Therapy/Physical Therapy/Speech Therapy at all locations ▪ **$25** copay for Dermatology Services ▪ **$30** copay for individual sessions for outpatient Mental Health Specialty Services ▪ **$30** copay for individual sessions for outpatient Psychiatry Specialty Services ▪ **$30** copay for Opioid Treatment Program Services ▪ **$30** copay for individual sessions for outpatient Substance Abuse Specialty Services in an office setting ▪ **$0** copay for Diabetes Self-Management Training ▪ **$0** copay for Dietician Services	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Blue Dollars Benefits MasterCard® Prepaid Card *NOTE: See Healthy Blue Rewards*	▪ **Based on your plan's allowance and frequency amounts, funds will be loaded on your Blue Dollars Card automatically.** ▪ Use your Blue Dollars card for easy access to rewards and select allowance benefits that may be part of your plan.	▪ Not Available

	In-Network	Out-of-Network
	▪ Benefits, coverage and amounts vary by plan. Limitations, exclusions, and restrictions may apply. ▪ The Blue Dollars card will be mailed directly to you and replenished at the beginning of each month. Any unused monthly allowance will not be rolled over into the following month.	
SilverSneakers® Fitness Program	▪ Gym membership and classes available at fitness locations across the country, including national chains and local gyms. ▪ Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more.	▪ Not Available
HealthyBlue Rewards	▪ Your BlueMedicare plan rewards you for taking care of your health. Reward dollars will be loaded to your Blue Dollars card for completing and/or reporting preventive care and screenings. ▪ Rewards are available after opting in to the program.	▪ Not Available

Part D Prescription Drug Benefits

Deductible Stage

This plan does not have a prescription drug deductible.

Initial Coverage Stage

You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs, and you pay your share of the cost. You remain in this stage until your total yearly costs (your payments plus any Part D plan's payments) reach **$8,000**.

You may get your drugs at network retail pharmacies and mail order pharmacies. Our plan gives you preferred pharmacy options. You can fill your prescription drugs at one of our preferred pharmacies to save even more on most prescriptions.

See Evidence of Coverage for details.	**Preferred/Mail Order/LTC (31-day supply)**	**Standard Retail (31-day supply)**	**Preferred/Mail Order (90 to 100-day supply)**
Tier 1 - Preferred Generic	**$0** copay	**$8** copay	**$0** copay
Tier 2 - Generic	**$3** copay	**$15** copay	**$9** copay
Tier 3 - Preferred Brand	**$30** copay **$35** copay for insulin	**$40** copay **$35** copay for insulin	**$90** copay **$105** copay for insulin
Tier 4 - Non-Preferred Drug	**$60** copay **$35** copay for insulin	**$70** copay **$35** copay for insulin	**$120** copay **$105** copay for insulin
Tier 5 - Specialty Tier	**33%** of the cost	**33%** of the cost	**N/A**

Coverage Gap Stage

Because there is no coverage gap for this plan, this payment stage does not apply to you.

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$8,000**, you pay:

- **$0.00** copay for all Part D drugs in all tiers.

Additional Drug Coverage

- Please call us or see the plan's "*Evidence of Coverage*" on our website (**www.floridablue.com/medicare**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 (Non-Preferred Drug) cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.
- Our plan covers most Part D vaccines at no cost to you including shingles, tetanus and travel vaccines.

Disclaimers

Florida Blue is a PPO and Rx (PDP) plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat Florida Blue members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

If you have any questions, please contact our Member Services number at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Our hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

Health coverage is offered by Blue Cross and Blue Shield of Florida, Inc., dba Florida Blue, an Independent Licensee of the Blue Cross and Blue Shield Association.

Plans may offer supplemental benefits in addition to Part C and Part D benefits.

The Blue Dollars Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Mastercard and the circles design is a trademark of Mastercard International Incorporated.

We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. Visit floridablue.com/ndnotice for information on our free language assistance services.

Nosotros cumplimos con las leyes federales de derechos civiles aplicables y no discriminamos por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. Para información sobre nuestros servicios gratuitos de asistencia lingüística, visite floridablue.com/es/ndnotice.

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-926-6565. (TTY users should call 1-800-955-8770). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-962-6565 (TTY: 1-877-955-8773). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-926-6565。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-926-6565。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-926-6565. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-926-6565. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-926-6565. sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-926-6565. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-926-6565. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-926-6565. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Form CMS-10802
(Expires 12/31/25)

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على بمساعدتك. هذه خدمة مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-926-6565. سيقوم شخص ما يتحدث العربية مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-926-6565. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-926-6565. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-926-6565. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-926-6565. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-926-6565. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-926-6565 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Form CMS-10802
(Expires 12/31/25)

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) 201-8568
Fax: (850) 201-8489