EMPLOYEE BENEFITS GUIDE

2022 BENEFlex Program

pcs
PINELLAS COUNTY SCHOOLS

WHO TO CALL FOR BENEFITS HELP

PLANS AND PROVIDERS	TELEPHONE	WEBSITE
RISK MANAGEMENT AND INSURANCE		
Main Number	727-588-6195 (Fax) 727-588-6182	www.pcsb.org/risk-benefits
Insurance Benefits and Deductions	727-588-6197	www.pcsb.org/risk-benefits
Retirement (Insurance Benefits/DROP)	727-588-6214	www.pcsb.org/retirement www.myfrs.com
Tax-Deferred Accounts	727-588-6141	http://www.tsacg.com/individual/plan-sponsor/florida/pinellas-county-schools/
Wellness for Employees	727-588-6031	www.pcsb.org/wellness
Workers' Compensation	727-588-6196	www.pcsb.org/risk-benefits
ONSITE REPRESENTATIVES		
Aetna (Claims Advisor)	727-588-6367	www.pcsb.org/healthinsurance
Aetna (Medical | Patient Advocate)	727-588-6137	www.pcsb.org/healthinsurance
Aetna (Wellness)	727-588-6134	www.pcsb.org/wellness
Standard Insurance Company (Disability Claims)	727-588-6444	www.pscb.org/disability
INSURANCE CARRIERS		
Aetna Concierge Customer Service	866-253-0599	www.aetnapcsb.com
EyeMed Vision	866-299-1358	www.eyemedvisioncare.com
Healthcare Bluebook	888-316-1824	www.pcsb.org/healthcarebluebook
Humana Advantage Dental (#548085)	800-979-4760	www.myhumana.com
MetLife Dental (#G95682)	800-942-0854	www.metlife.com/dental
MetLife Voluntary Benefits	800-438-6388	www.metlife.com/mybenefits
Resources for Living (RFL) Employee Assistance Program (EAP)	800-848-9392	www.resourcesforliving.com username: pcsb; password: eap
Standard Insurance Company (Life, AD&D, Disability Claims)	800-325-5757 Christine D'Angelo	Christine.D'Angelo@standard.com
Teladoc	855-835-2362	www.teladoc.com/aetna
NON-PCS PROGRAMS		
Florida Retirement System (FRS)	866-446-9377	www.myfrs.com
Florida KidCare	888-540-5437	www.floridakidcare.org
Federal Health Insurance Marketplace	800-318-2596	www.healthcare.gov

QUESTIONS?

Call the Benefits Team at **727-588-6197** or visit our website at **www.pcsb.org/risk-benefits**

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PAYROLL DEDUCTION RATE CHART

If you do not enroll in a PCS-sponsored medical plan, you are eligible to use up to a $75 per-pay-period Board Contribution credit toward the purchase of eligible supplemental benefits. Eligible benefits are marked on the rate sheets and Enrollment & Change form with a diamond ♦. Enrollment in these supplemental benefits is not automatic. You must complete an Enrollment & Change form and elect them. If you do not elect these supplemental benefits, you forfeit the $75 per-pay-period credit.

Rates Subject to Union Ratification and Board Approval

AETNA MEDICAL PLANS				
COVERAGE LEVEL	**SELECT OPEN ACCESS**	**CHOICE POS II**	**CDHP + HRA**	**BASIC ESSENTIAL**
Employee	$89.00	$99.00	$69.00	$31.00
Employee + Spouse	$238.00	$259.00	$195.00	$121.00
Employee + Child(ren)	$217.00	$238.00	$174.00	$113.00
Employee + Family	$315.00	$357.00	$256.00	$147.00
Two Board Family[1]	$220.00	$262.00	$161.00	$52.00

Payroll deduction **per-pay-period (20 pays, bi-weekly deductions)** AFTER the Board Contribution credit has been applied. **1** To be eligible for Two Board Family, three or more individuals must be covered under the plan and your legal spouse must be a benefits-eligible employee of the School Board.

♦ HUMANA AND METLIFE DENTAL PLANS			♦ EYEMED VISION PLAN	
COVERAGE LEVEL	**HUMANA ADVANTAGE**	**METLIFE PDP**	**COVERAGE LEVEL**	**EYEMED**
Employee	$7.93	$14.93	Employee	No Charge
Employee + 1	$14.56	$27.36	Employee + 1	$2.83
Employee + Family	$21.27	$39.49	Employee + Family	$5.92
Two Board Family[2]	$19.27	$37.49	Two Board Family[2]	$5.92

Payroll deduction **per pay period (20 pays, bi-weekly deductions)** AFTER the Board Contribution credit has been applied. **2** To be eligible for Two Board Family, three or more individuals must be covered under the plan and your legal spouse must be a benefits-eligible employee of the School Board.

♦ METLIFE HOSPITAL INDEMNITY PLAN (HIP)		METLIFE LEGAL PLAN
COVERAGE LEVEL	**HIP**	**CALL METLIFE TO ENROLL (800-438-6388)**
Employee Only	$8.00	
Employee + Spouse	$13.00	$11.85
Employee + Child(ren) up to age 26	$17.00	(no coverage level selection required)
Employee + Family	$21.00	

Pre-existing conditions apply to The Standard Disability plans, HIP, and the MetLife Legal Plan. See the online BENEFlex Guide for full details.

PAYROLL DEDUCTION RATE CHART

♦ DIAMOND = Eligible for the $75 Per-Pay Board Contribution Credit.

STANDARD INSURANCE COMPANY LIFE INSURANCE PLANS *

BASIC EMPLOYEE TERM LIFE INSURANCE [1]	OPTIONAL EMPLOYEE AND DEPENDENT TERM LIFE			
	EMPLOYEE[2] & SPOUSE[3]		CHILDREN[4]	FAMILY[5]
	Age (as of effective date of coverage)	Rate (per $10,000)	Rates (per $2,000)	Rates (per family unit)
One times base annual earnings rounded up to the next $1,000 is provided for all eligible PCS employees at no cost to you.	Under 30	$0.34	$0.24	$0.90
Minimum: $15,000	30-34	0.48		
Maximum: $200,000	35-39	0.54		
*Keep in mind that the mount of coverage you elect will be reduced at certain ages. The $12.36 contribution shown for age 70 and above actually buys coverage of $6,500 at ages 70–74, $4,500 at ages 75–79, and $3,000 at age 80 and above.	40-44	0.60		
	45-49	0.90		
	50-54	1.38		
	55-59	2.58		
	60-64	3.96		
	65-69	7.62		
	70+	12.36		

1 This coverage is "guarantee issue" and no evidence of good health is required.

2 Optional Employee Term Life: $10,000 minimum, up to $200,000 in $10,000 increments or $250,000, up to $500,000 maximum in $50,000 increments; "guarantee issue" (new hire only) to $100,000 or your current coverage amount; for additional amounts, you must provide evidence of good health; subject to reduction schedules at age 70.

3 Optional Dependent Term Life for Spouse: $10,000 increments to $100,000; evidence of good health is required; coverage terminates at age 70.

4 Optional Dependent Term Life for Child(ren): $2,000 increments to $10,000; one premium covers all eligible unmarried child(ren) under 26 years old.

5 Optional Family Term Life: One premium covers spouse and unmarried child-(ren) under 26 years old.

♦ STANDARD INSURANCE COMPANY OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

BENEFIT AMOUNT	EMPLOYEE ONLY	EMPLOYEE + FAMILY
$50,000	$0.60	$1.05
$100,000	$1.20	$2.10
$200,000	$2.40	$4.20
$300,000	$3.60	$6.30

Basic Employee AD&D Insurance is provided for all eligible PCS employees at no cost to you. Coverage Amount: $2,000

♦ STANDARD INSURANCE COMPANY DISABILITY INSURANCE PLANS

An eligible employee may select one plan and one waiting period, outlined below, provided the Monthly Disability Benefit does not exceed $66^{2/3}$% of the person's regular monthly base salary.

IF YOUR ANNUAL BASE SALARY IS AT LEAST	MONTHLY DISABILITY BENEFIT	TWO YEAR PLAN AND WAITING PERIODS			TO SSNRA[4] PLAN AND WAITING PERIODS		
		14 DAYS	30 DAYS	60 DAYS	14 DAYS	30 DAYS	60 DAYS
$ 7,200	$ 400	$ 5.28	$ 3.38	$ 1.88	$ 6.83	$ 4.54	$ 2.86
10,800	600	7.91	5.08	2.82	10.25	6.80	4.29
14,400	800	10.55	6.77	3.76	13.67	9.07	5.72
18,000	1,000	13.19	8.46	4.70	17.08	11.33	7.15
21,600	1,200	15.83	10.15	5.65	20.50	13.60	8.58
25,200	1,400	18.47	11.84	6.59	23.92	15.87	10.01
28,800	1,600	21.11	13.54	7.52	27.33	18.13	11.44
32,400	1,800	23.75	15.23	8.47	30.75	20.40	12.88
37,800	2,100	27.71	17.77	9.88	35.87	23.80	15.02
43,200	2,400	31.67	20.30	11.29	41.00	27.20	17.17
48,600	2,700	35.62	22.84	12.70	46.12	30.60	19.31
54,000	3,000	39.58	25.38	14.11	51.25	34.00	21.46
63,000	3,500	46.18	29.61	16.46	59.79	39.67	25.03
72,000	4,000	52.78	33.84	18.82	68.33	45.34	28.61
81,000	4,500	59.38	38.07	21.17	76.87	51.01	32.18
90,000	5,000	65.97	42.30	23.52	85.41	56.67	35.76

Pre-existing conditions, including pregnancy, apply during the first year of new or increased coverage. See pages 32-34 located in the online BENEFlex Guide for full details.

4 Social Security Normal Retirement Age (SSNRA)

GENERAL ENROLLMENT INFORMATION

At Pinellas County Schools, our employees are our greatest asset. You're the reason for our students' success, and we appreciate the contribution you make to our future. We also realize that you have a life outside of your job — a family, friends, activities. So we want to provide you with quality benefit plans and programs that meet your needs and those of your family, through the BENEFlex program.

This guide contains details about the BENEFlex program, including eligibility, plan features and provisions, and their associated costs. Please take the time to review this guide carefully and use the contact information if you have any questions or would like additional information. The decisions you make will remain in effect through December 31, 2022.

This guide is not an employee/employer contract. It is not intended to cover all provisions of your plans, but rather a quick reference to help answer most of your questions. Please see your Summary Plan Description and/or carrier certificates for complete details. We hope this benefits guide will give you an overview of your benefits and help you be better prepared for the enrollment process. In the event of a conflict between this guide and the plan documents, the plan document will control.

BENEFITS ELIGIBILITY

WHO? Full-time, regular employees who work at least 30 hours per week, job sharing employees, and part-time, regular employees in two or more authorized positions who work at least 30 hours per week.

HOW? Complete and return an Enrollment and Change form to Risk Management and Insurance Department. Return your form within 31 days from your date of hire or date of change to eligible status.

WHEN? Benefits are effective the first day of the month following 60 days of employment in eligible status or change to eligible status.

WHAT? It is your responsibility to read the benefits information provided, complete the required enrollment forms, and ensure that they are received by the Risk Management and Insurance Department on or before your enrollment due date.

LATE? If you fail to submit the required enrollment forms by the enrollment due date, you will have to wait until the next Annual Enrollment to enroll in our benefit program.

DEPENDENT ELIGIBILITY AND COVERAGE

You may elect coverage (when available) for your eligible dependents, including:

Your legal spouse as defined by the State of Florida.

Your children including natural, foster, step, legally adopted children, children proposed for adoption, and children for whom you have been appointed legal guardian.

Medical, Dental, and/or Vision Plan Coverage for children. Your children can be covered under a PCS medical, dental, and/or vision plan through the end of the calendar year in which they reach age 26, regardless of marital, financial, or student status. A covered child's spouse is not eligible for coverage. As allowed by Florida law, you may cover a grandchild from birth to age 18 months provided your child was covered under your PCS medical plan when your grandchild was born. Coverage for the grandchild will end prior to 18 months if the child's parent ceases to be covered.

Dependent Life Insurance. You can purchase dependent life insurance for your legally married spouse up to age 70. You may also cover your unmarried dependent children up to the end of the calendar year in which they reach age 26.

Caution! Please note that enrolling individuals who are not eligible under our plans may subject you to disciplinary action by PCS. You will be responsible for the repayment of premiums and claims. In addition to our internal policies, the Florida Department of Financial Services views this activity as fraud and considers it prosecutable under the law.

GENERAL ENROLLMENT INFORMATION

DEPENDENT ELIGIBILITY AND COVERAGE, CONTINUED

Handicapped Dependents. There is no age limitation for an unmarried handicapped dependent child provided all requirements are met.

- The dependent must be chiefly dependent upon the employee for support and maintenance, and be incapable of self-support due to mental or physical incapacity, either of which commenced prior to reaching a limiting age.
- The dependent had continuous coverage under a Pinellas County Schools Group health insurance plan.
- The employee must submit proof of the handicapped dependent's condition and eligibility to the Risk Management and Insurance Department and the appropriate health plan(s) within 31 days after the end of the year in which the dependent reaches a limiting age.

Enrolling a Newborn Child. You may submit an enrollment application for your child prior to the birth of the child or within 31 days after birth to Pinellas County Schools Risk Management & Insurance Department.

You may submit an enrollment application to Pinellas County Schools between 31 and 60 days after your newborn child's birth. However, your medical plan may require that any additional prepayment fees (premium) be remitted for the period beginning at the date of birth through the date of enrollment.

When these requirements are met, the effective date of coverage is the date of birth. If you do not meet these requirements, you may enroll your child during the next Annual Enrollment period for the next plan year.

Do not contact Aetna to add a newborn.

TERMINATION OF COVERAGE

Insurance benefits, with the exception of disability, will cease **the end of the month** in which the following occur (provided all premiums have been paid:

- Termination of employment
- Reduction in hours, or an employment status change in which employee no longer meets the plan's eligibility requirement
- Loss of child's dependent status (dependent coverage)
- Divorce (dependent coverage)

Disability insurance coverage will terminate on the date your employment ends.

Note: In the event additional premiums are due, you will be sent a billing notice for the premium(s) required to continue coverage to the end of the month.

Please see the additional notices document to find important information about your rights and responsibilities for continuation of insurance coverage through COBRA.

CHANGE IN STATUS EVENT

Life changes. People get married, have babies, get divorced or change jobs and may need to change their benefit elections during the year. According to IRS regulations, you cannot change your benefit elections during the year unless you experience a qualified change in status event. If you experience a qualified change in status event, your request **must be consistent with, and correspond to, the qualified status change.**

To change your benefit elections, you must submit an Enrollment and Change Form (PCS 3-227) along with the documentation required consistent with your life event, to Risk Management within 31 days of the qualified change in status event. If you are benefits-eligible and have not met the required waiting period, you may be eligible to change your benefit elections. Changes in coverage are effective the first day of the month following the change in status event and receipt of the forms by Risk Management.

The following page includes qualifying events to add and drop medical, dental or vision coverage and the documentation needed.

Qualifying Events to ADD Medical, Dental or Vision	
QUALIFYING EVENT	**DOCUMENTATION REQUIRED**
Marriage	Copy of marriage certificate
Divorce	Copy of divorce certificate
Death	Copy of death certificate when available
Birth of a Child	Copy of birth certificate when available: • Within 31 days to avoid paying first month's additional premium. • Within 60 days or coverage will be allowed and billed from date of birth.
Legal Adoption or Intent to Adopt	Copy of adoption paperwork
Legal Guardianship	Copy of guardianship paperwork
Judgement, decree or order requiring you to provide health coverage for a dependent	Copy of judgement, decree or order
Grandchild	Copy of birth certificate identifying covered dependent as parent
Return to work from unpaid leave	Return to work notification (received from Personnel)
Loss of benefits from employer group plan, federal or state sponsored plan	HIPAA letter or statement from other coverage sponsor stating why coverage was terminated. Dropping coverage voluntarily or cancellation of coverage for non-payment is NOT a qualifying event.
Loss of COBRA benefits	COBRA termination letter showing end of eligibility
Significant premium cost change attributed to employee or dependents benefit plan	Statement from other coverage sponsor stating cost change and effective date

Qualifying Events to DROP Medical, Dental or Vision	
QUALIFYING EVENT	**DOCUMENTATION REQUIRED**
Starting unpaid leave of absence	Copy of the leave
Marriage	Copy of the marriage certificate
Divorce	Copy of the divorce decree (first and last page of the document)
Birth of a Child	Copy of birth certificate when available
Legal Adoption or intent to adopt	Copy of adoption paperwork
Death of a spouse or child	Cope of the death certificate when available
Grandchild	Automatic termination when grandchild turns 18 months of age. Provide documentation of legal guardianship to extend.
Gain benefits from employer group plan or federal– or state-sponsored plan	Proof of other insurance coverage with effective date, or documentation of employer's annual enrollment
Significant premium cost change attributed to employee or dependents benefit plan	Statement from other coverage sponsor stating cost change and effective date
You or your dependent have a change in place of residence or work outside of the service area (only applies to dental coverage)	Copy of driver's license, lease, utility bill to show change of address. Copy of enrollment in school. Copy of documentation from employer.

Healthcare Flexible Spending Account (FSA): You can only drop or decrease your contributions if you experience these qualifying events: death, divorce, or unpaid leave of absence.

GENERAL ENROLLMENT INFORMATION

BOARD CONTRIBUTION CREDIT

If you do not enroll in a PCS-sponsored medical plan, you are eligible to use up to $75 per-pay-period Board Contribution credit toward the purchase of eligible supplemental benefits. Enrollment in these supplemental benefits is not automatic. You must complete an Enrollment & Change form and elect them. If you do not elect these supplemental benefits, you forfeit the $75 per-pay-period credit.

The Board Contribution credit may be applied to your payroll deductions for dental, vision, AD&D, long-term disability, and/or the Hospital Indemnity Plan (HIP). The contribution cannot be used to purchase Optional Term Life insurance or be contributed to a Dependent Care FSA.

If you are not enrolled in a medical plan and you enroll in a Healthcare FSA, you can deposit from $10 to $25 of your Board Contribution credits into your Healthcare FSA. **This is not automatic**—you must actively enroll in a Healthcare FSA to receive the credits the first year you enroll. In subsequent years, your FSA contribution amount will continue unless you change it during Annual Enrollment.

Board Contribution credits do not accumulate and are not automatic. You must enroll for the benefits listed above and any amount not used will be forfeited.

TWO BOARD EMPLOYEES

If both you and your legal spouse are active benefits-eligible School Board employees, the Two Board Family option may be selected if:

- You both want to be covered under the same medical plan, AND you are covering one or more dependents (for a total of three or more covered individuals).
- Note, if you and your spouse are not covering dependents, you are not eligible for two-board coverage and it may be more cost effective for each of you to enroll in employee-only coverage.

One of the employees must complete an Enrollment and Change form, and select the "Two Board" option. (The employee completing the form will be known as the "health insurance contract holder.") The other employee/spouse and all dependent children you want to enroll must be listed on this form. The other employee must also complete an Enrollment and Change form and mark the area called "Spouse" and write in the health insurance contract holder's name and Social Security number.

Both Board Contribution amounts will be credited to the contract holder's paycheck. Any required additional medical insurance payroll deductions will be taken from the contract holder's paycheck.

If the employee/spouse selects other insurance coverage (e.g., Optional Term Life), those premiums will be deducted from his or her paycheck, not the health insurance contract holder's paycheck.

Employees who are eligible for Two Board Family medical insurance may also elect Two Board Family dental insurance.

CHANGE IN TWO BOARD STATUS

The following events will require that the contract holder change to a regular family rate or two separate policies:

- If you or your spouse take an unpaid regular leave of absence, terminate, or retire from Pinellas County Schools.
- If you or your spouse reduce your hours and are no longer in a benefits-eligible status.
- If you no longer have three or more eligible individuals to be covered under a medical and/or dental plan.
- If you and your spouse divorce.

You and your spouse will be required to notify the Risk Management and Insurance Department within 31 days of the above events and change to a regular family rate or two separate policies. If you or your spouse fail to notify the Risk Management and Insurance Department within 31 days of the above events, you and/or your spouse will be responsible for any premium owed for the current coverage tier. These premiums will be collected from a personal payment or deducted from your paycheck. In addition, you may be subject to disciplinary action for electing a benefit you are not eligible to receive.

GENERAL ENROLLMENT INFORMATION

CAPTURING DEPENDENTS' SOCIAL SECURITY NUMBERS

Due to a federal mandate, all Social Security numbers for dependents must be captured by insurance carriers. During the enrollment process, you will be required to list the Social Security numbers of your spouse and eligible dependent children who you enroll under your medical, dental, and vision plans.

COORDINATION OF BENEFITS

If your spouse or child(ren) has coverage under another health care plan (medical, dental, etc.) in addition to coverage under your PCS plan, coordination of benefits (COB) between the health plans generally will apply. Usually, the "birthday rule" order of benefit determination will apply. This means that the health plan of the spouse or parent whose birthday occurs earlier in the year will pay regular benefits and the other health plan will coordinate their benefits with the primary plan.

MEDICARE COORDINATION OF BENEFITS

If you are an active employee and you have Medicare or one of your covered dependents has Medicare, your PCS medical plan will be primary. Your PCS medical plan will pay its regular benefits and Medicare may request information from you or Aetna about your claims.

If you are a retiree from PCS and you have Medicare or one of your covered dependents has Medicare, generally, Medicare will be your primary health plan and pay its regular benefits. If you also have coverage through PCS, your PCS health plan will coordinate benefits with Medicare as long as any regular benefits would be available.

If you have questions about your specific situation or claims, please call the plan's Member Services number on your medical ID card.

RETIREE INSURANCE

You may participate in the Retiree Insurance program if you meet the following criteria at the time of your termination of employment. **If you were hired prior to July 1, 2011** and you retire with six or more years of creditable service **OR you were hired on July 1, 2011 or after** and you retire with eight or more years of service and you either:

- Receive benefits from the Florida Retirement System (FRS) Pension Plan, OR
- Are at least age 59½ with eight years of service (six if hired prior to July 1, 2011) and eligible for withdrawals under the FRS Investment Plan.

Retirees may only continue the medical, dental, vision, and Board Life insurance in effect at the time of retirement. Life insurance benefits may be continued or decreased but may not be increased. Retiree life insurance benefits are subject to a reduction formula and a slightly higher premium.

Dependent health insurance coverage may continue or be cancelled. Newborns may be added subject to state regulatory and carrier requirements.

Accidental Death & Dismemberment and Basic and Optional Term Life insurance benefits may be continued within 31 days of your retirement date as an individual contract subject to insurance company procedures. Disability coverage ends upon retirement.

Prior to your retirement, you will receive a Retiree Enrollment Guide that explains all of your options in detail.

AETNA MEDICAL PLANS

You can choose from four Aetna medical plans.

PLAN	NETWORK
Aetna Select Open Access	Aetna Select Open Access
Choice POS II (Point of Service II)	Choice POS II
CDHP + HRA (Consumer Directed Health Plan with Health Reimbursement Account)	Aetna Select Open Access
Basic Essential	Aetna Select Open Access

Each plan offers a network of doctors and other health care providers who offer their services at a reduced or specified rate. Using in-network providers lowers your out-of-pocket expenses. Please review this information before making your decision and visit www.aetnapcsb.com.

Take time to understand how the plans work and how much you will pay in both out-of-pocket costs and payroll deductions. Just because a plan has lower payroll deductions, it may not be the lowest cost option if you and/or your dependents need a lot of care. Once you are enrolled in a plan, you and your covered dependents will have access to Aetna's services and programs described at www.aetnapcsb.com.

If you are covered by your spouse's medical plan or have other medical coverage, you may consider declining medical coverage under the BENEFlex benefit program and use up to $75 of the Board Contribution credit to purchase supplemental benefits. You can also deposit between $10 and $25 of these credits in a Healthcare FSA.

	SELECT OPEN ACCESS	CHOICE POS II	CDHP + HRA	BASIC ESSENTIAL
Do I have to stay in-network to receive plan benefits?	Yes	No	Yes	Yes
What is the coverage area?	National	National	National	National
Do I have to select a PCP?	Not Required	Not Required	Not Required	Not Required
Do I need a referral to see specialists?	No	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	PCP co-pay; Deductible and coinsurance on all other services
Is preventative care covered at 100%?	Yes, In-network only	Yes, In-network only	Yes, In-network only	Yes, In-network only
Is there a Health Reimbursement Account (HRA)?	No	No	Yes (see page 12)	No
Is there prescription drug coverage?	All four plans offer the Aetna Prescription Drug Program			

Be in the know before you enroll. See how plans compare on pages 13-16.

Search for your doctors and providers at aetnapcsb.com and select "Find a Doctor" from the top menu. Under "Not a member yet?" select "Plan from an employer". You may continue as a guest, or, if you are already a member, select "already a member" and follow the prompts.

Questions? Call Aetna Concierge Customer Service at 866-253-0599, Monday—Friday, 8:00 a.m.—6:00 p.m.

AETNA MEDICAL PLANS

AETNA SELECT OPEN ACCESS

- Visit any doctor in the network.
- No out-of-network coverage except for emergencies as defined by the plan.
- You don't have to select a PCP or get referrals to specialists.
- You will have a higher co-pay to visit specialists.

CHOICE POS II

- You don't have to select a PCP or get referrals to specialists
- You can visit licensed providers who are not in the network. Going out-of-network may cost you more.

CDHP + HRA

- You can visit any doctor in the network.
- No out-of-network coverage except for emergencies as defined by the plan.
- You don't have to select a PCP or get referrals to specialists.
- When you enroll in the Consumer Driven Health Plan with Health Reimbursement Account (CDHP + HRA) PCS will fund an Aetna PayFlex Card® (See CDHP HRA Contribution chart).

BASIC ESSENTIAL

- You can visit any doctor in the network.
- There is no out-of-network coverage except for emergencies as defined by the plan.
- You don't have to select a Primary Care Physician (PCP) or get referrals to specialists.
- You will pay a higher individual deductible* and out-of-pocket maximum compared to the other medical plans offered by PCS.
- You pay a co-pay for PCP visits, TelaDoc visits and prescriptions (expect brand specialty drugs) that are not subject to the deductible.

* Please note this plan does not qualify for a Health Savings Account (HSA) since there are services built into the plan design that are not subject to the deductible. However, you can contribute to a Health Care Flexible Spending Account (FSA) to pay your eligible out-of-pocket expenses tax-free.

HOW THE CDHP + HRA WORKS

- You choose when to use your HRA, Aetna will not automatically apply your HRA funds when they process your claims.
- 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.

CDHP HEALTH REIMBURSEMENT ACCOUNT CONTRIBUTIONS

The amount of money deposited to your HRA is based on your benefits effective date as shown in this chart.

	EMPLOYEE	EE & SP	EE & CHILD	FAMILY
January 1	$500	$750	$750	$1,000
February 1	$458	$688	$688	$916
March 1	$416	$625	$625	$833
April 1	$375	$563	$563	$750
May 1	$333	$500	$500	$666
June 1	$291	$438	$438	$583
July 1	$250	$375	$375	$500
August 1	$208	$313	$313	$416
September 1	$166	$250	$250	$333
October 1	$125	$188	$188	$250
November 1	$83	$125	$125	$166
December 1	$41	$63	$63	$83

HRA ROLLOVER MAXIMUM

Effective January 1, 2023, the amount of HRA funds you can carryover from one year to another will be subject to the new maximum.

- $1,000 Employee Only Rollover Maximum
- $1,500 Employee plus Spouse Rollover Maximum
- $1,500 Employee plus Child(ren) Rollover Maximum
- $2,000 Family Rollover Maximum

Any funds in your account in excess of the maximum will be forfeited as of December 31, 2022.

AETNA MEDICAL PLANS COMPARISON CHART

	SELECT OPEN ACCESS	CHOICE POS II	
BENEFIT	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
Service Areas/Networks	Any provider in the Aetna Select Open Access national network	Any provider in the Choice POS II Network (national network)	Any Provider
Health Reimbursement Account (HRA) —Individual/Family HRA funds can only be used for medical plan and prescription drug expenses.	N/A	N/A	N/A
Deductibles—Individual/Family	N/A	$500 individual; $1,000 family (combined in– and out-of-network)	
Medical Out-of-Pocket Maximum - Includes medical deductible, coinsurance, and/or co-pays	$5,000 individual; $10,000 family	$5,000 individual; $10,000 family (combined in– and out-of-network)	
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible	$2,000 individual; $4,000 family	$2,000 individual; $4,000 family (combined in– and out-of-network)	
Lifetime Maximum	Unlimited	Unlimited	
PHYSICIAN OFFICE VISITS	**YOU PAY**	**YOU PAY**	**YOU PAY**
Primary Care Physician (PCP)	$35 co-pay	20% after deductible	40% after deductible
Specialist (SPC)	$60 co-pay	20% after deductible	40% after deductible
Teladoc: Doctor	$25 co-pay	$25 co-pay	N/A
Teladoc: Behavioral Health	$25 co-pay	20% after deductible	N/A
Preventative Adult Physical Exams	No co-pay	0%	40% after deductible
Preventative GYN Care (including Pap test) (direct access to participating providers)	No co-pay	0%	40% after deductible
Mammography Preventive Screening	No co-pay	0%	40% after deductible
Immunizations	No co-pay	0%	40% after deductible
Allergy Injections	Co-pay waived for allergy injections billed separately	20% after deductible	40% after deductible
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	20% after deductible	40% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	No co-pay	0%	40% after deductible
Chiropractic Services (limits apply) (direct access to participating providers)	$60 co-pay, 20 visits per calendar year	20% after deductible	40% after deductible
		20 visits per calendar year combined in– or out-of-network	
Hearing Exam	$25 co-pay	20% after deductible	40% after deductible

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.

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.

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

AETNA MEDICAL PLANS COMPARISON CHART

	CDHP + HRA	BASIC ESSENTIAL
BENEFIT	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Service Areas/Networks	Any provider in the Aetna Select Open Access national network	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.	$500 individual $750 employee + child(ren) $750 employee + spouse $1,000 family HRA contributions are prorated based on your date of hire	N/A
Deductibles—Individual/Family	$1,500 individual; $3,000 family	$2,300 individual, $6,900 family
Medical Out-of-Pocket Maximum - Includes medical deductible, coinsurance, and/	$5,000 individual; $10,000 family	$8,550 individual; $17,100 family
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible	$2,000 individual; $4,000 family	Combined with medical
Lifetime Maximum	Unlimited	Unlimited
PHYSICIAN OFFICE VISITS	**YOU PAY**	**YOU PAY**
Primary Care Physician (PCP)	20% after deductible	$50 co-pay
Specialist (SPC)	20% after deductible	30% after deductible
Teladoc: Doctor	$25 co-pay	$40 co-pay
Teladoc: Behavioral Health	20% after deductible	0% no deductible
Preventative Adult Physical Exams	0%, no deductible	0%, no deductible
Preventative GYN Care (including Pap test) (direct access to participating providers)	0%, no deductible	0%, no deductible
Mammography Preventive Screening	0%, no deductible	0%, no deductible
Immunizations	0%, no deductible	0%, no deductible
Allergy Injections	20% after deductible	30% after deductible
Allergy Tests **Lab** **X-Ray Outpatient** **Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)**	20% after deductible	30% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	0%, no deductible	0%, no deductible
Chiropractic Services (limits apply) (direct access to participating providers)	20% after deductible; 20 visits per calendar year	30% after deductible; 20 visits per calendar year
Hearing Exam	20% after deductible	30% after deductible

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. The amount deposited in your HRA is prorated based on your benefits effective date. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified.

Medical Plan Deductible (Choice POS II, CDHP + HRA, Basic Essential). The amount you pay for medical expenses before the plan begins paying benefits.

Coinsurance (Choice POS II, CDHP + HRA, Basic Essential). 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. 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. In the Basic Essential plan, the deductible does not apply to the non-preferred brand drugs. More information can be found on page 17.

AETNA MEDICAL PLANS COMPARISON CHART

	SELECT OPEN ACCESS	CHOICE POS II	
HOSPITAL	**IN-NETWORK ONLY**	**IN-NETWORK**	**OUT-OF-NETWORK[1]**
Inpatient (Includes maternity and newborn services)	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day; up to 5-day maximum	40% after deductible
Outpatient Surgery (including facility charges)	$500 co-pay	20% after deductible	40% after deductible
Emergency Room Services	$500 co-pay	20% after deductible	20% after deductible
Ambulance	No co-pay	20% after deductible	20% after deductible
Urgent Care Facility	$50 co-pay	20% after deductible	40% after deductible
Maternity Care/OB Visits	$50 co-pay for initial visit only	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES			
Outpatient Mental Health Services	$25 co-pay	20% after deductible	40% after deductible
Inpatient Mental Health Services	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day; up to 5-day maximum	40% after deductible
MISCELLANEOUS			
Home Health Care (limits apply)	$25 co-pay	20% after deductible	40% after deductible
Hospice—Inpatient (limits apply)	$500 co-pay per day; up to 5-day maximum[2]	$500 co-pay per day; up to 5-day maximum[2]	40% after deductible; 30-day lifetime maximum
Skilled Nursing Facility (limits apply)	$500 co-pay per day; up to 5-day maximum; up to 120-visit limit per calendar year	$500 co-pay per day; up to 120-visit per calendar year	40% after deductible, 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	$25 co-pay per visit, 60-visit limit per calendar year for all therapies combined	20% after deductible; 60-visit limit per calendar year for all therapies combined	40% after deductible, 60-visit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	See prescription drugs below	See prescription drugs below	See prescription drugs below
Durable Medical Equipment (DME)	$50 co-pay	20% after deductible	40% after deductible
AETNA PRESCRIPTION DRUG PROGRAM—SOME DRUGS MAY BE SUBJECT TO STEP-THERAPY OR PRECERTIFICATION[3]			
Up to 30-day supply: Some drugs may be subject to step-therapy or precertification	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic **Preferred Brand** **Non-Preferred Brand** **Specialty—PrudentRx***	$15 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	$15 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	NOT COVERED
90-day Supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.)	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic **Preferred Brand** **Non-Preferred Brand** **Specialty—PrudentRx***	$30 co-pay, no Rx deductible $120 co-pay, no Rx deductible $180 co-pay, after Rx deductible N/A	$30 co-pay, no Rx deductible $120 co-pay, no Rx deductible $180 co-pay, after Rx deductible N/A	NOT COVERED

1 Usual, customary, reasonable (UCR) fees. Out-of-network charges that exceed UCR fees may be billed to the member.
2 Waived if transferred from hospital
3 See page 17 for Aetna Prescription Drug Program and step-therapy information
***** May be eligible for $0 co-pay under PrudentRx program, see page 18 for details.

AETNA MEDICAL PLANS COMPARISON CHART

	CDHP + HRA	BASIC ESSENTIAL
HOSPITAL	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Inpatient (Includes maternity and newborn services)	20% after deductible	30% after deductible
Outpatient Surgery (including facility charges)	20% after deductible	30% after deductible
Emergency Room Services	20% after deductible	30% after deductible
Ambulance	20% after deductible	30% after deductible
Urgent Care Facility	20% after deductible	30% after deductible
Maternity Care/OB Visits	20% after deductible	30% after deductible
MENTAL HEALTH SERVICES	**YOU PAY**	**YOU PAY**
Outpatient Mental Health Services	20% after deductible	0% no deductible
Inpatient Mental Health Services	20% after deductible	30% after deductible
MISCELLANEOUS		
Home Health Care (limits apply)	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Hospice—Inpatient (limits apply)	20% after deductible	30% after deductible
Skilled Nursing Facility (limits apply)	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)	20% after deductible; 60-visit limit per calendar year for all therapies combined	30% after deductible; 60-visit limit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	See prescription drugs below	N/A
Durable Medical Equipment (DME)	20% after deductible	30% after deductible
AETNA PRESCRIPTION DRUG PROGRAM—SOME DRUGS MAY BE SUBJECT TO STEP-THERAPY OR PRECERTIFICATION[3]		
Up to 30-day supply:	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic	$15 co-pay, no Rx deductible	$25 co-pay, no Rx deductible
Preferred Brand	$60 co-pay, no Rx deductible	$60 co-pay, no Rx deductible
Non-Preferred Brand	$90 co-pay, after Rx deductible	$90 co-pay, no Rx deductible
Specialty—PrudentRx*	30% coinsurance, $0 if enrolled	30% coinsurance, $0 if enrolled
90-day Supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.)	*Mandatory Generics Unless Dispensed As Written*	*Mandatory Generics Unless Dispensed As Written*
Generic	$30 co-pay, no Rx deductible	$50 co-pay, no Rx deductible
Preferred Brand	$120 co-pay, no Rx deductible	$120 co-pay, no Rx deductible
Non-Preferred Brand	$180 co-pay, after Rx deductible	$180 co-pay, no Rx deductible
Specialty—PrudentRx*	N/A	N/A

Aetna Concierge
(Group #109718)
Customer Service
866-253-0599

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.

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.

See the Diabetes CARE Program information for details about free diabetic testing supplies.

3 See page 17 for Aetna Prescription Drug Program and step-therapy information.

***May be eligible for $0 co-pay under PrudentRx program, see page 18 for details. Some exclusions apply. Any specialty prescriptions not eligible under PrudentRx will fall to applicable tier for that drug.

AETNA PRESCRIPTION DRUG PROGRAM

All medical plans include prescription drug coverage from Aetna. The program uses Aetna's Standard Formulary. Each drug is grouped as a generic, preferred brand, non-preferred brand, or brand 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. See the medical plan comparisons on pages 13-16 for your out-of-pocket costs.

UNDERSTANDING THE DRUG CLASSIFICATION			
Generic Drugs **Lowest Cost**	**Preferred Brand Drugs** **Higher Cost**	**Non-Preferred Brand Drugs** **Higher Cost**	**Speciality Drugs—PrudentRx** **Highest Cost**
The least expensive drugs, such as generics and select brand-name drugs.	Brand-name drugs that have proven to be the most effective in their class.	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. **May be eligible for $0 co-pay under PrudentRx program. If not enrolled, 30% coinsurance applies.** See page 18 for details.
Maintenance Choice Program: 90-day supply for two co-pays after applicable deductibles at a CVS pharmacy or vis CVS Caremark mail order. Brand specialty drugs are not available through this program. See next page for details.			Not available

RESTRICTIONS

Regardless of Rx tier, some drugs may be subject to limitations and restrictions such as precertification requirements and step therapy. Contact an Aetna concierge at 866-253-0599 for questions or additional information.

Step therapy requires you to try one or more alternative drug(s) before a step therapy drug is covered. The alternative drugs treat the same conditions, are equally effective, have U.S. Food and Drug Administration (FDA) approval, and may cost less. If you do not 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 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. Visit *aetnapcsb.com* to find a pharmacy.

AETNA PRESCRIPTION DRUG PROGRAM

MAINTENANCE CHOICE PROGRAM

The Maintenance Choice Program requires that all maintenance drugs be filled with a 90-day supply through CVS retail pharmacy or CVS Caremark mail order delivery. Maintenance medications are the kind of drugs taken on a regular basis to treat ongoing conditions like allergies, diabetes, high cholesterol, heart disease, high blood pressure, and many other conditions.

Cost Savings: The member only pays two co-pays for a 90-day supply when obtaining those maintenance prescriptions through CVS.

After two 30-day supply retail fills at any pharmacy in the Aetna network, members are required to fill a 90-day supply of maintenance drugs through CVS Caremark mail order delivery or CVS Pharmacy, unless they call Aetna Pharmacy Management to opt out. If they call to opt out, they may continue to fill 30-day supplies of their maintenance medicine at any retail pharmacy in the network without penalty.

Maintenance Choice Program Transition Period

A transition period is available for members who are currently filling maintenance prescriptions with a 30-day supply and for members who are filling 90-day maintenance drugs at non-CVS pharmacies. Each prescription you fill will have a transition period. You will be able to obtain your maintenance drug at any pharmacy in the network for a 30-day supply (not 90 days) up to two retail fills per maintenance drug. Once you have completed the transitional period, you will have three options:

- Switch to a 90-day supply and fill your order through CVS or have your 90-day prescription transferred to a CVS.
- Opt out of the program and fill your maintenance drugs with a 30-day supply at CVS or other network pharmacies.
- Pay the full cost of your prescriptions, if you do nothing.

PrudentRx

Your specialty prescription benefit plan will look a little different this year.

Here's what's new — PrudentRx has collaborated with CVS Caremark® to offer a third-party (manufacturer) copay assistance program* that may help save you money when you fill your prescription through CVS Specialty®.

How it works — We will work with you to obtain third-party copay assistance for your medication, if available.** Once you're enrolled, you'll pay nothing out-of-pocket †– that's right, **$0!** – for medications on your plan's specialty drug list dispensed by CVS Specialty.

How to get started — You will be contacted once CVS receives a specialty prescription under the plan and they can enroll you for the program. You may opt-out if you do not wish to participate.

Specialty Prescriptions — Some exclusions do apply to the medications covered under the PrudentRx program. Any specialty drugs not on the PrudentRx drug list will be charged based on their normal Drug Classification: Generic, Preferred Brand or Non-Preferred Brand.

*Not all specialty prescriptions offer assistance. Eligibility for third-party copay assistance program is dependent on the applicable terms and conditions required by that particular program and are subject to change.

**Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must call PrudentRx to participate in the copay assistance for that medication. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for 30 percent of the cost of your specialty medications.

Questions?

Visit pcsb.org/pharmacy for a list of covered medications and additional details on the PrudentRx program.

Call PrudentRx, 1-800-578-4403, Monday through Friday, 8 AM to 8 PM ET.

Visit www.prudentrx.com

AETNA TOOLS AND RESOURCES TO MAXIMIZE YOUR COVERAGE

AETNA MATERNITY PROGRAM

Have questions about your pregnancy? The Aetna Maternity Program can help you have a successful pregnancy. You'll learn what you need to know so you can prepare for early labor symptoms, what to expect before and after delivery, and newborn care. This program is already included with your Aetna health benefits and insurance plan—there's no extra cost to you.

START WITH YOUR SECURE MEMBER WEBSITE

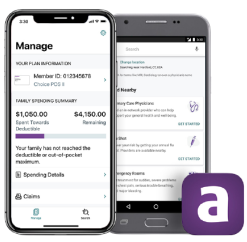
When you're a member with us, you get tools and resources to help you manage your health and your benefits. You'll find all your personal plan information and cost-saving tools in one place—your secure member website. You just need to sign up. Members can register at www.aetnapcsb.com, and select "Aetna Member Website" to get started.

CALL CONCIERGE MEMBER SERVICES

1-866-253-0599. Your concierge is your personal assistant for health care when you have questions about your Aetna medical plan. Your concierge will listen to you, understand your needs, and find solutions that are right for you.

Call or chat with your concierge Monday through Friday from 8:00 a.m. to 6:00 p.m. by phone or online (just log in at www.aetnapcsb.com and chat online).

DOWNLOAD THE AETNA MOBILE APP



The Aetna Mobile app puts our most popular online features at your fingertips. It's available for Android™ and iPhone® mobile devices. Visit your app store or www.aetna.com/mobile.

ESTIMATE COSTS

After you enroll and register for your member website, you can access the Member Payment Estimator tool and compare and estimate costs for office visits, tests, and surgeries. This online tool factors in any deductible, coinsurance, and co-pays that are part of your plan, plus Aetna's contracted rates. You can see how much you'll have to pay and how much Aetna will pay. To use the estimator tool, go to www.aetnapcsb.com, select "Aetna Member Website" at the top of the page, and log in to your secure member website.

INFORMED HEALTH® LINE

1-800-556-1555. You can get your health questions answered whether it's the middle of the night, you're away from home, or you're just not sure if you need to call your doctor, Informed Health® Line is here for you.

Call to speak to one of Aetna's nurses—24 hours a day, 365 days a year. For speech or hearing impaired, dial 711 and ask the relay operator to dial 800-556-1555 and select the option to speak to a nurse. Or, log in to your secure member website at www.aetnapcsb.com, and select "Aetna Member Website" at the top of the page to explore the resources available to you.

With one simple call, you can:

- Learn about health conditions that you or your family members have
- Get emails from a nurse with videos that are relevant to your question or topic
- Find out more about a medical test or procedure
- Get help preparing for a doctor's visit

AETNA TOOLS AND RESOURCES TO MAXIMIZE YOUR COVERAGE

CVS HEALTH HUB AND NEIGHBORHOOD WELL-BEING COUNSELING

Want to start working on your health goals? Aetna makes well-being services available to you at MinuteClinic® walk-in medical clinics inside select CVS Pharmacy® locations—right in your own neighborhood. Trying to quit smoking? Concerned with your weight? Interested in understanding your health screening numbers? Have a chronic condition such as diabetes, high blood pressure, or high cholesterol you need help monitoring?

MinuteClinic can help. Just follow these steps:

1. Visit your neighborhood MinuteClinic inside CVS Pharmacy. You can find your closest location at www.minuteclinic.com/locations.

2. Sign in at the clinic kiosk and choose from the following wellness services:*

- Smoking cessation, weight loss program, comprehensive health screening**

3. Or choose from the following monitoring services:***

- Diabetes monitoring, high cholesterol monitoring, high blood pressure evaluation
- Show your Aetna member ID card

* Your Aetna medical plan's preventive benefits may cover these wellness services. If you have questions about your coverage, simply call the toll-free number on your Aetna member ID card.

** Coaching services available for screenings conducted at MinuteClinic inside CVS Pharmacy only.

*** Additional charges may apply for tests associated with these services. If you have any questions about your coverage, just call the toll-free number on your Aetna member ID card.

AETNA | ABLETO: VIRTUAL BEHAVIORAL HEALTH CARE

Meet 1-on-1 with a coach, licensed therapist, or both who will guide you through a personalized 8-week program proven to reduce depression, stress, and anxiety. Available for Aetna health plan members as a confidential program offered at no cost to you.* Visit www.ableto.com/aetna to get started today.

AETNA ONE CHOICE

Aetna One Choice provides personalized one-on-one nurse support as long-term conditions become more complex, or severe issues arise. Aetna's clinical nurse team will reach out to assist you and your family, providing help with everything from health questions to medical referrals. Aetna's predictive technology will detect issues early. That way we not only support you today, but help you prepare for tomorrow. The program offers:

- One-on-one phone calls with a trusted family nurse
- Digital personal health record, health decision support, and wellness videos
- Customized health action plans based on your needs and preferences

Log in to your secure member website at www.aetnapcsb.com, and select "Aetna Member Website" at the top of the page to get started.

MEMBER DISCOUNTS

Once you're an Aetna member, just log in to your secure member website at www.aetnapcsb.com, and select "Aetna Member Website" at the top of the page. It's the place to take care of your benefits and save, too. You can find a vision, hearing, or natural therapy professionals, sign up for a weight-loss program, buy health products, find a gym, and more!

YOUR AETNA ONSITE TEAM IS HERE TO HELP!

Speak to a Pinellas County Schools Aetna onsite representative about ongoing health and wellness programs.

Aetna Onsite Account Manager, 727-588-6367

Aetna Onsite Wellness Specialist, 727-588-6134

Aetna Onsite Patient Advocate, 727-588-6137

HEALTHCARE BLUEBOOK: COMPARE, CHOOSE, SAVE

When you are enrolled in a PCS Aetna medical plan you and your enrolled dependents can access the Healthcare Bluebook. This free online and mobile resource makes it easy to shop for affordable high-quality health care—from diagnostics and imaging to outpatient surgery—at a fair price. Go to pcsb.org/healthcarebluebook or download the free Healthcare Bluebook mobile app and start shopping for a Fair Price provider while you are with your doctor.

Go Green to Get Green

You can look up a Fair price, compare provider prices, and find the best value in your area. Click the "Go Green to Get Green" banner and you'll earn from $25 to $200 in rewards (on select procedures) when you choose a Fair Price provider. To be eligible for the reward, you must log in to Healthcare Bluebook and search for your procedure, test or service prior to visiting a Fair Price provider.

HEALTHCARE BLUEBOOK TOP ELIGIBLE SERVICES	
ELIGIBLE PROCEDURE	**CASH REWARD**
Arthroscopic Surgery (knee, shoulder, hip, etc.)	$200
Upper GI Endoscopy, Colonoscopy	$100
CTs	$75
MRIs	$50
Non-Obstetric Ultrasound	$25

See pcsb.org/healthcarebluebook for a full list of procedures eligible for a reward.

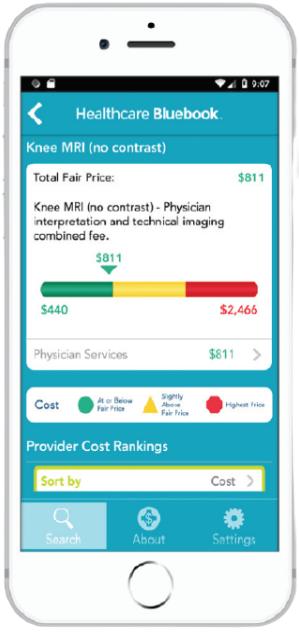
Start Saving Now

Healthcare Bluebook gives you and your enrolled dependent the power to choose a high-quality provider and/or facility for your health care and save some serious money:

- Log on to: pcsb.org/healthcarebluebook
- Company code: PCSB
- Search for the procedure you are considering prior to visiting a Fair Price provider. Remember—if you do not search for the procedure prior to the date of service, you will not be eligible for the reward.
- Healthcare Bluebook will send checks to your home.

Scan to download the mobile app and get started today!

Mobile code: PCSB



QUESTIONS?

For a full list of qualifying procedures and reward amounts, visit http://www.healthcarebluebook.com/cc/pcsb.

If you have any questions call 888-316-1824 or email support@healthcarebluebook.com.

METLIFE HOSPITAL INDEMNITY PLAN (HIP)

Hospital stays can be costly and are often unexpected. Even the best medical plans may leave you with extra expenses to pay out of your pocket like deductibles, coinsurance, and co-pays. The MetLife Hospital Indemnity Plan (HIP) pays a cash benefit when you or a covered dependent is hospitalized due to an accident or illness. Please see the Certificate of Coverage for full information.

PLAN HIGHLIGHTS

HIP coverage can help you be better prepared by providing you with a payment to use as you see fit if you experience a covered event and meet the policy and certificate requirements. Typically, a flat amount is paid for hospital admission, and a per-day amount is paid for each day of a covered hospital stay, from the very first day of your stay. This payment can help you focus more on getting back on track and less on the extra expenses an accident or illness may bring.

ENROLLING IN THE METLIFE HIP

To enroll, call 1-800-438-6388. Please see plan certificate for inpatient hospital exclusions at www.pcsb.org/risk-benefits, "MetLife Voluntary Plans" Link.

INCOME TAX CONSIDERATIONS FOR HIP

When you enrol in the MetLife Hospital Indemnity Plan, your payroll deductions are automatically deducted on a pre-tax basis. Therefore, any payments you receive will be subject to federal income taxes, unless you submit a request in writing to Risk Management to change you deduction from pre-tax to after-tax. When your payroll deductions are deducted on a post-tax basis, you will not have to pay federal income tax on any HIP benefit payment you may receive.

BENEFITS	BENEFIT AMOUNT
Hospital Admission Benefit	$500
Hospital Confinement Benefit	$250 per day, up to 30 days
Inpatient Rehabilitation Benefit	$100 per day, up to 15 days per covered person, per accident but not to exceed 30 days per calendar year.

Pre-existing conditions limitations apply. Benefits will not be payable for pre-existing conditions for which, in 12 months before an insured becomes covered they received medical advice, treatment, or care from a physician; or the covered person had symptoms, or any medical or physical conditions that would cause an ordinarily prudent person to seek diagnosis, care, or treatment. If you are concerned about a pre-existing condition, please call MetLife at 800-438-6388 to understand how this may or may not affect you. Benefits reduced 25% for ages 65 to 69. Benefits reduced 50% for age 70+. Please see plan certificate for inpatient hospital exclusions at pcsb.org/risk-benefits, "MetLife Voluntary Plans" link

THE BE SMART WELLNESS PROGRAM

Wellness programs change lives.

That's why Pinellas County Schools supports the Be SMART Wellness Program. In addition to providing employees and their family members opportunities to make positive behavior changes, our wellness program also boosts morale, improves quality of life, increases productivity and job performance, and saves money from reduced health claims, turnover, absenteeism/substitute pay, disability, and workers compensation costs. The end result…higher student achievement when employees are present, happy, and healthy! Your participation in the PCS Be SMART program is critical to the District's vision of 100% student success.

The Be SMART worksite wellness program has something for everyone, including programs described here and online at www.pcsb.org/wellness.

Wellness Champion On-site Program—Classes on fitness, nutrition, stress, and more offered at your worksite by your Wellness Champion. Programs are planned according to the results on the employee interest survey.

Employee Assistance Program—Free, confidential 24-hour assistance with depression, finances, substance abuse, conflicts, stress, parenting, and other personal concerns. Services for legal and financial concerns are also available. Call 800-848-9392 or visit resourcesforliving.com (username: pcsb | password: eap).

SMART Start Newsletter—Your resource for keeping up-to-date with the wellness program and what we offer, plus recipes, articles, insurance information, and more. Emailed District-wide every month during the school year.

Diabetes CARE Program—Diabetics who are enrolled and up-to-date on the Diabetes CARE checklist receive waived co-pays on supplies. Available to you and anyone on your health plan.

Telephonic or Online Health Coaching—Work with a health coach to help you set goals and explore ways to increase activity, improve eating habits, reduce stress, improve back care, or stop smoking. Free to you and anyone on your health plan.
Aetna In-Touch Care: 877-243-2752

Aetna On-site Health & Wellness Advocate—Speak to an Aetna on-site representative at 727-588-6134 about ongoing wellness programs, including: incentive programs, free diabetic supplies, and quit tobacco resources.

Corporate Fitness & Weight Loss Discounts—Discounts available to any PCS employee.

For more information on wellness programs available to PCS employees, visit www.pcsb.org/wellness or contact 727-588-6031.

RESOURCES FOR EMOTIONAL WELLBEING SUPPORT

Resources *for* Living®

The Employee Assistance Program (EAP) provides short-term problem resolution to help you deal with life challenges. Your member website offers a full range of tools and resources to help with emotional well-being and work/life balance. We're always here to help with a wide range of issues, including:

- Emotional well-being support, daily life assistance, online resources, legal services, financial services and more!

Resources for Living (RFL) is an employer sponsored program, available at no cost to you, family members living in your household, and dependent children up to age 26, no matter where they live. Services are confidential and available 24 hours a day, seven days a week. You are eligible for up to eight counseling sessions per issue. You can call 24 hours a day for in-the-moment emotional well-being support. Counseling sessions are available face to face or online with televideo. Services are free and confidential.
To access EAP services, call 1-800-848-9392 or visit resourcesforliving.com (username: pcs, password: eap)

talkspace

Talkspace is an online therapy platform that makes it easy and convenient for you to connect with a licensed behavioral therapist—from anywhere, at any time. With Talkspace, you can send text, video and audio messages to your dedicated therapist via web browser or the Talkspace mobile app. No commutes, appointments or scheduling hassles. Available at no cost to all PCS employees. Subject to the EAP benefit of up to 8 sessions per issue. 1 week of chat therapy qualifies as 1 of the 8 sessions.
Visit pcsb.org/eap for more information on how to use and access Talkspace.

aetna®

Aetna Behavioral Health Plan benefits are provided to all members with the Aetna medical insurance through PCS. Receive face to face sessions with a psychologist, psychiatrist or licensed mental health counselor, all able to treat more complex mental health issues or long-term program resolution. Cost is subject to Aetna Member's plan selection.
Visit aetnapcsb.com for additional information.

Health HUB™

CVS Health Hubs provide medical and behavioral health services on-site or telephonically. Check your HealthHUB to verify they have a therapist on staff. Cost is subject to Aetna Member's plan selection. Aetna members may also utilize their EAP benefit for behavioral health visits. Prior authorization from EAP is required.
Visit cvs.com/healthhub or contact the Aetna Concierge Customer Service at 866-253-0599 for additional information.

TELADOC®

Teladoc is Aetna's telemedicine provider for both medical and behavioral health benefits. Teladoc provides access 24 hours a day, 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. Aetna members also have access to Teladoc Behavioral Health. Employees and eligible dependents (age 18 or older) may have appointments with psychiatrists, psychologists, and licensed therapists by video.
Visit www.teladoc.com/aetna and click "set up account" or, download the mobile app available in your phone's app store, or call 855-835-2362 for additional information.

LIMEADE

Limeade is a physical, emotional and financial well-being program for Pinellas County School employees enrolled in the health plan and their dependent spouses!

Whether you're at work or at home, we want you to be your best self. That's why we do everything we can to help your family thrive—physically, financially, and emotionally.

The Limeade engagement portal offers a number of activities to ensure no matter where you are on your well-being journey, you will have the support you need to achieve your goals.

Employees with medical insurance coverage through Pinellas County Schools and their dependent spouses can engage in activities and earn points towards rewards by:

PHYSICAL	EMOTIONAL	FINANCIAL
Completing your annual wellness preventative exam and tests. Syncing your fitness device to track steps. Learn new recipes based on your needs through FoodSmart.	Finding new approached to decrease stress. Learning techniques to help build and maintain relationships.	Learning about building and committing to a budget. Contributing to your retirement plan. Finding supermarket deals for your recipes with FoodSmart.

As you interact with activities designed to build positive habits, you will earn points. The points accumulate towards levels. When you reach a new level, you earn a Tango gift card. Tango gift cards have a wide variety of retail locations where you can redeem them, including Amazon, Walmart, Target, Starbucks and more!

foodsmart

Through Limeade, participants have access to Foodsmart. Foodsmart is a nutrition program where participants can create meal plans, download shopping lists, and find supermarket deals. Foodsmart takes the guesswork out of healthy eating through a digital nutrition solution that offers personalized meal recommendations. Foodsmart is available through the Limeade ONE app or pcsb.limeade.com website.

MORE INFORMATION? Visit www.pcsb.org/limeade

QUESTIONS? Call the Limeade Customer Support Team at 888-984-3638

LOG ON TODAY. Pcsb.limeade.com or download the Limeade ONE app.

DENTAL BENEFITS

PCS offers two dental plans, the HumanaDental Advantage Plus 2S Plan and the MetLife Preferred Dentist Program. The chart below compares the plan benefits. All services are subject to plan limits, exclusions and other provisions. A complete description of the plan can be found on the Certificate of Coverage.

	HUMANA DENTAL (#548085) 800-979-4760 | WWW.MYHUMANA.COM	METLIFE PREFERRED DENTAL PROGRAM (#95682) 1-800-GET-MET8 | WWW.METLIFE.COM/DENTAL
	State of Florida Service Area. In-network only. This is an Open Access Dental HMO.	In or out-of-network. Save the most when you choose a participating In-network provider.
Network	Humana Dental Advantage Plus 2S Plan	MetLife Preferred Dentist Program (PDP Plus)
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
Preventative Services	No charge	No charge, no deductible (Type A)
Basic Services	No charge	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

HUMANA DENTAL ADVANTAGE PLUS 2S PLAN HIGHLIGHTS

The HumanaDental Advantage Plus 2S Plan combines the best features of a dental health maintenance organization with the preferred benefits of traditional dental coverage.

- You may select any dentist or specialist from the Humana Advantage Plus 2S network, and you may change your selection at any time.
- You may choose a different dentist for each covered family member.
- There are no office visit charges, claim forms, deductibles, or annual maximums.
- Covered services are listed on the Schedule of Benefits and have designated co-payments; you receive a 20% discount on other services (not listed on the schedule).
- The plan provides adult and child orthodontia benefits.

METLIFE PREFERRED DENTIST PROGRAM PLAN HIGHLIGHTS

The MetLife Preferred Dentist Program (PDP) operates like a preferred provider organization (PPO). You can choose to visit any dentist, although you can reduce your out-of-pocket expenses by visiting a dentist in the MetLife network.

- You may visit the dentist of your choice, no primary dentist selection requirement and no specialist referrals.
- Reduced out-of-pocket expenses on covered services and on services not covered by your benefit plan when you use a participating PDP dentist.
- Coverage provided for most preventive and routine services.
- Choice of over 100,000 participating PDP dentists who agree to accept our negotiated fees as payment in full.
- A $1,000 maximum orthodontic benefit for dependent children under age 19.

MetLife does not issue ID cards. The Group Number is G95682. For more information, visit metlife.com/dental or call 800-942-0854.

The service categories shown above represent an overview of your Plan of Benefits but are not a complete description of the plan. An insurance certificate describing all benefits and limitations will be made available following your plan's effective date, and will govern if any discrepancies exist between this overview and the certificate of insurance and group insurance policy.

VISION PLAN

EYEMED ADVANTAGE PLAN (GROUP #9856857)

Periodic eye examinations are an important part of routine preventive health care. Because many eye and vision conditions have no obvious symptoms, employees may be unaware they have problems. Early detection and treatment is critical for maintaining good vision and preventing permanent vision loss. Eye exams can detect symptoms for diseases such as diabetes, hypertension, glaucoma, cataracts, and macular degeneration. This is why Pinellas County Schools offers quality vision care for you and your family through the EyeMed Vision Care Plan.

WHO IS ELIGIBLE?

All employees who meet the eligibility criteria listed on page 6 are eligible for vision coverage. During your initial enrollment period as a new employee, you can enroll in free employee-only vision coverage. You can enroll your eligible dependents and pay the additional cost for their coverage. Or, if you decline medical coverage and enroll yourself and your dependents in vision coverage, you can offset the cost of dependent vision coverage with Board credits. Eligible dependents include your spouse and/or your eligible children through the end of the year in which they reach age 26.

All services are subject to plan limits, exclusions and other provisions. Below is an overview of your plan benefits, a complete description of the plan can be found on the Certificate of Coverage.

SERVICE	WHEN YOU USE PARTICIPATING IN-NETWORK PROVIDERS	WHEN YOU VISIT A NONPARTICIPATING PROVIDER
Vision Exam	Once per calendar year	Once per calendar year
Eyeglasses or Contact Lenses	Once per calendar year	Once per calendar year
Frames	Every other calendar year	Every other calendar year
Exam with Dilation	$10 co-pay	Up to $35
Eyeglass Lenses		
Single vision	$15 co-pay	Up to $35
Bifocal	$15 co-pay	Up to $40
Trifocal	$15 co-pay	Up to $60
Standard Progressive	$50 co-pay	N/A
Frames	$110 allowance (20% off the balance over $110)	Up to $55
Contact Lenses		
Conventional	$110 allowance (15% off the balance over $110)	$90
Disposable	$110 allowance (full amount over $110)	$90
Medically Necessary	Paid in full	$210

LASIK

As an EyeMed member, you are eligible for a 15% discount off of retail prices of 5% off of promotional prices for LASIK or PRK from the U.S. Laser Network owned and operated by LCS Vision.

ADDITIONAL PLAN COSTS AND DISCOUNTS

Lens options are available at discounted rate. Following are a few options available at participating network providers.

UV & Scratch Resistant Coating, $12
Antireflective Coating, $10
Polycarbonate, $30
Transitions, $50

QUESTIONS?

Call EyeMed Vision Care Customer Service, **866-299-1358,**
Monday—Saturday 7:30 a.m.—11:00 p.m. ET, Sunday 11:00 a.m.—8:00 p.m. ET

Visit **www.eyemed.com** to view benefits, check claims, and access other services.

FLEXIBLE SPENDING ACCOUNT (FSA) — PAYFLEX

INCREASE YOUR TAKE-HOME PAY WITH FLEXIBLE SPENDING ACCOUNTS

Would you like to save money this year? You can when you enroll in the Healthcare FSA and/or the Dependent Care FSA. Flexible spending accounts (FSAs) allow you to pay for certain eligible expenses with tax-free dollars. To manage your FSAs online and view the most up-to-date information about your account, log in to www.aetnapcsb.com.

KEEP MORE MONEY IN YOUR POCKET

- Pay no federal income tax or Social Security tax on your FSA payroll deductions
- Increase your take-home pay by reducing your taxable income.
- Pay dependent health care expenses through the Healthcare FSA, even if you enroll in employee only health plan coverage.*
- Employees must be actively at work to enroll.
- When your benefits are effective, you can get more information and check your FSA balances at www.payflex.com.

*Expenses for domestic partners and/or grandchildren are not FSA-eligible.

MAKE YOUR FSA WORK FOR YOU

Estimate Your Expenses—Take the time to estimate your health care and/or dependent care needs for the year. Use the Healthcare FSA and Dependent Care FSA planners at www.payflex.com.

- Estimate carefully! The IRS "use it or lose it" rule state that any FSA balance not used by the end of the plan year must be forfeited. You have 90 days after the end of the plan year, or date of termination, whichever is earlier, to submit receipts for reimbursement of services received during the plan year or employment period.
- Healthcare Flexible Spending Accounts may only be dropped or decreased due to these qualifying events: death, divorce, or unpaid leave of absence.

Decide How Much to Contribute—Deposit any whole dollar amount (minimum $10 per paycheck) in pre-tax dollars into your Healthcare Flexible Spending Account (FSA), up to a maximum of $2,700 per calendar year for your Healthcare FSA and up to $5,000 per calendar year for your Dependent Care FSA ($2,500 if married and filing separately). If you do not enroll in a medical plan, you can enroll in a Healthcare FSA and authorize from $10 to $25 of your Board Contribution Credits to be deposited in your account each payday.

HOW TO ELECT AFTER TAX DEDUCTIONS

Current employees can elect after-tax deductions by submitting a written request to the Risk Management and Insurance Department during Annual Enrollment or within 31 days of a change in status event.

New employees can elect after-tax deductions by submitting a written request to the Risk Management and Insurance Department within 31 days of hire.

SAVE YOUR RECEIPTS FOR THE FSA AND HRA—The IRS requires that all payments made from FSAs and HRAs be substantiated and 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.

FLEXIBLE SPENDING ACCOUNT (FSA) — PAYFLEX

ACCESSING YOUR FSA FUNDS

Get reimbursed from your account for eligible expenses.

HEALTHCARE FSA

- Your Healthcare FSA full annual amount is available on the effective date of your benefits, allowing you to use your money immediately while your contributions are deducted each pay.
- When you enroll in a Healthcare FSA, you will receive the PayFlex debit card loaded with an amount equal to your annual election (Note: you may be required to submit receipts to support the eligibility of your debit card purchases)
- Use your PayFlex debit card to pay for eligible medical, dental, and vision deductibles, coinsurance, and co-pays including prescription drug co-pays. You may be required to submit receipts to support the eligibility of your debit card purchases. You cannot use your card to pay prior year expenses (i.e., you go to the doctor on January 5, 2022 and have a balance from a December 2021 visit. You cannot use your PayFlex debit card to pay the December 2021 expense).
- See IRS Publication 502 for a list of eligible expenses.

DEPENDENT CARE FSA

- Your Dependent Care FSA funds cannot be used until they have been deducted from your paycheck and deposited into your account. Please take this into account as your budget your dependent care expenses.
- Get reimbursed from your account for **eligible dependent day care expenses** for your children or elderly parents so you (and your spouse) can work.
- You will have to file manual claims for Dependent Care FSA reimbursements—you cannot use the debit card to pay dependent day expenses.
- Eligible expenses must be incurred in the plan (calendar) year or through the end of the month in which you terminate employment. Any amount remaining in your account after eligible claims have been processed will be forfeited.
- See IRS publication 503 for a list of eligible expenses.

ATTENTION CDHP MEMBERS

Enrolled in the CDHP+HRA and a Healthcare FSA?

If you are enrolled in the CDHP with a Health Reimbursement Account (HRA) and a Healthcare FSA, you will receive two PayFlex debit cards—one for your HRA and one for your Healthcare FSA.

Because FSAs are subject to the "use it or lose it" rule, you may want to use the money in your Healthcare FSA first to avoid losing any money in your FSA at the end of the plan year.

PayFlex Contact Information—888-678-8242

PayFlex Mobile App—available in your phone's app store. Manage your account and view alerts. Snap a photo of your receipts to submit claims. View eligible expense items, and more.

LIFE INSURANCE—THE STANDARD

While no amount of income can compensate for the death of a family member, it is comforting to know that survivors are able to meet family financial obligations through a sound life insurance program.

Life insurance coverage is issued by The Standard. The following information is designed to be a summary. Please view the Certificate of Coverage which includes the entire plan provisions, exclusions, and limitations.

Your BENEFlex life insurance program includes:

- Basic Employee Term Life
- Optional Employee Term Life
- Optional Dependent Term Life (Spouse)
- Optional Dependent Term Life (Child[ren])
- Optional Family Term Life

Pinellas County Schools provides Basic Employee Life insurance coverage—through Standard Insurance Company—of one times your annual base salary, rounded up to the next $1,000, with minimum coverage of $15,000. Optional Term Life coverage provides options of up to $500,000 for you and $100,000 for your spouse.

LIFE INSURANCE—EMPLOYEE	
Covers	Employee
Amount of Coverage[1]	**Basic Employee Term Life:** One times your annual base salary, rounded up to the next $1,000 with a minimum benefit of $15,000 and maximum benefit of $200,000 **Optional Employee Term Life:** $10,000 minimum, up to $200,000 in $10,000 increments, or $250,000 up to $500,000 maximum in $50,000 increments (guaranteed coverage available up to $100,000, if you enroll within 31 days of becoming eligible)
Cost	**Basic Employee Term Life:** None **Optional Employee Term Life:** Age based, premiums are based on your age as of January 1
Actively at Work	Yes
Medical Evidence	**Basic Employee Term Life:** Health questions not required. **Optional Employee Term Life:** Medical history questionnaire required; new hires may select up to $100,000 with no questions during the initial new hire enrollment period only

EMPLOYEE TERM LIFE INSURANCE

REDUCTION/TERMINATION OF COVERAGE

At age 70, your coverage will be reduced to 65% of your amount before age 70. At age 75, your coverage will be reduced to 45% of your amount before age 70. At age 80, your coverage will be reduced to 30% of your amount before age 70. This coverage will end on termination of employment, but you may convert to an individual life insurance policy through The Standard.

IMPUTED INCOME

Federal regulations require payment of income and Social Security taxes on the value of your total life insurance (basic plus optional coverage you purchase) in excess of $50,000. This value is known as "imputed income." To determine the value of your total insurance coverage that is more than $50,000, the IRS uses a table that is based in part on your age. As you get older, the value of your life insurance increases.

Beneficiaries must be listed on the Enrollment and Change form and may be changed at any time by submitting a new Enrollment and Change form online.

1 Amounts of employer-provided insurance in excess of $50,000 are subject to taxation under Section 79 of the Internal Revenue Code. The tax is based on the value of the coverage as determined by rates established in the Internal Revenue Code.

LIFE INSURANCE—THE STANDARD

LIFE INSURANCE—DEPENDENTS	
Optional Family Term Life	
Covers	Spouse and eligible children
Amount of Coverage	$5,000/dependent
Cost	See rate schedule, page 5
Board Contribution	You may **not** use
Actively at Work	Yes
Medical Evidence	No health questions required

LIFE INSURANCE—DEPENDENTS	
Optional Dependent Term Life (Spouse and/or Children)	
Covers	Spouse[2] and/or unmarried child(ren)
Amount of Coverage	**Spouse:** $10,000 increments up to the $100,000 maximum.* **Child(ren):** $2,000 increments up to the $10,000 maximum
Cost	See rate schedule, page 5; premiums for spouse coverage are based on the individual's age as of January 1
Board Contribution	You may **not** use
Actively at Work	Yes
Medical Evidence	**Spouse:** Medical history questionnaire required **Child(ren):** No health questions required

LIFE INSURANCE FOR YOUR DEPENDENTS—ELIGIBILITY TO PARTICIPATE

OPTIONAL FAMILY TERM LIFE

You do not need to be enrolled in Optional Employee Term Life for your spouse and dependent children to enroll in Optional Family Term life. Optional Family Term Life is a package plan that covers all dependents for one premium amount.

You may enroll your spouse and dependent children for coverage in the amount of $5,000 for each dependent. Optional Family Term Life coverage has one premium rate that covers your spouse and/or all eligible children.

Coverage amounts for spouse and child(ren) are guaranteed and not subject to evidence of good health. In addition, you may only enroll your eligible dependents in this plan during Annual Enrollment or within 31 days of a qualifying life event.

OPTIONAL DEPENDENT TERM LIFE (SPOUSE AND/OR CHILD)

You may enroll your spouse in Optional Dependent Term Life, regardless of your enrollment status in Optional Employee Term Life. You may elect this option for your spouse, your children, or both spouse and children.

You may enroll your spouse for coverage in increments of $10,000 up to a maximum of $100,000.* You may enroll your dependent children for coverage in increments of $2,000, up to a maximum of $10,000. Optional Dependent Term Life coverage has one premium rate that covers all eligible children.

Beneficiaries must be listed on the Enrollment and Change form and may be changed at any time by submitting a new Enrollment and Change form online.
2 Optional spouse coverage may be written without employee enrollment. * Total amount of spouse coverage cannot exceed the employee's total life insurance coverage (basic plus any optional employee life).

Life Insurance Certificate of Coverage Insured by The Standard Insurance Company

This is designed to be a summary only, the Certificate of Coverage, which includes the entire plan provisions, exclusions, and limitations, is available on the Risk Management and Insurance Department website (www.pcsb.org/certificates) or by contacting the Risk Management and Insurance Department directly. Policy #755556. Basic Employee Term Life, Basic AD&D, Optional Employee Term Life, Optional Dependent Term Life, and Optional AD&D coverages are underwritten by Standard Insurance Company. This section is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. If there is a discrepancy between this document and the Group Contract/Booklet-Certificate issued by Standard Insurance Company, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series 83500.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE — THE STANDARD

Accidental Death and Dismemberment coverage is issued by The Standard. The following information is designed to be a summary. Please view the Certificate of Coverage which includes the entire plan provisions, exclusions, and limitations.

Each year, more than 95,000 Americans lose their lives to accidents, the fourth leading cause of death in this country. For workers under age 38—when they are at their peak earning years for establishing a comfortable standard of living—accidents are the leading cause of death. Even if you are extremely careful and safety-conscious—on the job, on the road, at home, or on vacation—you cannot always control the circumstances that could place you in danger of an accident. Furthermore, it is very difficult to evaluate in advance the extent to which an accident could affect your family's financial security.

The Accidental Death & Dismemberment (AD&D) Plan may help you and your family deal with some of the financial consequences of an accident.

Your AD&D insurance includes:

- **Basic Employee AD&D of $2,000**
- **Optional AD&D for you, or you and your family**

BASIC EMPLOYEE AD&D	
Covers	Employee
Amount of Coverage	$2,000
Cost	None
OPTIONAL AD&D—EMPLOYEE ONLY	
Covers	Employee
Amount of Coverage	$50,000, $100,000, $200,000, or $300,000
Cost	See rate chart on page 4

OPTIONAL AD&D—EMPLOYEE AND FAMILY	
Covers	Employee and Family
Amount of Coverage	**Employee:** $50,000, $100,000, $200,000, or $300,000 **Spouse only:** 50% of employee's coverage **Child(ren) only:** 15% of employee's coverage **Spouse and Child(ren):** 40% and 10%, respectively, of employee's coverage
Cost	See rate chart on page 4
Board Contribution	You may use

IS YOUR SPOUSE ALSO A PCS EMPLOYEE, OR A PCS RETIREE?

For Life and AD&D Insurance:

- He or she cannot be covered as a dependent
- Only one of you can cover your eligible dependents

REDUCTION/TERMINATION OF COVERAGE

At age 70, your coverage will be reduced to 65% of your amount before age 70. At age 75, coverage will be reduced to 45% of your amount before age 70. At age 80, your coverage will be reduced to 30% of your amount before age 70. This coverage will end on your termination of employment or retirement. Spouse coverage will terminate at age 70.

Policy #755556. Basic Employee Term Life, Basic AD&D, Optional Employee Term Life, Optional Dependent Term Life, and Optional AD&D coverages are underwritten by Standard Insurance Company. This section is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. If there is a discrepancy between this document and the Group Contract/Booklet-Certificate issued by Standard Insurance Company, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series 83500.

DISABILITY INSURANCE—THE STANDARD

What would you do if illness or injury kept you out of work for a long time without pay? Disability insurance provides replacement income to help pay your bills. The disability plan allows you to choose a monthly benefit, a benefit duration, and a waiting period.

Disability insurance coverage is issued by The Standard. The following information is designed to be a summary. Please view the Certificate of Coverage which includes the entire plan provisions, exclusions, and limitations, call The Standard at 800-325-5757, or email Christine.D'Angelo@standard.com for questions or more information.

MONTHLY BENEFIT	BENEFIT DURATION
Choose a preferred monthly benefit amount between $400 and $5,000 (to up to $66^{2/3}$% of your salary)	Choose a benefit duration: Two years OR up to the Social Security Normal Retirement Age (SSNRA)
WAITING PERIOD	
Choose 14, 30, or 60 days until the plan starts paying benefits (14- and 30-day waiting periods are waived with hospital admission)	

PLAN HIGHLIGHTS

- Evidence of Insurability (EOI) is not required. You do not have to fill out a medical questionnaire to be approved.
- Pre-existing conditions will apply. Please refer to "Pre-existing Condition Limitation" section.
- If a claim is submitted in the first 12 months of the policy effective date, a minimum benefit of $400 will be paid for the first 90 days after the waiting period. A review will be conducted to determine if the claim is subject to pre-existing conditions. If the claim is determined to be a pre-existing condition, then benefits will stop after the 90-day payment. If not, and there is no pre-existing condition, then benefits will continue based on the disability amount you selected, and any retro payment owed by The Standard will also be paid.
- First Day Hospital Benefit on 14- and 30-day plans. If you have a claim for a hospital admission/confinement, the 14- and 30-day waiting period will be waived.
- Lifetime Security Benefit. This only applies to the benefit duration of up to SSRNA. Your disability benefit (amount in effect when the claim closes) could continue beyond your Social Security normal retirement age if you are unable to perform two or more activities of daily living or are suffering from severe cognitive impairment.
- Disability coverage will end on the date your employment terminates.

ELIGIBILITY

All Pinellas County Schools and Pinellas County Education Foundation employees who work 30 hours or more each week (includes job-sharing employees) and who are actively working full time on the date of enrollment are eligible to apply.

To become insured, you must satisfy the eligibility requirements, serve an eligibility waiting period, and be actively at work (able to perform all duties of your job) on the day before the scheduled effective date of insurance. If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

PRE-EXISTING CONDITION LIMITATION

Benefits will be limited at any time for a period of disability occurring in the first 12 months that your insurance or an increased benefit amount is in effect, if that disability was caused or contributed by an accidental injury or sickness, including pregnancy, for which you did any of the following in the six months before your insurance became effective:

- Received medical treatment
- Took prescribed drugs
- Consulted a doctor

Note: For new enrollees, The Standard will pay $400 per month in benefits even if you have a condition subject to the preexisting condition limitation for the first 90 days of disability. After 90 days, The Standard will continue benefits only for conditions for which the preexisting condition exclusion or limitation does not apply. Benefit amounts subject to the preexisting condition exclusion will be excluded from payment.

DISABILITY INSURANCE—THE STANDARD

PLAN BENEFITS

Plan Maximum Monthly Benefit—The lesser of $5,000 or 66$^{2/3}$% of your pre-disability earnings.

Plan Minimum Monthly Benefit—The greater of $100 or 25% of your disability benefit before reduction by deductible income.

Benefit Waiting Period—The benefit waiting period is the period of time that you must be continuously disabled before benefits become payable. Benefits are not payable during the benefit waiting period. The benefit waiting period options associated with your plan include:

ACCIDENTAL INJURY	OTHER DISABILITIES
14 days	14 days
30 days	30 days
60 days	60 days

Plan Schedule of Benefits—You may select one of the benefit levels outlined below, provided the monthly disability benefit does not exceed 66$^{2/3}$% of your regular monthly salary.*

IF YOUR ANNUAL SALARY IS AT LEAST	YOU ARE ELIGIBLE FOR A MAXIMUM DISABILITY BENEFIT
$7,200	$400
$10,800	$600
$14,400	$800
$18,000	$1,000
$21,600	$1,200
$25,200	$1,400
$28,800	$1,600
$32,400	$1,800
$37,800	$2,100
$43,200	$2,400
$48,600	$2,700
$54,000	$3,000
$63,000	$3,500
$72,000	$4,000
$81,000	$4,500
$90,000	$5,000

*Your monthly benefit may be reduced by other income benefits and disability earnings.

Own Occupation—For the benefit waiting period and the first 24+ months for which disability benefits are paid, you are considered disabled when you are unable as a result of physical disease, injury, pregnancy, or mental disorder to perform with reasonable continuity the material duties of your own occupation AND are suffering a loss of at least 20% of your indexed pre-disability earnings when working in your own occupation.

Any Occupation—After the own occupation period of disability, you will be considered disabled if you are unable as a result of physical disease, injury, pregnancy, or mental disorder to perform with reasonable continuity the material duties of any occupation.

MAXIMUM BENEFIT DURATION PERIOD

You may choose a maximum benefit period of either two years or to Social Security Normal Retirement Age (SSNRA). The maximum periods for which benefits are payable are shown below.

OPTION 1: TWO YEARS

If you become disabled before age 66, disability benefits may continue during disability for two years. If you become disabled at age 66 or older, the benefit duration is determined by your age when disability begins:

Age	Maximum Benefit Period
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

OPTION 2: SSNRA

If you become disabled before age 62, disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or three years and six months, whichever is longer. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

DISABILITY INSURANCE—THE STANDARD

ADDITIONAL PLAN FEATURES

24 Hour Coverage—24-hour disability coverage for disabilities occurring on or off the job.

Waiver of Premium—waiver of premium will begin on the first day of the month following 90 days of disability.

Survivors Benefit—if you die while disability benefits are payable, and on the date you die you have been continuously disabled for at least 180 days, a survivors benefit equal to three times your unreduced disability benefit may be payable (any survivors benefit payable will first be applied to any overpayment of your claim due to The Standard).

First Day Hospital Benefit—If you are hospital confined* for at least four hours during the benefit waiting period, the following applies: the remained of your waiting period will be waived, disability benefits become payable on the first day you are hospital confined, and your maximum benefit period will begin on the date your disability benefits are payable.

*Hospital confined means you are admitted to a hospital as an inpatient, and for which you are charged for room ad board. You are eligible for this benefit only if you elected a benefit waiting period of 14 or 30 days.

WHEN BENEFITS END

LTD Benefits end automatically on the earliest of:

- The date your employment ends
- The date you are no longer disabled
- The date your maximum benefit period ends
- The date you die
- The date benefits become payable under any other disability insurance plan under which you become insured through employment during a period of temporary recovery
- The date you failed to provide proof of continued disability and entitlement to benefits

EXCLUSIONS

Subject to state variations, you are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot
- An intentionally self-inflicted injury
- War or any act of war
- The loss of your professional or occupational license or certification
- If applicable, with respect to insurance increases, a decrease in the benefit waiting period and/or an increase in the maximum benefit period, you are not covered for the insurance enhancement if your disability is caused or contributed by a preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date you become disabled, you have been continuously insured under the elected plan selection for the specified exclusion and limitation period, and you have been actively at work for at least one full day after the end of the specified exclusion and limitation period Preexisting Condition Provision.

PREEXISTING CONDITIONS

A preexisting condition is a mental or physical condition:

- For which you would have consulted a physician or other licensed medical professional; received medical treatment, services or advice; undergone diagnostic procedures, including self-administered procedures; or taken prescribed drugs or medications
- Which, as a result of any medical examination, including routine examination, was discovered or suspected

DISABILITY BENEFITS DURING PREGNANCY

The plan provides coverage for a disability period up to six weeks postpartum for an uncomplicated pregnancy, and up to eight weeks postpartum for a cesarean delivery, providing that certification of disability is submitted by the attending physician. Benefits are subject to a waiting/elimination period. A pregnancy that began prior to the effective date of the plan will be considered preexisting.

VOLUNTARY BENEFITS

Welcome to a benefit program that can help make getting coverage you need easier and more convenient through a variety of voluntary services and insurance products. Pinellas County Schools is please to continue offering the following employee benefits:

FARMERS INSURANCE™ AUTO & HOME

With the Farmers Insurance Auto & Home* program, you have access to quality auto and home insurance, as well as a full range of other personal insurance policies, including renters, condo, boat, and personal excess liability (also referred to as "umbrella" coverage). You can also save with our special discounts, including a group discount, and other money-saving discounts, if you pay your premium through automatic payroll deductions. The Farmers Auto & Home program also offers 24-hour claim reporting, extended customer service hours, and flexible payment options. The program is available to PCS employees and their dependents. **You may apply for coverage at any time.** Visit www.myautohome.farmers.com for more information.

*Subject to underwriting approval. Some areas of Florida may not be eligible for home insurance.

METLIFE LEGAL PLAN

With MetLife Legal Plan, you'll have easy access to a nation wide network of participating attorneys who can provide you with a wide range of legal services—for a fraction of the regular cost. No matter how many times you use a participating attorney over the course of the year for covered legal matters, all you pay is your monthly premium, no co-payments and no deductibles. Just pay your legal plan premium, which can be conveniently deducted from your paycheck. Your spouse and dependent children also have access to the plan benefits. Some pre-existing exclusion may apply. For complete details of the coverage and more information, go to https://info.legalplans.com and use the access code PCS. You may enroll in coverage as a new hire or during annual enrollment.

METLIFE PET INSURANCE (PET FIRST)

Help make sure your furry family members are protected in case of an accident or illness with pet insurance offered by MetLife.* With their deep understanding of pet owners' needs, they have designed a plan that better services those needs—providing enhance coverage that is simple and easy to use. Pet insurance can help you manage the high cost of veterinary services for your pet. Go to www.metlife.com/mybenefits for further information. Pet insurance may not cover pre-existing conditions. You may apply for coverage at any time.

*Independence American Insurance Company ("IAIC") is the insurance carrier for this product. PetFirst Healthcare, LLC, a MetLife company, is the policy administrator authorized to offer and administer pet insurance policies. Independence American Insurance Company, a Delaware insurance company, is headquartered at 485 Madison Avenue, NY, NY 10022. For costs, complete details of coverage and exclusions, and a listing of approved states, please contact PetFirst Healthcare, LLC. Like most insurance policies, insurance policies issued by IAIC contain certain exclusions, exceptions, reductions, limitations, and terms for keeping them in force.

ENROLLING IN METLIFE VOLUNTARY PLANS

You may enroll for MetLife Pet Insurance at any time. You must enroll in the MetLife Legal Plan during annual enrollment. For more information, or to enroll in any of the MetLife voluntary plans (except for MetLife HIP) call the toll-free number 800-438-6388 or visit the MetLife website at www.metlife.com/mybenefits. Note that rates are only provided when you call to enroll in or renew your policy.

HORACE MANN AUTO PAYROLL DEDUCTION PLAN

Horace Mann and PCS have teamed up to provide you with the convenience of paying your auto insurance premiums through payroll deductions. When you purchase your auto insurance from Horace Mann you get the advantage of 12-month policy terms and easy payroll deductions. Advantages include:

- 12-month policy terms and no bills to pay—your premiums are deducted from each paycheck.*
- Discounted coverage
- Educator Advantage® benefits and features at no additional cost
- Customer services available 24/7, 365 days a year, and online claims service. Licensed agents available 24/7 at three local offices.

For more information call 813-600-3268 or 727-576-5555. Visit www.floridaeducatorsinsurance.com for a free quote.

**20 paychecks per year—no summer deductions.*

VOLUNTARY RETIREMENT PROGRAMS
PRE-TAX AND AFTER-TAX OPTIONS

Putting money aside for your retirement years should be an important part of your personal financial plan. The Pinellas County Schools Voluntary Retirement Program gives you three practical, convenient ways to save for retirement: two pre-tax options (a traditional 403(b) and a 457(b) plan), and an after-tax option (a Roth 403(b)).

HOW THE PLANS WORK

Pre-Tax Traditional 403(b) and 457(b) Plans

Contributions made to traditional 403(b) and 457(b) accounts are taken from your paycheck on a pre-tax basis and are considered a salary reduction. As a result, your taxable income is reduced for every contribution you make. Any earnings on your deposits are tax-deferred until withdrawn, usually during retirement. Withdrawals from traditional 403(b) accounts are taxed during the year of the withdrawal at your applicable income tax rate for that year.

After-Tax Roth 403(b) Plan

Contributions made to a Roth 403(b) account are taken from your paycheck on an after-tax basis. Your taxable income is not reduced by contributions you make to your account. Any earnings on your contributions are not taxed as long as they remain in your account for five years from the date your first Roth contribution was made and you have a qualifying distributable event. All qualified distributions from Roth 403(b) accounts are tax-free.

Maximum Allowable Contributions

You can participate in one, two, or all three of the plans. However, federal regulations limit the amount you can defer during a calendar year. These limits are determined by Maximum Allowable Contribution (MAC) calculations. The MAC is calculated on a calendar year basis from January 1 through December 31. The limit for 2021 is $19,500. The 2022 limits were not available at the time this guide was printed. (If you turn age 50 or older during the year, you can contribute an additional $6,500 for a total of $26,000.) **You are responsible for making sure that the amount deferred each year does not exceed IRS limits.** MAC calculation estimates and retirement benefit handbooks are available online during the first quarter of each calendar year to help you determine the amount of your annual retirement account contribution.

403(B) AND 457(B)
DISTRIBUTION TRANSACTIONS

Distribution transactions may include any of the following: loans, rollovers, exchanged, hardships, or other normal distributions. You may request these distributions by completing the necessary forms obtained from your provider and TSA Consulting Group, Inc. (TSACG) as required. All completed provider forms, accompanied by the Transaction Routing Request form, should be submitted to TSACG for processing. TSACG's Transaction Routing Request form may be downloaded at https://www.tsacg.com.

If you have questions about a vendor, you can call:

Florida Department of Financial Services
Consumer Helpline, 800-342-2762

To file a complaint about a vendor, go online to:

Florida Office of Financial Regulations,
www.flofr.com/sitePages/fileacomplaint.htm

VOLUNTARY RETIREMENT PROGRAMS
PRE-TAX AND AFTER-TAX OPTIONS

ENROLLING IN THE PLANS

To participate, you must select an investment plan from the list of authorized investment providers below. Check the list to determine whether the provider you select offers the plan(s) you want. Carefully compare investment products before you select a provider and take the time to understand the investments you are choosing and the implications of your investment decision. If you do not understand the information presented to you by a sales representative or are unsure about a product, do not complete the online payroll deduction authorization. The authorized list does not reflect any opinion as to financial strength or the quality of the product or service for any company. The products that these companies provide are typically standard-interest annuities, variable annuities, and mutual funds. Payroll deductions are permitted for those vendors who have made proper application and are on Pinellas County Schools' list of authorized vendors. Pinellas County Schools does not endorse or recommend any product or vendor and does not offer financial advice.

2020-2021 VOLUNTARY RETIREMENT PROGRAM | LIST OF AUTHORIZED INVESTMENT PROVIDERS					
Company Name	**Products Available**			**Agent of Record**	**Telephone**
	403(B)	457	ROTH 403(b)		
Aetna	X	X	X	Diane Petita	813-281-3751
AXA Advisors	X	X	X	Ryan Lau	813-466-3195
Fidelity Funds (No Load)*	X	X		www.fidelity.com/atwork	800-343-0860
Franklin Templeton	X		X	John Kelley	727-299-7143
Horace Mann	X	X	X	Gary Cucchi	813-600-3268
Lincoln Investment	X	X	X	Brett Smith	800-771-7732
VOYA	X	X	X	Keista Ransom	813-281-3743
AIG Retirement Services (Valic)	X	X	X	Chris Brown	813-269-3362

*Call Fidelity or go online to request a 403(b) or 457(b) enrollment kit and fund prospectus. Contact Risk Management at 727-588-6141 to request a salary reduction agreement to authorize payroll reductions.

TSA Consulting Group is the third party administrator for the Pinellas County Schools' Voluntary Retirement Program. If you wish to start a deduction, increase, decrease or suspend your deduction to your Roth, 403(b) or 457 plan, you must utilize the online system. The ART system is used when requesting loans, rollovers, distributions, and contract exchanges from your account. The online process eliminates the need for paper SRAs and allows around-the-clock access for employees. To use the ART system you will need to establish your initial ART system login, visit the secure ART login website: http://www.tsacg.com/individual/art-help. To open up an account you must go through a current representative of the district's 403(b) and 457 approved Investment Providers who are trained and able to assist employees. TSA Consulting Group has a toll free customer service help line to assist you (888) 796-3786, Option 5.

QUICKENROLL

Thinking about enrolling in a 403(b) voluntary retirement plan? Opening a 403(b) account through QuickENROLL allows you to quickly start saving for your future retirement needs. Simply select from the list of participating investment provider companies, complete the required fields in the online application process, submit, and you are done. Deductions should start within 1-2 paychecks.

QuickEnroll Website
Step-by-Step Instructions for QuickEnroll

FLORIDA RETIREMENT SYSTEM (FRS)

The Florida Retirement System (FRS) was established in 1970 to provide a retirement program for participating public sector employers. The FRS gives eligible new employees the opportunity to participate in either the Pension Plan or the Investment Plan. You must elect one of the two plans within your first eight months of employment. If no election is made, you will default into the Investment Plan. Your 2nd Election can be used to switch plans one time during your active career with an FRS employer.

KEY DIFFERENCES BETWEEN FRS PLANS	
PENSION PLAN	**INVESTMENT PLAN**
A traditional retirement plan designed for longer-service career employees.	**A retirement plan designed for shorter service and more mobile em-**
You qualify for a benefit after eight[1] years of service. You are always fully vested in your own contributions as long as you remain in the Pension Plan[2].	**You qualify for a benefit after one year of service. You are always fully vested in your own contributions as long as you remain in the Investment Plan[2].**
PCS contributes the majority of your FRS retirement plan contribution based on a fixed percentage of your gross salary as determined by the state legislature. A mandatory 3% pre-tax contribution is deducted from your paycheck and deposited into the Pension Plan trust fund[3].	**PCS contributes the majority of your FRS retirement plan contribution based on a fixed percentage of your gross salary. A mandatory 3% pre-tax contribution is deducted from your paycheck and deposited into your retirement account[3].**
Pays a guaranteed lifetime monthly benefit using a formula based on the service and salary while you are working for an FRS employer. Plan underfunding or future cost increases could make it necessary for the Florida Legislature to reduce benefits.	**Your benefit depends on the amount of money contributed to your account and its growth over time. You decide how to allocate the money in your account among the available investment funds. Future plan cost increases could make it necessary for the Florida Legislature to reduce the amount that employers contribute to the plan, which may result in a lower benefit.**

1 If you have any Pension Plan service prior to July 1, 2011, you are subject to six-year vesting. If you join the Pension Plan on or after July 1, 2011 and have no previous Pension Plan service, you are subject to eight-year vesting. 2 How your employee contributions are distributed or refunded to you depends on a number of factors, especially if you use your 2nd Election to switch Plans in the future. You can call the MyFRS Financial Guidance Line at 1-866-446-9377, Option 2, for information. 3 Contribution rates are fixed by law, and the Florida Legislature can increase or decrease the amount that you and our employer contribute to your account.

ABOUT THE DROP OPTION

The Deferred Retirement Option Program (DROP) allows FRS Pension Plan participants to retire without terminating employment for up to five years while your retirement benefits continue to accumulate and earn interest. You can participate in DROP when you reach your normal retirement age or date. Administrators and Support Personnel who do not join DROP within 12 months of becoming eligible to participate will lose their opportunity to join DROP. Investment Plan members are not eligible for DROP.

ABOUT THE MyFRS FINANCIAL GUIDANCE PROGRAM

The MyFRS Financial Guidance Program is available to all Florida Retirement System members. As a member, you have free access to unbiased EY financial planners who serve as your personal retirement and financial advocate and answer any retirement and financial questions you have. (Your financial planner does not sell any investment or insurance products.) You can also register for an educational financial planning workshop in your area conducted by a financial planner. You can speak with a financial planner about:

- Retirement planning
- Investment planning, including investments outside the FRS, such as a PCS Voluntary Retirement plan
- Investment fund performance
- Estate planning
- Debt, spending , and credit issues

The www.myFRS.com website serves as your gateway to a host of tools and information about the FRS Pension Plan and Investment Plan. For more information about the Florida Retirement System, the MyFRS Financial Guidance Program, and DROP:

Call: The PCS Retirement Team: 727-588-6214 or MyFRS Financial Guidance Line: 866-446-9377, Option 2

Visit: www.MyFRS.com

pcs
PINELLAS COUNTY SCHOOLS