Leon County School Board
Welfare Benefits Plan

WRAP

SUMMARY PLAN DESCRIPTION

PLAN NUMBER 501

April 1, 2019

Prepared by

Medcom
BENEFIT SOLUTIONS

Leon County School Board Welfare Benefits Plan
Summary Plan Description

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INTRODUCTION

Leon County School Board (the "Employer") established the Leon County School Board Welfare Benefits Plan (the "Plan") effective October 1, 2018. This Summary Plan Description describes the Plan as amended and restated effective April 1, 2019.

This revised Summary Plan Description supersedes all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document will prevail in the event of any inconsistency.

OTHER SUMMARY PLAN DESCRIPTIONS

This Plan incorporates the terms of all Welfare Benefit Plans listed in Appendix A in addition to the terms of all Welfare Benefit Plans sponsored by the Employer or any Affiliated Employer who has adopted the Plan.

You will receive separate Summary Plan Descriptions and/or certificates of coverage from each of the Welfare Benefit Plans that are component parts of this Plan. In the separate Summary Plan Descriptions and/or certificates of coverage you will find information about eligibility, benefits, and employee/employer contributions for each of the separate Welfare Benefit Plans. You are eligible to participate in this Plan if you are eligible to participate in one of the Welfare Benefit Plans that are component parts of this Plan. In addition, in general, all benefits of this Plan are provided by the Welfare Benefit Plans that are component parts of this Plan.

This Summary Plan Description incorporates the terms of the other Summary Plan Descriptions and/or certificates of coverage for each of the Welfare Benefit Plans that are component parts of this Plan.

If applicable, the Employer will pay its contributions/premiums and any employee contributions to the insurance carriers as required for each such coverage. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using the Employer’s contributions to pay for the cost of such benefit. The Employer’s contributions to the Welfare Benefit Plans that are component parts of this Plan shall be made from the general assets of the Employer and on a basis consistent with any regulations that govern such programs and policies. For certain benefit programs, employees may make pre-tax salary reduction elections to pay for benefits through an employer-provided cafeteria plan, if available. For more information, refer to the cafeteria plan governing document. For more information related to contribution shares, refer to subsidiary contract documents or benefit booklets, if available.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is Leon County School Board.

   Its address is
   2757 W. Pensacola St.
   Tallahassee, Florida 32304

   Its telephone number is 850-487-7150.

   Its Employer Identification Number is 59-6000709.

2. The Plan is a Welfare Benefit Plan which has been designated by the sponsor as its plan number is 501.

3. The Employer's fiscal year ends on September 30 and the Plan Year ends on September 30.

4. While the Plan Administrator has the primary fiduciary duties, insurance companies are also held to fiduciary responsibilities as it relates to the benefits they insure.

5. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.

6. The Plan allows other employers to adopt its provisions. You or your beneficiaries may examine or obtain a complete list of employers, if any, who have adopted your Plan by making a written request to the Plan Administrator.

ELIGIBILITY AND ENROLLMENT

How to Become a Participant in the Plan

Before you become a Participant, you must meet the eligibility requirements for the Plan, work (or be expected to work) the required number of hours per week on average, and satisfy the applicable Waiting Period or other measurement period as described in this section.

Enrollment

You will become a Participant in this Plan once you have satisfied the requirements and formally elect benefits. If you do not want any or all of the benefits offered under the Plan, you may elect not to receive such benefits in accordance with the procedures established by the Plan Administrator.

Eligibility for Medical Benefits

The Employer offers coverage to Eligible Employees, their Spouses, and Dependents, including Dependents who have been adopted or placed for adoption with a Participant.

The following employees would be considered Eligible Employees under this Plan:

- Employees in the LCTA bargaining unit who work at least 18.75 hours per week in a regularly established position for employees.
- Employees in the Local 1010 bargaining unit (International Union of Painters & Allied Trades) who work at least 17.5 hours per week.
- Employees in the LESPA bargaining unit who work at least 20 hours per week.
- Employees who are hired as an hourly-as-needed teacher who work at least 18.75 hours per week in a program that is continuing from year to year.

Substitutes, OPS employees, summer school employees, and employees who work less than 17.5 hours per week are not considered Eligible Employees.

If you were expected to be an Eligible Employee at the time of hire, you may become a Participant following completion of the Waiting Period. If you choose to enroll, participation will begin the first of the month following your first paycheck. Before you can join the Plan, you must complete an application/initial election to participate in the Plan within 30 days from your date of hire.

If you are designated as a Variable Hour Employee at the time of hire, and later become an Eligible Employee, you will be allowed to become a Participant after the Initial Administrative Period. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.

If you are an Ongoing Employee who becomes an Eligible Employee following the Standard Measurement Period, you will be allowed to become a Participant after the Standard Administrative Period.

Measurement, Administrative, and Stability Periods

In determining eligibility for the group health plan, the Employer intends to follow IRS regulations and any subsequent guidance when administering the measurement, administrative, and stability periods.

If you are a Variable Hour Employee, you must first complete an Initial Measurement Period during which you will not be eligible for coverage. At the end of the Initial Measurement Period, if you are determined to be an Eligible Employee, you will be notified by the Plan Administrator and will be eligible to participate in the group health plan after the Initial Administrative Period. The Employer will use the Initial Administrative Period to determine whether you are eligible and to give you the opportunity to enroll if you are determined to be an Eligible Employee. If you choose to enroll, participation will begin on the first day of the Initial Stability Period.

Eligibility When Rehired

If your employment with the company is terminated and you are later rehired, company policies and complex IRS rules will be used to determine whether you are eligible.

Changes that may Affect Eligibility Status

If your hours of work are reduced, or you move to a different job within the company, your eligibility for benefits may change. Company policies and complex IRS rules will be used to determine whether you are eligible.

Eligibility for Other Benefits

Unless otherwise here stated, the eligibility requirements of each separate welfare benefit can be found in the applicable Summary Plan Descriptions and/or certificates of coverage. If the eligibility terms stated above differ from the applicable Summary Plan Descriptions and/or certificates of coverage, the terms stated above will apply.

CLAIMS

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

Third Party Recovery

If you are paid benefits from any other plan or policy, the Plan may be entitled to reimbursement. In particular, the Plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien, or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. You and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan. And, at that time, you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

You and your covered dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Coordination of Benefits

If you, your spouse, or dependents are covered by more than one health plan (referred to as an “Arrangement”), detailed rules will be used to determine which Arrangement pays or provides benefits first. If applicable, a secondary Arrangement may reduce the benefits it pays so that payments from all Arrangements do not exceed 100% of the total allowable amount.

The rules for coordination of benefits are further explained in the Summary Plan Descriptions and other documents governing the Arrangements.

Medical Loss Rebates

Under the Patient Protection and Affordable Care Act (ACA), the law requires insurers to issue Medical Loss Ratio (MLR) rebates in certain circumstances. MLR rebates are based upon aggregated market data in each state and not upon a particular group health plan's experience. The portion of the rebate attributable to Participant contributions may be distributed to you, applied towards future premiums, or held in trust for the benefit of Plan Participants. This section applies only for fully insured medical plans.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If your Employer is subject to FMLA, you may qualify to take up to 12 weeks of FMLA leave in a 12 month period each year for any of the following reasons:

- for the birth of your child and to bond with the newborn child within one year of birth;
- for placement of a child for adoption or foster care in your home and to bond with the newly placed child within one year of placement;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition;
- to take medical leave when you are unable to work because of a serious health condition; or
- for any qualifying exigency arising out the fact that a spouse, son, daughter, or parent is

a military member on covered active duty or call to covered active duty status.

You may also qualify to take up to 26 weeks of FMLA leave in a single 12 month period:

- to care for a covered servicemember with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the servicemember (military caregiver leave).

You are eligible for leave if you have worked for your Employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where your Employer (or Division) employs 50 or more employees within 75 miles. If your division employs less than 50 employees within the 75-mile radius, you may not be eligible for medical leave.

Time taken off work due to pregnancy complications can be counted against the 12 weeks of family and medical leave.

COBRA continuation coverage is available upon the expiration of the 12-week period of FMLA leave, if desired. If you fail to return to active employment following the expiration of the 12-week FMLA period, you will be eligible for COBRA coverage up to 18-months starting from the date of your qualifying event (termination of employment or reduction of hours worked).

Your Employer will establish a payment method, should you wish to continue coverage while on FMLA leave, as prescribed for all such FMLA events which will be consistent with every new request for leave.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO).

What is a Qualified Medical Child Support Order (QMCSO)?
A "QMCSO" is a medical child support order (from a court or administrative agency) that creates or recognizes the right of an "alternate recipient" to receive benefits for which a Participant or beneficiary is eligible under a group health plan. It is recognized by the group health plan as "qualified" because it includes information and meets other requirements.

Who can be an "alternate recipient"?
Any child of a Participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such Participant is an alternate recipient.

What information must a medical child support order contain to be a "qualified" order?
A medical child support order must contain the following information in order to be qualified:

- The name and last known mailing address of the Participant and each alternate recipient, except that the order may substitute the name and mailing address of a State or local official for the mailing address of any alternate recipient;
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined);
- The period to which the order applies; and
- An order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain State laws.

A "National Medical Support Notice" can also be a qualified medical support notice.

The Plan Administrator has established the QMCSO procedures outlined below.

Upon receiving a medical child support order the Plan Administrator will:

1. Determine if the document is a National Medical Support Notice or a judgment order or decree from a court or administrative process.
2. Notify the Participant, each alternate recipient and the issuing court or agency in the case of a National Medical Support Notice of the receipt of the order and provide a copy of these procedures.

3. Review the employment status of the affected employee/parent and review the Plan provisions to determine which, if any, group health plan benefits are available to the alternate recipient.
4. Determine if the document is a qualified medical support order.
5. Notify the Participant and the alternate recipient whether the document is a qualified medical support order within a reasonable time after receipt of the order (not to exceed 40 days in the case of a National Medical Support Notice).

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. If you or your dependents become ineligible for Medicaid or a state child health program (CHIP) or become eligible for premium assistance under Medicaid or a state child health program (CHIP), you must request enrollment within 60 days. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

Newborns' and Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may

not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires group health plans that provide mental health and substance abuse benefits to cover these services in a manner equal to their coverage of medical and surgical services. For example, separate deductibles may not be applied for treatment of mental health or substance use disorders, as opposed to medical or surgical treatment. The MHPAEA generally applies to employers with more than 50 employees. However, MHPAEA does not apply if your Plan does not currently offer any mental health or substance abuse benefits.

Loss of Benefit

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

Medicaid

State Medicaid agencies might mistakenly pay claims for which a third party may be liable, because they are not aware of the existence of other coverage. If you are participating in an employer-sponsored health plan for which that health plan is responsible for making benefit payment, and Medicaid has rendered such benefit payment instead for the same service, the state Medicaid agency has the right under an assignment of benefits to recoup such payment from the employer-sponsored health plan.

Collective Bargaining

If the Plan Sponsor has entered into a collective bargaining agreement that includes welfare benefits offered under this Plan, the collective bargaining agreement may determine certain coverage provisions, including eligibility, employer and employee contribution amounts, types of benefits offered, and other coverage terms for employees who are members of the collective bargaining group.

Amendment and Termination

The Employer has the right to amend, terminate or merge the Plan at any time, and to change the types of benefits offered from time to time. Any insurers, third party

administrators, or other service providers will be selected by the Employer at its sole discretion.

If the Plan is terminated, any remaining plan assets will be used to pay outstanding benefit claims. Following payment of these claims, remaining assets that are not returned to the Plan Sponsor will be refunded to Participants, if allowed by the terms of the applicable subsidiary contracts.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

No warranty or any other representation that any pre-tax premiums or benefits made to you or on behalf of you will be treated as nontaxable for local, state or federal income purposes, is made by the Employer or the Plan Administrator. If it is determined that an amount paid as a benefit is includable in your gross income for income tax purposes, under no circumstances will you have any recourse against the Employer, the Plan Administrator or any Adopting Employer with respect to any increased taxes or any other losses or damages suffered by you as a result. You should consult with a professional tax advisor to determine the tax consequences of your participation.

Wellness

In general, a wellness plan that offers a reward for participating or satisfying a health-based outcome must not offer a reward that exceeds 30 percent of the total premium for employee-only coverage under the plan. An additional 20 percent can be applied to a wellness program designed to prevent or reduce tobacco use (up to 50 percent of the total premium). If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under the program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under the program, contact the Plan Administrator to discuss another way to qualify for the reward.

If your employer offers a wellness plan, you will receive additional materials describing the operation of the plan, eligibility to participate, and the amount and conditions for any rewards.

This Summary Plan Description incorporates the terms of the additional materials for the wellness plan herein by reference.

HIPAA Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

Will my health information be kept confidential?

Under HIPAA, group health plans and the third party service providers (where applicable) are required to take steps to ensure that certain "Protected Health Information" is kept confidential.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- If you feel we have violated your rights, you can complain by contacting the Plan Administrator or HIPAA Privacy Officer.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
- *Example: We use health information about you to develop better services for you.*

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

COBRA NOTICE

Introduction

This notice applies only to the extent the Employer is subject to COBRA regulations, and to the extent you are participating in certain Employer-sponsored medical benefits (hereafter within this notice referred to as the "Plan").

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment; death of the employee; the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notification to the COBRA contact at:

2757 W. Pensacola St.
Tallahassee, Florida 32304.

The Employer's telephone number is 850-487-7150.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified

beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Leon County School Board
2757 W. Pensacola St.
Tallahassee, Florida 32304
850-487-7150

APPENDIX A
WELFARE BENEFIT PLANS

The following welfare benefits of the Plan Sponsor are covered the Plan:

WELFARE BENEFIT	FUNDING TYPE
Medical	Fully-insured
Dental	Fully-insured
Vision	Fully-insured
Group Life	Fully-insured
Specified Voluntary Worksite Plans	Fully-insured
Health Flexible Spending Account (FSA)	Self-insured
Employee Assistance Program (EAP)	Fully-insured

GLOSSARY

"Affiliated Employer" means a related company which adopts the Plan and participates in one or more of the benefits offered under the Plan.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, which gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

"Dependent" means any person who qualifies as a dependent under a subsidiary contract for purposes of that contract.

"Eligible Employee" Is an employee who meets the eligibility requirements for one or more of the benefits offered under this Plan.

"Employer" means the company sponsoring the Plan and any related companies which participate in one or more of the benefits offered under the Plan.

"FMLA" means the Family Medical Leave Act of 1993.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

"Initial Administrative Period" means the time during which new Variable Hour Employees who have completed the Initial Measurement Period and have been determined to be Eligible Employees can enroll in or waive medical coverage. This period may not last longer than ninety (90) days and may include a partial month prior to the beginning of the Initial Measurement Period. The Initial Administrative Period, or its second part, begins the next day after the end of the Initial Measurement Period.

"Initial Measurement Period" means the period of time during which a new Variable Hour Employee's hours of service are measured to determine whether the employee will become an Eligible Employee.

"Initial Stability Period" means the minimum period of time during which medical coverage must be offered to an employee who was previously a Variable Hour Employee and has been determined to be an Eligible Employee. The Initial Stability Period may not be shorter in duration than the Initial Measurement Period.

"Ongoing Employee"	means an employee who was employed with the Employer on the first day of a Standard Measurement Period.
"Participant"	means an employee who participates in benefits that are offered under this Plan.
"PHI"	means Protected Health Information as defined under HIPAA.
"Plan"	means the benefit programs that are described in this document.
"Plan Year"	means each 12-consecutive month period ending on: **September 30**.
"Seasonal Employee"	means an employee who is hired for a position for which the customary annual employment period is six (6) months or less and which begins at approximately the same time of each calendar year. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.
"Spouse"	means an individual who is lawfully married under any state law or as currently recognized under prevailing Federal law.
"Standard Administrative Period"	means the time during which Ongoing Employees who have completed the Standard Measurement Period can enroll in or disenroll from medical coverage. This period occurs between the Standard Measurement Period and the Standard Stability Period.
"Standard Measurement Period"	means the period during which the Employer counts each Ongoing Employee's hours of service. This period cannot be less than three (3) months nor more than twelve (12) months.
"Standard Stability Period"	means the period of time during which an Ongoing Employee is eligible for medical coverage under the Plan. The Standard Stability Period may not be shorter than the Standard Measurement Period.
"Variable Hour Employee"	means an employee for whom the Employer is not able to determine, at the employee's hire date, whether the employee is reasonably expected to work the required number of hours per week for eligibility.
"Waiting Period"	means the time period during which a newly hired Eligible Employee must be employed by the Employer prior to becoming a Participant.
"Welfare Benefit Plan"	means any plan or program that is offered by the Employer to Eligible Employees, other than pension or retirement programs.