BENEFIex 2019

ANNUAL COBRA ENROLLMENT NEWSLETTER

Nov 12 – Nov. 26, 2018

pcs PINELLAS COUNTY SCHOOLS

Annual Enrollment Is Nov. 12 – Nov. 26, 2018

This is the one time each year when you can enroll in, change, and/or drop benefits. Follow these steps to get the coverage you and your family will need in 2019. You may even save some money!

1. RESEARCH

Read this newsletter and review the choices available.

Visit the new Aetna website just for PCS employees at *aetnapcsb.com*

Call Aetna Concierge Customer Service at

866-253-0599
Monday through Friday
8:00 a.m. to 6:00 p.m.

Company Name:
Pinellas County Schools
Group Number: 109718

Call Risk Management and Insurance

727-588-6197
Monday through Friday
8:00 a.m. to 4:30 p.m.

2. ENROLL

Review the information and complete your Enrollment Form by November 26, 2018. Your enrollment decisions are effective Jan. 1 through Dec. 31, 2019. You cannot change your benefits during the year unless you have a qualified life event.

Take Action or You Will Be Enrolled in a Default Medical Plan

If you don't enroll or cancel your coverage by Nov. 26, 2018, you'll automatically be defaulted as shown below at the same coverage level and new rates. Your other benefit elections will continue in 2019, including Flexible Spending Accounts (FSAs).

Medical Plan Default

Your plan today	Your new plan effective Jan. 1, 2019
HMO STAFF	Aetna Select Open Access
NPOS	Aetna Choice POS II (Point of Service II)
CDHP	Aetna CDHP + Health Reimbursement Account (HRA)*

**The HRA will replace the Personal Care Account (PCA). They work the same, but the name has changed.*

What's Changing for 2019

Aetna: New Medical Plans

Review pages 7–21 to make sure you understand how this change affects you.

You will still choose from three plans—new names, similar plan designs with prescription drug and premium changes. The provider networks will also change. Visit *aetnapcsb.com* or *aetna.com* to confirm that your doctors and other providers are part of the network before you enroll.

All three plans are now open access—No primary care physician (PCP) designation and no specialist referrals will be required! This gives you more flexibility to choose your doctors.

No Changes to Other Benefits

There are no benefit changes to the dental and vision benefit plans.

Remember, if you had a **Flexible Spending Account** in 2018, you **must submit** all 2018 claims to Humana by **March 31, 2019** or you will forfeit any money left in your account.

Get Ready to Enroll—2019 Annual Enrollment Timeline

Questions About Your Benefits?

Call: 727-588-6197
Or Visit: pcsb.org/annual-enrollment

Annual Enrollment ENDS Nov. 26

Other Options for Medical Insurance

If you cannot afford to enroll them in a PCS medical plan, consider the following:

- **Children:** Consider Florida KidCare, the state-sponsored health care program for children from birth through age 18 who meet specific eligibility requirements. For more information, call **800-821-5437** or visit *floridakidcare.org*.
- **Spouse and/or child(ren)**: If your spouse is employed, consider his or her employer's group health insurance. If your spouse is not employed or his or her employer doesn't offer group health insurance, the federal Health Insurance Marketplace may offer cost-effective alternatives. You can also enroll your child(ren) in a Marketplace plan.

Not Making Benefit Changes?

No enrollment is required unless you want to cancel your medical coverage.

Medical plan default. If you are enrolled in a medical plan today and do not enroll in a new plan or cancel your coverage during Annual Enrollment, you will be automatically enrolled in a similar Aetna plan at the same coverage level.

All other benefits. If you don't enroll or make any changes, your current benefit elections will continue in 2019 with the new payroll deductions, coverage levels, and plan designs, where applicable.

Midyear Benefit Changes

The choices you make during Annual Enrollment are effective Jan. 1 through Dec. 31, 2019. If you experience a qualified change in status event, you have 31 days to change your elections. Change in status events include but are not limited to: marriage or divorce; death of a spouse or other dependent; or birth or adoption of a child.

You Have Choices!

Your benefits cost money, for both you and PCS. Not having the right coverage could cost a lot more. Take time to consider your and your family's benefit needs and review your options. Learn more on the pages noted and review rates on pages 30–31.

PREPARE

Look back: What have you spent on health care this year?

Look ahead: What expenses do you expect to have in 2019?

EVALUATE YOUR OPTIONS

NEW Aetna Medical

Review pages 7–21 and the rates on page 30 and visit *aetnapcsb.com*.

◆ Dental

Choose from two dental plans.

◆ VISION

Enroll in the vision plan.

ENROLL BY YOUR DEADLINE!

Follow the instructions, review and enroll in your 2019 benefits. If you don't enroll or cancel your coverage by Nov. 26, 2018, you'll automatically be defaulted into a similar medical plan at the same coverage level and new rate. Your other benefit elections will continue in 2019. You cannot change your benefits during the year unless you have a qualified life event.

Benefit Summaries

This section of the newsletter describes all your benefits options. For more information, access the comprehensive BENEFlex Guide at *pcsb.org/annual-enrollment*.

Medical—Meet Aetna

Choose from Three Plans • New Names, Similar Benefits

You will continue to choose from three medical plans, shown below. The benefits under each plan will be very similar to the current plans, but the plan names and provider networks will change. If you do not make a change during Annual Enrollment, you will automatically be enrolled in the corresponding plan, and new rate, at the same coverage level you currently have.

TODAY	NEW PLAN EFFECTIVE JAN. 1, 2019	
	PLAN NAME	NETWORK
HMO STAFF	Select Open Access	Aetna Select Open Access
NPOS	Choice POS II (Point of Service II)	Choice POS II (Point of Service II)
CDHP	CDHP + HRA* (Health Reimbursement Account)	Aetna Select Open Access

* *The HRA will replace the Personal Care Account (PCA). They work the same, but the name has changed. See page 13 for details about the HRA.*

Medical Plan Improvements and Changes

Open Access Gives You Control

All three plans feature national networks of doctors and other health care providers. Regardless of the plan you choose, you do not have to select a PCP and specialist referrals are not required.

- **The Select Open Access and CDHP + HRA are in-network-only plans**—you must use network providers to receive benefits (except for qualified emergencies).
- **The Choice POS II** offers out-of-network coverage (at a higher cost to you). Consider this plan if you need to use out-of-network providers. When you use in-network providers, you will pay lower negotiated rates, compared to out-of-network providers.

New ID Cards

You will receive two ID cards per family. If you need additional cards, you can request cards from Aetna Concierge Customer Service, access your ID cards on the Aetna Mobile app, or print cards after you register for your personal member website.

Continues on next page.

Medical—Aetna (continued)

Aetna Prescription Drug Program

Review pages 14–15 for more information about the prescription drug program.

Prescription drug deductibles and co-pays will not change for 2019; however, the name of the drug levels have changed, and how drugs are assigned to each level are based on Aetna's formulary (drug list). Our initial analysis of the new formulary indicated that 45% of prescriptions will fall into a lower co-pay level and 45% will remain in the same co-pay level.

The program uses Aetna's Premier Plus Open Formulary. Each drug is grouped as a generic, preferred-brand, non-preferred brand or specialty drug. You pay co-pays for generic and preferred brand drugs. You will pay a deductible first, then co-pays for non-preferred brand and specialty drugs.

Aetna Rx Co-pays

30-Day Supply Retail

Level	Co-pay/Deductible
Generic	$20
Preferred Brand	$50
Non-Preferred Brand	$90 + $250 annual deductible
Specialty	$120 + $250 annual deductible

90-day Supply Maintenance Rx

2 co-pays at a retail pharmacy or by mail order. Does not apply to specialty drugs.

You will save the most when you use generic drugs, and preferred brand drugs when a generic is not available. Non-preferred brand drugs are higher cost and often have a generic or preferred brand alternative that can save you money. Specialty drugs have the highest cost and typically include drugs that require special handling, special storage, or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled, or taken by mouth.

Following are highlights of other program features. Please call Aetna's Concierge Customer Service at **866-253-0599** if you have any questions about your prescription drug coverage.

Step Therapy. Step therapy requires you to try one or more alternative drug(s) before a step therapy drug is covered. See page 14.

Precertification. Certain drugs require precertification by Aetna, even if they were previously covered by Humana. You or your doctor will need to get approval from Aetna before your prescription will be covered. See page 14.

90-Day Prescription Drug Transition of Coverage (TOC). If you or a covered dependent are currently taking medications that will require precertification by Aetna, precertification and/or step therapy will be waived for any refill prescriptions received during the first 90-days of coverage (January 1 – March 31, 2019). This will allow you or your covered dependent(s) avoid disruption to an effective drug regimen. Additionally, you will not need to go through the precertification process for the refilled prescriptions after the transition period—your medication will be automatically "grandfathered" for the remainder of 2019.

Please note that prescription drug TOC does NOT apply to all medications, such as certain analgesics and injectables, and includes:

- Controlled substances because they must be managed
- Specialty medications that are used to treat complex or rare chronic conditions. Examples of these medications are HUMIRA, ENBREL, and XOLAIR
- Medications with safety edits as typically seen on pain killers or methamphetamines
- Prescriptions listed under the Aetna National precertification list

Aetna Rx Home Delivery. You can have maintenance drugs sent right to your home or anywhere else you choose with Aetna Rx Home Delivery® pharmacy. These are generic, preferred brand and non-preferred brand drugs that are taken regularly for chronic conditions like arthritis, diabetes, or asthma. Specialty drugs are not available via home delivery. Depending on your plan, you can get up to a 90-day supply of medicine for less cost. It's fast and convenient, and standard shipping is always free. See page 15 for more information.

Out-of-Pocket Maximums

- Out-of-pocket maximums are the most you will to pay for covered services in a plan year. When the amounts you pay for deductibles, co-pays, and coinsurance add up to the individual maximum, your medical plan pays 100% of the costs of covered services for the remainder of the year.
- In 2019, there will be a medical out-of-pocket-maximum and a separate Rx out-of-pocket maximum. Each medical plan has an individual and a family out-of-pocket maximum. Here is how it works.
  - **Individual maximum.** When the amounts you pay for the deductible, coinsurance, and co-pays for one person add up to the individual maximum, your plan will pay 100% of the allowed amount for that person for the remainder of the calendar year. If you have family coverage, this applies to each person until the family maximum is reached.
  - **Family maximum.** When the amounts you pay for deductibles, coinsurance, and co-pays for multiple family members add up to the family out-of-pocket maximum, your plan will pay 100% of the allowed amount for everyone enrolled in the plan for the remainder of the calendar year.

Out of Pocket Maximum	2019 Individual/Family
Medical only	$4,500/$9,000
Pharmacy only	$1,750/$3,500

Teladoc Replaces Doctor On Demand

Aetna medical plan members will pay a $25 co-pay per visit for all plans. See page 13.

Medical—Aetna (continued)

Aetna Is Here to Serve You

Aetna's medical plans include access to personalized resources that can help you get the most out of your coverage.

www.aetnapscb.com. This website is dedicated to the PCS-sponsored Aetna medical and prescription drug benefits. Start here to learn about your coverage and access provider directories, tools, and more.

Your personal member website. After you are enrolled, you can register for your personal member website, where you can track your health history, access your ID card, view your claims, and more.

Aetna Mobile app. Download the app from your app store for instant access to your ID card, provider claims, coverage and benefits, and more.

Concierge Customer Service at 866-253-0599. An Aetna concierge can help you understand your benefits so you can make more informed decisions about your health care. You will need to provide the Group Number 109718 when you call. Concierges are available Monday through Friday, 8:00 a.m. to 6:00 p.m., and can help you:

- Understand your coverage and costs
- Select doctors and other providers based on your needs
- Plan for upcoming treatment
- Schedule appointments
- Use the online tools to make decisions right for you

Onsite Aetna representatives. You will be able to contact an onsite Aetna representative by phone or in person (see the list on the inside back cover).

Aetna Mobile App

Download the Aetna Mobile App today!

Android users: Aetna Mobile app

Apple users: Aetna Mobile app

Before You Choose a Medical Plan

Check the Provider Networks at *aetnapcsb.com*

Avoid surprises in January by checking the provider networks at *aetnapcsb.com* before you decide on a plan. If you are enrolled in the HMO Staff today, you will be pleasantly surprised with the new Aetna Select Open Access plan—it uses a larger national Open Access Aetna Select network.

Check the Prescription Drug Network and Formulary

The program's network includes **all major retail pharmacies** as well as many independent pharmacies participating in the Aetna Pharmacy Management (APM) national retail pharmacy network. You can search the directory at *aetnapcsb.com* or *aetna.com* to find a pharmacy.

The prescription drug program uses the Premier Plus Open Formulary. The new Aetna formulary may classify drugs differently than Humana. It is very important that you review the formulary with your doctor before filling your first prescriptions in 2019.

You can view and print the drug list at *aetnapcsb.com* or call **866-253-0599** to speak with a concierge who can answer your questions.

Regardless of the Rx tier, some drugs may be subject to limitations and restrictions such as prior authorization requirements, quantity limits, and step therapy. Contact an Aetna concierge or see the online BENEFlex Guide at *pcsb.org/annual-enrollment* for more information.

Choose from Three Aetna Medical Plans

- Select Open Access
- Choice POS II (Point of Service II)
- CDHP + HRA (Consumer Directed Health Plan with Health Reimbursement Account)

Medical Transition of Care

If you or a covered family member is being treated for a medical condition and your current provider is **not participating** in the Aetna network, you may be able to temporarily continue an active course of treatment care with your current provider(s) at the in-network rate when your new coverage takes effect on Jan. 1, 2019.

Contact Aetna Concierge Customer Service at **866-253-0599** with questions and to request a Transition of Care form. You must submit your form to Aetna by March 31, 2019. Aetna will notify you if you have been approved.

Prescription Drug Transition of Care

If you or a covered dependent are currently taking medication that may require precertification or step-therapy, you may qualify for transition of care for those medications. See page 7 for details and contact Aetna Concierge Customer Service at **866-253-0599** with questions.

Which Medical Plan Is Right for Me?

Choosing a medical plan is an important decision. Here are some key differences between each plan. Please review the online BENEFlex Guide and visit *pcsb.org/new-hire* or *aetna.com* for more information.

	Select Open Access	Choice POS II	CDHP + HRA
Do I have to stay in-network to receive plan benefits?	YES	NO	YES
What is the coverage area?	National	National	National
Do I have to select a PCP?	Not Required	Not Required	Not Required
Do I need a referral to see specialists?	NO	NO	NO
What do I pay for medical services?	Co-pays for all services, no deductible	Deductibles, coinsurance, and co-pays	Deductibles and coinsurance
Is preventive care covered at 100%?	YES In-network only	YES In-network only	YES In-network only
Is there a Health Reimbursement Account (HRA)?	NO	NO	YES (see page 10)
Is there prescription drug coverage?	All three plans offer the Aetna Prescription Drug Program. Details are provided on page 11.		

Medical—Aetna (continued)

Locate a Aetna Medical Provider

Each medical plan has its own provider network. Before you choose a plan, you should verify that your doctors, specialists, and other providers are in-network.

Call Aetna Concierge Service at 866-253-0599

- Go to *aetnapcsb.com* and select "Find a doctor" from the top menu.
- Under "Not a member yet?" select "Plan from an employer."
- Before you are enrolled, continue as a guest and enter your home location and follow the prompts.
- After you are enrolled in a plan, follow the steps under "Already a member" to register or log in to your secure member website and follow the prompts.

Aetna Medical Plan Networks

Plan	Network Name
Select Open Access	Aetna Select Open Access
Choice POS II	Choice POS II
CDHP + HRA	Aetna Select Open Access

Register for Your Secure Member Website

Your secure Aetna member website can help you get more from your health care. Register for access to personal health and benefits information, your ID card, secure messages from Aetna, claim activities, a cost estimator, and more.

Go to *aetnapcsb.com*, select "Log In/Register," select "Register," and complete the registration process as prompted. It's that easy!

Health Management on the Go

Download the Aetna Mobile app to find care, access your ID card offline, manage your prescriptions, find an urgent care center, and more!

Android users: Aetna Mobile App

Apple users: Aetna Mobile App

The CDHP Health Reimbursement Account (HRA)

- When you enroll in the CDHP + HRA, PCS will fund an Aetna PayFlex card with up to $500 (individual) or $1,000 (family) each year. This amount is prorated based on your month of hire.
- You choose when to use the HRA. Aetna will not automatically apply your HRA funds when they process your claims.
- When you use your HRA PayFlex Card® you can pay the first $500 (individual) or $1,000 (family) of your eligible medical and/or prescription drug expenses. (You may also submit claim forms and receipts for reimbursement.)
- Any funds remaining in your HRA at the end of the plan year will roll over to the next plan year if you remain enrolled in the CDHP. If you enroll in another medical plan during annual enrollment or leave PCS, the HRA balance will be forfeited.
- Although you can use your HRA card to pay eligible expenses at the time of your visit, we recommend you wait until you receive your explanation of benefits (EOB) from Aetna. Pay the balance due based on your EOB to ensure you do not overpay.

Important Information About the PayFlex HRA and FSA Cards

When you enroll in the CDHP + HRA plan and you also enroll in a Healthcare Flexible Spending Account (FSA), you will receive **two** PayFlex debit cards to pay your eligible out-of-pocket expenses (including deductibles, coinsurance, and co-pays).

Payflex Card		Eligible Out-of-Pocket Expenses
HRA PayFlex Card	➔	Pay for Medical/Rx Expenses
HCFSA PayFlex Card	➔	Pay for Medical/Rx, Dental, and Vision Expenses

The IRS requires that all payments made from FSAs and HRAs be substantiated or verified. While PayFlex will make every effort to automatically verify payments, in some cases they may ask you for documentation. If you do not respond by the deadline, your card will be "frozen" until you provide documentation, or you reimburse your HRA or FSA the amount of the payment.

Medical—Aetna (continued)

Aetna Prescription Drug Program

All medical plans include prescription drug coverage from Aetna. The program uses Aetna's Premier Plus Open Formulary. Each drug is grouped as a generic, preferred brand, non-preferred brand, or specialty drug.

You can view and print the drug list at *pcsb.org/healthinsurance*. Call Aetna Concierge Customer Service at **866-253-0599** with questions.

Generic Drugs Lowest Cost	Preferred Brand Drugs Higher Cost	Non-Preferred Brand Drugs Higher Cost	Specialty Drugs Highest Cost
$20 co-pay	**$50 co-pay**	**$90 co-pay**	**$120 co-pay**
No deductible		**Deductible applies:** $250/individual $500/family	
You will save the most when you use generic drugs and preferred brand drugs when a generic is not available.		Non-preferred brand drugs are higher cost and often have a generic or preferred brand alternative that can save you money.	Specialty drugs are the most expensive, high-technology and self-administered injectable medications not available on other levels.

3 for 2 Generic, preferred, and non-preferred brand maintenance drugs: You pay two co-pays for a three-month supply at the local retail pharmacy or through the Aetna Home Delivery service, after applicable deductibles. Specialty drugs are not available through this service.

Restrictions

Regardless of the Rx tier, some drugs may be subject to limitations and restrictions such as precertification requirements and step therapy. Contact an Aetna concierge or see the online BENEFlex guide at *pcsb.org/beneflex-guide* for more information. Call Aetna's Concierge Customer Service at **866-253-0599** with questions.

Step therapy requires you to try one or more alternative drug(s) before a step therapy drug is covered. The alternative drug(s) treat the same conditions, are equally effective, have U.S. Food and Drug Administration (FDA) approval, and may cost less. If you don't try the alternative drug(s) first, you may need to pay full cost for the brand-name version.

Precertification. Certain drugs require precertification and you or your doctor will need to get approval from Aetna before your prescription will be covered. This is one way that Aetna helps you and your doctor find safe, appropriate drugs and keep costs down. Generally, precertification applies to:

- Ensure compliance with dosing guidelines
- Avoid duplicate therapies
- Help health care providers confirm the use of your medication is based on generally accepted medical criteria

Locate a Participating Pharmacy

You can use **all major retail pharmacies** as well as many independent pharmacies participating in the Aetna Pharmacy Management (APM) National Retail Pharmacy Network. Go to *aetnapcsb.com* to find a pharmacy.

Aetna Rx Home Delivery

Enjoy convenient home delivery when you use Aetna's Rx Home Delivery service. You pay two co-pays for a 90-day supply of generic, preferred brand, or non-preferred brand drugs only. You can re-order online, by phone or by mail. Here's how to get started:

Use your secure member account. When you register and log in to your account you can download forms, re-order and track your prescriptions.

Call Aetna Concierge Customer Service at 866-253-0599 and they will contact your doctor for you. It will speed up the process if you let your doctor know Aetna will be calling.

Mail your home delivery order form and prescription. Ask your doctor to write a prescription for a 90-day supply with three refills. Download the form after you log in to your secure Member Website. You can also download the form from Aetna's website. Select "Individuals" on the home page, then "Find a form" under "For members." Complete the form and send it with your 90-day prescription to the address listed on the form.

Ask your doctor to submit your prescription.

- **Online.** Your doctor can submit your mail order prescriptions using his or her e-prescribing service.
- **Fax.** Your doctor can your prescription to 877-270-3317. **Please note, only your doctor can fax a prescription.** Ask your doctor to be sure the cover sheet includes your:
  - Member ID Number
  - Birthdate
  - Mailing address

Aetna Specialty Pharmacy®

Your doctor may prescribe a specialty medication which may be injected, infused or taken by mouth. Normally these drugs are not available from a retail pharmacy. Aetna's team of experienced nurses and pharmacists helps you understand how to use your medicine. They can answer your questions, provide training on self-injectable drugs, and help you cope with your condition throughout your therapy.

You can order medications through Aetna Specialty Pharmacy by calling 866-253-0599 or having your doctor submit your prescription through their e-prescribe service or by fax. You'll need to send Aetna a completed patient profile form. Forms are available when you log in to your secure member website or on Aetna's website (Select "Individuals" on the home page, then "Find a form" under "For members.")

Compound Medications

A Compound Medication is the mixture of two or more ingredients, with at least one of the ingredients being a federal or state restricted drug, which is prepared for patients by a pharmacist. These medications are prepared at the pharmacy by the pharmacist, as opposed to manufactured medications that are prepared by a pharmaceutical company. Members can receive covered compound medications at any in-network retail pharmacy, provided the pharmacy agrees to Aetna's Maximum Negotiated Price for the compound medication.

Medical—Aetna (continued)

When You Need a Doctor, Make a Smart Choice

While your regular doctor is your normal "go to" for care, sometimes your doctor isn't available or convenient—for example, at night and on weekends. When you are enrolled in a PCS medical plan, you have several options when it comes to getting care. See the Medical Plans Comparison Chart for cost details.

If you are not sure where to go, call Aetna's 24-hour Nurse Advice Line at 800-556-1555 for guidance. However, if it's a serious or life-threatening situation, call 911 or go immediately to a hospital emergency room (ER).

Teladoc®: $25 Co-pay	Family Doctor	Urgent Care	ER
• Available 24/7/365, anywhere[1] • Talk to a doctor in minutes • Visit by phone or video • Get a prescription[2] • Never costs more than an office visit • Cannot treat severe medical conditions	• May not be available for days • Long-term relationship • Periodic checkups • Treats more severe issues • You must leave home or work and may sit in a waiting room with other sick people	• Availability varies • Treats minor illness or injury issues • Higher cost of care • Potentially long wait times • You must leave home or work and may sit in a waiting room with other sick people	• Available 24/7/365 • Provides life-or-limb-saving care for emergency issues • Highest cost of care • Long wait times • You must leave home or work and may sit in a waiting room with other sick people

[1] *Not available outside of the U.S.*

[2] *If medically necessary*

Teladoc: $25 Co-pay

Teladoc provides access 24 hours, 7 days a week to a U.S. board-certified doctor by phone, video, or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.

Online	Go to ***www.Teladoc.com/Aetna*** and click "set up account."
Mobile app	Download the app and click "Activate account." Visit *www.teladoc.com/mobile* to download the app.
Call	855-Teladoc (835-2362) Teladoc can help you register your account over the phone.
Pay less …	**… than a visit to an urgent care: $25 co-payment for all three of the medical plans.**

Aetna Medical Plans Comparison Chart

Please note: The dollar amounts are co-pays, deductibles, and maximums, which you pay; the percentages are coinsurance amounts, which you pay after you meet applicable deductibles. The amount the plan pays may be based on usual, reasonable, and customary (URC) fees for out-of-network services only.

NEW = PCS Plan Changes

Understanding How Much You Have to Pay

- Health Reimbursement Account (HRA) (CDHP only). Use your HRA to pay your deductible, coinsurance, and Rx co-pays, reducing your out-of-pocket costs. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified.
- Medical Plan Deductible (Choice POS II and CDHP + HRA). The amount you pay for medical expenses before the plan begins paying benefits.
- Coinsurance (Choice POS II and CDHP + HRA). The percentage of eligible medical expenses you pay after paying the deductible for most services.
- Co-pays The fixed amount you pay for medical care and prescriptions.
- Aetna Prescription Drug Program (all plans). You pay co-pays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay co-pays.
- Out-of-Pocket (OOP) Maximums. This is the most you will pay for deductibles (if applicable), co-pays, and/or coinsurance in a plan year. There are two OOPs, one for medical expenses and one for Rx. When you reach an OOP maximum, the plan will pay 100% of those eligible expenses for the remainder of the plan year.

Aetna Concierge (Group #109718) Customer Service 866-253-0599	Select Open Access
Benefit	**In-Network Only**
Service Area/Networks	Any provider in the Aetna Select Open Access national network
Health Reimbursement Account (HRA)—Individual/Family HRA funds can only be used for medical plan and prescription drug expenses.	N/A
Deductibles—Individual/Family	N/A
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or co-pays	$4,500 Individual; $9,000 Family
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible NEW	$1,750 Individual; $3,500 Family NEW
Lifetime Maximum	Unlimited
Physician Office Visits	**You Pay:**
Primary Care Physician (PCP)	$25 co-pay
Specialist (SPC)	$50 co-pay
Teladoc NEW	$25 co-pay
Preventive Adult Physical Exams	No co-pay
Preventive GYN Care (including Pap test) (direct access to participating providers)	No co-pay
Mammography Preventive Screening	No co-pay
Immunizations	No co-pay
Allergy Injections	Co-pay waived for allergy injections billed separately
Allergy Tests Lab X-Ray Outpatient Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)	$50 co-pay $25 co-pay $50 co-pay $250 co-pay
Colonoscopy Screenings—Preventive and Diagnostic	No co-pay
Chiropractic Services (limits apply) (direct access to participating providers)	$50 co-pay 20 visits per calendar year
Hearing Exam	$25 co-pay

This chart provides a brief outline of the medical coverage options available to you through Aetna. Complete details are in the official plan documents. In any conflict between the plan documents and this basic comparison chart, the plan documents will control.

Choice POS II		CDHP + HRA
In-Network	**Out-of-Network[1]**	**In-Network Only**
Any provider in the Choice POS II Network (national network)	Any provider	Any provider in the Aetna Select Open Access national network
N/A	N/A	$500 Individual; $1,000 Family (No maximum rollover amount) HRA contributions are prorated based on your date of hire.
$500 Individual; $1,000 Family (combined in- and out-of-network)		$1,500 Individual; $3,000 Family
$4,500 Individual; $9,000 Family (combined in- and out-of-network)		$4,500 Individual; $9,000 Family
$1,750 Individual; $3,500 Family (combined in- and out-of-network) NEW		$1,750 Individual; $3,500 Family NEW
Unlimited		Unlimited
You Pay:	**You Pay:**	**You Pay:**
20% after deductible	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
$25 co-pay NEW	N/A	$25 co-pay NEW
0%	40% after deductible	0% no deductible
0%	40% after deductible	0% no deductible
0%	40% after deductible	0% no deductible
0%	40% after deductible	0% no deductible
20% after deductible; allergy injections billed separately	40% after deductible; injections billed separately	20% after deductible
20% after deductible	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
0%	40% after deductible	0% no deductible
20% after deductible	40% after deductible	20% after deductible 20 visits per calendar year
20 visits per calendar year combined in- or out-of-network		
20% after deductible	40% after deductible	20% after deductible

[1] *Usual, customary, reasonable (UCR) fees. Out-of-network charges that exceed UCR fees may be billed to the member.*

Continued on next page

Aetna Medical Plans Comparison Chart

Please note: The dollar amounts are co-pays, deductibles, and maximums, which you pay; the percentages are coinsurance amounts, which you pay after you meet applicable deductibles. The amount the plan pays may be based on usual, reasonable, and customary (URC) fees for out-of-network services only.

NEW = PCS Plan Changes

Rx Deductible May Apply

For non-preferred brand and specialty drugs, you must pay the $250 per person or $500 per family Rx deductible before you begin paying co-pays.

This chart provides a brief outline of the medical coverage options available to you through Aetna. Complete details are in the official plan documents. In any conflict between the plan documents and this basic comparison chart, the plan documents will control.

Aetna Concierge (Group #109718) Customer Service 866-253-0599 **Benefit**	Select Open Access **In-Network Only**
Hospital Inpatient (Includes maternity and newborn services)	$500 co-pay per day; up to 5-day maximum
Outpatient Surgery (including facility charges)	$500 co-pay
Emergency Room Services	$500 co-pay
Ambulance	No co-pay
Urgent Care Facility	$50 co-pay
Maternity Care/OB Visits	$50 co-pay for initial visit only
Mental Health Services Outpatient Mental Health Services	$25 co-pay
Inpatient Mental Health Services	$500 co-pay per day; up to 5-day maximum
Miscellaneous Home Health Care (limits apply)	No co-pay
Hospice—Inpatient (limits apply)	$500 co-pay per day; up to 5-day maximum[2]
Skilled Nursing Facility (limits apply)	$500 co-pay per day; up to 5-day maximum[2]
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	$25 co-pay per visit 60-visit limit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	See prescription drugs below
Durable Medical Equipment (DME)	$50 co-pay
Aetna Prescription Drug Program *Some drugs may be subject to step-therapy or precertification*	***Mandatory Generics Unless Dispensed As Written***
Up to 30-day supply **Generic** NEW **Preferred Brand** **Non-Preferred Brand** **Specialty**	$20 co-pay; no Rx deductible $50 co-pay; no Rx deductible $90 co-pay; after Rx deductible $120 co-pay; after Rx deductible
90-day Supply (maintenance medications) at retail or mail order (mail order must be through Aetna Rx Home Delivery service)	***Mandatory Generics Unless Dispensed As Written***
Generic NEW **Preferred Brand** **Non-Preferred Brand**	$40 co-pay; no Rx deductible $100 co-pay; no Rx deductible $180 co-pay; after Rx deductible

[1] *Subject to usual, customary, reasonable (UCR) fees* [2] *Waived if transferred from hospital*

Choice POS II		CDHP + HRA
In-Network	**Out-of-Network[1]**	**In-Network Only**
$500 co-pay per day; up to 5-day maximum	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
20% after deductible	20% after deductible	20% after deductible
20% after deductible	20% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible
$500 co-pay per day after deductible; up to 5-day maximum	40% after deductible	20% after deductible
20% after deductible	40% after deductible	20% after deductible; 120-visit limit per calendar year
$500 co-pay per day after deductible; up to 5-day maximum[2]	40% after deductible; 30-day lifetime maximum	20% after deductible
$500 co-pay per day after deductible; up to	40% after deductible	20% after deductible 120-visit limit per calendar year
120-visit limit per calendar year		
20% after deductible	40% after deductible	20% after deductible
60-visit limit per calendar year for all therapies combined		60-visit limit per calendar year for all therapies combined
See prescription drugs below	See prescription drugs below	See prescription drugs below
20% after deductible	40% after deductible	20% after deductible
Mandatory Generics Unless Dispense As Written		***Mandatory Generics Unless Dispense As Written***
$20 co-pay; no Rx deductible $50 co-pay; no Rx deductible $90 co-pay; after Rx deductible $120 co-pay; after Rx deductible	**NOT COVERED**	$20 co-pay; no Rx deductible $50 co-pay; no Rx deductible $90 co-pay; after Rx deductible $120 co-pay; after Rx deductible
Mandatory Generics Unless Dispense As Written		***Mandatory Generics Unless Dispense As Written***
$40 co-pay; no Rx deductible $100 co-pay; no Rx deductible $180 co-pay; after Rx deductible	**NOT COVERED**	$40 co-pay; no Rx deductible $100 co-pay; no Rx deductible $180 co-pay; after Rx deductible

◆ Humana Advantage and MetLife Dental Plans

Smile! You and your family can choose the dental plan that best meets your needs, either the Humana Advantage Dental Plan or the MetLife Preferred Dentist Program.

Which Dental Plan Is Right for Me?

Here are some key differences between each plan. Please review the online BENEFlex Guide, a schedule of benefits, co-pays, and exclusions for each plan. Visit *pcsb.org/new-hire* or the carrier sites listed below for more information.

	Advantage Plan (#548085) Humana	Preferred Dentist Program (PDP Plus) MetLife
	State of Florida Service Area In-network Only. You must choose a primary dentist and use participating network providers.	In or Out-of-network. Save the most when you choose a participating network provider.
Primary Care Dentist and Specialist Referrals	Not required	Not required
Deductible	None	$50/individual; $150/family (Applies to Type B and C Services)
Calendar Year Maximum	None	$1,250 per person
Preventive Services	No charge	No charge, no deductible (Type A)
Basic Services	Scheduled co-pays	20% coinsurance after deductible (Type B)
Major Services	Scheduled co-pays	50% coinsurance after deductible (Type C)
Orthodontia	Scheduled co-pays (Adult and Child)	50% (up to age 19)
Lifetime Orthodontia Limit	N/A	$1,000/individual

Locate a Humana Advantage Plan (AVF-1) Provider

To receive benefits under this plan you must stay in-network and select a primary dentist who will coordinate your dental care and refer you to specialists. You do not need to list your primary dentist on the enrollment and change form. Follow these steps to find an in-network provider.

1. Go to *www.humana.com*
2. Click on "Member Resources"
3. Scroll to: "find a doctor"
4. Search type: Dental, then click ➔ **Go**
5. Coverage type: check "all dental networks"
6. Enter your zip code or the zip code for the provider
7. Choose "Humana Dental Advantage Plus" from the Network drop down menu
8. To search
   a. by name, choose "Name" from the drop down menu and type your dentist's name in the box
   b. for a provider listing, choose "Specialty" from the drop down menu and type "All" in the box (The list may be viewed or exported to a pdf file)

ID Cards. You should receive an ID card in approximately two weeks before your coverage starts. Provide the information on your ID card to your dental office.

Locate a MetLife Preferred Dental Provider (PDP) #G95682

While you have the option of using out-of-network providers and you receive the same percentages for in- and out-of-network services, the amount you pay if you go out-of-network could vary greatly. An in-network provider charges the negotiated PDP fee, which is lower than the dentist's actual charges. An out-of-network provider can charge you the negotiated fee plus the difference between the in-network PDP fee and his or her service charge. Here's how to find an in-network provider.

- **Go to** *metlife.com*.
- **Select** Dentist in the "I want to find a MetLife:" box on the home page. Enter your zip or city, state and under "Select Your Network" choose PDP Plus.

No MetLife ID Cards

MetLife does not issue ID cards. The Group Number is G95682. For more information call MetLife Dental customer service at 800-942-0854 or go to *metlife.com/dental*.

EyeMed Vision Plan

PCS offers quality vision care for you and your family through EyeMed Vision. As a benefits-eligible employee, you can enroll in free employee-only vision coverage. You may enroll your dependents in the vision plan for an additional cost.

Here is a quick overview of the plan's in-network benefits. You can find more information in the online BENEFlex Guide or at *eyemed.com*.

When You Use Participating In-Network Providers

Basic Benefits	Frequency
Vision Exam	Once per calendar year
Lenses or Contact Lenses	Once per calendar year
Frames	Every other calendar year
Benefit	**In-Network Provider**
Exam with Dilation	
As necessary	$10 co-pay
Eyeglass Lenses	
Single vision	$15 co-pay
Bifocal	$15 co-pay
Trifocal	$15 co-pay
Standard Progressive	$50 co-pay
Frames	$110 allowance (You receive 20% off the balance over $110)
Contact Lenses	
Conventional	$110 allowance (You receive 15% off the balance over $110)
Disposable	$110 allowance (You pay full amount over $110)
Medically Necessary	Paid in full

Contact Lenses Allowance

If you prefer contact lenses instead of eyeglasses, a contact lens allowance is provided instead of (not in addition to) your eyeglass lens benefit. In addition to your $10 co-pay for your comprehensive eye exam, you are responsible for the contact lens fitting fees up to $40. If your contact lens fitting is more extensive, you will receive a 10% discount on the cost of a premium fitting.

About EyeMed Providers

EyeMed providers are independent eye care professionals contracted with EyeMed to provide services at negotiated rates. The EyeMed plan emphasizes high-quality routine eye care from a network of independent eye care professionals. Retail store providers include LensCrafters©, America's Best®, Sears Optical™, Target Optical©, JCPenney© Optical, and most Pearle Vision locations. Please check the provider directory available on the EyeMed Vision Care website before making your appointment.

Locate an EyeMed Vision Provider

While the plan provides reimbursements when you use an out-of-network provider, you pay less when you use an in-network provider.

- **Go to:** *eyemed.com*. Select "Find a Provider" in the top right bar on the home page.
- **Enter** your zip code and select "Advantage" under "Choose Network."

Federal and Legal Notices

Patient Protection and Affordable Care Act (PPACA, or Health Care Reform)

Starting in 2019, most Americans are no longer required to purchase health insurance coverage or pay a penalty. However, whether you are eligible for a premium subsidy depends on the plan offered by your employer. The medical plan offered by PSC does meet the affordability and coverage requirements.

- If you are offered health coverage through PCS, you will not be eligible for a premium subsidy through the Federal Marketplace.
- If you receive a premium subsidy, and you are insurance benefits eligible you may be responsible to pay the premium subsidy back to the IRS.
- If you cannot afford to enroll your spouse and/or child(ren) in a PCS medical plan, there may be cost-effective options through the federal Marketplace and/or Florida KidCare. If you choose to opt out of PCS coverage and buy insurance in the Marketplace:
  - You will not receive a contribution from PCS towards the cost of your Marketplace coverage
  - You will not be eligible for a government premium subsidy to help pay for your Marketplace coverage
  - You may be responsible to pay the premium subsidy back to the IRS if you receive one and are eligible for insurance benefits

HIPAA

Special Enrollment Rights

If you or your eligible dependent(s) lose coverage under a Children's Health Insurance Program (CHIP) or Medicaid due to loss of eligibility for such coverage or become eligible for the optional state premium assistance program, if available in your state, you may enroll in a District-sponsored medical plan within 60 days of the date coverage was terminated or the date of eligibility for the optional state premium assistance program. To review the full notice please go to pcsb.org/page/464.

Employee Privacy Notice

Under HIPAA legislation, your employer and your health plan are obligated to protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. To review the full notice please go to pcsb.org/page/464.

HIPAA requires your employer and your health plan to notify you and your beneficiaries about their policies and practices to protect the confidentiality of your health information.

Refer to your plan's privacy notice for a detailed description of:

- Your plan's information privacy policy;
- Ways the plan may use and disclose health information about you;
- Your rights; and
- Obligations the plan has regarding the use and disclosure of your health information.

Family and Medical Leave of Absence

The Family Medical and Leave Act (FMLA) of 1993 allows you to take a leave of absence, without pay, for up to 12 weeks during any continuous 12-month period, for the following reasons:

- Birth of a child
- Adoption of a child
- Placement of a foster child into your care
- Caring for your seriously ill child, spouse, or parent
- Your own serious health condition
- For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or called to covered active duty status.

An eligible employee may also take up to 26 work weeks of leave during a "single 12-month period" to care for a covered service member with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the service member.

If you take a family medical leave to care for an ill family member or for your own serious illness, you may take the leave intermittently, as necessary.

You are eligible for family medical leave if you have worked for Pinellas County Schools for one year and have worked at least 1,250 hours during the previous 52 weeks prior to requesting the leave. You will pay the same group medical and dental insurance rates during your leave. When you return from your leave, you will be reinstated to the same or equivalent position.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires your health care plan to provide benefits for mastectomy-related services. These services include reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedemas). Coverage for these benefits or services will be provided in consultation with the participant's or beneficiary's attending physician.

If you are receiving, or in the future receive, benefits under a group medical contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above if you elect breast reconstruction. Your qualified dependents are also entitled to coverage for those benefits or services on the same terms. Coverage for the mastectomy-related services or benefits required under the Women's Health law are subject to the same deductibles and coinsurance or co-payment provisions that apply to other medical or surgical benefits your group medical contract provides.

Maternity and Newborn Length of Stay

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 normal vaginal delivery, or 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice Regarding the Wellness Program

Pinellas County Public Schools Be SMART is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be offered the opportunity to complete a biometric screening, which will include a finger stick blood test for cholesterol, triglycerides, and glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Incentives may be available from the wellness program for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation through the wellness program. A member may submit a Disability Accommodation form, also available upon request from the wellness program, to request alternative engagement options to accommodate the disability.

IRS rules state that certain incentives, such as gift cards, given to employees through an employee wellness program are taxable. All cash and cash-equivalent (example: gift cards) incentives, regardless of value, will be reported to payroll and included in the employee's income and are subject to payroll taxes.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as the Diabetic Care Program, YMCA Diabetic Prevention program, or the Tobacco Care Program. You also are encouraged to share your results or concerns with your own doctor.

Continued on next page.

Federal and Legal Notices, continued

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Pinellas County Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, no one will ever disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Aetna's patient advocate in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact April Paul at 727-588-6136.

Important Notice from Pinellas County Schools About Your Prescription Drug Coverage and Medicare Part D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pinellas County Schools 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:

- 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.
- Pinellas County Schools has determined that the prescription drug coverage offered by the Aetna Prescription Drug Program 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 through 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-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 and drop your current Pinellas County Schools coverage, be aware that you and your dependents will not be able to get this coverage back.

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 Pinellas County Schools and don't join a Medicare drug plan within 63 continuous days after your current prescription drug 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 19 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 November to join.

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

More information, contact the Pinellas County Schools Risk Management and Insurance Department.
Note: You'll get this notice each year prior to the annual Medicare drug plan enrollment period, and if your coverage through Pinellas County Schools changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

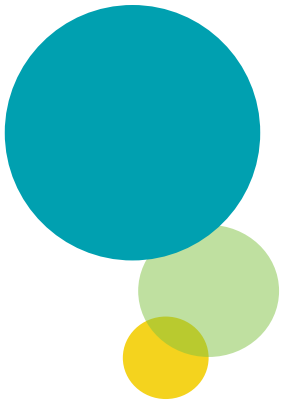
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit *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 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

Date of Notice: October 2018

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 socialsecurity.gov*, 800-772-1213 (TTY 800-325-0778).*



Name of Entity/ Sender:	Contact:	Address:	Phone Number:
Pinellas County Schools	The Risk Management and Insurance Department	301 4th Street S.W., Largo, FL 33770	727-588-6197

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from Pinellas County Schools (PCS) but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Florida, you can contact the Florida Medicaid office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact the Florida Medicaid office or dial 877-KIDS NOW or go to *insurekidsnow.gov* to find out how to apply. If you qualify, you can ask if Florida has a program that might help you pay the premiums for an employer-sponsored plan. (NOTE: If your children live outside of Florida, contact the appropriate Medicaid office for that state.)

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, PCS's health plan is required to permit you and your dependents to enroll in the plan—as long as you and your dependents are eligible but not already enrolled in an PCS plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

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

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

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

COLORADO – Health First Colorado
(Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: http://www.indianamedicaid.com
All other Medicaid Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

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

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

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

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

NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

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

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

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

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

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

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

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

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

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

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

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

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

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

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any more states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration • www.dol.gov/agencies/ebsa • 866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services • www.cms.hhs.gov • 877-267-2323, Menu Option 4, Ext. 61565

Contact Information

Onsite Representatives

Aetna (Claims Advisor) *Effective 1-1-19*	727-588-6367
Aetna (Medical—Patient Advocate) *Effective 1-1-19*	727-588-6137
Aetna (Health & Wellness Advocate) *Effective 1-1-19*	727-588-6134

Risk Management and Insurance

Main Number	727-588-6195 • (Fax) 727-588-6182
Insurance Benefits and Deductions—Employee	727-588-6197
Retirement (Insurance Benefits, DROP)	727-588-6214
Wellness	727-588-6031

Insurance Carriers

Aetna Concierge Customer Service • Member Services (Group #109718) • Pharmacy • Aetna PayFlex FSA Administration	866-253-0599 www.aetnapcsb.com
Aetna Mail Order Pharmacy	888-792-3862 N/A
EyeMed Vision Care	866-299-1358 eyemed.com
Health Advocate Employee Assistance Program (EAP)	877-240-6863 healthadvocate.com/member
Humana Advantage Dental (548085)	800-979-4760 www.MyHumana.com
MetLife® Dental Plan—PDP (G95682)	800-942-0854 metlife.com/dental
Teladoc	855-835-2362 teladoc.com/aetna

Non-PCS Programs

Florida KidCare	800-821-5437 floridakidcare.org
Federal Health Insurance Marketplace	800-318-2596 healthcare.gov

This newsletter describes Pinellas County Schools employee benefit programs that will be effective for the plan year beginning January 1, 2019. This is only a summary of the benefit programs. Additional restrictions and/or limitations not included in this guide may apply. In the event of a conflict between this guide and the plan documents, the plan documents will control.

BENEFlex 2019

Questions?

Call the Benefits Team:
727-588-6197

or visit our website at www.pcsb.org/risk-benefits

Departments • Human Resources • Risk Management

pcs
PINELLAS COUNTY SCHOOLS