2018 COBRA ENROLLMENT NEWS

ANNUAL ENROLLMENT December 6 — December 18, 2017

Choose Your 2018 Benefits!

Annual COBRA Enrollment will be held December 6 to December 18, 2017. This is your opportunity to enroll in the benefits that can provide you and your family with security and peace of mind. Follow these directions to make sure you have the coverage you need in 2018.

START by reviewing this newsletter. Be sure to check out what's changing on page 2.

CONSIDER all your and your family's benefit needs.

CHOOSE the right benefits to meet your anticipated needs.

PROCEED to the packet mailed to you from WageWorks and follow the instructions on how to enroll.

COBRA ENROLLMENT

COBRA Enrollment will be administered by **WageWorks**. All questions and inquiries should be directed to WageWorks.

WageWorks Customer Service 866-924-6938
Monday through Friday, 7:00 a.m. to 7:00 p.m.

Medicare Part D Notice, see page 16

What's Changing for 2018

Making sure our employees have quality, affordable health care coverage is a priority for Pinellas County Schools. Our goal is to ensure that the BENEFlex program continues to offer comprehensive coverage while controlling long-term health care costs. Here are highlights of this year's changes and important reminders.

Medical

Rate Increases • See page 20

All Plans • **Increased Medical Out-of-Pocket Maximums**

NPOS • **Increased Deductible**
Individual: from $400 to $500
Family: from $800 to $1,000

Dental

Humana CompBenefits is now Humana Advantage Dental
Rate reductions
Some copayment changes

Not Making Benefit Changes?

Review your current benefit elections, dependents, and beneficiaries to make sure they are correct for 2018. If you don't enroll or make any changes, your current benefit elections will continue in 2018 with the new deduction amounts, coverage levels, and plan designs, where applicable.

Humana Medical Plans

You can choose from three Humana medical plans, the HMO Staff, the National POS (NPOS) and the Consumer Directed Health Plan (CDHP). Each medical plan includes a network of doctors and other health care providers who offer their services at a lower negotiated rate. Your medical coverage includes Rx 4 prescription drug coverage.

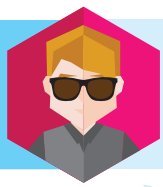
Which Medical Plan Is Right for Me?

Choosing a medical plan is an important decision. Here are some key differences between each plan.

	HMO Staff	NPOS	CDHP
Do I have to stay in-network?	YES	NO	YES
What is the coverage area?	Very limited 8 counties	National	Florida and several other states
Do I have to select a PCP?	YES	NO	NO
Do I need a referral to see specialists?	YES	NO	NO
What do I pay for medical services?	Co-pays for all services, no deductible	Deductibles, coinsurance and co-pays	Deductibles and coinsurance
Is preventive care covered at 100%?	YES	YES	YES
Is there a Personal Care Account (PCA)?	NO	NO	YES
Is there prescription drug coverage?	All three plans offer the Rx4 Traditional Prescription Drug Program. Details are provided on page 10.		

Health Care Reform and You—the Individual Mandate

The ACA requires most Americans to purchase health insurance or pay a penalty. This is called the "individual mandate." The medical plans offered by PCS meet or exceed the affordability and coverage requirements. So being enrolled in a PCS medical plan satisfies the individual mandate. For more information about Health Care Reform, please see the online BENEFlex Guide at *pcsb.org/beneflex-guide*.



Answers about Humana medical and dental plans are just a phone call away!

Humana HotLine
Oct. 11 through Dec. 31, 2017

888-393-6765, Monday – Friday
8:00 a.m. – 8:00 p.m.

Locate a Humana Medical Provider

Each medical plan has its own provider network. Before you choose a plan and periodically during the year, you should verify that your doctors, specialists, and other providers are in-network. You can call **Humana Member Services at 877-230-3318** or use the Humana Find a Doctor tool. This tool gives you online access to the most current provider directories, as well as other information.

Go to *humana.com* and scroll down to "Find a doctor or pharmacy" and select Search. Make sure search type is on Medical, then search by Humana plan. When asked, select the appropriate network.

Humana Medical Plan Networks

Plan	Network Name
HMO Staff	HMO Staff[1]
National Point of Service (NPOS)	National POS—Open Access[2]
Consumer Directed Health Plan (CDHP)	HMO Premier

[1] *If you enroll in the HMO Staff Plan, you will need to enter your PCP's ID# when you enroll. It is listed on the right of the search box.*

[2] ***Caution:*** *There are two national POS networks listed. The correct one is Open Access.* ***Do not*** *select Open Access Plus.*

How Much Will I Pay?

Consider your health care needs and those of your eligible dependents. Then review the comparison chart on pages 5-8 to estimate how much you will pay for that care under each plan. Finally, review the rates on page 13 and add in your monthly rates. That is your estimated annual cost.

Your total out-of-pocket costs (deductibles, co-pays and coinsurance plus Rx costs) + **Your annual payments** (see page 13 and multiple the rate times 12 months) = **Your Total Estimated Annual Cost**

Medical Plans Comparison Chart

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

Understanding How Much You Have to Pay

- Personal Care Account (PCA) (CDHP only). Use your up-front allowance to pay your deductible, coinsurance, and Rx co-pays, reducing your out-of-pocket costs. The amount deposited in your PCA is prorated based on your benefits effective date. See page 8.
- Medical Plan Deductible (CDHP and NPOS). The amount you pay for certain medical expenses before the plan begins paying benefits.
- Rx4 Traditional Deductible (all plans). The amount you pay for Tier 3 and/or Tier 4 drugs before you begin paying Rx co-pays for those tiers.
- Combined Out-of-Pocket (OOP) Maximum. The maximum amount you pay for eligible medical **and** Rx expenses during a plan year.
- Coinsurance (CDHP and NPOS). 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.

Humana Member Services 877-230-3318	HMO Staff Q7444	National Point-of-Service (NPOS) 548085		Consumer Directed Health Plan (CDHP) 548085
Benefit	**In-Network Only**	**In-Network**	**Out-of-Network[1]**	**In-Network Only**
Service Areas	Any provider in the HMO Staff Network for Citrus, Hernando, Hillsborough, Manatee, Pasco, Pinellas, Polk, Sarasota counties	Any provider in the NPOS Open Access Network (national network)	Any provider	Any provider in the HMO Premier Network (includes Florida and several other states)
Personal Care Account (PCA)—Individual/Family PCA funds can only be used for medical plan and prescription drug expenses.	N/A	N/A	N/A	$500 Individual; $1,000 Family (No maximum rollover amount) PCA contributions are prorated based on your date of hire. See page 8 for details.
Deductibles—Individual/Family	N/A	$500 Individual; $1,000 Family (combined in- and out-of-network)		$1,500 Individual; $3,000 Family
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or co-pays	$4,500 Individual; $9,000 Family	$4,500 Individual; $9,000 Family (combined in- and out-of-network)		$4,500 Individual; $9,000 Family
Combined Out-of-Pocket Maximum—Includes deductible, coinsurance, and/or co-pays, **and** Rx deductible and co-pays	$6,250 Individual; $12,500 Family	$6,250 Individual; $12,500 Family (combined in- and out-of-network)		$6,250 Individual; $12,500 Family
Lifetime Maximum	Unlimited	Unlimited		Unlimited
Physician Office Visits	**You Pay:**	**You Pay:**	**You Pay:**	**You Pay:**
Primary Care Physician (PCP)	$25 co-pay	20% after deductible	40% after deductible	20% after deductible
Specialist (SPC)	$50 co-pay	20% after deductible	40% after deductible	20% after deductible
Doctor On Demand	$25 co-pay	$40 or 20% after deductible	N/A	$40 or 20% after deductible
Preventive Adult Physical Exams	No co-pay	0%	40% after deductible	0% no deductible
Preventive GYN Care (including Pap test) (direct access to participating providers)	No co-pay	0%	40% after deductible	0% no deductible
Mammography Preventive Screening	No co-pay	0%	40% after deductible	0% no deductible
Immunizations	No co-pay	0%	40% after deductible	0% no deductible
Allergy Injections	Co-pay waived for allergy injections billed separately	20% after deductible; allergy injections billed separately	40% after deductible; injections billed separately	20% after deductible
Allergy Tests	$50 co-pay	20% after deductible	40% after deductible	20% after deductible
Lab	$25 co-pay	20% after deductible	40% after deductible	20% after deductible
X-Ray Outpatient	$50 co-pay	20% after deductible	40% after deductible	20% after deductible
Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)	$250 co-pay	20% after deductible	40% after deductible	20% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	No co-pay	0%	40% after deductible	0% no deductible
Chiropractic Services (direct access to participating providers)	$50 co-pay; 20 visits per calendar year	20% after deductible; 20 visits per calendar year in- or out-of-network	40% after deductible	20% after deductible
Hearing Exam	$25 co-pay	20% after deductible	40% after deductible	20% after deductible

This chart provides a brief outline of the medical coverage options available to you through Humana. 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.

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

Continued on next page

Medical Plans Comparison Chart

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

Rx4 Traditional for Tier 3 and Tier 4 Drugs

You must pay the $250 per person or $500 per family Rx deductible before you begin paying Tier 3 and/or Tier 4 co-pays.

Rx4 Traditional Preferred Pharmacy

You must use one of the preferred pharmacies to receive the preferred Rx4 Traditional benefits: **CVS, Walmart, Sam's Club, and Humana Pharmacy**.

Diabetes CARE

See the online BENEFlex Guide for details about the Diabetes CARE Program and free diabetic testing supplies.

This chart provides a brief outline of the medical coverage options available to you through Humana. 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.

Humana Member Services 877-230-3318	HMO Staff Q7444	National Point-of-Service (NPOS) 548085		Consumer Directed Health Plan (CDHP) 548085
Benefit	**In-Network Only**	**In-Network**	**Out-of-Network[1]**	**In-Network Only**
Hospital	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day; up to 5-day maximum	40% after deductible	20% after deductible
Inpatient (Includes maternity and newborn services)				
Outpatient Surgery (including facility charges)	$500 co-pay	20% after deductible	40% after deductible	20% after deductible
Emergency Room Services	$500 co-pay	20% after deductible	20% after deductible	20% after deductible
Ambulance	No co-pay	20% after deductible	20% after deductible	20% after deductible
Urgent Care Facility	$50 co-pay	20% after deductible	40% after deductible	20% after deductible
Maternity Care/OB Visits	$50 co-pay for initial visit only	20% after deductible	40% after deductible	20% after deductible
Mental Health Services				
Outpatient Mental Health Services	$25 co-pay	20% after deductible	40% after deductible	20% after deductible
Inpatient Mental Health Services	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day after deductible; up to 5-day maximum	40% after deductible	20% after deductible
Miscellaneous	No co-pay	20% after deductible	40% after deductible	20% after deductible; 120-visit limit per calendar year
Home Health Care				
Hospice—Inpatient	$500 co-pay per day; up to 5-day maximum[2]	$500 co-pay per day after deductible; up to 5-day maximum[2]	40% after deductible; 30-day lifetime max; 90-day limit per calendar year	20% after deductible 90-day limit per calendar year
Skilled Nursing Facility	$500 co-pay per day; up to 5-day maximum[2]	$500 co-pay per day after deductible; up to 5-day maximum[2] 120 days per calendar year	40% after deductible	20% after deductible 120-day 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[3]	40% after deductible	20% after deductible 60-visit limit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	See prescription drugs below	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	20% after deductible
Rx4 Traditional Prescription Drug Program *Some drugs may be subject to step-therapy or precertification*	**Preferred Pharmacy** ***Mandatory Generics Unless Dispensed As Written***	**Preferred Pharmacy** ***Mandatory Generics Unless Dispense As Written***	**Non-Preferred Pharmacy** ***30% of submitted cost after:***	**Preferred Pharmacy** ***Mandatory Generics Unless Dispense As Written***
Up to 30-day supply **Tier 1**	$20 co-pay; no Rx deductible	$20 co-pay; no Rx deductible	$20 co-pay; no Rx deductible	$20 co-pay; no Rx deductible
Tier 2	$50 co-pay; no Rx deductible	$50 co-pay; no Rx deductible	$50 co-pay; no Rx deductible	$50 co-pay; no Rx deductible
Tier 3	$90 co-pay; after Rx deductible	$90 co-pay; after Rx deductible	$90 co-pay; after Rx deductible	$90 co-pay; after Rx deductible
Tier 4	$120 co-pay; after Rx deductible	$120 co-pay; after Rx deductible	$120 co-pay; after Rx deductible	$120 co-pay; after Rx deductible
90-day Supply (maintenance medications) at retail or mail order (mail order must be through Humana Pharmacy)	***Mandatory Generics Unless Dispensed As Written***	***Mandatory Generics Unless Dispense As Written***	***30% of submitted cost after:***	***Mandatory Generics Unless Dispense As Written***
Tier 1	$40 co-pay; no Rx deductible	$40 co-pay; no Rx deductible	$40 co-pay; no Rx deductible	$40 co-pay; no Rx deductible
Tier 2	$100 co-pay; no Rx deductible	$100 co-pay; no Rx deductible	$100 co-pay; no Rx deductible	$100 co-pay; no Rx deductible
Tier 3	$180 co-pay; after Rx deductible	$180 co-pay; after Rx deductible	$180 co-pay; after Rx deductible	$180 co-pay; after Rx deductible
Tier 4	$240 co-pay; after Rx deductible	$240 co-pay; after Rx deductible	$240 co-pay; after Rx deductible	$240 co-pay; after Rx deductible

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

Humana Medical Plans, continued

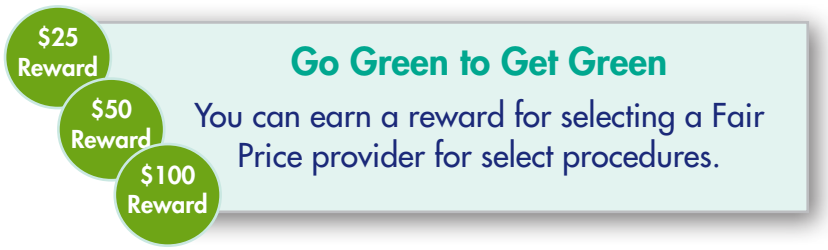
Compare, Choose, Save: Healthcare Bluebook

When you enroll in a PCS Humana medical plan you have access to the Healthcare Bluebook. This free online and mobile resource makes it easy to shop for high quality health care—from diagnostics and imaging to outpatient surgery—at a fair price.

Download the free Healthcare Bluebook mobile app and start shopping for prices and locations while you are with your doctor. Together you decide which location fits your budget and your medical care needs.

Go Green to Get Green

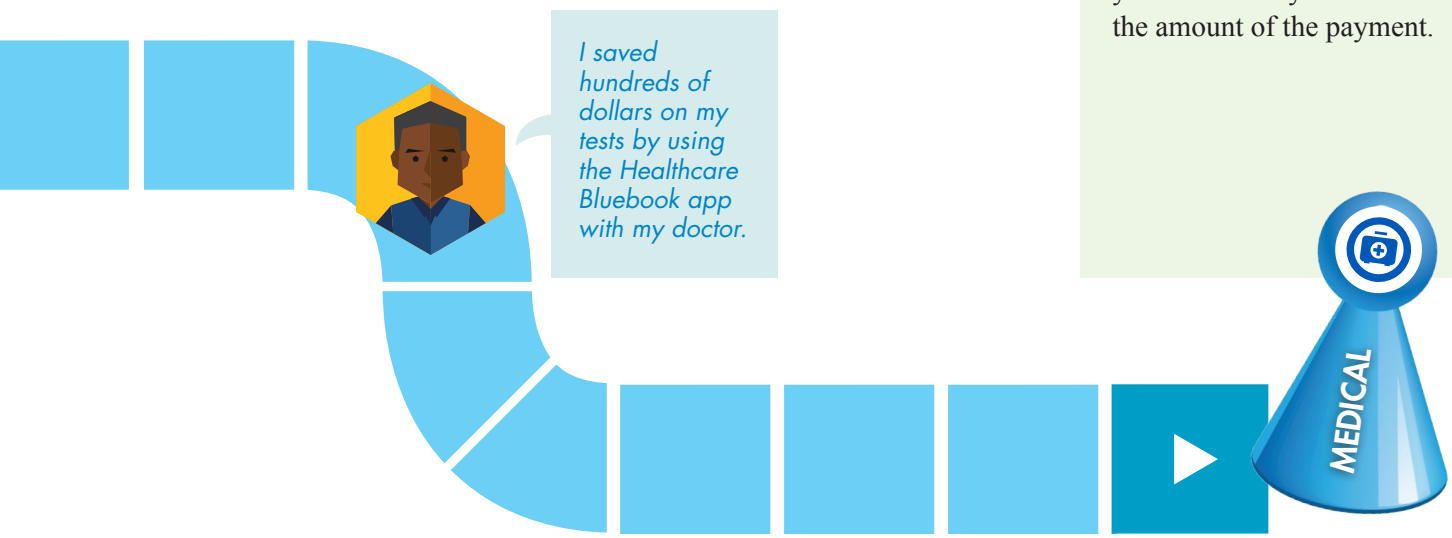
You can look up a Fair Price, compare provider prices, *and* find the best value in your area. Click the **"Go Green to Get Green" banner** and you'll earn a **$25**, **$50**, or **$100** reward (on select procedures) when you choose a Fair Price provider.



Start Saving Now

Healthcare Bluebook gives you 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*
- Bluebook Support: 888-316-1824
- Company Code: PCSB



Important Information About the PCA Card

The Humana CDHP PCA member ID card will also serve as your PCA card and will include more detailed information on the front, including the CDHP plan numbers, ID numbers, and network information.

Note: The IRS requires that 100% of disbursements made from your PCA be substantiated or verified.

Humana will make every effort to automatically substantiate disbursement transactions. However, in some cases, Humana won't be able to substantiate transactions automatically and will request documentation from you.

If you do not respond by the deadline, your card will be "frozen" until appropriate documentation is provided or you reimburse your PCA for the amount of the payment.

Where to Get Care

When Your Doctor Isn't Available

While your regular doctor would be your "go to" for care, sometimes your doctor isn't available or convenient—for example, at night and on the weekend. When you are enrolled in a PCS Humana medical plan you have a lot of different ways to get care. If you are not sure where to go, call Humana's 24-hour Nurse Advice Line at 800-622-9529 for guidance. However, if it's a serious or life-threatening situation, call 911 or go immediately to a hospital emergency room (ER).

$ **PCP/Pediatrician Office.** Your primary care physician (PCP) or pediatrician knows you and your dependents best and should be your first option for non-emergency situations. You'll pay a co-pay in the HMO Staff, or coinsurance in the NPOS or CDHP (after you meet the deductible).

$ **Doctor On Demand.** When you enroll in a Humana medical plan, you and your covered dependents can participate in a live video doctor visit from a mobile device or computer 24 hours a day, 365 days a year. Doctor On Demand physicians can treat colds, sore throats, flu symptoms, allergies and sinus infections, earaches, and more. Visit *doctorondemand.com/humana* or download the free Doctor On Demand app from the App Store or Google Play. What you pay depends on the plan in which you are enrolled: Staff HMO: $25 co-pay • NPOS and CDHP: $40 or 20% of $40 after deductible.

$$ **Urgent care centers** make sense when you need treatment after office hours for a minor illness or injury. See the medical plan comparison chart for cost details. Call Humana Member Services at 800-463-2441 to find an urgent care center near you.

$$$ The **ER** was designed to provide fast, life-or-limb-saving care. See the Medical Plans Comparison Chart for cost details.

I called the HumanaFirst Nurse Advice Line and within minutes I knew what to do and where to go.

I used the Doctor On Demand app at 7 p.m. when my little girl was sick. I got the help I needed and didn't need to leave the house.

Be SMART About Your Health

When it comes to wellness, PCS has you and your family covered! Go to *pcsb.org/wellness* to learn more.

Get Going With Humana Go365*

Humana's Go365 voluntary wellness program gives you a personalized plan and access to tools and resources that help you set, meet, and keep your health and wellness goals. And, it's free if you are enrolled in a Humana Medical Plan. **Plus you can earn bucks for prizes!**

You must be enrolled in a Humana Medical Plan to participate in Go365.

Points must be redeemed while coverage is active. Bucks will expire on the date Humana coverage ends.

I reached Silver Status! I can hardly wait to spend my Bucks!

◆ Humana and MetLife Dental Plans

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

Which Dental Plan Is Right for Me?

Here are some key differences between each plan. Please review the online BENEFlex Guide and visit *pcsb.org* or the carrier sites listed below for more information.

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

Locate a Humana Advantage Provider

In this plan you must stay in-network, only emergencies are covered out of network. That's why it is important that you check the provider listing to make sure you can find a provider you like.

- **Go to** *MyHumana.com* where you can search for a provider and find detailed information about the plan.
- **Select** "Search for Providers" on the left and enter the required information.

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

Locate a MetLife Preferred Dental Provider (PDP)

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

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

MetLife ID Cards

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

EyeMed Vision Plan

PCS offers quality vision care for you and your family through EyeMed Vision.

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

When You Use Participating In-Network Providers

Basic Benefits	Frequency
Vision Exam	Once per calendar year
Lenses or Contact Lenses	Once per calendar year
Frames	Every other calendar year
Benefit	**In-Network Provider**
Exam with Dilation	
As necessary	$10 co-pay
Eyeglass Lenses	
Single vision	$15 co-pay
Bifocal	$15 co-pay
Trifocal	$15 co-pay
Standard Progressive	$50 co-pay
Frames	$110 allowance (You receive 20% off the balance over $90)
Contact Lenses	
Conventional	$110 allowance (You receive 15% off the balance over $110)
Disposable	$110 allowance (You pay full amount over $110)
Medically Necessary	Paid in full

Locate an EyeMed Vision Provider

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

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

Contact Lenses Allowance

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

About EyeMed Providers

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

2018 COBRA RATE CHART

Rates are based on monthly payments.

PLAN NAME		Type of Coverage	COBRA Rates
HUMANA CONSUMER DIRECTED HEALTH PLAN		Single	$ 642.60
		Individual + Child	$ 1,132.20
		Individual + Spouse	$ 1,276.70
		Family	$ 1,842.80
HUMANA STAFF HMO		Single	$ 674.90
		Individual + Child	$ 1,196.80
		Individual + Spouse	$ 1,341.30
		Family	$ 1,932.90
HUMANA NPOS		Single	$ 690.20
		Individual + Child	$ 1,373.60
		Individual + Spouse	$ 1,229.10
		Family	$ 1,997.50
HUMANA COMP BENEFITS DENTAL		Single	$ 22.13
		2 Person	$ 37.43
		Family	$ 54.45
MET LIFE DENTAL		Single	$ 31.38
		2 Person	$ 54.50
		Family	$ 78.68
EYE MED VISION		Single	$ 3.72
		2 Person	$ 8.54
		Family	$ 13.78

Federal and Legal Notices

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

The Affordable Care Act (ACA) has brought sweeping changes to the U.S. health insurance system. Its goal is to make health insurance available to everyone, regardless of medical history or ability to pay. Many of the ACA changes have affected employer plans, such as covering adult children through age 26, free preventive care, and reducing or removing annual or lifetime limits on essential health benefits. These changes are explained on the following page.

Medical Plan Enhancements

All of the medical plans offered by PCS will comply with the required changes and result in the following changes: (1) The annual maximum includes the annual deductible. (2) The annual out-of-pocket maximum is capped, lowering the maximum amount you could pay for eligible health care expenses in a year.

Health Care Reform and You—the Individual Mandate

The ACA requires most Americans to purchase health insurance or pay a penalty. This is called the "individual mandate." The medical plans offered by PCS meet or exceed the affordability and coverage requirements. So being enrolled in an PCS medical plan satisfies the individual mandate.

HIPAA

Special Enrollment Rights

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

Employee Privacy Notice

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

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

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

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

Health Care Reform and You

The Affordable Care Act (ACA) requires most Americans to purchase health insurance or pay a penalty. This is called the "individual mandate." The medical plans offered by PCS meet or exceed the affordability and coverage requirements of the ACA. If you have a family, the individual mandate also applies to your spouse and children. If you cannot afford to enroll them in a PCS medical plan, consider the following:

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

For more information about health care reform, go to:
pcsb.org/affordable-care-act.

Women's Health and Cancer Rights Act

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

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

Maternity and Newborn Length of Stay

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

Notice Regarding the Wellness Program

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

Incentives may be available from Go365 for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. Beginning January 2018, you may request a reasonable accommodation through Humana's Go365 customer service at 1-877-230-3318. A member may submit a Disability Accommodation form, also available upon request from Humana Go365, to request alternative engagement options to accommodate the disability.

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

Protections from Disclosure of Medical Information

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

Federal and Legal Notices, continued

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

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. none Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

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

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

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

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

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Pinellas County Schools has determined that the prescription drug coverage offered by the Humana Rx4 Traditional Prescription Drug Program is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan and drop your current Pinellas County Schools coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Pinellas County Schools and don't join a Medicare drug plan within 63 continuous days after your current prescription drug coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

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

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

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

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

For more information about Medicare prescription drug coverage:

- Visit *www.medicare.gov*.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

Date of Notice: October 2017

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, *800-772-1213 (TTY 800-325-0778).*

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

Federal and Legal Notices, continued

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Florida, you can contact the Florida Medicaid office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact the Florida Medicaid office or dial 1-877-KIDS NOW or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask if Florida has a program that might help you pay the premiums for an employer-sponsored plan. (Note, if your children live outside of Florida, contact the appropriate Medicaid office for that state.)

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

ALABAMA – Medicaid

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

ALASKA – Medicaid

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

ARKANSAS – Medicaid

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA – Medicaid

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

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

IOWA – Medicaid

Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

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

PENNSYLVANIA – Medicaid

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

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

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

VERMONT– Medicaid

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

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

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

WEST VIRGINIA – Medicaid

Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

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

To see if any more states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, you can contact either:

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

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

Contact Information

Humana HotLine • Oct. 11 through Dec. 31, 2017

888-393-6765, Monday – Friday 8:00 a.m. – 8:00 p.m.

COBRA Administrator - WageWorks **WageWorks Customer Service**	866-924-6938

Onsite Representatives

Humana (Claims Advisor)	727-588-6367
Humana (Medical—Patient Advocate)	727-588-6137
Humana (Health & Wellness/Go365 Advocate)	727-588-6134

Insurance Carriers

Doctor On Demand	doctorondemand.com/humana
Healthcare Bluebook	888-316-1824 pcsb.org/healthcarebluebook
Humana—Advantage Dental (548085)	800-342-5209 MyHumana.com
EyeMed Vision Care	866-299-1358 eyemedvisioncare.com
Humana Medical Member Services and Claims	877-230-3318 humana.com orMyHumana.com
Humana Pharmacy (Mail Order Rx)	800-833-1315 humanapharmacy.com
MetLife® Dental Plan—PDP (G95682)	800-942-0854 metlife.com/dental

Non-PCS Programs

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

This newsletter describes Pinellas County Schools COBRA benefit programs that will be effective for the plan year beginning January 1, 2018. This is only a summary of the benefit programs. Additional restrictions and/or limitations not included in this guide may apply. In the event of a conflict between this guide and the plan documents, the plan documents will control.

BENEFlex 2018

pcs PINELLAS COUNTY SCHOOLS