## Contact Information

### Onsite Representatives

<table>
<thead>
<tr>
<th>Company</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna (Claims Advisor)</td>
<td>727-588-6367</td>
</tr>
<tr>
<td>Aetna (Medical—Patient Advocate)</td>
<td>727-588-6137</td>
</tr>
<tr>
<td>Aetna (Health &amp; Wellness Advocate)</td>
<td>727-588-6134</td>
</tr>
<tr>
<td>Sun Life Financial (Disability Claims)</td>
<td>727-588-6444</td>
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### Risk Management and Insurance

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Insurance Benefits and Deductions—Employee</td>
<td>727-588-6195</td>
<td>727-588-6182</td>
</tr>
<tr>
<td>Retirement (Insurance Benefits, DROP)</td>
<td>727-588-6214</td>
<td></td>
</tr>
<tr>
<td>Tax-Deferred Accounts</td>
<td>727-588-6141</td>
<td></td>
</tr>
<tr>
<td>Wellness</td>
<td>727-588-6031</td>
<td></td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td>727-588-6196</td>
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### Insurance Carriers

<table>
<thead>
<tr>
<th>Insurance Carrier</th>
<th>Phone Number</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Aetna Concourse Customer Service</td>
<td>866-253-0599</td>
<td><a href="http://www.aetnapcsb.com">www.aetnapcsb.com</a></td>
</tr>
<tr>
<td>• Member Services (Group #109718)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Aetna PayFlex FSA Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna Mail Order Pharmacy</td>
<td>888-792-3862</td>
<td>N/A</td>
</tr>
<tr>
<td>EyeMed Vision Care</td>
<td>866-299-1358</td>
<td>eyemed.com</td>
</tr>
<tr>
<td>Advantage Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Advocate</td>
<td>877-240-6863</td>
<td>healthadvocate.com</td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare Bluebook</td>
<td>888-316-1824</td>
<td></td>
</tr>
<tr>
<td>pscb.org/healthcarebluebook</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humana Advantage Dental (548085)</td>
<td>800-979-4760</td>
<td><a href="http://www.MyHumana.com">www.MyHumana.com</a></td>
</tr>
<tr>
<td>MetLife® Dental Plan—PDP (G95682)</td>
<td>800-942-0854</td>
<td>metlife.com/dental</td>
</tr>
<tr>
<td>MetLife® Voluntary Benefits (HIP, Auto, Legal, Pet Insurance, etc.)</td>
<td>800-438-6388</td>
<td>metlife.com/mybenefits</td>
</tr>
<tr>
<td>Standard Insurance Company Life/AD&amp;D Claims</td>
<td>800-628-8600</td>
<td></td>
</tr>
<tr>
<td>Teladoc</td>
<td>855-835-2362</td>
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### Non-PCS Programs

<table>
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<th>Program</th>
<th>Phone Number</th>
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</thead>
<tbody>
<tr>
<td>Florida KidCare</td>
<td>800-821-5437</td>
<td>floridakidcare.org</td>
</tr>
<tr>
<td>Federal Health Insurance Marketplace</td>
<td>800-318-2596</td>
<td>healthcare.gov</td>
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</table>

This newsletter describes Pinellas County Schools employee benefit programs that will be effective for the plan year beginning January 1, 2019. This is only a summary of the benefit programs. Additional restrictions and/or limitations not included in this guide may apply. In the event of a conflict between this guide and the plan documents, the plan documents will control.
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<th>Page</th>
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<td>Dependent Coverage and Eligibility</td>
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</tr>
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<td>Coordination of Benefits</td>
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<td>Termination of Coverage</td>
<td>13</td>
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<td>Board Contribution</td>
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<td>Two Board Employees</td>
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<td>Change in Two Board Status</td>
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<td>Retiree Insurance</td>
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<td>Life Insurance Medical History Information</td>
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<td>The FLEX Plan</td>
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<td>Premium Conversion</td>
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<td>Change in Status Events</td>
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<td>Flexible Spending Accounts (FSAs)</td>
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<td>The Be SMART Wellness Program</td>
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<td>Dental Plans</td>
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<td>EyeMed Vision Plan</td>
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<td>Life and AD&amp;D Insurance</td>
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<td>Disability Insurance Plans</td>
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<td>Voluntary Benefits</td>
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</tbody>
</table>
Introduction
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 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—everything you need to know to make informed choices.

Please take the time to review this guide carefully and use the contact information printed on the inside front cover if you have any questions or would like additional information. The decisions you make will remain in effect through December 31, 2019.

Medical Plans
• Choose from three Aetna medical plans: Select Open Access, Choice POS II (Point of Service II), and the CDHP + HRA (Consumer Driven Health Plan + Health Reimbursement Account).
• Enroll your legal spouse, and/or your children who may be eligible for coverage through the end of the year in which they turn age 26 (see pages 10–12 for information about dependent coverage and eligibility, including coverage for dependent children ages 26–30).
• The medical plans offered by PCS meet or exceed the affordability and coverage requirements. See page 89 for more information about The Patient Protection and Affordable Care Act (PPACA).
• Medical Plan members can use the Healthcare Bluebook, a free online and mobile resource that offers rewards up to a maximum of $200 when you use a Fair Price provider. See page 33 for details.

MetLife Hospital Indemnity Plan (HIP)
HIP pays a daily amount for hospital confinement. See page 46 for details about this plan.

Be SMART Wellness Programs
• Participate in district-sponsored programs for physical activity, nutrition, tobacco cessation, flu shots, financial wellness, resiliency, and many more throughout the year.
• Choose from programs offered at your school based upon employee interest, such as walking programs, Yoga, softball competitions, informative speakers, and other creative opportunities.
• Medical plan members can participate in the Aetna Health Promise program that provides opportunities to improve and maintain good health. See pages 41–46 for details.

Board Contribution Credit
• 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 benefit, you forfeit the $75 per-pay-period credit.
• The Board Contribution credit may be applied to your payroll deductions for dental, vision, AD&D, short- or 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 Contributions 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 contribution amount will continue unless you change it during Annual Enrollment. See page 13 for more information.
• 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.
Healthcare Flexible Spending Account

- Deposit any whole dollar amount (minimum of $10 per paycheck) in pre-tax dollars into your Healthcare Flexible Spending Account (FSA), up to a maximum of $2,500 per calendar year (see pages 23–25).
- Deposit up to $25 per pay of your unused Board Contribution (see below).
- Reduce your federal income and Social Security tax payroll deductions.
- Get reimbursed from your account for eligible medical, dental, or vision expenses not covered by your health care plan(s), including deductibles, co-payments, and coinsurance.
- Your full annual contribution is available on your effective date.
- 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. You must “use it or lose it” by the end of the plan year.
- Many over-the-counter drugs and medical care items are not eligible expenses without a doctor’s prescription (see page 24).
- Use your PayFlex debit card to pay for eligible medical, dental, and vision deductibles, coinsurance, and co-pays including prescription drug co-pays (see page 25).
- Keep your receipts. You may be required to submit receipts or an Explanation of Benefits (EOB) to support the eligibility of your debit card purchases.

Dependent Care Flexible Spending Account

- Deposit any whole dollar amount (minimum of $10 per paycheck) in pre-tax dollars into your Dependent Care Flexible Spending Account (FSA), up to a maximum of $5,000 or $2,500 if you are married and file taxes jointly (see page 23–25).
- Get reimbursed from your account for eligible dependent day care expenses for your children or elderly parents. (This account is not for health care expenses.)
- Reduce your federal income and Social Security taxes.
- Eligible expenses must be incurred in the plan (calendar) year. Any amount remaining in your account after all eligible claims have been processed will be forfeited.

FSA Alert: Employees must be actively at work to enroll in FSAs.

Employee Assistance Program

- Contact a qualified representative for confidential assistance with a variety of personal issues, including stress, depression, parenting, marital or family problems, child/elder care, legal, or financial issues (see page 45).
- Receive up to eight visits per member per incident per year at no charge.
- Coverage is provided for you and your eligible family members.
- Call Health Advocate 877-240-6863 for help and information.

Put Your Board Contribution Credits to Good Use

If you do not enroll in a PCS-sponsored medical plan you can have $10 to $25 of your Board Contribution credits deposited into your Healthcare FSA per pay period—giving you up to $500 per year to pay eligible medical, dental, and vision expenses.
2019 Benefit Plans Summaries

Dental Plans
Humana Dental Advantage Plus 2S Plan

- Choose any Humana Advantage Plus 2S network dental provider; no primary dentist or specialist referrals required.
- No office visit co-pays, deductibles, or annual maximum.
- No charge for preventive and basic services.
- Adult and child orthodontia benefits available.
- See pages 52–56 for details.

MetLife® Preferred Dentist Program (PDP)

- Choose a participating dentist or any dentist of your choice.
- Select from more than 100,000 dentists nationwide with more than 100 in Pinellas County.
- Reduce your out-of-pocket expenses when you visit a participating preferred provider.
- Pay annual deductibles of $50 per individual and $150 per family maximum before the plan pays coinsurance.
- There is a calendar-year maximum benefit of $1,250 per person.
- There is a $1,000 lifetime maximum orthodontia benefit for dependent children up to age 19.
- See pages 56–60 for details.

Vision Plan

- As a benefits-eligible employee, you can enroll in free employee-only vision coverage.
- You may enroll your dependents in the vision plan for an additional cost.
- The EyeMed Vision Care Plan emphasizes high-quality routine eye care from a network of independent and retail eye care professionals. Check the provider directory available on the PCS website before making your first appointment.
- Receive one eye exam and lenses or contact lenses per calendar year, and frames every other calendar year for you and your covered dependents for reasonable co-payments.
- Get reimbursed from the plan if you visit a nonparticipating provider (exceptions apply).
- See pages 61–63 for details.

Life Insurance

- Receive Basic Life insurance coverage, paid by the Board, at one times your annual base salary rounded up to the next $1,000, with a coverage minimum of $15,000. Coverage amounts in excess of $50,000 are subject to taxation under Section 79 of the Internal Revenue Code.
- At retirement, you can continue Board Life insurance and convert Optional Term Life coverage to an individual policy.
- Select additional coverage, if needed:
  - Optional Employee Term Life insurance: up to $500,000 (guaranteed coverage available up to $100,000, if you enroll within 31 days of becoming eligible).
  - Spouse: up to $100,000, not to exceed the employee’s total life insurance coverage (basic plus any optional employee life). (Coverage is subject to medical underwriting.)
  - Child(ren): up to $10,000 (no medical underwriting).
  - Optional Family Term Life insurance: $5,000 per dependent.
  - Disabled employees can apply for a continuation of benefits to age 65.
- See pages 64–71 for details.
Accidental Death & Dismemberment (AD&D) Plan

• Receive Board-paid Basic AD&D coverage of $2,000.

• Select Optional AD&D coverage for employee and family, if needed.

• Choose from employee coverage amounts of $50,000, $100,000, $200,000, or $300,000. Coverage amounts for spouse and/or child(ren) are a percentage of the employee’s coverage. See pages 64–71 for details.

Voluntary Benefits

• Auto and Home Insurance* through Horace Mann and MetLife.

• MetLaw® Group Legal Services Plan offered by Hyatt Legal Plans (a MetLife company).

• MetLife Veterinary (VPI®) Pet Insurance.

• See pages 78–80 for details.

* Subject to underwriting approval. Some areas in Florida may not be eligible for Home Insurance.

Disability Insurance Plans

Select any of the following plans:

• Sun Life Financial Disability Plans—you must enroll in Short-term Disability (STD) before you can enroll in Long-term Disability (LTD). See pages 72–77 for details, including pre-existing condition exclusions.

  — Short-term Disability (STD) (Base Plan)—provides benefits for up to two years for a disability due to illness or up to five years for a disability due to injury. Coverage is available from $400 to $5,000 per month based on salary, with benefits starting on the 16th, 31st, or 61st day, depending on the Elimination Plan chosen by the employee. The elimination period means a period of consecutive days of disability for which no benefit is payable.

  — Long-term Disability (LTD)—provides benefits for disabilities that extend beyond the Base Plan. Coverage available from a $400 to $5,000 benefit per month.

Voluntary Retirement Programs

• Pre-tax plans: 403(b) or 457(b).

• After-tax plan: Roth 403(b).

• Make deposits via easy payroll deductions.

• Choose from a variety of investment programs.

• Change your salary reduction amount up to four times per calendar year.

• Enroll or cancel participation anytime during the calendar year.

• See pages 81–84 for details.

Employee Discount Program

• Pinellas County Schools periodically offers discounts to various theme parks, car rentals, hotel stays, and cruise packages. Discounts are available to all employees. See www.pcsb.org/discounts for current discounts.
Payroll Deduction Rate Chart

Medical Rates Subject to Union Ratification and Board Approval

◆ DIAMOND = Eligible for Board Contribution

If you do not enroll in a PCS-sponsored medical plan, you are eligible to use up to a $75 per-pay-period Board 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 benefit, you forfeit the $75 per-pay-period credit.

### Aetna Medical Plans

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Select Open Access</th>
<th>Choice POS II</th>
<th>CDHP + HRA</th>
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<tbody>
<tr>
<td>Employee</td>
<td>$79.00</td>
<td>$88.00</td>
<td>$60.00</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$214.00</td>
<td>$234.00</td>
<td>$174.00</td>
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<tr>
<td>Employee + Child(ren)</td>
<td>$197.00</td>
<td>$217.00</td>
<td>$157.00</td>
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<tr>
<td>Employee + Family</td>
<td>$283.00</td>
<td>$322.00</td>
<td>$228.00</td>
</tr>
<tr>
<td>Two Board Family*</td>
<td>$193.00</td>
<td>$232.00</td>
<td>$138.00</td>
</tr>
</tbody>
</table>

Payroll deduction per-pay-period (20 pays) AFTER the Board Contribution has been applied.

* 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 or MetLife Dental Plans

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Humana Advantage Dental Coverage</th>
<th>MetLife® PDP Dental Coverage</th>
<th>EyeMed Vision Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$7.02</td>
<td>$12.46</td>
<td>$No Charge</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>13.02</td>
<td>23.06</td>
<td>$2.83</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>19.03</td>
<td>33.28</td>
<td>5.92</td>
</tr>
<tr>
<td>Two Board Family**</td>
<td>17.03</td>
<td>31.28</td>
<td>5.92</td>
</tr>
</tbody>
</table>

Payroll deduction per pay period (20 pays) AFTER the Board Contribution has been applied.

** 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.

### Standard Insurance Company Life Insurance Plans***

#### Basic Employee Term Life Insurance

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Rates (per $10,000)</th>
<th>Rates (per $2,000)</th>
<th>Formerly “Dependent Life” Rates (per family unit)</th>
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</thead>
<tbody>
<tr>
<td>Age (as of effective date of coverage)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>under 30</td>
<td>$0.34</td>
<td>$0.24</td>
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<td>30–34</td>
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<td>35–39</td>
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<td>40–44</td>
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<td>60–64</td>
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<td>65–69</td>
<td>7.62</td>
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</tr>
<tr>
<td>70+</td>
<td>12.36</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This coverage is “guarantee issue” and no evidence of good health is required.

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.

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

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

Optional Family Term Life: One premium covers spouse and eligible child(ren).

Keep in mind that the amount 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.

*** 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.

Keep in mind that the amount 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.
## Payroll Deduction Rate Chart

**◆ Standard Insurance Company Optional**

**Accidental Death & Dismemberment Insurance**

<table>
<thead>
<tr>
<th>Benefit Amount</th>
<th>Employee Only</th>
<th>Employee + Family</th>
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</thead>
<tbody>
<tr>
<td>$50,000</td>
<td>$0.60</td>
<td>$1.05</td>
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<tr>
<td>$100,000</td>
<td>$1.20</td>
<td>$2.10</td>
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</table>

<table>
<thead>
<tr>
<th>Benefit Amount</th>
<th>Employee Only</th>
<th>Employee + Family</th>
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<tbody>
<tr>
<td>$200,000</td>
<td>$2.40</td>
<td>$4.20</td>
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<tr>
<td>$300,000</td>
<td>$3.60</td>
<td>$6.30</td>
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</table>

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

**◆ Sun Life Financial Income Protection Short-term Disability Plan (STD) (Base Plan)**

An eligible employee may select one of the benefit levels 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

<table>
<thead>
<tr>
<th>Benefit Amount</th>
<th>Employee Only</th>
<th>Employee + Family</th>
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<td>$ 7,200</td>
<td>$ 400</td>
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20 deductions per year when Accident and Sickness Benefits begin after the WAITING/ELIMINATION PERIOD:

<table>
<thead>
<tr>
<th>15-Day Plan</th>
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<tbody>
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</tr>
<tr>
<td>80.48</td>
<td>64.95</td>
<td>50.30</td>
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Pre-existing conditions apply to Sun Life disability plans, HIP, and MetLaw. See the online BENEFlex Guide for full details.

## Sun Life Financial Long-term Disability Plan (LTD)

You must enroll in STD in order to enroll in LTD

If Your Annual Base Salary Is at Least

<table>
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<th>20 Deductions Per Year</th>
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20 deductions per year:

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**◆ MetLife Hospital Indemnity Plan (HIP)**

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<td>Employee + Spouse</td>
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<td>Employee + Family</td>
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<table>
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<tr>
<th>MetLaw Call MetLife (800-438-6388) to Enroll</th>
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<tr>
<td>$11.85 (no coverage level selection required)</td>
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Pre-existing conditions apply to Sun Life disability plans, HIP, and MetLaw. See the online BENEFlex Guide for full details.
Welcome to Pinellas County Schools! As a new employee, this is your opportunity to enroll in the benefit plans of your choice. Making benefit choices is easy when you take the time to read the general enrollment information and review the benefit plan highlights in this guide.

Please remember:

When you are enrolling

- Your enrollment forms must be **received** by the Risk Management and Insurance Department no later than **31 days from your date of hire or date of change to eligible status**. Insurance coverage begins the first day of the month following 60 days of employment in an eligible status. See page 9 of this BENEFlex Guide.

- We recommend you read this BENEFlex Guide, rather than ask questions of your coworkers, as they may not have the answers that best meet your or your family’s benefit or financial needs. You may also contact the Risk Management and Insurance Department Benefits Team.

- Pinellas County Schools’ Enrollment and Change form highlights important areas that must be completed as you select your benefit options. **If you enroll in the disability insurance plans and/or the optional term life plans, you must complete additional forms (illustrated on pages 18–19) for the insurance carriers.**

When you can make benefit changes

**Annual Enrollment**

- Every year in the fall during Annual Enrollment, employees may change their benefits elections online. You may add or drop coverage, change plans, and add or drop family members at that time. Any changes you make at Annual Enrollment will be effective January 1 of the following year.

**Change in Status Event**

- During the calendar year, you may only make benefit changes if you have a change in status event, which is explained on page 12 in this BENEFlex Guide. You must request the change within 31 days of your change in status event. The change will be effective the first of the month following the status event effective date and the receipt of the enrollment form.

Be sure to visit [www.pcsb.org/new-hire](http://www.pcsb.org/new-hire) for more information.
General Enrollment Information

Eligibility

WHO
• Full-time, regular employees who work at least 30 hours per week.
• Job-sharing employees.
• Part-time, regular employees in two or more authorized positions who work at least 30 hours per week.

HOW
• You must complete and return an Enrollment and Change form to the 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 an eligible status or change to eligible status.

WHAT
• It is your responsibility to read the benefit 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 programs.

Enrollment and Effective Dates

An Enrollment and Change form (PCSB 3-2247C) must be completed to enroll for coverage for the first time. The form is also used to change coverage, add or delete dependents, cancel insurance, or change life insurance beneficiaries.

New Coverage
Enrollment forms must be received by the Risk Management and Insurance Department no later than 31 days from your date of hire or date of your eligible change in status event. Insurance coverage begins the first day of the month following 60 days of employment in an eligible status.

Enrolling a Newborn Child
You may submit an enrollment application for your newborn child prior to the birth of the child or within 31 days after birth to Pinellas County Schools, Risk Management and Insurance Department. Do not call Aetna.

Should you submit an enrollment application to Pinellas County Schools between 31 and 60 days after your newborn child’s birth, 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.
Dependent Coverage and Eligibility

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

- **Your legal spouse** as defined by the state of Florida.

- **Your children**, including biological children, stepchildren, legally adopted children, and children for whom you have permanent legal guardianship.

- **Medical, Dental, and/or Vision Plan Coverage for Children**

  Your eligible 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. **Please note, 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.**

- **Handicapped Dependents**. There is no age limitation for an unmarried handicapped dependent child provided the following 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.

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

Spouse and Dependent Certification Required

Upon request, you will need to verify that each of the dependents you are enrolling is eligible for coverage and provide proof of eligibility.

- **For your legal spouse:** Submit a copy of your marriage license or other documentation as requested.

  **Note:** A former spouse (divorced) is not eligible.

- **For children** (including legally adopted children, stepchildren, and children for whom you have permanent legal guardianship): Submit birth certificates, adoption certificates, and/or guardianship certificates.

Why are you being asked to do this?

PCS periodically performs dependent eligibility audits. It is illegal to enroll ineligible dependents. It also drives up the plan costs for all of us.

Ineligible dependents end up being an expense both for the employee and the School Board.

Studies show that employees who enroll ineligible dependents in their company’s insurance plans cost the employer between $2,000 and $5,000 per ineligible dependent per year.*

Typically, ineligible dependents are either ex-spouses or children of employees who “age out,” are no longer dependent upon you, or who are ineligible grandchildren. The fact that they are still listed as dependents is usually an oversight. Whether enrolling ineligible dependents is just an oversight or done intentionally, this action constitutes fraud and comes with a penalty.

* Source: Business Insurance Magazine

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 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

Those who enroll ineligible dependents will be responsible for repayment of premiums and claims. You may be subject to disciplinary action by PCS, up to and including possible termination. In addition, the Florida Department of Financial Services views this activity as prosecutable under Florida law. Rather than subjecting yourself to these actions, it’s better to pay attention up-front and make sure all your covered dependents are eligible.

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.

Changes in Coverage

In certain instances you may be allowed to change your insurance during the plan (calendar) year if you or a dependent experience a change in status event, explained on page 8. You may enroll, change, or cancel your or your dependents’ health insurance and/or supplemental insurance elections (dental, vision, life, AD&D, or income protection) consistent with the change in status event. Income protections and life insurance changes are subject to medical underwriting and approval by the carrier.

A request to change benefits must be submitted with an Enrollment and Change form and the required documentation, and must be received in the Risk Management and Insurance Department within 31 calendar days of the occurrence of the change in status event. Changes in coverages are effective the first day of the month following the change in status event and receipt of the forms by the Risk Management and Insurance Department.

You are responsible for notifying Risk Management and Insurance of a divorce or a child losing dependent status. In order for your dependent to be offered the opportunity to continue coverage through COBRA, timely notice (60 days) must be provided by you or your family member to Risk Management.

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.

Medicare Part D Notice

See page 93 for information about Medicare Part D.
Termination of Coverage

Insurance benefits 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 the employee no longer meets the plan’s eligibility requirement
- Loss of child’s dependent status (dependent coverage)
- Divorce (dependent coverage)

**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 pages 87–89 to find important information about your rights and responsibilities for continuation of insurance coverage through COBRA.

Annual Enrollment

Annually, Pinellas County Schools provides an Annual Enrollment period held in the fall. During Annual Enrollment you may add, cancel, or change your benefits. Changes requested are effective the following January 1, subject to carrier approval for some plans.

Board Contribution

Each pay period during the school year, the Board contributes toward the cost of your benefits. The Board Contribution is earned each pay period in which you receive a Board paycheck. In any pay period in which you do not receive a paycheck, you will owe **both** the Board Contribution amount and your normal insurance deduction(s) unless you are on an approved family medical leave. (See page 15.) If you choose medical insurance, the rates reflected on the Payroll Deduction Rate Chart (on page 6) are the amounts that will be deducted from your check. The Board Contribution has already been applied toward the full rate.

“**No Health**” Board Contribution

If you do not purchase medical insurance, you can apply up to $75 per-pay-period credit toward the purchase of eligible supplemental benefits—such as the dental, vision, AD&D, and/or short- or long-term disability, and hospital indemnity plan (HIP). You may **not** use these credits to purchase optional term life, MetLife voluntary benefits, or apply toward a Dependent Care FSA. You can apply up to $25 of any remaining Board Contribution credit toward a Healthcare FSA.*

The Board Contribution is not cumulative; any Board Contribution not used is forfeited.

If you subsequently elect medical insurance due to a family change in status event, you will then be responsible for the premium for any supplemental benefits you wish to continue.

* **Please note:** If you are not currently enrolled in Healthcare FSA, you must actively enroll in a Healthcare FSA before the Board Contribution credits can be deposited.
General Enrollment Information

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 each of you must 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.
- If you or your spouse 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.
Payroll Deductions

Premiums are due in advance, therefore deductions begin the month before the insurance effective date. For example, deductions in September pay for October’s coverage, deductions in October pay for November’s coverage, etc. Deductions are taken over 20 pay periods with no scheduled deductions taken in the summer. (This also applies to 12-month employees.) You pay for insurance coverage over a 10-month period but are covered for the entire calendar year.

Your rates are based upon 20 deductions and should not be compared to insurance plans where rates are based upon 24 or 26 deductions. Please see the Payroll Deduction Rate Chart on pages 6–7.

The amount deducted from your paycheck represents both current coverage and a portion for summer coverage. This “summer premium” may be an additional amount owed upon your initial enrollment (new hires) or if you change benefits during the year. You will be notified by the Risk Management and Insurance Department of any missed deduction or “summer premium” owed. Any amount due will be payroll deducted or a personal payment will be requested.

Leave of Absence (LOA)

Family and Medical Leave of Absence

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

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

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

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

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

Continued on next page
General Enrollment Information

Leave of Absence
Leaves of absence are available under the Family Medical Leave Act (FMLA) and in some instances, may be extended as provided under the collective bargaining agreements. For those employees who do not qualify for FMLA leave, they may be entitled to a short-term leave for reasons approved by the superintendent.

If you have any questions or want more information about leaves of absence, please contact the Human Resource Department.

If you are on a long-term unpaid leave of absence, your Healthcare FSA and/or Dependent Care FSA will terminate. If the amount you have been reimbursed for claims exceeds the amount in your Healthcare FSA, you will not be billed for the balance. You must be actively at work to enroll in an FSA.

Insurance Billing—Leave of Absence
When on a non-FMLA leave, you are required to pay the entire cost of all of your insurance plans, including your Board-paid Life Insurance in order to continue your insurance coverages.*

When you are no longer receiving a Board paycheck you will be billed through monthly coupons (provided you have completed the appropriate leave of absence forms through Personnel). Payment must be received by the Risk Management and Insurance Department by the first of each month.

If you are no longer eligible for the Two Board Family option (see page 14), you will need to complete an Enrollment and Change form within 31 days of the change in status event. Please contact the Risk Management and Insurance Department if you have any questions.

FLEX guidelines and School Board policies permit you to enroll or cancel your insurance coverages by sending written notification and a completed Enrollment and Change form to the Risk Management and Insurance Department within 31 days of the start of, or return from, your unpaid leave of absence. If you fail to make premium payments when due, your insurance will immediately be cancelled for nonpayment.

* If you are on a family medical leave, you will only be billed for your regular employee deductions.
Continuation or Waiver of Insurance Premium

While on a Regular, Unpaid Leave of Absence

Premium Continuation of Term Life Insurance

You may continue Basic and Optional Employee Term Life with premium payments if you become disabled prior to age 60. Please refer to page 69 for details.

Waiver of Sun Life Disability Premium

Under Short-term Disability Plan (STD) (Base Plan), if you are disabled and entitled to payment of benefits under the policy for three consecutive months, your premium, which becomes due during the remaining compensable period of disability, will be waived. Waiver of Premiums will cease on the earlier of (1) the date total disability ceases, or (2) the date the maximum benefit period has expired. Premiums for Hospital Indemnity Plan (HIP) and Long-term Disability (LTD) policies will be waived simultaneously with the premium for the STD (Base Plan). After Waiver of Premiun ceases, you may continue your insurance by resuming payments on the first premium due date on or after you return to work.

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 are hired prior to July 1, 2011 and you retire with six or more years of creditable service OR you are 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.
Enrollment Information
Sample Supplemental Form

Complete this form ONLY if you are applying for coverage under these plans.

Disability Plans
Sun Life Financial (underwritten by Union Security Insurance Company)

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<td>2/16/2023</td>
<td>$45,000</td>
<td>Pinellas County Schools</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of School</th>
<th>Position</th>
<th>Tenure</th>
<th>Are you employed on a full-time basis?</th>
<th>Are you actively at work full-time?</th>
<th>On the date of this enrollment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>John J. Public High School</td>
<td>Teacher</td>
<td>10 yrs</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Beneficiary and Relationship: John J. Public, Husband

Check Boxes that Apply
- [ ] New Enrollment
- [ ] Change in Coverage
  - [ ] Short Term Disability
  - [ ] Long Term Disability
  - [ ] EMP G1
  - [ ] EMP EVID

<table>
<thead>
<tr>
<th>Benefits Without Evidence of Insurability</th>
<th>New Hire Only</th>
<th>Benefits Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td>20 Salary Deductions Per Year</td>
<td>Benefit Amount</td>
</tr>
<tr>
<td>$2,000</td>
<td>$83.00</td>
<td>$</td>
</tr>
<tr>
<td>$2,000</td>
<td>$10.68</td>
<td>$</td>
</tr>
</tbody>
</table>

H.O. Evidence Approval
- Evidence Initials: Date: Evidence Entry Initials: Date: G.I. Entry Initials: Date:

I am enrolling for insurance in accordance with the terms of the policy for which I am eligible. By signing this application, I, the undersigned, to the best of my knowledge and belief, represent that I am now in good health and free from physical impairment (except for those items indicated on this application), and I represent that all the answers are true and complete, and I understand that the proposed insurance will become effective unless and until Union Security Insurance Company approves this application and initial premium is received. I understand that any false statements or misrepresentations in this application may result in loss of insurance, if such false statements materially affect the acceptance of the risk or the hazard assumed by Union Security Insurance Company.

If a health questionnaire is not required, I agree that the effective date will coincide with the period covered by my initial premium payment. Union Security Insurance Company reserves the right to change the effective date stated above if necessary. No insurance will be effective for any policy for which all eligibility requirements have not been met.

I authorize the Payroll Department to deduct my premium contribution from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and Union Security Insurance Company, and are to be paid to the Union Security Insurance Company when due. I understand that I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction.

I understand that in order to revoke this authorization, I must notify the Payroll Department in writing to cancel the premium deductions and abide by any rules specified by the employer’s benefit plan and/or by law. I understand that the insurance applies for continuance exclusions and limitations.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signed: Jane P. Public, Licensed Resident Agent
Date: 2/16/2016
License #: #12345678

PLEASE COMPLETE THE HEALTH QUESTIONNAIRE ON BACK OF THIS FORM IF NEEDED.

See page 7 for the Sun Life Financial disability rates.
Complete the online Medical History Statement if you are applying for coverage requiring this for these plans (see guidelines below).

Optional Employee and Family Term Life Insurance Plans
Standard Insurance Company

Life Insurance Medical History Statement (Online) Instructions – Standard Insurance Company

You must submit your Medical History Statement using the Standard Insurance Company’s online statement. This statement is only required if you are requesting employee life insurance coverage greater than $100,000 or spouse term life insurance.

The process takes approximately 15 minutes. NOTE: You need to have the amount of coverage you are requesting, physician names and addresses, and personal identification information to complete your submission.

Go to https://www.standard.com/mybenefits/pinellas/eeoi.html and check the “I Agree” button located at the bottom of the page to get started. Follow these steps:

1. Answer the Initial Questions. Enter the applicant’s name. This is the person applying for coverage, i.e., employee or spouse. Enter address information.

2. Demographic Questions. Select an applicant type. This is the person applying for coverage. The applicant’s date of birth is a required field. All other fields on this page are optional.

3. Employment Questions. Your policy number of 755556 is prefilled. All other fields are optional.

4. Coverage Questions. Indicate the type of application. As a new hire, you will select “Initial.”

5. Medical Questions. You must answer all of the health questions in order to advance to the next screen.

6. Notices and Signatures. After reading all of the information, click the “I Agree” button to go to the next screen.

7. Submit Form. You now have the option to make changes or print a copy of your Medical History Statement and submit your statement. If you do not click the “Submit” button, your application will not be received by Standard Life Insurance Company.

8. Application Confirmed. When you receive this notification, you have successfully submitted your application.
The BENEFlex program includes the FLEX Plan (a Section 125 Cafeteria Plan). The plan includes a Premium Conversion feature and Flexible Spending Accounts (see pages 23–25). The plan is designed in accordance with Internal Revenue Service regulations and any changes in their rules may require the plan to be changed in the future.

**Premium Conversion**

The Premium Conversion feature allows you to pay most of your insurance premiums on a pre-tax basis, reducing your taxable income and increasing your take-home pay. This saves both Social Security (FICA) and federal income tax on the cost of your insurance.

To show the effect of paying insurance premiums with pre-tax dollars, see the example below of a full-time employee with family health coverage, whose total pay for the year is $30,000. By using Pinellas County Schools’ FLEX Plan, this employee saved a total of $657 a year on taxes which resulted in an increased take-home pay by $657 for the year! Your actual tax savings will vary based on your own pay, withholding, etc.

**Eligibility**

You are automatically enrolled in the FLEX Plan’s Premium Conversion feature and pay for benefits pre-tax except for Optional Life Insurance, which is paid on an after-tax basis. You may also elect after-tax deductions.

### Example A: Tax Advantage of the FLEX Plan’s Pre-tax Feature

<table>
<thead>
<tr>
<th></th>
<th>NO FLEX</th>
<th>WITH FLEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Income</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Annual Insurance Premiums</td>
<td>– 3,560</td>
<td>– 3,560</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>30,000</td>
<td>26,440</td>
</tr>
<tr>
<td>Federal Income and Social Security Taxes</td>
<td>– 2,684</td>
<td>– 2,027</td>
</tr>
<tr>
<td>Take-home Pay</td>
<td>$23,756</td>
<td>$24,413</td>
</tr>
</tbody>
</table>

**Note:** If you are a FLEX Plan participant and enroll in a Short or Long-term Disability plan, any disability payments you receive will be considered taxable income for the calendar year in which they are received and subject to FICA for the first six months for which you receive benefits.

**Pre-Tax Deductions and Disability, the FRS, and Social Security**

Short- and Long-Term Disability premiums are automatically deducted pretax unless you elect after-tax deductions for all of your benefits. This means that any disability benefit payments you may receive will be considered taxable income. You may elect after-tax payroll deductions, in which case any disability benefit payments you may receive will not be taxed. Please note, when you elect after-tax deductions, all of your benefit plan premiums will be deducted on an after-tax basis.

There is no effect on your earnings base for Florida Retirement System (FRS) Pension Plan calculations and minimal effect on Social Security benefits. We recommend you speak with a tax professional if you have any questions or concerns about pre-tax deductions.

**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.

**$657 Saved!**

Assumptions: $30,000 gross income • Consumer Directed Health Plan Employee + Family Coverage 2018 tax tables, filing married with four exemptions. This chart is for illustrative purposes only.
Change in Status Events

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 (also called life event).

If you experience a qualified change in status event, your request must be consistent with, and correspond to, the qualified status change. For example, if you are divorced and had been covered under your spouse’s medical plan, it is consistent to elect medical coverage. If you did not lose coverage as a result of the divorce, you cannot elect medical coverage.

To change your benefit elections, you must submit an Enrollment and Change Form 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.

Use the charts on the next page to guide you through the changes allowed following a particular life event.

Change in Status FAQs

When am I required to notify Risk Management about a life event change?

You have 31 days from the date of your event to make a change. If you miss the deadline, you must wait until Annual Enrollment to make a change for the next plan year.

How do I notify Risk Management?

You must submit an Enrollment and Change Form (PCS 3-2247) along with the documentation required consistent with your life event. 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.

If you do not have supporting documentation (e.g., birth certificate), do not wait to submit the Enrollment and Change Form. Submit the form within 31 days and we will hold it, pending the documentation.

If I change my benefits, when will I see a change in my paycheck?

Changes that affect your payroll deductions generally start within one to two pay periods after you notify us of your change. You will receive a letter regarding your payroll adjustment.

If I cancel coverage for my child(ren) or spouse during Annual Enrollment will they be eligible for COBRA?

No. If you cancel dependent coverage during open enrollment, your dependent is not eligible for COBRA. However, if you drop your dependent from coverage during the year because of a life event change, and you notify Risk Management within 31 days of the event, your dependent will be sent a COBRA package if he or she is eligible.

I am on maternity leave. What do I need to do?

You must complete a Leave of Absence request form. We recommend that you complete a Pre-enrollment form to add your newborn (Enrollment and Change form PCS-3-2247) and submit it to Risk Management prior to the birth of your baby. After your baby is born, call Risk Management with the name, date of birth, etc. Please do not call Aetna to add your newborn to your plan. If you do not complete a Pre-enrollment form, you have 31 days from the date of the child’s birth to add your baby to the plan.

Can I cancel my benefits while on leave?

You may cancel your benefits while in an unpaid leave status; at the end of your Family Medical Leave; or because of a qualified life event (e.g. birth of a baby).

When and how can I re-enroll?

You have 31 days from your return-to-work date to complete and return an Enrollment and Change Form to Risk Management to reenroll in your benefits. Reenrollment is not automatic.

GRANDCHILDREN—May be covered for up to 18 months from the date of birth, provided the parent is covered under the employee’s plan at the time of birth. Coverage for the grandchild will end if the parent becomes ineligible before the 18 months of coverage ends.

Continued on next page
The FLEX Plan

### Qualifying Events to **ADD** Medical, Dental, or Vision

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Copy of marriage certificate</td>
</tr>
<tr>
<td>Divorce</td>
<td>Copy of divorce decree</td>
</tr>
<tr>
<td>Death</td>
<td>Copy of death certificate when available</td>
</tr>
<tr>
<td>Birth of a Child</td>
<td>Copy of birth certificate when available:</td>
</tr>
<tr>
<td></td>
<td>• Within 31 days to avoid paying first month’s additional premium</td>
</tr>
<tr>
<td></td>
<td>• Within 60 days or coverage will be allowed and billed from date of birth</td>
</tr>
<tr>
<td>Legal Adoption or intent to adopt</td>
<td>Copy of adoption paperwork</td>
</tr>
<tr>
<td>Legal Guardianship</td>
<td>Copy of guardianship paperwork</td>
</tr>
<tr>
<td>Judgment, decree or order requiring you to provide health coverage for dependent child</td>
<td>Copy of judgment, decree, or order</td>
</tr>
<tr>
<td>Grandchild</td>
<td>Copy of birth certificate identifying covered dependent as parent</td>
</tr>
<tr>
<td>Return to work from unpaid leave</td>
<td>Return to Work notification (received from Personnel)</td>
</tr>
<tr>
<td>Loss of benefits from employer group plan, federal or state sponsored plan</td>
<td>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 life event</td>
</tr>
<tr>
<td>Loss of COBRA benefits</td>
<td>COBRA termination letter showing end of eligibility</td>
</tr>
<tr>
<td>Significant premium cost change attributable to employee or dependents benefit plan</td>
<td>Statement from other coverage sponsor stating cost change and effective date</td>
</tr>
</tbody>
</table>

### Qualifying Events to **DROP** Medical, Dental, or Vision

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting unpaid leave of absence</td>
<td>Copy of the leave</td>
</tr>
<tr>
<td>Marriage</td>
<td>Copy of marriage certificate</td>
</tr>
<tr>
<td>Divorce</td>
<td>Copy of the divorce decree (first and last page of the document)</td>
</tr>
<tr>
<td>Birth of a child</td>
<td>Copy of birth certificate when available</td>
</tr>
<tr>
<td>Legal adoption or intent to adopt</td>
<td>Copy of adoption paperwork</td>
</tr>
<tr>
<td>Death of a spouse or child</td>
<td>Copy of the death certificate when available</td>
</tr>
<tr>
<td>Grandchild</td>
<td>Automatic termination when grandchild turns 18 months of age. Provide documentation of legal guardianship to extend.</td>
</tr>
<tr>
<td>Gain benefits from employer group plan or federal- or state-sponsored plan</td>
<td>Proof of other insurance coverage with effective date, or documentation of employer’s annual enrollment</td>
</tr>
<tr>
<td>Significant premium cost change attributable to employee or dependents benefit plan</td>
<td>Statement from other coverage sponsor stating cost change and effective date</td>
</tr>
<tr>
<td>You or your dependent have a change in place of residence outside of the service area or work outside the coverage area</td>
<td>Copy of driver’s license, lease, utility bill to show change of address</td>
</tr>
<tr>
<td></td>
<td>Copy of enrollment in school</td>
</tr>
<tr>
<td></td>
<td>Copy of documentation from employer</td>
</tr>
</tbody>
</table>

### Healthcare Flexible Spending Accounts (FSA)

You can only cancel or decrease your contributions if you experience these qualifying events: death, divorce or unpaid leave of absence.
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.

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 or on a Family Medical Leave to enroll.
- When your benefits are effective, you can get more information and check your FSA balances at www.aetnapcsb.com, where you can link to PayFlex.

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

The FLEX Plan
Flexible Spending Accounts (FSAs)

Make FSAs 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.aetnapcsb.com, where you can link to PayFlex.
- Decide How Much to Contribute
  — Healthcare FSA = $200 to $2,500
  — Dependent Care FSA = $200 to $5,000 ($2,500 if married and filing separately)
- Board Credits Count! If you do not enroll in a medical plan, you can enroll in a Healthcare FSA and authorize from $10 up to $25 of your Board Credits to be deposited in your account each payday.
- WARNING! Estimate Carefully—The IRS “use it or lose it” rule says you must use all of the money you deposit into your FSA(s) by the end of the plan year or you will forfeit any remaining balance in your account(s).
- Enjoy Your Tax Savings—The chart below shows how much three employees could save on taxes.

How Much Can You Save On Taxes?
The actual amount you will save will vary by how much you contribute, your annual income, tax filing status, and exemptions. In these examples, Kirin, Dave, and Tonya contribute different amounts to their FSA(s) and have a different tax filing status.

<table>
<thead>
<tr>
<th>Kirin Saved $1,651</th>
<th>Dave Saved $303</th>
<th>Tonya Saved $757</th>
</tr>
</thead>
<tbody>
<tr>
<td>Her savings equaled a mortgage payment</td>
<td>His savings paid for eight tanks of gas</td>
<td>Her savings paid for a new laptop computer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Annual Salary</th>
<th>$35,000</th>
<th>$22,000</th>
<th>$42,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSA Payroll Deductions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare FSA</td>
<td>-$450</td>
<td>-$1,000</td>
<td>-$2,500</td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>-$5,000</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Taxable Salary</td>
<td>$29,550</td>
<td>$21,000</td>
<td>$39,500</td>
</tr>
<tr>
<td>Taxes on Annual Salary</td>
<td>$6,494</td>
<td>$2,555</td>
<td>$8,615</td>
</tr>
<tr>
<td>Reduced Taxes on Taxable Salary</td>
<td>$4,843</td>
<td>$2,252</td>
<td>$7,858</td>
</tr>
<tr>
<td>Total Tax Savings</td>
<td>$1,651</td>
<td>$303</td>
<td>$757</td>
</tr>
</tbody>
</table>

Tax Status: Single with 3 exemptions, Single with 1 exemption, Married with 3 exemptions
Changing Your FSA Elections

You cannot change your elections during a plan year unless you experience a qualifying change in status event (see pages 21–22). Your change must be a direct result of and consistent with the event.

Special note about changing your Dependent Care FSA (DCFSA) Election: You can only change or cancel your DCFSA election when:

• The change in status affects your eligibility for the DCFSA.
• Your dependents are no longer considered eligible dependents (i.e. they reach the age limit).
• Your daycare provider is an independent third-party provider (someone other than a relative) and significantly increases or decreases the cost of care, or you change providers.

Accessing Your FSA Funds

Healthcare FSA

Your Healthcare FSA annual election amount is available on the effective date of your benefits (or January 1 for Annual Enrollment elections), allowing you to use your money immediately while your contributions are deducted each pay. It’s like getting a tax-free, interest-free loan to pay eligible expenses.

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. If you remain enrolled in a Healthcare FSA from year to year, your debit card will automatically renew and reload with your annual election amount on January 1. You cannot use your debit card to pay prior year expenses (i.e., you go to the doctor on January 5, 2019 and have a balance due from a December 2018 visit. You cannot use your debit card to pay the December 2018 expense).

If you do not want to use your debit card, do not activate it. You can submit manual claims along with your receipts to the address listed on the PayFlex reimbursement claim form, available online.

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 you budget for your dependent care expenses. You will have to file manual claims for Dependent Care FSA reimbursements—you cannot use the debit card to pay dependent day care expenses. Your reimbursement claims will be paid via direct deposit or by check through the mail. Claims are generally processed in five to seven business days of receipt by PayFlex. Reimbursement checks are processed and mailed on a daily basis.

FSA Eligible Expenses

Healthcare FSA

• Eligible medical, dental, and vision plan deductibles, coinsurance, or co-pays.
• Prescription eyeglasses, contact lenses, and supplies.
• LASIK and other surgery to correct or improve vision.
• Smoking cessation programs.
• Eligible over-the-counter (OTC) supplies. IRS rules state that OTC medications such as pain relievers, cough syrup, and allergy medicines require a prescription in order to be eligible for reimbursement from a Healthcare FSA. You cannot use the PayFlex debit card to purchase OTC medications even if you have a prescription.

Se view IRS Publication 502 for a list of eligible expenses.

Dependent Care FSA

• Pay an eligible day care provider or caregiver to take care of your children or elderly parents so you (and your spouse) can work.
• See IRS Publication 503 for a list of eligible expenses.
• Note: Medical, dental, vision, and other eligible health care expenses for your dependent children can only be reimbursed from a Healthcare FSA.
PayFlex Makes Managing Your FSAs Easy

To manage your FSAs online, log in to www.aetnapcsb.com. The website includes the most up-to-date information about your account. You can:

• View your account balance by going to the “Spending Accounts” page in the “Claims & Spending” section.
• Review all posted and pending FSA transactions.
• Request additional PayFlex debit cards.
• Download a reimbursement claim form.
• Review frequently asked questions about using the FSA, verifying expenses, and getting the most value from your account.
• See a sample list of qualified expenses (the list may not be all-inclusive; check with Aetna’s on-site representative or call Aetna at 866-253-0599 for specifics).
• Review year-to-date spending.
• Estimate costs for health care services and prescription drugs.
• Compare doctors, hospitals, and outpatient centers when you log in to your secure Aetna member website.
• Use Healthcare FSA and Dependent Care FSA planners.

Use It or Lose It Rule—Estimate Your FSA Contributions Carefully

The IRS “use it or lose it” rule states 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, to submit receipts for reimbursement of services received during the plan year or employment period.

PayFlex Contact Information
Aetna Concierge Customer Service
www.aetnapcsb.com • 866-253-0599

Keep It Simple with the Aetna PayFlex Mobile® App
Manage your account and view alerts. Snap a photo of your receipts to submit claims. View common eligible expense items, and more.

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.

Healthcare Flexible Spending Accounts (FSA)
May only be dropped or decreased due to these qualifying events: death, divorce, or unpaid leave of absence.

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

You can choose from three Aetna medical plans.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna Select Open Access</td>
<td>Aetna Select Open Access</td>
</tr>
<tr>
<td>Choice POS II (Point of Service II)</td>
<td>Choice POS II</td>
</tr>
<tr>
<td>CDHP + HRA (Consumer Directed Health Plan with Health Reimbursement Account)</td>
<td>Aetna Select Open Access</td>
</tr>
</tbody>
</table>

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.

This section provides detailed comparisons of plan features, benefits, and costs. Please review this information and visit www.aetnapcsb.com before making your decision.

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 on pages 38–44 and at www.aetnapcsb.com.

You Have Other Options

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 (see page 23 for details).

If you cannot afford to enroll your spouse and/or child(ren) in a PCS medical plan, consider the following:

- 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.

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

Be in the Know
Before You Enroll
See how the plans compare on pages 34–37.

Search for your doctors and providers:
- Go to aetnapcsb.com and select “Find a doctor” from the top menu.
- Under “Not a member yet?” select “Plan from an employer.”
- Before you are enrolled, continue as a guest and enter your home location and follow the prompts.
- After you are enrolled in a plan, follow the steps under “Already a member” to register or log in to your secure member website and follow the prompts.
- You can also call a concierge to request a printed directory.

Go to www.aetnapcsb.com to learn about Aetna and your medical benefits.

Take Charge
After You Enroll

Register for Your Secure Member Website.
Make this your first “to do” after you are enrolled. You can access your ID card, track your health history, view your claims, and more.

Make It Easy with the Aetna Mobile App.
Access your secure member information, anytime, anywhere to access your ID card, search for a doctor or facility, find urgent care centers and walk-in clinics, view claims, and more. Available in your app store.
• 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.

Important Information for Women

Woman’s Preventive Care—Coverage for All Plans. Women’s preventive care is covered at 100% for all plans when you use an in-network provider, including:

• Well-woman exam
• Health screenings and counseling
• Three gestational diabetes screening tests
• Breast-feeding support, supplies, and counseling
• Contraceptive methods and counseling; generic contraceptives are covered at 100% and brand contraceptives at 100% when a generic is not available

OB/GYN Direct Access. Female members have direct access to participating obstetricians and gynecologists for routine well-woman exams, Pap tests, and obstetric or gynecological problems without a referral for services rendered in the physician’s office. Obstetricians and gynecologists may provide a referral to other participating providers for covered obstetric and gynecological services performed outside the physician’s office. Birthing Centers are also available. For additional information, contact Pinellas County Schools’ Aetna on-site representative at 727-588-6367.

Choosing the Right Medical Plan

Here are some key differences to consider in addition to the financial aspects of each plan.

<table>
<thead>
<tr>
<th></th>
<th>Select Open Access</th>
<th>Choice POS II</th>
<th>CDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do I have to stay in-network to receive plan benefits?</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>What is the coverage area?</td>
<td>National</td>
<td>National</td>
<td>National</td>
</tr>
<tr>
<td>Do I have to select a PCP?</td>
<td>Not Required</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td>Do I need a referral to see specialists?</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>What do I pay for medical services?</td>
<td>Co-pays for all services, no deductible</td>
<td>Deductibles, coinsurance and co-pays</td>
<td>Deductibles and coinsurance</td>
</tr>
<tr>
<td>Is preventive care covered at 100%?</td>
<td>YES In-network only</td>
<td>YES In-network only</td>
<td>YES In-network only</td>
</tr>
<tr>
<td>Is there a Health Reimbursement Account (HRA)?</td>
<td>NO</td>
<td>NO</td>
<td>YES (see page 8)</td>
</tr>
<tr>
<td>Is there prescription drug coverage?</td>
<td>All three plans offer the Aetna Prescription Drug Program. Details are provided on pages 30–31.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Aetna Medical Plans
Aetna Resources

Aetna Select Open Access
In-Network Only Coverage: Aetna Select Open Access
• 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 PCP or get referrals to specialists.
• You will have a higher co-pay to visit specialists. (A specialist is a doctor who focuses only on treating certain conditions or diseases.)

Choice POS II
Network: 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.

Out-of-network doctors and hospitals do not contract with Aetna and can charge more for their services, and you may have to pay the difference between what the plan pays for services and the amount the out-of-network provider charges.

Out-of-network providers may not submit claims or get approval for coverage when needed—this means you may need to handle these details on your own.

CDHP + HRA
In-Network Only Coverage: Aetna Select Open Access
• 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 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® with up to $500 (individual) or $1,000 (family) each year. See “How the CDHP + HRA Works” for details.

NOT REQUIRED: PCP Designation or Specialist Referrals
You don’t have to choose a primary care physician (PCP), but you may want to. PCPs do more than give you a checkup. They know your medical history, and they can help direct your care. If you choose a PCP, you can change your PCP anytime. Just call Aetna Concierge Customer Service or go log in to your secure member website.

You can visit any network doctor or specialist without a referral. Network doctors contract with Aetna to offer rates that are often lower than their regular fees. The network doctor or specialist will provide care, get approval from Aetna before giving you certain services, and file claims for you.

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

<table>
<thead>
<tr>
<th>From</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>February 1</td>
<td>$458</td>
<td>$916</td>
</tr>
<tr>
<td>March 1</td>
<td>$416</td>
<td>$833</td>
</tr>
<tr>
<td>April 1</td>
<td>$375</td>
<td>$750</td>
</tr>
<tr>
<td>May 1</td>
<td>$333</td>
<td>$666</td>
</tr>
<tr>
<td>June 1</td>
<td>$291</td>
<td>$583</td>
</tr>
<tr>
<td>July 1</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>August 1</td>
<td>$208</td>
<td>$416</td>
</tr>
<tr>
<td>September 1</td>
<td>$166</td>
<td>$333</td>
</tr>
<tr>
<td>October 1</td>
<td>$125</td>
<td>$250</td>
</tr>
<tr>
<td>November 1</td>
<td>$83</td>
<td>$166</td>
</tr>
<tr>
<td>December 1</td>
<td>$41</td>
<td>$83</td>
</tr>
</tbody>
</table>

Important Information About the PayFlex HRA and Healthcare FSA Cards

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

<table>
<thead>
<tr>
<th>PayFlex Card</th>
<th>Eligible Out-of-Pocket Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>HRA PayFlex Card</td>
<td>➔ Pay for Medical/Rx Expenses</td>
</tr>
<tr>
<td>Healthcare FSA PayFlex Card</td>
<td>➔ Pay for Medical/Rx, Dental, and Vision Expenses</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Drug Tier</th>
<th>Cost</th>
<th>Restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$20 co-pay</td>
<td>Lowest Cost: You will save the most when you use generic drugs and preferred brand drugs when a generic is not available.</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$50 co-pay</td>
<td>Higher Cost: Non-preferred brand drugs are higher cost and often have a generic or preferred brand alternative that can save you money.</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>$90 co-pay</td>
<td>Higher Cost: Specialty drugs are the most expensive, high-technology and self-administered injectable medications not available on other levels.</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$120 co-pay</td>
<td>Highest Cost: You will save the most when you use generic drugs and preferred brand drugs when a generic is not available.</td>
</tr>
</tbody>
</table>

No deductible: $250/individual $500/family

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

Restrictions

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

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

- **Precertification.** Certain drugs require precertification, and you or your doctor will need to get approval from Aetna before your prescription will be covered. This is one way that Aetna helps you and your doctor find safe, appropriate drugs and keep costs down. Generally, precertification applies to:
  - Ensure compliance with dosing guidelines
  - Avoid duplicate therapies
  - Help health care providers confirm the use of your medication is based on generally accepted medical criteria

Locator a Participating Pharmacy

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

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

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

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

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

Aetna Specialty Pharmacy®

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

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

Compound Medications

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

Rx Cost Savings Tips

- Pay less when you use generic and lower-cost brand-name medications. Be sure to take a copy of the Aetna drug list to your doctor and request a lower-cost alternative whenever possible.
- Take advantage of free and low-cost options at retail and grocery store pharmacies, including those offered by the preferred pharmacies.
- Consider an over-the-counter (OTC) alternative, available for many common conditions.
Teladoc: $25 Co-pay

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

<table>
<thead>
<tr>
<th>Online</th>
<th>Go to <a href="http://www.Teladoc.com/Aetna">www.Teladoc.com/Aetna</a> and click &quot;set up account.&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile app</td>
<td>Download the app and click &quot;Activate account.&quot; Visit <a href="http://www.teladoc.com/mobile">www.teladoc.com/mobile</a> to download the app.</td>
</tr>
<tr>
<td>Call</td>
<td>855-Teladoc (835-2362) Teladoc can help you register your account over the phone.</td>
</tr>
<tr>
<td>Pay less …</td>
<td>… than a visit to an urgent care: $25 co-payment for all three of the medical plans.</td>
</tr>
</tbody>
</table>

When You Need a Doctor, Make a Smart Choice

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

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

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

\(^1\) Not available outside of the U.S.

\(^2\) If medically necessary
Healthcare Bluebook: Compare, Choose, Save

When you enroll 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. Together, you and your doctor can decide which provider fits your medical care needs and your budget.

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. For example, search for an imaging procedure prior to having an MRI or CT.

Start Saving Now

Healthcare Bluebook gives you and your enrolled dependents 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.

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

Quality is Key

When it comes to inpatient medical procedures, quality is key. One study showed that patients at the worst hospitals are 13 times more likely to have complications.* With Healthcare Bluebook, you can see quality ratings on hundreds of procedures across thousands of hospitals nationwide. See how hospitals in your area rate before you schedule your procedure.

* PLOS One, 2016.
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. See page 8. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified.

- **Medical Plan Deductible** (Choice POS II and CDHP + HRA): The amount you pay for medical expenses before the plan begins paying benefits.

- **Coinsurance** (Choice POS II and CDHP + HRA): The percentage of eligible medical expenses you pay after paying the deductible for most services.

- **Co-pays** (Aetna Select Open Access): The fixed amount you pay for medical care and prescriptions.

- **Aetna Prescription Drug Program** (all plans): You pay co-pays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay co-pays.

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

### Aetna Medical Plans Comparison Chart

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Only</th>
<th>In-Network</th>
<th>Out-of-Network¹</th>
<th>In-Network Only</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Areas/Networks</strong></td>
<td>Any provider in the Aetna Select Access national network</td>
<td>Any provider in the Choice POS II Network (national network)</td>
<td>Any provider</td>
<td>Any provider in the Aetna Select Open Access national network</td>
</tr>
<tr>
<td><strong>Health Reimbursement Account (HRA)</strong>—Individual/Family</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$500 Individual; $1,000 Family (combined in- and out-of-network)</td>
</tr>
<tr>
<td><strong>Deductibles</strong>—Individual/Family</td>
<td>N/A</td>
<td>N/A</td>
<td>$500 Individual; $9,000 Family (combined in- and out-of-network)</td>
<td>$1,500 Individual; $3,000 Family</td>
</tr>
<tr>
<td><strong>Medical Out-of-Pocket Maximum</strong>—Includes medical deductible, coinsurance, and/or co-pays</td>
<td>$4,500 Individual; $9,000 Family</td>
<td>$4,500 Individual; $9,000 Family (combined in- and out-of-network)</td>
<td>$1,750 Individual; $3,500 Family (combined in- and out-of-network)</td>
<td>$4,500 Individual; $9,000 Family</td>
</tr>
<tr>
<td><strong>Rx Out-of-Pocket Maximum</strong>—Includes Rx co-pays and deductible</td>
<td>$1,750 Individual; $3,500 Family</td>
<td>$1,750 Individual; $3,500 Family (combined in- and out-of-network)</td>
<td>$1,750 Individual; $3,500 Family (combined in- and out-of-network)</td>
<td>$1,750 Individual; $3,500 Family</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Physician Office Visits</strong></td>
<td>You Pay:</td>
<td>You Pay:</td>
<td>You Pay:</td>
<td>You Pay:</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>$25 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Specialist (SPC)</td>
<td>$50 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Teladoc</td>
<td>$25 co-pay</td>
<td>$25 co-pay</td>
<td>N/A</td>
<td>$25 co-pay</td>
</tr>
<tr>
<td>Preventive Adult Physical Exams</td>
<td>No co-pay</td>
<td>0%</td>
<td>40% after deductible</td>
<td>0% no deductible</td>
</tr>
<tr>
<td>Preventive GYN Care (including Pap test) (direct access to participating providers)</td>
<td>No co-pay</td>
<td>0%</td>
<td>40% after deductible</td>
<td>0% no deductible</td>
</tr>
<tr>
<td>Mammography Preventive Screening</td>
<td>No co-pay</td>
<td>0%</td>
<td>40% after deductible</td>
<td>0% no deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No co-pay</td>
<td>0%</td>
<td>40% after deductible</td>
<td>0% no deductible</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>Co-pay waived for allergy injections billed separately</td>
<td>20% after deductible; allergy injections billed separately</td>
<td>40% after deductible; injections billed separately</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Allergy Tests</td>
<td>$50 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Lab</td>
<td>$25 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>X-Ray Outpatient</td>
<td>$50 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Advanced Radiology Services (MRI, CAT scan, PET scan, etc.)</td>
<td>$250 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Colonoscopy Screenings—Preventive and Diagnostic</td>
<td>No co-pay</td>
<td>0%</td>
<td>40% after deductible</td>
<td>0% no deductible</td>
</tr>
<tr>
<td>Chiropractic Services (limits apply) (direct access to participating providers)</td>
<td>$50 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Hearing Exam</td>
<td>$25 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
<td>20% after deductible</td>
</tr>
</tbody>
</table>

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

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.

Continued on next page
### Aetna Medical Plans Comparison Chart

Please note the dollar amounts are co-pays, deductibles, and maximums which you pay; and 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.

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.

#### Rx Deductible May Apply
For non-preferred brand and specialty drugs, you must pay the $250 per person or $500 per family Rx deductible before you begin paying copays.

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

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

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Select Open Access</th>
<th>Choice POS II</th>
<th>CDHP + HRA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Only</td>
<td>In-Network</td>
<td>Out-of-Network&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>Hospital (Inpatient includes maternity and newborn services)</td>
<td>$500 co-pay per day; up to 5-day maximum</td>
<td>$500 co-pay per day; up to 5-day maximum</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery (including facility charges)</td>
<td>$500 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$500 co-pay</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Ambulance</td>
<td>No co-pay</td>
<td>20% after deductible</td>
<td>20% after deductible</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$50 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Maternity Care/OB Visits</td>
<td>$50 co-pay for initial visit only</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health Services</td>
<td>$25 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Inpatient Mental Health Services</td>
<td>$500 co-pay per day; up to 5-day maximum</td>
<td>$500 co-pay per day after deductible; up to 5-day maximum</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care (limits apply)</td>
<td>No co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Hospice—Inpatient (limits apply)</td>
<td>$500 co-pay per day; up to 5-day maximum&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$500 co-pay per day after deductible; up to 5-day maximum&lt;sup&gt;2&lt;/sup&gt;</td>
<td>40% after deductible; 30-day lifetime maximum</td>
</tr>
<tr>
<td>Skilled Nursing Facility (limits apply)</td>
<td>$500 co-pay per day; up to 5-day maximum&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$500 co-pay per day after deductible; up to 120-visit limit per calendar year</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Short Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)</td>
<td>$25 co-pay per visit</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Diabetic Supplies (syringes, test strips)</td>
<td>See prescription drugs below</td>
<td>See prescription drugs below</td>
<td>See prescription drugs below</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>$50 co-pay</td>
<td>20% after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Aetna Prescription Drug Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some drugs may be subject to step-therapy or preauthorization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to 30-day supply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Preferred Brand</td>
<td>Mandatory Generics Unless Dispensed As Written</td>
<td>Mandatory Generics Unless Dispensed As Written</td>
<td>Mandatory Generics Unless Dispensed As Written</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$20 co-pay; no Rx deductible</td>
<td>$20 co-pay; no Rx deductible</td>
<td>$20 co-pay; no Rx deductible</td>
</tr>
<tr>
<td>Specialty</td>
<td>$50 co-pay; no Rx deductible</td>
<td>$50 co-pay; no Rx deductible</td>
<td>$50 co-pay; no Rx deductible</td>
</tr>
<tr>
<td>$90 co-pay; after Rx deductible</td>
<td>$90 co-pay; after Rx deductible</td>
<td>$90 co-pay; after Rx deductible</td>
<td></td>
</tr>
<tr>
<td>$120 co-pay; after Rx deductible</td>
<td>$120 co-pay; after Rx deductible</td>
<td>$120 co-pay; after Rx deductible</td>
<td></td>
</tr>
<tr>
<td>90-day Supply (maintenance medications) at retail or mail order (mail order must be through Aetna Rx Home Delivery service)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Preferred Brand</td>
<td>Mandatory Generics Unless Dispensed As Written</td>
<td>Mandatory Generics Unless Dispensed As Written</td>
<td>Mandatory Generics Unless Dispensed As Written</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$40 co-pay; no Rx deductible</td>
<td>$40 co-pay; no Rx deductible</td>
<td>$40 co-pay; no Rx deductible</td>
</tr>
<tr>
<td>$100 co-pay; no Rx deductible</td>
<td>$100 co-pay; no Rx deductible</td>
<td>$100 co-pay; no Rx deductible</td>
<td></td>
</tr>
<tr>
<td>$180 co-pay; after Rx deductible</td>
<td>$180 co-pay; after Rx deductible</td>
<td>$180 co-pay; after Rx deductible</td>
<td></td>
</tr>
</tbody>
</table>

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<sup>1</sup> Subject to usual, customary, reasonable (URC) fees  
<sup>2</sup> Waived if transferred from hospital
Aetna Medical Plans
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.

You will receive personalized nurse support if you have a health condition or other risk that could affect your pregnancy. Our nurse case managers will work with you to manage or maybe even lower those risks. In most cases, full-term babies have fewer health problems. So if you’re at risk for early labor, this program will help to explain the signs and symptoms, and talk about new treatment options.

Online Health Assessment

You can access the online health assessment on your secure member website. The assessment only takes minutes to complete. It is divided into three sections to assess your health:

1. **Every day you**—Asks questions about your lifestyle.
2. **Energy and you**—Assesses your energy levels, sleep history, and physical activity.
3. **Your body and you**—Focuses on your body and biometric values.

Answer a few questions on your confidence level in changing lifestyle behaviors. Knowing where you are right now helps Aetna help you move forward. Immediately after you complete the assessment, you’ll receive a health report. You can download or print this to share with your doctor. You will also get directions to get you started on the path of better health. We’ll direct you to the online program that’s right for you. Choose our recommendation, or pick from others.

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.

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.
Call Concierge Member Services—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). A concierge can assist you with:

• A question about a diagnosis
• Selecting a doctor
• Learning about your coverage
• Planning for upcoming treatment
• Think of the concierge as your personal assistant for health care. Your concierge will:
  — Find solutions that fit your needs
  — Show you how to use our online tools to make the decisions that are right for you
  — Find network providers based on your medical needs
  — Even assist you in scheduling appointments

Need Help Planning for Health Care Expenses?

Your concierge can show you how to estimate your costs before you make an appointment. You can find out what it would cost to see a network doctor versus an out-of-network doctor. You can learn the difference between inpatient and outpatient care. And see the difference in cost. Knowing your options and cost estimates in advance can help you make decisions and better manage your health care expenses.

We’ve all been there—needing help with our health plan and not knowing where to turn.

• How can I find the right specialist?
• I have my diagnosis but what do I do now?
• Is this covered by my health plan?
• My doctor said I need surgery. I’m so worried. I have so many questions. I don’t know where to start.
• How much is this going to cost me?

If you have any questions about your coverage, call or chat with a concierge! Your concierge will listen to you, understand your needs, and find solutions that are right for you.

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—
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 800-556-1555 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.aetnpesb.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 more 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
• Go online for even more health information

If you like to go online for health information, check out the “Informed Health Line” page on your secure member website. Here’s what you can do:
• Use our symptom checker
• Learn about an upcoming medical test
• Research a new medication you’re taking
• And more

CVS Neighborhood Well-being Counseling

Want to start working on your health goals? Can’t seem to find the time? Now you have a fast and convenient way to get started. 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 Medical Plans
Tools and Resources to Maximize Your Coverage

MinuteClinic providers will work one-to-one with you to help you reach your goals. It’s personal and confidential. The details about your sessions will stay private. With your permission, MinuteClinic can send your doctor a copy of your records to keep everyone up to date.

Well-being services close to home—on your schedule. Visit your neighborhood MinuteClinic when you need care. It’s open seven days a week, including evenings. You don’t need an appointment. Just walk in. You can also view wait times and hold your place in line before you leave the house. And you’ll receive a text notification when you are next in line. Go to www.minuteclinic.com or download the CVS Pharmacy app.†

We understand your time is valuable. So is your health. We make it convenient for you to meet with a MinuteClinic provider and take another step along your path to wellness. It’s right in your own neighborhood.

† Restrictions apply. Visit www.minuteclinic.com for details.

Aetna In Touch Care℠ Program

Aetna In Touch Care 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.

To You Benefit—Aetna’s Digital Programs and Resources

Log in to your secure member website to access:

- **Personal health record.** Organize and store your health history and information so you can share it with your doctor.
- **Health assessment.** Get a step-by-step plan for better health.
- **Health decision support.** Learn about your health care and treatment options.
- **Online programs.** Find health coaching programs that offer personalized support.
- **Personal health database.** View hundreds of on-demand videos for health and wellness programs and resources.
Simple Steps to a Healthier Life®

It can be hard to fit healthy into your life. But Aetna is here to support, you every step of the way with this program.

**Get started.** Log in to your secure member website, look for the “Stay Healthy” icon, and take the short assessment. It’s like a mini health survey that helps us pair you with programs and tips geared to your unique health goals.

The questions are easy, like “How often do you exercise?” or “Do you apply sunscreen?” And many focus on the habits you can change, like eating more fruits and veggies. Or getting preventive care.

Your responses are kept confidential, just between you and us (and your digital coach, if you choose one). Of course, you can always share your results with your doctor, too.

You get a line of digital coaching programs included with your health plan. All online—all personalized to your health goals—whether you’re managing a health risk, overcoming an old habit ... or just eating healthier.

• You choose the goals to work on
• You choose when we reach you
• You choose the pace—you’re 100 percent in charge

**Get Going.** If you’d like, you can work with your very own digital health coach to help you take big or small steps, navigate the pitfalls, and celebrate your successes. Or you can choose to work on your health goals without a digital coach. It’s always your call.

Each coaching program is broken up into simple steps, so you can reach small victories on your way to the grand prize, a healthier you.

Within each program, you’ll find realistic recommendations, like adding 15 minutes to your daily walk or not smoking for just one day. You choose the goals and when to work on them. You can even pause, restart, or retake a program.

<table>
<thead>
<tr>
<th>You Decide</th>
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</thead>
<tbody>
<tr>
<td>Start with Simple Steps to reach health goals like:</td>
</tr>
<tr>
<td>• Beat back pain</td>
</tr>
<tr>
<td>• Stress less</td>
</tr>
<tr>
<td>• Kick tobacco</td>
</tr>
<tr>
<td>• Get heart healthy</td>
</tr>
<tr>
<td>• Manage asthma or diabetes</td>
</tr>
<tr>
<td>• Eat healthier</td>
</tr>
<tr>
<td>• And more</td>
</tr>
</tbody>
</table>

**Get Rewarded.** You score points and badges for reaching milestones. You can even earn a $50 incentive when you take your health assessment and complete at least one recommended online health coaching program. You’ll receive an electronic gift certificate to redeem at www.aetnarewards.com.

**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. Your place to save, too. You can:

• Find a vision, hearing, or natural therapy professional
• Sign up for a weight-loss program
• Buy health products
• Find a gym
• And more
Savings on Hearing Aids and Exams

Hearing Care Solutions

- Discounts on a large choice of hearing aids
- Three-year supply of batteries when you join a discount battery mail-order program
- Free in-office service of hearing aids for one year
- Free routine cleanings and battery door replacements for one year after purchase from the original provider

Amplifon Hearing Health Care

- Discounts on many styles of hearing aids, including programmable and digital hearing aids from leading makers
- Savings on hearing exams and hearing aid repairs
- Free follow-up services for one full year
- A two-year supply of batteries

Savings on Gyms and Health Coaching

Discounts on Gym Memberships

Health coaching to quit smoking, ease stress, lose weight, and more. On your schedule.

At-home weight-loss programs that may offer menu options, online tools and coaching, counseling, etc.

Savings on home exercise equipment. Build your body—and your home gym—with discounts on home exercise helpers.

Natural therapy services and products that can save you on massage, acupuncture, chiropractic care, and nutrition services. You can also order healthy items like over-the-counter vitamins, yoga equipment, and more.

Metabolic Health Syndrome Program

Metabolic syndrome is a group of five risk factors—high triglycerides, blood pressure, blood sugar, body fat around the waist, and HDL cholesterol. These factors increase the risk for heart disease, stroke, and diabetes. Through Aetna Health Promise, we can help you treat metabolic syndrome and reduce your risk.

Screenings identify risk. Metabolic syndrome screenings may be offered at work or through a local Quest Diagnostics® patient service center. Screening results are integrated into our CareEngine® system. This turns patient data into action for providers and members. Results are easy to understand and delivered through a profile report.

Aetna and PCS will sponsor on-site metabolic screenings each year. Watch for dates and times announcing the screenings.

The Metabolic Health Advisor program raises awareness of metabolic syndrome and motivates employees to receive screenings.

The Metabolic Health in Small Bytes online group coaching program targets obesity. The rise in adult obesity rates is making metabolic syndrome more common.

The Aetna Get Active℠ program provides fun challenges and activities throughout the year. This group-based behavior change program addresses healthy eating and activity. Your PCS wellness team will be sharing information with you on when these exciting programs will occur!
Aetna Get Active Program

As an Aetna member, you now have more ways to enjoy the Aetna Get Active program, available online or as an app on your favorite device. Our enhanced user experience helps you improve your well-being by making it easier to start, and stick with, healthy habits and behaviors.

- Engage with a website that’s fun and easy to use
- Participate in individual and team-based challenges
- Link to wearable devices like your fitness tracker or Apple Watch®

Need to mix it up? No problem! With new challenges every quarter, you can stay motivated and improve your fitness and health throughout the year.

If getting healthier is one of your goals, this program can help.

Aetna Get Active Mobile App

Living better every day just got a whole lot easier. With the Aetna Get Active® app, get the best features of the Virgin Pulse program—wherever you are. And when you set up your mobile alerts, you won’t miss any news and updates.

* Aetna Get Active is powered by Virgin Pulse.

Installation’s a snap. Download the app from your app store, search for Virgin Pulse, and install the app to:

**Review stats**
- Connect a device
- Track activity
- Log steps
- Log a workout

**Take part in challenges**
- Join and check your progress
- Create or join personal challenges

**Access your account at any time**
- Track your progress and so much more
- Earn a trophy the first time you log in
The following services and items is a list of the general exclusions under your medical plans. This is not a comprehensive list; a full list of plan exclusions is available in your plan documents.

- Contraception services and supplies—over-the-counter (OTC) contraceptive supplies and any drug, or supply to prevent or terminate a pregnancy
- Cosmetic services and plastic surgery
- Dental care, except as otherwise noted
- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies.
- Facility charges—Rest homes, assisted living facilities, health resorts, spas or sanitariums, and infirmaries at schools, colleges, or camps
- Foot care—the treatment of calluses, bunions, toenails, hammertoes, or fallen arches and routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Growth/Height care—a treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth and surgical procedures to stimulate growth
- Hearing aids and exams
- Jaw joint disorder—non-surgical treatment of jaw joint disorder (TMJ)
- Medical supplies—outpatient, disposable supplies
- Other primary payer—payment for a portion of the charge that Medicare or another party is responsible for as the primary payer
- Services, supplies and drugs received outside of the United States
- Strength and performance—Services, devices and supplies such as drugs or preparations designed primarily for enhancing your strength, endurance, physical condition and performance
- Treatment of infertility
- Wilderness treatment programs
- Work related illness or injuries
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.

**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.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Benefit Amount</th>
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</thead>
<tbody>
<tr>
<td>Hospital Admission Benefit</td>
<td>$500</td>
</tr>
<tr>
<td>Hospital Confinement Benefit</td>
<td>$250 per day, up to 30 days</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Benefit</td>
<td>$100 per day, up to 15 days per covered person, per accident but not to exceed 30 days per calendar year</td>
</tr>
</tbody>
</table>

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 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.

**Enrolling in the MetLife HIP**

When you enroll as a new employee, you and your eligible family members are guaranteed acceptance. You also have the benefits of competitive group rates and convenient payroll deductions that ensure continuous, worry-free coverage.

If you opt out of medical insurance, your Board Contribution can be applied to offset your payroll deductions for this coverage. If you don’t enroll in this plan during annual enrollment, you can’t enroll in it until the next annual enrollment or you experience a qualified change in status. For more information, call 800-438-6388.

Please see plan certificate for inpatient hospital exclusions at pcsb.org/risk-benefits, “MetLife Voluntary Plans” link.

1 Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.

**Income Tax Considerations for HIP and SunLife Disability**

When you enroll in the SunLife Disability and/or the MetLife Hospital Indemnity Plan your payroll deductions are automatically deducted on a pre-tax basis, along with all your other benefit deductions (except Optional Life Insurance). This means that any disability benefit or HIP payments you receive will be subject to federal income taxes. To avoid paying taxes on these payments, you can elect to have your premiums deducted on an after-tax basis. If requested, your payroll deductions for all benefits will be taken on an after-tax basis. Your request must be in writing. For more information contact the Benefits Team at 727-588-6197.
Employee Assistance Program (EAP)

Health Advocate, our EAP provider, offers programs that are tailored to the needs of employees and eligible family members. You can access Health Advocate services 24/7 with a licensed, professional counselor available for immediate assistance. What’s more, Health Advocate offers telephone, face-to-face, and web-based assistance.

An EAP is more than just a help line for stress, depression, and substance abuse. Its Solution Centers offer resources to help you through some of life’s toughest challenges, including:

- adoption
- alcohol
- anxiety
- buying a car or home
- cancer
- child and elder care
- diabetes
- dieting
- eating disorders
- fitness
- grieving
- heart health
- military life
- pregnancy
- smoking
- student life
- wills
- debt and bankruptcy
- divorce and child custody
- post-traumatic stress disorder
- financial planning (estate, retirement, investing)
- hurricane preparedness
- marriage and living together
- obsessive-compulsive disorder

How does the EAP work?
EAP services include an initial clinical assessment by a licensed professional to determine if short-term counseling is appropriate. If short-term counseling is appropriate, you may receive up to eight (8) counseling sessions per issue. Should the assessment indicate a need for longer-term therapy, you will be referred to qualified resources outside of the EAP.

What is the cost?
The EAP is a free, confidential service provided as part of your employee benefits.

Will I be required to use the EAP?
The EAP is a voluntary program. However, your manager may refer you to the EAP if appropriate. Regardless of the situation, you will always make the decision when and if to use the EAP.

Who will know that I have used the EAP?
Health Advocate adheres to the confidentiality guidelines mandated by law. PCS receives a report that contains only collective statistical information.

EAP FAQs

How do I access the EAP?
Call Health Advocate at 877-240-6863 and a client services team member will make every effort to address your needs and match you with an EAP counselor located near your home or work. All counselors are licensed, seasoned professionals with broad expertise. Counselors are available 24 hours a day.

EAP Highlights

EAP services include:
- 24-hour counseling assistance
- Counsel from licensed professionals
- Multiple site locations
- Short-term problem resolution
- Referrals to community resources

To get the right help at the right time, call the EAP at 877-240-6863 or go online:
www.pcsb.org/eap

Administrator:
Health Advocate
Pinellas County Schools is committed to maintaining a drug- and alcohol-free workplace. Employees are prohibited from manufacturing, distributing, dispensing, possessing, being under the influence of, or using alcohol or a controlled substance in the workplace, during the workday, on duty, or in the presence of students’ families as part of any school or work-related activities.

Employees who violate this policy will be subject to disciplinary action, which could include termination and referral for prosecution.

If you have a drug or alcohol problem that is interfering with your work, please feel free to contact any one of the resources provided by Pinellas County Schools:

**Employee Assistance Plan (EAP)**
877-240-6863

**Prevention Office**
(formerly Safe and Drug Free Schools)
727-588-6130

**Risk Management and Insurance Department**
727-588-6195

**Office of Professional Standards**
727-588-6471 or 727-588-6470

**Human Resources**
727-588-6000 ext.1936

The district will work with you to provide you a leave of absence, if necessary, to address your problem.

**Keep in mind:**
- The EAP is available to all full- and part-time employees and members of their households
- Mental health and substance abuse benefits are available to all employees and their dependents enrolled in any of the BENEFlex medical plans
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 programs is critical to the District’s vision of 100% student success.

The Be SMART Worksite Wellness program has something for everyone, and includes the programs described here and online at www.pcsb.org/vitality.

- **Onsite wellness programs / Wellness Champion 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.

- **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 Onsite Health & Wellness Advocate**
  Speak to an Aetna on-site representative at 727-588-6031 about any of these programs:
  - Financial Wellness
  - YMCA Pre-Diabetic Program
  - Quit Tobacco Resources
  - Free Diabetic Supplies

### Aetna Health Promise

Aetna Health Promise provides employees with the opportunity to improve and maintain good health with these resources:

<table>
<thead>
<tr>
<th>Secure Member Website</th>
<th>Online Health Assessment</th>
<th>Online Health Coaching Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-hour Nurse Line (Informed Health® Line)</td>
<td>Beginning Right Maternity Program</td>
<td>CVS Neighborhood Wellbeing Counseling</td>
</tr>
<tr>
<td>Member Discounts</td>
<td>Metabolic Syndrome Screenings</td>
<td>Metabolic Health in Small Bytes</td>
</tr>
<tr>
<td>Metabolic Health Advisor</td>
<td>Get ActiveSM Fitness Challenge</td>
<td>$50 Gift Card Incentive</td>
</tr>
</tbody>
</table>

### Wellness Incentives

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

**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.

**Employee Assistance Program**
Free, confidential 24-hour CARELINE. Call 800-327-9757 for assistance with depression, finances, alcohol/drug abuse, conflicts, stress, parenting, any other personal concern. Also have services for legal and financial concerns. Available to you and any family member living in your household. See page 47 for details.

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

**SMART START Newsletter**
Your resource for keeping up-to-date with the wellness program and what we offer, plus recipes, articles, insurance information, etc. Emailed district wide every other week during the school year.

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**For More Information • Visit www.pcsb.org/wellness**

| Employee Wellness Coordinator,  
| Caleigh Bean | 727-588-6031 | beanc@pcsb.org |
| Benefits and Wellness Consultant,  
| Leslie Viens | 727-588-6142 | viensl@pcsb.org |
| Employee Wellness Specialist,  
| Dawn Handley | 727-588-6151 | handleyd@pcsb.org |
| Employee Assistance Program On-Site Representative—Health Advocate,  
| Darlene Rivers | 727-588-6507 | PCS.RIVERSD@pcsb.org |
| Aetna Patient Advocate | 727-588-6137 | |
| Aetna Claims Advisor | 727-588-6367 | |
| Aetna Health & Wellness Advocate | 727-588-6134 | |
| PCS Benefits Team | 727-588-6197 | |

**Effective January 1, 2019**
PCS offers two dental plans, the HumanaDental 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. Read the following pages to learn more about each plan or call the insurance carrier with questions.

If your spouse or child(ren) has coverage under another dental plan in addition to your PCS plan, please review the coordination of benefits clause in your dental plan certificate or call your plan’s member services.

<table>
<thead>
<tr>
<th>Network</th>
<th>HumanaDental Plus 2S Plan</th>
<th>MetLife Preferred Dentist Program (PDP Plus)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Florida Service Area</td>
<td></td>
<td>In or out-of-network. Save the most when you choose a participating network provider.</td>
</tr>
<tr>
<td>In-network only. You must choose a participating network provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Dentist and Specialist Referrals</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>Deductible</td>
<td>None</td>
<td>$50/individual; $150/family (Applies to Type B and C Services)</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>None</td>
<td>$1,250 per person</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>No charge</td>
<td>No charge, no deductible (Type A)</td>
</tr>
<tr>
<td>Basic Services</td>
<td>No charge</td>
<td>20% coinsurance after deductible (Type B)</td>
</tr>
<tr>
<td>Major Services</td>
<td>Scheduled co-pays</td>
<td>50% coinsurance after deductible (Type C)</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>Scheduled co-pays (Adult and Child)</td>
<td>50% (up to age 19)</td>
</tr>
<tr>
<td>Lifetime Orthodontia Limit</td>
<td>N/A</td>
<td>$1,000/individual</td>
</tr>
</tbody>
</table>
Dental Plans
HumanaDental Advantage Plus 2S Plan

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.

Dependent Eligibility

You and your spouse and/or your eligible children through the end of the calendar year in which they reach age 26 may be enrolled in your dental plan.

Please see pages 10–11 for comprehensive eligibility information.

Frequently Asked Questions

How do I make an appointment?
Call the participating provider you chose on or after the date you enroll in coverage.

How do I pay for services?
If your visit is for covered preventive care, like a routine exam, cleaning, or X-Ray, there is no charge for the procedure. For other covered procedures, a co-payment may be required. See your Schedule of Benefits for amounts. You pay co-payments directly to the dentist.

How many times a year can I visit a dentist?
You are encouraged to visit your dentist regularly. With your Humana Advantage Plus 2S dental plan, you are not limited to a specific number of visits per year.

Must I choose a primary provider?
No. You are not required to preselect a dentist. This means that any dentist within the network can treat you. Benefits are only available to members who receive care from in-network providers.

What if I need a specialty dentist?
Should you need a specialist (i.e., endodontist, oral surgeon, periodontist, pediatric dentist) and you visit a Humana Advantage Plus 2S network specialist, you will receive benefits as shown on your Schedule of Benefits. Procedures not listed on the Schedule of Benefits that are performed by a participating specialist are charged at the participating specialist’s usual and customary fee less 20%. Check with the Member Services Department to verify that a particular specialty is available.

Does coverage include corrective braces?
Yes. Orthodontic (braces) benefits are included in Humana Advantage Plus 2S dental plan. Benefits include free initial consultation and partial coverage of orthodontist fees.

Is there any maximum coverage limitation?
There are no limitations on benefits.

How can I get more information?
You can contact Member Services at 800-979-4760, Monday through Friday, 8:00 a.m. – 6:00 p.m. Member Services can provide you with plan information or help you obtain emergency services. You can also access information online at MyHumana.com
### Summary of services

- **Preventive**: Selected preventive services are available for a limited time. Services not listed on the chart are not covered under the plan.

#### Preventive Preventive Member pays

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120a</td>
<td>Periodic oral examination</td>
<td>no charge</td>
</tr>
<tr>
<td>D0145a</td>
<td>Limited oral evaluation—problem focused</td>
<td>no charge</td>
</tr>
<tr>
<td>D0150a</td>
<td>Comprehensive oral evaluation—new/established</td>
<td>no charge</td>
</tr>
<tr>
<td>D0160a</td>
<td>Limited/comprehensive/detailed and extensive</td>
<td>no charge</td>
</tr>
<tr>
<td>D0170a</td>
<td>Re-evaluation—limited problem focused</td>
<td>no charge</td>
</tr>
<tr>
<td>D0180a</td>
<td>Comprehensive periodontal evaluation—new/</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>established patient (limit 1 every 24 months)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0210a</td>
<td>X-ray intraoral—complete series</td>
<td>no charge</td>
</tr>
<tr>
<td>D0220a</td>
<td>X-ray intraoral—periapical, first radiographic</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>image (limit 9 every 12 months includes D0230)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0230a</td>
<td>X-ray intraoral—periapical, each additional</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>radiographic image (limit 9 every 12 months</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>includes D0220)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0240a</td>
<td>Extra-oral—2D projection radiographic image</td>
<td>no charge</td>
</tr>
<tr>
<td>D0250a</td>
<td>Extra-oral—accidental radiographic image</td>
<td>no charge</td>
</tr>
<tr>
<td>D0270a</td>
<td>Bitewing—single radiographic image</td>
<td>no charge</td>
</tr>
<tr>
<td>D0271a</td>
<td>Bitewings—two radiographic images</td>
<td>no charge</td>
</tr>
<tr>
<td>D0272a</td>
<td>Bitewings—four radiographic images</td>
<td>no charge</td>
</tr>
<tr>
<td>D0273a</td>
<td>Vertical bitewings—7 to 8 radiographic images</td>
<td>no charge</td>
</tr>
<tr>
<td>D0330a</td>
<td>Panoramic radiographic image (limit 1 every</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>3 years)</td>
<td>no charge</td>
</tr>
<tr>
<td>D0470a</td>
<td>Diagnostic casts</td>
<td>no charge</td>
</tr>
<tr>
<td>D1120a</td>
<td>Prophylaxis—child (inclusive of D4910)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1206a</td>
<td>Topical application of fluoride varnish (for</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>child &lt;16)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1208a</td>
<td>Topical application of fluoride—excluding</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>varnish (for child &lt;16)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1351a</td>
<td>Sealant—per tooth (limit 1 per tooth every</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>12 months for child &lt;14)</td>
<td>no charge</td>
</tr>
</tbody>
</table>

#### Basic Basic Member pays

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1510a</td>
<td>Space maintainer—fixed, unilateral (limit to</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>child &lt;14)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1515a</td>
<td>Space maintainer—fixed, bilateral</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>(limited to child &lt;14)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1520a</td>
<td>Space maintainer—removable, unilateral</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>(limited to child &lt;14)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1525a</td>
<td>Space maintainer—removable, bilateral</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>(limited to child &lt;14)</td>
<td>no charge</td>
</tr>
<tr>
<td>D1550a</td>
<td>Re-cement or re-bond space maintainer</td>
<td>no charge</td>
</tr>
<tr>
<td>D2140a</td>
<td>Amalgam—one surface primary or permanent.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2150a</td>
<td>Amalgam—two surfaces primary or permanent no</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>charge</td>
<td>no charge</td>
</tr>
<tr>
<td>D2160a</td>
<td>Amalgam—three surfaces primary or permanent no</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>charge</td>
<td>no charge</td>
</tr>
<tr>
<td>D2161a</td>
<td>Amalgam—four/more surfaces</td>
<td>no charge</td>
</tr>
<tr>
<td>D2330a</td>
<td>Resin based composite—one surface, anterior.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2331a</td>
<td>Resin based composite—two surfaces, anterior.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2332a</td>
<td>Resin based composite—three surfaces, anterior.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2335a</td>
<td>Resin based composite—for or more surfaces,</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>involving incisal angle</td>
<td>no charge</td>
</tr>
<tr>
<td>D2390a</td>
<td>Resin based composite—crown anterior.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2391a</td>
<td>Resin based composite—one surface, posterior.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2392a</td>
<td>Resin based composite—two surfaces, posterior.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2393a</td>
<td>Resin based composite—three surfaces, posterior.</td>
<td>no charge</td>
</tr>
<tr>
<td>D2394a</td>
<td>Resin based composite—for or more surfaces,</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>posterior</td>
<td>no charge</td>
</tr>
<tr>
<td>D2396a</td>
<td>Resin based composite—for or more surfaces,</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>posterior</td>
<td>no charge</td>
</tr>
<tr>
<td>D2397a</td>
<td>Resin based composite—for or more surfaces,</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>posterior</td>
<td>no charge</td>
</tr>
<tr>
<td>D3336a</td>
<td>Resin based composite—for or more surfaces,</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>posterior</td>
<td>no charge</td>
</tr>
<tr>
<td>D4341a</td>
<td>Periodontal scaling and root planing—per</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>quadrant, four or more teeth</td>
<td>no charge</td>
</tr>
<tr>
<td>D4342a</td>
<td>Periodontal scaling and root planing—per</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>quadrant, 1-3 teeth</td>
<td>no charge</td>
</tr>
<tr>
<td>D4355a</td>
<td>Full mouth debridement to enable</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>comprehensive evaluation and diagnosis</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>(limit 1 every 5 years)</td>
<td>no charge</td>
</tr>
<tr>
<td>D4910a</td>
<td>Periodontal maintenance (limit 1 every 6 months,</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>inclusive of D1110 and D1120)</td>
<td>no charge</td>
</tr>
<tr>
<td>D7111a</td>
<td>Extraction coronal remnants deciduous tooth</td>
<td>no charge</td>
</tr>
<tr>
<td>D7140a</td>
<td>Extraction erupted tooth or exposed root</td>
<td>no charge</td>
</tr>
</tbody>
</table>

### Major Major Member pays

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2530a</td>
<td>Inlay—metallic, three or more surfaces</td>
<td>$410.00</td>
</tr>
<tr>
<td>D2520a</td>
<td>Inlay—metallic, two surfaces</td>
<td>$355.00</td>
</tr>
<tr>
<td>D2510a</td>
<td>Inlay—metallic, one surface</td>
<td>$313.00</td>
</tr>
</tbody>
</table>
Dental Plans

Humana Dental Advantage Plus 2S Plan

D2542b Onlay—metallic, two surfaces ........................................ $402.00
D2543b Onlay—metallic, three surfaces ........................................ $420.00
D2544b Onlay—metallic, four or more surfaces ......................... $437.00
D2610b Inlay—porcelain/ceramic, one surface ......................... $368.00
D2620b Inlay—porcelain/ceramic, two surfaces ......................... $390.00
D2630b Inlay—porcelain/ceramic, three or more surfaces .......... $414.00
D2642b Onlay—porcelain/ceramic, two surfaces ......................... $403.00
D2643b Onlay—porcelain/ceramic, three surfaces ......................... $434.00
D2644b Onlay—porcelain/ceramic, four or more surfaces .......... $461.00
D2650b Inlay—resin based composite, one surface ..................... $242.00
D2651b Inlay—resin based composite, two surfaces ..................... $288.00
D2652b Inlay—resin based composite, three or more surfaces .... $303.00
D2662b Onlay—resin based composite, two surfaces ................. $263.00
D2663b Onlay—resin based composite, three surfaces ................. $310.00
D2664b Onlay—resin based composite, four or more surfaces ...... $332.00
D2710b Crown—resin based composite, indirect ......................... $187.00
D2720b Crown—resin with high noble metal ............................... $461.00
D2721b Crown—resin with predominantly base metal ............... $432.00
D2722b Crown—resin with noble metal ........................................ $441.00
D2740b Crown—porcelain/ceramic substrate ............................... $411.00
D2750b Crown—porcelain fused to high noble metal ................. $405.00
D2751b Crown—porcelain fused predom base metal .................. $434.00
D2752b Crown—porcelain fused to noble metal ......................... $445.00
D2790b Crown—full cast high noble metal ................................. $430.00
D2791b Crown—full cast predom base metal ......................... $426.00
D2792b Crown—full cast noble metal ......................................... $434.00
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration ..... $41.00
D2920 Re-cement or re-bond crown ............................................. $36.00
D2929 Crown—prefabricated porcelain/ceramic crown—primary crown ................................................... $115.00
D2930 Crown—prefabricated stainless steel, primary tooth .......... $115.00
D2931 Crown—prefabricated stainless steel, permanent tooth ........ $131.00
D2932 Crown—prefabricated resin .............................................. $142.00
D2940 Edgewise orthodontics ...................................................... $44.00
D2950 Core buildup including any pins ........................................ $94.00
D2951 Pin retention—tooth addition restoration ....................... $23.00
D2952 Cast post and core in addition to crown ......................... $168.00
D2954 Prefabricated post and core in addition to crown .......... $139.00
D3120 Therapeutic pulpotomy .................................................... $75.00
D3310 Root canal therapy—anterior ............................................ $315.00
D3320 Root canal therapy—bicuspids ......................................... $385.00
D3330 Root canal therapy—molar ................................................ $428.00
D3346 Previous root canal therapy—anterior ......................... $424.00
D3347 Previous root canal therapy—bicuspids ......................... $500.00
D3348 Previous root canal therapy—molar ................................. $601.00
D3410 Apicoectomy/periradicular surgery—anterio r ............... $361.00
D3421 Apicoectomy/periradicular surgery—bicuspids .............. $394.00
D3425 Apicoectomy/periradicular surgery—molar ...................... $445.00
D3426 Apicoectomy/periradicular surgery—each addtl root .......... $148.00
D3430 Retrograde filling—per root .............................................. $109.00
D4210 Gingivectomy/gingivoplasty—four or more teeth, quad ........ $278.00
D4211 Gingivectomy/gingivoplasty—four or more teeth, quad .... $153.00
D4240c Gingival flap proc—four or more teeth, quad. ............... $421.00
D4241c Gingival flap proc—1 to 3 teeth, quad ............................. $217.00
D4249 Clinical crown lengthening—hard tissue ....................... $481.00
D4260 Osseous surgery (including elevation of a full thickness flap and closure) — four or more contiguous teeth or tooth bounded spaces per quadrant .......... $680.00
D4261 Osseous surgery (including elevation of a full thickness flap and closure) — one to three contiguous teeth or tooth bounded spaces per quadrant .......... $354.00
D5110b Complete denture—maxillary ......................................... $498.00
D5120b Complete denture—mandibular ...................................... $642.00
D5130b Immediate denture—maxillary ....................................... $700.00
D5140b Immediate denture—mandibular ...................................... $700.00
D5211d Maxillary partial denture—resin base .......................... $542.00
D5212d Mandibular partial denture—resin base ......................... $629.00
D5213d Maxillary partial denture—cast metal—resin base .......... $709.00
D5214d Mandibular partial denture—cast metal—resin base .......... $709.00
D5221 Immediate maxillary partial denture—resin base (including any conventional clasps, rests and teeth) .......... $700.00
D5222 Immediate mandibular partial denture—resin base (including any conventional clasps, rests and teeth) .......... $700.00
D5223 Immediate maxillary partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .......... $700.00
D5224 Immediate mandibular partial denture—cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) .......... $700.00
D5410d Adjust complete denture—maxillary ............................... $35.00
D5411c Adjust complete denture—maxillary ............................... $35.00
D5421c Adjust partial denture—maxillary .................................... $35.00
D5422c Adjust partial denture—mandibular ................................ $35.00
D5510 Repair broken complete denture base ......................... $70.00
D5520 Replace missing/broken teeth—complete denture .............. $59.00
D5610 Repair resin denture base . ................................................ $76.00
D5620 Repair cast framework ................................................... $82.00
D5630 Repair or replace broken clasp—per tooth ...................... $100.00
D5640 Replace broken teeth—per tooth ..................................... $64.00
D5650 Add tooth to existing partial denture ......................... $88.00
D5660 Add clasps to existing partial denture—per tooth .......... $105.00
D5710d Rebase complete maxillary denture— ......... $261.00
D5711c Rebase complete maxillary denture— ......... $249.00
D5720b Rebase maxillary partial denture ...................................... $246.00
D5721b Rebase mandibular partial denture .................................... $246.00
D5730d Reline complete maxillary denture ............................... $147.00
D5731d Reline complete mandibular denture .............................. $147.00
D5740d Reline maxillary partial denture ....................................... $135.00
D5741d Reline mandibular partial denture .................................... $135.00
D5750d Reline complete maxillary denture ............................... $196.00
D5751d Reline complete mandibular denture .............................. $196.00
D5760d Reline maxillary partial denture ....................................... $193.00
D5761d Reline mandibular partial denture .................................... $193.00
D5850 Tissue conditioning maxillary ......................................... $61.00
D5851 Tissue conditioning mandibular ........................................ $61.00
D6091c Insertion or re-insertion of implant supported crown .... $42.00
D6092 Insertion or re-insertion of implant supported crown .... $42.00
D6093 Re-cement or re-bond implant/abutment ......................... $57.00
D6210c Pontic—cast high noble metal ......................................... $378.00
D6211d Pontic—cast predominantly base metal ......................... $404.00
D6212d Pontic—cast noble metal ................................................ $420.00
D6240c Pontic—porcelain fused to high noble metal ............... $426.00
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D6241</td>
<td>Pontic—porcelain fused predom base metal</td>
<td>$393.00</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic—porcelain fused to noble metal</td>
<td>$415.00</td>
</tr>
<tr>
<td>D6250</td>
<td>Pontic—resin with high noble metal</td>
<td>$420.00</td>
</tr>
<tr>
<td>D6251</td>
<td>Pontic—resin with predominantly base metal</td>
<td>$388.00</td>
</tr>
<tr>
<td>D6252</td>
<td>Pontic—resin with noble metal</td>
<td>$400.00</td>
</tr>
<tr>
<td>D6600</td>
<td>Retainer inlay—porcelain/ceramic, two surfaces</td>
<td>$355.00</td>
</tr>
<tr>
<td>D6601</td>
<td>Retainer inlay—cast high noble metal, two surfaces</td>
<td>$373.00</td>
</tr>
<tr>
<td>D6602</td>
<td>Retainer inlay—cast high noble metal, three or more surfaces</td>
<td>$380.00</td>
</tr>
<tr>
<td>D6603</td>
<td>Retainer inlay—cast high noble metal, three or more surfaces</td>
<td>$418.00</td>
</tr>
<tr>
<td>D6604</td>
<td>Retainer inlay—cast predom base metal, two surfaces</td>
<td>$372.00</td>
</tr>
<tr>
<td>D6605</td>
<td>Retainer inlay—cast predom base metal, three or more surfaces</td>
<td>$394.00</td>
</tr>
<tr>
<td>D6606</td>
<td>Retainer inlay—cast noble metal, two surfaces</td>
<td>$366.00</td>
</tr>
<tr>
<td>D6607</td>
<td>Retainer inlay—cast noble metal, three or more surfaces</td>
<td>$406.00</td>
</tr>
<tr>
<td>D6608</td>
<td>Retainer onlay—porcelain/ceramic, two surfaces</td>
<td>$386.00</td>
</tr>
<tr>
<td>D6609</td>
<td>Retainer onlay—porcelain/ceramic, three or more surfaces</td>
<td>$403.00</td>
</tr>
<tr>
<td>D6610</td>
<td>Retainer onlay—cast high noble metal, two surfaces</td>
<td>$409.00</td>
</tr>
<tr>
<td>D6611</td>
<td>Retainer onlay—cast high noble metal, three or more surfaces</td>
<td>$448.00</td>
</tr>
<tr>
<td>D6612</td>
<td>Retainer onlay—cast predom base metal, two surfaces</td>
<td>$407.00</td>
</tr>
<tr>
<td>D6613</td>
<td>Retainer onlay—cast predom base metal, three or more surfaces</td>
<td>$426.00</td>
</tr>
<tr>
<td>D6614</td>
<td>Retainer onlay—cast noble metal, two surfaces</td>
<td>$399.00</td>
</tr>
<tr>
<td>D6615</td>
<td>Retainer onlay—cast noble metal, three or more surfaces</td>
<td>$414.00</td>
</tr>
<tr>
<td>D6720</td>
<td>Retainer crown—resin with high noble metal</td>
<td>$474.00</td>
</tr>
<tr>
<td>D6721</td>
<td>Retainer crown—resin with predom base metal</td>
<td>$450.00</td>
</tr>
<tr>
<td>D6722</td>
<td>Retainer crown—resin with noble metal</td>
<td>$458.00</td>
</tr>
<tr>
<td>D6740</td>
<td>Retainer crown—porcelain/ceramic, two surfaces</td>
<td>$499.00</td>
</tr>
<tr>
<td>D6750</td>
<td>Retainer crown—porcelain fused to high noble metal</td>
<td>$426.00</td>
</tr>
<tr>
<td>D6751</td>
<td>Retainer crown—porcelain fused to predom base metal</td>
<td>$453.00</td>
</tr>
<tr>
<td>D6752</td>
<td>Retainer crown—porcelain fused to noble metal</td>
<td>$464.00</td>
</tr>
<tr>
<td>D6780</td>
<td>Retainer crown—3/4 cast high noble metal</td>
<td>$458.00</td>
</tr>
<tr>
<td>D6790</td>
<td>Retainer crown—full cast high noble metal</td>
<td>$469.00</td>
</tr>
<tr>
<td>D6791</td>
<td>Retainer crown—full cast predom base metal</td>
<td>$445.00</td>
</tr>
<tr>
<td>D6792</td>
<td>Retainer crown—full cast noble metal</td>
<td>$461.00</td>
</tr>
<tr>
<td>D6930</td>
<td>Re-cement or re-bond fixed partial denture</td>
<td>$ 57.00</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal—erupted tooth</td>
<td>$ 91.00</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth—soft tissue</td>
<td>$135.00</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth—partially bony</td>
<td>$179.00</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth—completely bony</td>
<td>$211.00</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth—completely bony w/comp</td>
<td>$265.00</td>
</tr>
<tr>
<td>D7250</td>
<td>Surgical removal of residual tooth roots</td>
<td>$114.00</td>
</tr>
<tr>
<td>D7310</td>
<td>Alveoplasty in conjunction w/extractions—1-3 teeth</td>
<td>$125.00</td>
</tr>
<tr>
<td>D7311</td>
<td>Alveoplasty in conjunction w/extractions—1-3 teeth</td>
<td>$ 97.00</td>
</tr>
<tr>
<td>D7320</td>
<td>Alveoplasty not conjunction w/extractions—1-3 teeth</td>
<td>$181.00</td>
</tr>
<tr>
<td>D7321</td>
<td>Alveoplasty not conjunction w/extractions—1-3 teeth</td>
<td>$153.00</td>
</tr>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess—intraoral</td>
<td>$120.00</td>
</tr>
<tr>
<td>D7520</td>
<td>Incision and drainage of abscess—extraoral</td>
<td>$ 570.00</td>
</tr>
<tr>
<td>D7960</td>
<td>Fenestration—separate procedure</td>
<td>$111.00</td>
</tr>
<tr>
<td>D7970</td>
<td>Excision of hyperplastic tissue—per arch</td>
<td>$ 272.00</td>
</tr>
<tr>
<td>D9110</td>
<td>Palliative treatment dental pain—minor procedure</td>
<td>$  45.00</td>
</tr>
<tr>
<td>D9215</td>
<td>Local anesthesia</td>
<td>no charge</td>
</tr>
<tr>
<td>D9310</td>
<td>Professional consultation by non-treating dentist</td>
<td>no charge</td>
</tr>
<tr>
<td>D9951</td>
<td>Occlusal adjustment—limited</td>
<td>$  58.00</td>
</tr>
<tr>
<td>D9952</td>
<td>Occlusal adjustment—complete</td>
<td>$326.00</td>
</tr>
</tbody>
</table>

**Orthodontics**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>D8070</td>
<td>Comprehensive Orthodontic treatment of the transitional/adult dentition;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children up to 19 years of age; Up to 24 months of routine orthodontic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment for Class I and Class II cases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultation</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>Evaluation</td>
<td>$ 35.00</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive Orthodontic treatment of the transitional/adolescent dentition;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children up to 19 years of age; Up to 24 months of routine orthodontic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment for Class I and Class II cases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultation</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>Evaluation</td>
<td>$ 35.00</td>
</tr>
<tr>
<td>D8090</td>
<td>Comprehensive Orthodontic treatment of the transitional/adult dentition;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adults 19 years of age and older; Up to 24 months of routine orthodontic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>treatment for Class I and Class II cases</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consultation</td>
<td>no charge</td>
</tr>
<tr>
<td></td>
<td>Evaluation</td>
<td>$ 35.00</td>
</tr>
<tr>
<td>D8680</td>
<td>Retention</td>
<td>$ 450.00</td>
</tr>
</tbody>
</table>
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.

Although you receive the same percentages for in- and out-of-network services, the amount you pay could vary greatly. An in-network provider charges the negotiated PDP fee, which is lower than the dentist’s actual charges. In contrast, an out-of-network provider can charge you the negotiated fee plus the difference between the amount allowed by the plan (negotiated PDP fee) and his or her service charge. It is always to your financial advantage to use in-network providers.

### Basis of Reimbursement

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network or Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A – Preventive</td>
<td>100%</td>
</tr>
<tr>
<td>Type B – Basic</td>
<td>80%</td>
</tr>
<tr>
<td>Type C – Major</td>
<td>50%</td>
</tr>
<tr>
<td>Type D – Orthodontia</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Individual Deductible (Annual)**

- $50

**Family Deductible (Annual)**

- $150

**Deductible Applies To**

- Basic and Major

**Calendar Year Maximum**

- $1,250 per person

**Lifetime Orthodontia Maximum**

- $1,000 per person

* Negotiated PDP fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any deductibles, cost sharing, and benefits maximums.

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.

### Allocation of Services: Primary Plans

<table>
<thead>
<tr>
<th>Type A Preventive</th>
<th>Type B Basic</th>
<th>Type C Major</th>
<th>Type D Orthodontia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Exams</td>
<td>Periapicals and other X-Rays</td>
<td>Inlays/Onlays</td>
<td>Child Only (up to age 19)</td>
</tr>
<tr>
<td>Full mouth X-Rays</td>
<td>Labs and other tests</td>
<td>Crowns</td>
<td>Orthodontic Diagnostics</td>
</tr>
<tr>
<td>Bitewing X-Rays</td>
<td>Fillings</td>
<td>Endodontics/Root Canal</td>
<td>Orthodontic Treatment</td>
</tr>
<tr>
<td>Prophylaxis/Cleaning</td>
<td>Pulp Capping/Pulpal Therapy</td>
<td>Periodontics</td>
<td>Periodontics</td>
</tr>
<tr>
<td>Fluoride Treatments</td>
<td>Periodontal Maintenance</td>
<td>Rebases/Relines</td>
<td>Simple Extractions</td>
</tr>
<tr>
<td>Sealants</td>
<td>General Anesthesia</td>
<td>Repairs</td>
<td>Surgical Extractions</td>
</tr>
<tr>
<td>Space Maintainers</td>
<td></td>
<td>Dentures</td>
<td>Oral Surgery</td>
</tr>
<tr>
<td>Palliative Care</td>
<td></td>
<td>Bridges</td>
<td>Consultations</td>
</tr>
</tbody>
</table>

HumanaDental
A Prepaid Limited Health Service Organization Licensed under Chapter 636 of the Florida Insurance Code

800-979-4760 • Member Services
www.MyHumana.com
Go to Basic Links, then search or click on “Provider Search”
Dependent Eligibility
You and your spouse and/or your eligible children through the end of the calendar year in which they reach age 26 may be enrolled in your dental plan.

Please see pages 10–11 for comprehensive eligibility information.

Plan Highlights:
• You may visit the dentist of your choice, no primary dentist selection requirement.
• There are 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. (For example, if you or your covered dependent over age 19 visit a participating PDP orthodontist, the orthodontist will extend a negotiated fee for a full course of orthodontic treatment. Contact MetLife for the current rate.)
• 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.

An Example of Savings When You Visit a Participating PDP Dentist
Take a look, the example below shows how receiving services from a PDP dentist can save you money:

Your dentist says you need a crown, a Type C service:

<table>
<thead>
<tr>
<th></th>
<th>PDP Negotiated Fee: $649.00</th>
<th>Dentist’s Usual Fee: $989.00</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please note:</strong></td>
<td>This example assumes that your annual deductible has been met.</td>
<td></td>
</tr>
<tr>
<td><strong>In-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negotiated PDP Fee:</td>
<td>$649.00</td>
<td>$989.00</td>
</tr>
<tr>
<td>Plan Pays: (50% of $649.00 PDP Fee)</td>
<td>$324.50</td>
<td>$324.50</td>
</tr>
<tr>
<td><strong>Your Out-of-Pocket Cost:</strong></td>
<td>$324.50</td>
<td>$664.50</td>
</tr>
</tbody>
</table>

In this example, you save $340.00 ($664.50–$324.50) by using a participating PDP dentist.

Limitations, Exclusions, and other Provisions by Type:

<table>
<thead>
<tr>
<th>Type A (Preventive)</th>
<th>Type B (Basic)</th>
<th>Type C (Major)</th>
<th>Type D (Orthodontia) Child Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral exams: twice in a year</td>
<td>Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during each 12-month period.</td>
<td>Adjustment of dentures (no earlier than six months after initial installation)</td>
<td>All dental procedures performed in connection with orthodontic treatment are payable as orthodontia</td>
</tr>
<tr>
<td>Two fluoride treatments, for dependent child to age 16, twice in a year</td>
<td>Initial installation of fixed bridgework</td>
<td>Initial installation of partial or full removable dentures</td>
<td>Initial payment due upon installation of the orthodontic appliance; repetitive payments for the orthodontic adjustments will be made quarterly at the end of the quarter based on the Orthodontic Lifetime Maximum Benefits end at cancellation</td>
</tr>
<tr>
<td>Cleaning of teeth (oral prophylaxis): twice in a year</td>
<td>Initial installation of partial or full removable dentures</td>
<td>Initial installation of crowns, inlays, and onlays (cost restorations): once every five years</td>
<td></td>
</tr>
<tr>
<td>Full mouth and panorex X-rays: once every 36 months</td>
<td>Root canal treatment is limited to once per tooth in a 24-month period</td>
<td>Root canal treatment is limited to one per quadrant every 36 months</td>
<td></td>
</tr>
<tr>
<td>Biting X-rays: twice in a year</td>
<td>Periodontal surgery, including gingivectomy or gingioplasty, gingival curettage, osseous surgery, bone replacement graft, and guided tissue regeneration once per quadrant every 36 months</td>
<td>Surgical Extractions including Impactions/Oral Surgery</td>
<td></td>
</tr>
<tr>
<td>Space maintainers: limitation of one space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants: limitation of one application of sealant material for each non-restored permanent 1st and 2nd molar teeth of a dependent child to age 13, once every 12 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Frequently Asked Questions

What is a participating PDP dentist?

A participating PDP dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for services provided to plan participants. PDP fees typically range from 10% to 35% below the average fees charged by dentists in your area for the same or substantially similar services.

How do I find a participating PDP dentist?

There are over 100,000 participating PDP dentist locations nationwide, including over 22,000 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/dental or call 800-GET-MET8 to have a list faxed or mailed to you.

What services are covered by the PDP?

The services covered by the MetLife PDP are those defined under your group dental benefits plan. Please review the plan benefits to learn more.

Does the PDP offer any discounts on non-covered services?

Yes. The PDP in-network discounts do extend even to noncovered services, such as cosmetic dentistry or orthodontia, providing plan participants with savings on these noncovered services as well.

May I choose a nonparticipating dentist?

Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible for paying for any difference between the dentist’s fee and your plan’s payment. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee and your plan’s payment. Please note: Plan designs may vary, so you should always refer to PCS’s specific plan to help determine actual out-of-network benefits. As always, plan deductibles must be met.

No MetLife ID Cards

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

Can my dentist apply for PDP participation?

Yes. If your current dentist does not participate in the PDP and you’d like to encourage him or her to apply for membership, tell your dentist to visit www.metedental.com, or call 877-MET-DDS9 (638-3379) for an application. Website and phone number are designed for use by dental professionals only.

How are claims processed?

The dentist may submit your claims for you, which helps to reduce your paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, you can find one online at www.metlife.com/dental or request one by calling 800-GET-MET8.
Fun Facts

- According to the Academy of General Dentistry, the average person only brushes for 45 to 70 seconds a day; the recommended amount of time is two to three minutes.¹
- If you don’t floss your teeth, you miss cleaning 35% of your teeth.²
- Regular dental cleanings can prevent heart attacks.²

² www.healthplex.com/resources/dental-trivia

Dental Exclusions

1. Temporomandibular joint disorders (TMJ)
2. Services received before coverage begins
3. Services not performed by a dentist, except cleaning and scaling of teeth and fluoride treatments performed by a licensed dental hygienist that is supervised and billed by a dentist
4. Cosmetic services, surgery, or supplies
5. When covered by any Workers’ Compensation laws, occupational disease laws, or employer’s liability laws, or which an employer is required by law to furnish in whole or in part
6. Which are received through a medical department or similar facility maintained by your employer
7. Home health aids used to prevent decay, such as toothpaste and fluoride gels
8. Appliances or treatment for bruxism (grinding teeth), including, but not limited to, occlusal guards and night guards
9. Duplicate appliances or duplicate prosthetic devices
10. Received where no charge would have been made in the absence of dental expense benefits, or which are not required to be paid
11. Materials or services that are experimental under generally accepted dental standards
12. Received as a result of dental disease, defect, or injury due to an act of war, or a warlike act in time of peace, which occurs while coverage is in effect
13. Instruction for oral care such as hygiene or diet
14. Periodontal splinting
15. Benefits otherwise provided under your employer’s plan or any other plan that your employer or an affiliate contributes to or sponsors
16. Charges for broken appointments or for completing dental forms
17. Sterilization supplies
18. Furnished by a family member
19. For Type C Expenses: 1) replacement of a lost, missing, or stolen crown, bridge, or denture; 2) initial installation of a denture or bridgework to replace one or more natural teeth lost before the dental expense benefits started; 3) replacement of an existing crown, removable denture, or fixed bridgework unless it is needed because the existing crown, denture, or bridgework can no longer be used and was installed at least (five years for crowns; 10 years for dentures) prior for crowns to its replacement; 4) replacement of existing immediate temporary full denture by a new permanent full denture unless: (a) the existing denture cannot be made permanent; and (b) the permanent denture is installed within 12 months after the existing denture was installed.
20. Adjustment of a denture or bridgework that is made within six months after installation by the same dentist who installed it
21. Temporary or provisional restorations and appliances
Dental Plans
MetLife® Preferred Dentist Program (PDP)

Covered Benefits Limitations
The fact that a dentist recommends a dental service does not mean that dental expense benefits will be paid under the Pinellas County Schools plan. Dental expense benefits will be based on the most cost-effective materials and methods of treatment that meet generally accepted dental standards. MetLife’s dental consultants may review dental expense benefits to decide whether the dental service is necessary in terms of generally accepted dental standards for the purpose of determining whether dental expense benefits are payable under the Pinellas County Schools plan.

Coordination of Benefits
The Pinellas County Schools plan contains a coordination of benefits clause that reduces the dental expense benefits payable by the amount of benefits received from the other group, employer, or government-sponsored plans.

Cancellation/Termination of Benefits
Coverage is provided under a group insurance policy (Policy form G.2130-S) issued by MetLife. Coverage terminates when your employment ceases, when your dental contributions cease, or upon termination of the group contract by the policyholder upon prior written notice to MetLife. The group policy may be discontinued by MetLife for nonpayment of premium or if participation requirements are not met. Coverage is made available under master group insurance policy number 95682.
The Vision of Good Health

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 9 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. See pages 10–11 for more information about dependent coverage and eligibility.

How Does the Plan Work?

Members can select any optometrist or ophthalmologist in the EyeMed Vision Care Advantage network. At the time of your appointment, you will pay the applicable co-pay(s) for your exam and your eyeglasses or contacts, plus the co-pay(s) for any extra covered option(s) you select. There are no forms to complete or claims to file when you use EyeMed in-network providers.

You can go to an out-of-network provider, but you will pay a higher amount. You will pay the out-of-network provider in full at the time of your visit and then submit your receipts to EyeMed for reimbursement. Your final cost will be based on the out-of-network reimbursement schedule.

The vision benefits are detailed on the next page.

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

Or

Visit www.eyemed.com to view benefits, check claims, and access other services.
Vision Plan
EyeMed Advantage Plan

EyeMed Vision Care Plan Benefits

Eligible employees and their covered dependents may receive the following benefits from network providers.

When You Use Participating In-Network Providers

<table>
<thead>
<tr>
<th>Basic Benefits</th>
<th>In-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td><strong>Exam with Dilation</strong></td>
</tr>
<tr>
<td>(based on calendar year)</td>
<td>As necessary $10 co-pay</td>
</tr>
<tr>
<td><strong>Vision Exam</strong></td>
<td>Once per calendar year</td>
</tr>
<tr>
<td><strong>Lenses or Contact Lenses</strong></td>
<td>Once per calendar year</td>
</tr>
<tr>
<td><strong>Frame</strong></td>
<td>Every other calendar year</td>
</tr>
<tr>
<td><strong>Benefit</strong></td>
<td><strong>In-Network Provider</strong></td>
</tr>
</tbody>
</table>

- **Exam with Dilation**
  - As necessary $10 co-pay

- **Eyeglass Lenses**
  - Single Vision $15 co-pay
  - Bifocal $15 co-pay
  - Trifocal $15 co-pay
  - Standard Progressive $50 co-pay

- **Frames**
  - $110 allowance
  - (You receive 20% off the balance over $110)

- **Contact Lenses**
  - Conventional $110 allowance
  - (You receive 15% off the balance over $110)
  - Disposable $110 allowance
  - (You pay full amount over $110)
  - Medically Necessary Paid in full

Contact Lenses

**Standard contact lens fit**—Applications of clear, soft, spherical (astigmatism less than .75D), daily-wear contact lenses for single-vision prescriptions—does not include extended/overnight wear. Standard fit includes:
- Disposable
- Conventional
- Daily
- Replacement

**Premium contact lens fit**—More complex applications, including but not limited to toric (astigmatism .62D or higher), bifocal/multifocal, cosmetic color, postsurgical, and gas-permeable—does include extended/overnight wear for any prescription. Premium fit includes:
- Cosmetic color
- Toric
- Multifocal; includes monovision
- Continuous wear
- RGP (Rigid Glass Permeable) lens
- Post-surgical and gas-permeable

In-Network Discounts

EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:
- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the plan at in-network providers

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.
Additional Plan Costs and Discounts

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

- UV coating $12
- Scratch resistant coating $12
- Polycarbonate $30
- Antireflective coating $10
- Transitions $50

LASIK Benefits

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

When You Visit a Nonparticipating Provider

Eligible employees and their covered dependents may receive the following features and be reimbursed according to the following chart.

Reimbursement Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Exam</td>
<td>Once per calendar year</td>
</tr>
<tr>
<td>Eyeglass or Contact Lenses</td>
<td>Once per calendar year</td>
</tr>
<tr>
<td>Frame</td>
<td>Every other calendar year</td>
</tr>
<tr>
<td>Exam with Dilation</td>
<td>As necessary: Up to $35</td>
</tr>
<tr>
<td>Eyeglass Lenses</td>
<td>Single Vision: Up to $35</td>
</tr>
<tr>
<td></td>
<td>Bifocal: Up to $40</td>
</tr>
<tr>
<td></td>
<td>Trifocal: Up to $60</td>
</tr>
<tr>
<td>Frames</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>Elective (conventional or disposable): $90</td>
</tr>
<tr>
<td></td>
<td>Medically Necessary: $210</td>
</tr>
</tbody>
</table>

Nonparticipating provider claims can be mailed to:

EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111

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.

Benefits are the same at all participating providers, no matter where they’re located or the amount they would otherwise charge.

How to Find a Provider

To find an EyeMed provider with convenient hours and locations, you can call 888-203-7437 or use the provider locator tool at www.eyemed.com to find a provider in your area. Choose the Advantage network in the drop down box.
Life and AD&D Insurance

Introduction

Life Insurance
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.

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 The Standard Insurance Company (The Standard)—of one times your annual base salary, rounded up to the next $1,000, with minimum coverage of $15,000. For example:

<table>
<thead>
<tr>
<th>Annual salary</th>
<th>Basic coverage is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>$12,000</td>
<td>$15,000 (minimum $15,000 coverage)</td>
</tr>
<tr>
<td>$25,000</td>
<td>$25,000 (one times your annual base salary)</td>
</tr>
<tr>
<td>$27,750</td>
<td>$28,000 (rounded up to next $1,000)</td>
</tr>
</tbody>
</table>

Optional Term Life coverage provides options of up to $500,000 for you and $100,000 for your spouse.

Life insurance coverage is issued by The Standard.

AD&D Insurance
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

More Information...
The Life and AD&D plans’ main provisions, range of benefits, and affordable group premium rates are outlined over the next several pages. Read them carefully before deciding whether this plan is right for you and your family.

AD&D insurance coverage is issued by The Standard.

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.
# Life and AD&D Insurance

## Life Insurance—Employee

<table>
<thead>
<tr>
<th>Covers</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount of Coverage</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>
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, see the rate schedule on page 6, 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 |

## Optional Family Term Life

<table>
<thead>
<tr>
<th>Covers</th>
<th>Spouse and eligible children (see page 68 for eligibility requirements)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount of Coverage</strong></td>
<td>$5,000/dependent</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td>See rate schedule on page 6</td>
</tr>
<tr>
<td><strong>Board Contribution</strong></td>
<td>You may not use</td>
</tr>
<tr>
<td>Actively at Work</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Evidence</td>
<td></td>
</tr>
</tbody>
</table>
Spouse: No health questions required  
Child(ren): No health questions required |

## Optional Dependent Term Life (Spouse and/or Child[ren])

<table>
<thead>
<tr>
<th>Covers</th>
<th>Spouse&lt;sup&gt;2&lt;/sup&gt; and/or child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount of Coverage</strong></td>
<td></td>
</tr>
</tbody>
</table>
Spouse: $10,000 increments up to the $100,000 maximum.<sup>*</sup>  
Child(ren): $2,000 increments up to the $10,000 maximum |
| **Cost**                 | See rate schedule on page 6; 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 |

---

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.
2. Optional spouse coverage may be written without employee contribution.

---

* The total amount of spouse coverage cannot exceed the employee’s total life insurance coverage (basic plus any optional employee life).

---

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.

---

<sup>*</sup> Optional spouse coverage may be written without employee contribution.
### Accidental Death & Dismemberment Insurance

**Basic Employee AD&D**

<table>
<thead>
<tr>
<th>Covers</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of Coverage</td>
<td>$2,000</td>
</tr>
<tr>
<td>Cost</td>
<td>None</td>
</tr>
</tbody>
</table>

**Optional AD&D—Employee Only**

<table>
<thead>
<tr>
<th>Covers</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount of Coverage</td>
<td>$50,000, $100,000, $200,000, or $300,000</td>
</tr>
<tr>
<td>Cost</td>
<td>See rate schedule on page 6</td>
</tr>
<tr>
<td>Board Contribution</td>
<td>You may use</td>
</tr>
</tbody>
</table>

**Optional AD&D—Employee and Family**

<table>
<thead>
<tr>
<th>Covers</th>
<th>Employee and Family</th>
</tr>
</thead>
</table>
| 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 schedule on page 6 |
| Board Contribution | You may use |
Life and AD&D Insurance
Life Insurance—Employee

Employee Term Life Insurance

Basic Employee Term Life
Pinellas County Schools offers Basic Term Life insurance at no cost to you. No evidence of good health is required, and you are automatically enrolled. Coverage amounts in excess of $50,000 are subject to taxation under Section 79 of the Internal Revenue Code.

Optional Employee Term Life
Pinellas County Schools offers you the opportunity to enroll in a group Optional Term Life insurance plan. You pay the cost of this optional coverage.

Eligibility to Participate
You must be an active, full-time employee working at least 30 hours per week or a job-share employee at Pinellas County Schools.

Coverage Amounts
Basic Employee Term Life: You are automatically enrolled for an amount equal to one times your annual base salary, rounded to the next higher $1,000, up to a maximum of $200,000. Your guaranteed minimum amount of coverage is $15,000.

Optional Employee Term Life: You may purchase up to $200,000 of coverage in increments of $10,000 or $250,000, up to a maximum of $500,000 in increments of $50,000.

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.

Accelerated Benefit Option
If you provide satisfactory proof that you are terminally ill with a life expectancy of 12 months or less, you may elect to receive up to 75% of your combined Basic and Optional Employee Term Life while still living, up to a maximum of $500,000. This benefit is only available once and is payable in a lump sum or 12 monthly installments. The death benefit payable to your beneficiary will be reduced by the amount you elect under this option.

Premium Continuation
If you are totally disabled and wish to continue your life insurance, contact Risk Management and Insurance at 727-588-6197.

Guaranteed Coverage/Medical Evidence Requirements (Optional Employee Term Life Only)

New Hires: Certain coverage is available without providing evidence of good health. If you enroll within 31 days of your date of eligibility, your guaranteed coverage amount is $100,000. You must provide evidence of good health for coverage amounts greater than $100,000.

Current Employees: If you enroll or change your coverage at any time you must provide evidence of good health for all amounts.

Portability: If your employment ends, you may receive similar Optional Term Life coverage under the portability provision, provided you are less than age 65. You will be advised of the cost of this coverage.

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.
As a result, older employees with a high amount of life insurance will have more imputed income (and correspondingly more to pay in taxes) than younger employees.

If you are subject to imputed income, the value of this additional amount, as determined by the IRS, will be added to your W-2 statement and taxed as ordinary income.

Although imputed income tax applies only to the value of School Board-paid life insurance over $50,000, it is important to have enough protection for your family. Remember, too, that additional life insurance for you under BENEFlex is offered at competitive rates: and any payroll deductions you may be required to make are with tax-free dollars.

### Life Insurance for Your Dependents

Pinellas County Schools offers you the opportunity to enroll your dependents in two group Optional Term Life insurance plans. You pay the cost of this optional coverage. (The Board Contribution cannot be used, and the premium is deducted on an after-tax basis.)

Dependents are your legally married spouse (not separated or divorced) and eligible children beginning at live birth up to the end of the calendar year in which they reach age 26. Eligible children include your legally adopted children, stepchildren, and foster children who depend on you for support. If your spouse or dependent child is confined for medical care or treatment at home or elsewhere, coverage will begin when confinement ends. If your spouse is an employee, or a Pinellas County Schools retiree, he/she cannot be covered as a dependent. Spouse coverage will terminate at age 70. If your employment ends, your spouse and dependent children may receive similar Optional Dependent Term Life coverage under the portability provision. You must purchase portable group life insurance coverage for yourself in order to purchase any other insurance for your dependents. You will be advised of the cost of this coverage.

### Coverage Amounts

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.

### Guaranteed Coverage/Medical Evidence Requirements

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)

**Eligibility to Participate**

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.

### Optional Family Term Life

**Eligibility to Participate**

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.
Life and AD&D Insurance
Dependants (continued) and AD&D Insurance

Coverage Amounts

**Spouse:** You may enroll your spouse for coverage in increments of $10,000 up to a maximum of $100,000.*

**Children:** 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.

**Medical Evidence Requirements**
Your spouse must provide evidence of good health satisfactory to The Standard for all coverage amounts. Coverage amounts for child(ren) are guaranteed.

* The total amount of spouse coverage cannot exceed the employee’s total life insurance coverage (basic plus any optional employee life).

Living Benefit Option
If your spouse provides satisfactory proof that he/she is terminally ill with a life expectancy of 12 months or less, he or she may elect to receive up to 75% of his or her term life benefit while still living, up to a maximum of $75,000. This benefit is only available once and is payable in a lump sum or 12 monthly installments. The death benefit payable to the beneficiary will be reduced by the amount he or she elects under this option.

**AD&D Insurance**

Pinellas County Schools offers you basic Employee Accidental Death & Dismemberment (AD&D) insurance at no cost to you. You are automatically enrolled for a coverage amount of $2,000.

In addition, Pinellas County Schools offers you and your dependents the opportunity to enroll in a group Optional AD&D insurance plan. Optional AD&D provides a benefit for loss of life and certain injuries resulting from a covered accident. Loss of life benefits are paid in addition to Optional Employee and Dependent Term Life. You pay the cost of this optional coverage and you may use the Board Contribution to pay for this coverage. Premium deductions are taken out on a pre-tax basis.

**Eligibility to Participate**
You must be an active, full-time employee working at least 30 hours per week or a job-share employee at Pinellas County Schools to enroll for Optional AD&D. Your dependents are eligible if you are enrolled in Optional AD&D. You do not need to provide evidence of good health to enroll in Optional AD&D.

**Coverage Amounts**

**You are automatically enrolled** for a coverage amount of $2,000.

**You may enroll** for Optional AD&D in a coverage amount of $50,000, $100,000, $200,000, or $300,000.

**Coverage for your spouse and dependent children** is as follows:
- **Spouse Only:** 50% of your coverage amount.
- **Children Only:** 15% of your coverage amount for each child, not to exceed your coverage amount.
- **Spouse and Children:** 40% of your coverage amount for your spouse and 10% of your coverage amount for each child.

**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.

Continued on next page
Life and AD&D Insurance

AD&D Insurance

**Standard Benefits**

Benefits are paid at certain percentages of your coverage amount for specific accidental losses as indicated below (no more than 100% of your coverage amount is payable for all losses due to the same accident):

<table>
<thead>
<tr>
<th>Accidental Losses</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>One hand or one foot and</td>
<td></td>
</tr>
<tr>
<td>sight in one eye</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and hearing in both ears</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight in one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing in both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger on the</td>
<td></td>
</tr>
<tr>
<td>same hand</td>
<td>25%</td>
</tr>
</tbody>
</table>

**Seat Belt Benefit**

The plan pays an additional benefit equal to the amount of the AD&D benefit for the loss of life, up to a maximum of $10,000.

**Air Bag Benefit**

The plan pays an additional benefit equal to the amount of the AD&D benefit for the loss of life, up to a maximum of $5,000 (only payable if a seat belt benefit is paid), if an accidental death occurs while you or your covered dependent is riding in an automobile equipped with an air bag system, and you or your covered dependent is wearing a seat belt in the prescribed manner.

**Loss Due to Coma**

The plan pays 1% of the coverage amount for each month you or your covered dependent remains in a coma that results from a covered accident. The coma must be total, continuous, permanent, begin within 365 days of the accident, and last for at least 21 days. This benefit is payable for up to 11 months while you or your covered dependent remains in a coma.

**Occupational Assault Benefit**

The plan provides an additional benefit if a member suffers a covered loss by an act of physical violence while actively at work. Lesser of $25,000 or 50% of the AD&D benefit.

**Career Adjustment Benefit**

The plan reimburses tuition expenses incurred by the spouse within 36 months from date of member’s death. The maximum benefit is $5,000 per year not to exceed a cumulative total of the lesser of $10,000 or 25% of AD&D life benefit.

**Higher Education Benefit**

The plan reimburses tuition expenses incurred by a child within 12 months of the member’s death. The maximum benefit is $5,000 per year for four years not to exceed a cumulative total of the lesser of $20,000 or 25% of the AD&D benefit.

**Child Care Benefit**

The plan reimburses child care expenses incurred within 36 months from date of member’s death. The maximum benefit is $5,000 per year not to exceed a cumulative total of the lesser of $10,000 or 25% of AD&D life benefit.
Disappearance

The plan allows an AD&D benefit to be paid if loss of life is due to a disappearance reasonably resulting from an accident and the disappearance continues for 365 days.

Exposure

The plan allows an AD&D benefit to be paid if loss is due to accidental exposure to adverse weather conditions.

Common Accident Benefit

The plan pays an additional benefit if both you and your spouse die as a result of the same accident for which AD&D insurance benefits are payable for the loss of both lives. The benefit will be paid in equal shares to each surviving child. In the event a common disaster benefit is payable, the amount is the lesser of $500,000 or the amount of the AD&D insurance benefit payable for the loss of the employee's life minus the spouse's life.

Exclusions

You are not covered for a loss caused or contributed to by:

1. War or act of war
2. Suicide or intentional self-inflicted injury, while sane or insane
3. Committing or attempting to commit assault or a felony, or actively participating in a riot or violent disorder
4. Voluntary use of poison, chemical compounds, alcohol, or drugs unless consumed according to the directions of a physician
5. Sickness or pregnancy existing at the time of the accident
6. Medical or surgical treatment or diagnostic procedure for any of the above
7. Heart attack or stroke
8. Boarding, leaving or being in or on any kind of aircraft, unless the employee is a fare-paying passenger on a commercial aircraft

Life and AD&D Insurance
AD&D Insurance

Life Insurance Certificate of Coverage Insured by The Standard Insurance Company

A 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/risk-benefits) 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 The 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 The Standard Insurance Company, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series 83500.

IFS A108213 Ed. 8/05

Continued on next page
Most of us depend on our paychecks to keep our lives running smoothly. What would we do if illness or injury kept us out of work for a long time and those paychecks stopped? It is something we do not like to think about, but it could happen.

Your BENEFlex program offers both Short- and Long-term Disability coverage.

**Short-term Disability Plan (Base Plan)**

<table>
<thead>
<tr>
<th>Covers</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>Provides benefits for up to two years for disability due to illness, or up to five years for disability due to injury</td>
</tr>
<tr>
<td>Cost</td>
<td>See rate schedule, page 7</td>
</tr>
</tbody>
</table>

**Elimination Period (Waiting Period)** means a period of consecutive days of disability for which no benefit is payable. The Elimination Period begins the first day of your disability. Benefits begin the day following the end of the Elimination Period.

The plan provides the following options for your Elimination Period:

a) 15 consecutive days for disability due to sickness or injury;

b) 30 consecutive days for disability due to sickness or injury; or

c) 60 days consecutive days for disability due to sickness or injury

Your Elimination Period would be the option you elect on the most recent Enrollment Form or during the last Annual Enrollment.

**Long-term Disability (LTD)**

<table>
<thead>
<tr>
<th>Covers</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>Provides benefits for disabilities that extend beyond the Base Plan</td>
</tr>
<tr>
<td>Cost</td>
<td>See rate schedule, page 7</td>
</tr>
</tbody>
</table>

- You must be enrolled in the Short-term (Base) Plan to enroll in the Long-term (LTD) Plan. Evidence of Insurability satisfactory to Sun Life is required for all late entrants.
- Evidence of Insurability is waived for new benefits-eligible employees who apply within 31 days of date of hire.
- Your LTD election cannot exceed your STD coverage.

Benefits received under the disability plans may be subject to federal income tax and will be integrated with Workers’ Compensation.

**Who Is Eligible?**

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.

Evidence of Insurability is waived for new benefits-eligible employees who apply for coverage within 31 days of the date of hire.

If you decline coverage during your initial enrollment period, subsequent requests for coverage will be subject to medical underwriting.

**Your Effective Date**

Your coverage will take effect on the first of the month following 60 days in an eligible status. If Evidence of Insurability is required, your new coverage will take effect on the first of the following month of the approved effective date after the insurance company approves your application. If you are not actively at work on the date your coverage is to take effect, you will not become insured until the date you return to full-time, active duty.

**Disability Benefits During Pregnancy**

The plan provides coverage for a disability period up to six weeks post-partum for an uncomplicated pregnancy, and up to eight weeks post-partum for a cesarean delivery, providing that certification of disability is submitted by the attending physician. Benefits are subject to a waiting/elimination period. This elimination period may apply if the employee is pregnant prior to the effective date of the plan.

An application for disability benefits prior to the actual delivery date requires review of medical documentation to determine if benefits are payable under the plan.

**Please note:** To be eligible for benefits under the plan, you must meet the plan definition of disability and all other provisions of the plan, including pre-existing conditions, when applicable. Benefits are subject to an Elimination Period.

See page 75 for important income tax considerations.
Disability Insurance Plans
Short-term Disability Plan (Base Plan)

Eligibility
Eligible employees who work at least 30 hours per week (including job sharing) and who are actively working full time on the date of enrollment are eligible to apply. Monthly benefits range from $400 to $5,000 per month.

A. Accident Insurance Benefit
Payable for disability resulting from a covered accident starting after the applicable waiting period not to exceed 60 months for any one period of disability.

B. Sickness Insurance Benefit
Payable for disabilities resulting from a covered sickness starting after the applicable waiting period and continuing for a period of time not to exceed 24 months for any one period of disability.

These benefits will also be paid for those days of the waiting period that you are confined in a lawfully operated hospital.

C. Increased When Hospitalized
Payable for disabilities for no more than two months for any one continuous period of disability while confined to any lawfully operated hospital; i.e., the monthly benefits otherwise payable are doubled.

D. Nondisabling Injury Benefit: $100
A benefit will be paid in the amount of the actual charge made by the doctor for medical treatment required and received within 48 hours after any accident that does not cause disability, not to exceed $100 for any one accident.

E. Accidental Death and Dismemberment Benefits
Payable in the event of loss through accidental bodily injury of both hands, both feet, the sight of both eyes, loss of any two such members, or loss of life. One-half the benefit selected is payable for the loss of a hand, a foot, or the sight of an eye.

The Accidental Death & Dismemberment benefit increases 10% of the original amount each year for five years, provided your coverage is continuously in force and premium is paid when due.

The Accidental Death & Dismemberment benefit is payable only for loss that occurs within 90 days of the date of the accident unless state statutes require otherwise. Losses due to suicide or attempted suicide and losses due to intentional, self-inflicted injuries are not covered. If more than one specified loss results from any one accident, only the specified total loss for the largest amount will be paid. The Accidental Death & Dismemberment benefit is paid in addition to the disability benefit that may be payable.

Base Plan Schedule of Benefits
You may select one of the benefit levels outlined below, provided the Monthly Disability Benefit does not exceed 66⅔% of your regular monthly salary.*

<table>
<thead>
<tr>
<th>If Your Annual Base Salary Is at Least</th>
<th>You are Eligible for a Maximum Disability Benefit</th>
<th>Total Monthly Benefit When Hospitalized</th>
<th>Accidental Death &amp; Dismemberment Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 7,200</td>
<td>$ 400</td>
<td>$ 800</td>
<td>$ 4,000</td>
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<tr>
<td>10,800</td>
<td>800</td>
<td>1,200</td>
<td>6,000</td>
</tr>
<tr>
<td>14,400</td>
<td>1,000</td>
<td>2,000</td>
<td>10,000</td>
</tr>
<tr>
<td>18,000</td>
<td>1,200</td>
<td>2,400</td>
<td>12,000</td>
</tr>
<tr>
<td>21,600</td>
<td>1,400</td>
<td>2,800</td>
<td>14,000</td>
</tr>
<tr>
<td>25,200</td>
<td>1,600</td>
<td>3,200</td>
<td>16,000</td>
</tr>
<tr>
<td>28,800</td>
<td>1,800</td>
<td>3,600</td>
<td>18,000</td>
</tr>
<tr>
<td>32,400</td>
<td>2,100</td>
<td>4,200</td>
<td>21,000</td>
</tr>
<tr>
<td>37,800</td>
<td>2,400</td>
<td>4,800</td>
<td>24,000</td>
</tr>
<tr>
<td>43,200</td>
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<tr>
<td>48,600</td>
<td>3,000</td>
<td>6,000</td>
<td>30,000</td>
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<tr>
<td>54,000</td>
<td>3,500</td>
<td>7,000</td>
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<tr>
<td>63,000</td>
<td>4,000</td>
<td>8,000</td>
<td>40,000</td>
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<tr>
<td>72,000</td>
<td>4,500</td>
<td>9,000</td>
<td>45,000</td>
</tr>
<tr>
<td>81,000</td>
<td>5,000</td>
<td>10,000</td>
<td>50,000</td>
</tr>
</tbody>
</table>

* Your monthly benefit may be reduced by other income benefits and disability earnings.
Disability Insurance Plans
Short-term Disability Plan (Base Plan)

F. Integration with Other Income Benefits

If you are entitled to Short-term Disability benefits under this plan and you have the right to benefits under any Workers’ Compensation law or similar law, the disability benefits payable under this policy will be reduced by the amount of benefits received from any Workers’ Compensation or similar law. In no event will the monthly disability benefits under this policy be reduced to less than 25% of the amount of the benefit otherwise payable.

G. Pre-Existing Conditions Exclusion

Benefits will not be paid 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 for which you did any of the following in the six months before your insurance became effective:

a. Received medical treatment
b. Took prescribed drugs
c. Consulted a doctor

Definition of Disability:

Total Disability
a. You are considered totally disabled if you are unable to perform the material and substantial duties of your regular occupation.
b. If school is not in session: You would be unable to perform the material and substantial duties of your regular occupation if school were in session; or
c. If on a Leave of Absence: You would be unable to perform the material and substantial duties of your regular occupation if you were required to work; and
d. You are under the regular care of a doctor.

Partial Disability
You are considered partially disabled if, due to your sickness or injury, you are:

a. Able to perform one or more, but not all, of the material and substantial duties of your regular occupation or any occupation for which you are or become fitted by education, training, and experience on a full-time or a part-time basis; or
b. Able to perform all of the material and substantial duties of your regular occupation or any occupation for which you are or become fitted by education, training, and experience on a part-time basis; and
c. Under the regular care of a doctor; and
d. Earning less than 80% of your monthly salary.

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 not be covered.
If you enroll in the Short-term Disability Plan (Base Plan) you may also enroll in the Long-term Disability Plan (LTD).

Long-term Disability Insurance Benefits

The monthly benefits (adjusted as described in “Limitations, Exceptions, Reductions, and Other Important Information,” pages 76–77) for the Long-term Disability Plan are payable starting after the benefits of the Base Plan have expired, but in no event prior to five years of accident disability or two years of sickness disability. The adjusted monthly benefit will continue to be payable for disability for the longest of the following benefit periods: (a) to age 65, (b) until payment under the Base Plan and the Long-term Disability Plan totals four years, but not beyond age 70, or at least (c) one year under the Long-term Disability Plan.

Total Disability

You are considered to be totally disabled if you are under the regular care of a doctor and you are unable to perform the duties of any occupation for which you are reasonably fitted by education or experience.

<table>
<thead>
<tr>
<th>If your annual base salary is at least</th>
<th>Accident and Sickness Monthly Disability Benefit**</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7,200</td>
<td>$400</td>
</tr>
<tr>
<td>10,800</td>
<td>600</td>
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<tr>
<td>14,400</td>
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<tr>
<td>21,600</td>
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<td>25,200</td>
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<tr>
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<td>63,000</td>
<td>3,500</td>
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<tr>
<td>72,000</td>
<td>4,000</td>
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<tr>
<td>81,000</td>
<td>4,500</td>
</tr>
<tr>
<td>90,000</td>
<td>5,000</td>
</tr>
</tbody>
</table>

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

** Evidence of Insurability is waived for new benefits-eligible employees who apply within 31 days of coverage. Your LTD election cannot exceed your STD coverage.

Income Tax Consideration

When you enroll in Short- or Long-term Disability, your payroll deductions are automatically deducted on a pre-tax basis, along with all of your other benefit deductions (except Optional Life Insurance). This means that any disability benefit you receive will be subject to federal income taxes unless you elect to have your premiums deducted on an after-tax basis, in which case all your payroll deductions for all benefits will be taken on an after-tax basis.
Disability Insurance Plans
Limitations, Exceptions, Reductions, and Other Important Information

Integration of Benefits
Monthly benefits under this plan shall be reduced by the following income sources:

a. Any group disability insurance plan
b. Social Security (including Primary and Dependents benefits)

c. State Teachers’ Retirement or Disability Plan
d. Workers’ Compensation or similar laws
e. Any other program providing disability or retirement benefits

The insurance company will offset against any of these benefits that you are entitled to receive whether or not you applied for them. However, the benefits under this plan will not be reduced to less than 25% of the amount of the benefit otherwise payable.

If the Social Security Act is amended to increase the Old Age, Survivors, and Disability Insurance Benefits while you are receiving monthly benefits under this plan, the amount of the increase will be disregarded in computing the benefit payable under this plan during your current period of disability.

Accident Defined
The term “accident” means bodily injury, caused by an accident, which in and of itself results in a disability within 90 days. Benefits will be payable only if the injury occurs while this insurance is in effect.

Sickness Defined
The term “sickness” means any cause of disability not excluded under “Important Information” that does not qualify as an accident. Sickness also includes pregnancy, childbirth, abortion, and related medical conditions.

Medical Treatment
To be eligible for benefits you must receive regular, personal medical treatment from a licensed physician.

Monthly Salary Defined
For the purpose of determining the percentage of salary limitation, monthly salary shall be annual salary from the Board of Education divided by 12. Daily benefits are computed by dividing the monthly benefit by 30.

Mental or Emotional Disorder Defined
Disability benefits due to a mental or emotional disease or disorder of any kind will be limited to a period not to exceed two years. Thereafter, benefits will be payable during a continuance of any such disability only when you are confined in a hospital or other institution qualified to provide care and treatment for such disability. When so confined for at least 14 consecutive days, the disability benefit will again be payable during the further continuance of total disability for a maximum of 90 days after termination of such confinement.

What Is Not Covered
This insurance does not cover any loss caused by suicide or attempted suicide, disabilities resulting from alcoholism or drug abuse, intentionally self-inflicted injuries, or war or acts of war, whether declared or undeclared.

Benefits will not be paid 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 for which you did any of the following in the six months before your insurance became effective:

a. Received medical treatment
b. Took prescribed drugs
c. Consulted a doctor

If you cease to be insured, we will, at your request, return any unearned premium to you.
Waiver of Premium

Under the Base Plan, if you are disabled and entitled to payment of benefits under the plan for three consecutive months, your premium, which becomes due during the remaining compensable period of disability, will be waived. Waiver of premium will cease on the earlier of (1) the date disability ceases, or (2) the date the maximum benefit period has expired. Premium for HIP and LTD Plans will be waived simultaneously with premium for the Base Plan. After waiver of premium ceases, you may continue your insurance by resuming payments on the first premium due date on or after you return to work.

Return to Duty Provision (Base and LTD)

Under the Base Plan and LTD Plan, if following a period of disability, you return to full-time, active duty for six consecutive months or more, any subsequent disability will be treated as a new disability even if the subsequent disability results from the same cause.

Leaves of Absence

Your insurance under the Base Plan, HIP, and LTD Plan may be continued for up to two years during a Board-approved leave of absence, such as:

a. Travel or study
b. Parental leave (for the birth or adoption of your child) or family leave (for the required care of your child, parent, spouse, or sibling) or for the duration of any leave of absence granted by your employer as required by the Family Medical and Leave Act of 1993 or similar state laws.

You must continue premium payments except when the waiver of premium provision applies.

Successive Period Interval (HIP)

Successive periods of hospital confinement for the same cause must be separated by at least 90 days or they will be considered one period of confinement.
Welcome to a benefit program that can help make getting the coverage you need easier and more convenient through a variety of voluntary services and insurance products. Pinellas County Schools is pleased to continue offering the following employee benefits:

- **MetLife Hospital Indemnity Plan (HIP)**
- MetLife Auto & Home®
- MetLaw® Group Legal Plan
- MetLife My Pet Protection
- Horace Mann Auto Payroll Deduction Plan

### MetLife Hospital Indemnity Plan (HIP)
Enroll as a new hire, during annual enrollment for the next plan year, or when you experience a qualified change in status.

New employee: Enroll using the PCS Enrollment and Change Form.

### MetLaw® Group Legal Plan
Enroll as a new hire or during annual enrollment for the next plan year. For more information, go to [https://info.legalplans.com](https://info.legalplans.com) and use the Access Code PCS.

To enroll in any of the MetLife voluntary plans (except for MetLife HIP) call the toll-free number or visit the MetLife website. 800-GETMet8 (800-438-6388)

### MetLife Auto & Home®
You may enroll in this plan anytime during the year.

To enroll in auto & home and legal plans, go to [www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)

PCS offers several MetLife voluntary plans. Like all benefits, you must enroll within 31 days of your date of hire. Otherwise, you can’t enroll in or change your election until the next annual enrollment period for the next plan year. With the exception of the legal plan, you can’t enroll in or change your benefit election or enroll during the year unless you experience a qualified change in status during the year.
MetLife My Pet Protection

MetLife offers My Pet Protection®, an enhanced plan for cats and dogs provided by Nationwide®, formerly Veterinary Pet Insurance (VPI®). With their deep understanding of pet owners’ needs, they’ve designed a plan that better serves those needs—providing enhanced coverage that’s 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 more information.

**Want to enroll (new election)?** As a new enrollee, you are able to enroll in the enhanced My Pet Protection plan at any time.

**If you enrolled in early 2018 or prior,** you are enrolled in a Veterinary Pet Insurance (VPI) policy. Prior to your annual renewal period, you will be contacted by MetLife (if you have not already been notified) and offered the opportunity to continue your current policy (Major Medical) or upgrade to the new enhanced My Pet Protection policy.

Contact MetLife at 1-800-GETMET8 for more information or to enroll. You may enroll at any time.

MetLaw Group Legal Plan

With MetLaw®, the group legal plan made available by Hyatt Legal Plans, a MetLife® Company, you’ll have easy access to a nationwide network of participating attorneys who can provide you with a wide range of legal services—for a fraction of the regular cost.

With MetLaw, 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 your MetLaw premium, which can be conveniently deducted from your paycheck. Your spouse and dependent children also have access to the plan benefits.

When you use a participating attorney for things like purchasing a home or preparing a will, these services are covered in full; there are no co-payments or deductibles. In most cases, the plan will pay for itself the first time you use it. You can contact an attorney for covered services, including advice and consultations, as often as you need to.

The plan provides you access to legal advice and representation on a wide range of matters including:

- Will preparation and estate planning
- Elder law
- Family law
- Financial matters including identity theft defense
- Traffic and criminal matters
- Immigration assistance and more

Some pre-existing exclusions may apply. For complete details of the coverage, call or write the company.

For more information, go to https://info.legalplans.com and use the Access Code PCS.

Eligibility and Enrollment

As a newly hired benefits-eligible employee of Pinellas County Schools, you’re eligible to participate in the Legal Plan. You must contact MetLife to enroll within 31 days from your date of hire or wait until Annual Enrollment.

**Once enrolled, you will be required to remain in the plan for the full benefit plan year. You cannot cancel it before that date,** except for termination, retirement, or leave of absence. New enrollments and changes or cancellations outside the initial new hire eligibility period must wait until Annual Enrollment.

Continued on next page
**Voluntary Benefits**

**Voluntary Products**

**MetLife Auto & Home®**

With the MetLife 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 MetLife 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.

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

**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:
  - Payroll deduction discount.
  - Member discounts, including FACA, PASA, NEA.
  - Special educator rates.
- Educator Advantage® benefits and features at no additional cost.
- Customer service 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](http://www.floridaeducatorsinsurance.com) for a free quote.

* 20 paychecks per year—no summer deductions.
Saving money for retirement is often a low priority in our busy lives. We usually have more immediate financial concerns, such as paying the mortgage, feeding our family, or saving for our children’s college education.

On the other hand, putting money aside for your retirement years should also 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)). These plans provide:

- Convenient savings through payroll deductions
- Tax-deferred growth potential
- A choice of investments

Both traditional and Roth 403(b) accounts offer benefits that are similar to retirement savings plans, but are very different in terms of federal tax treatment. You can participate in either or both of these account types during your career to take advantage of the following features:

- Contributions to individual accounts
- Convenience of payroll deductions
- High annual contribution limits
- Flexible loan provisions
- Flexible contributions
- Benefits paid to your beneficiaries at your death

**Please note:** Your contributions to your voluntary retirement account do not affect Florida Retirement System contributions, which are based on total gross income.

### 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.

The chart below illustrates how salary reduction savings through a traditional 403(b) or 457(b) plan can increase your take-home pay by lowering your taxes.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
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<td>$500.00</td>
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<tr>
<td>With VRD</td>
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<tr>
<td>Gross Pay</td>
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<td>$405.59</td>
</tr>
</tbody>
</table>

* Amounts shown as deductions for Social Security and federal income tax may differ depending on your federal tax rates and number of personal (W-4) exemptions.

Continued on next page
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 2017 is $18,000. The 2018 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 $5,500.) 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.

Enrolling in the Plans

To participate, you must select an investment plan from the list of authorized investment providers on the next page. 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.

You can enroll in a plan or cancel your contributions anytime up to a maximum of four changes during the calendar year. You must complete the standard Payroll Reduction Authorization for Pinellas County Schools online at http://www.tsacg.com/individual/art-help/.

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.

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:

Voluntary Retirement Programs
Pre-Tax and After-Tax Options

Other Information

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 with this online process. In addition, TSA Consulting Group has a toll free customer service help line to assist you (888) 796-3786, Option 5, available Monday–Thursday 8:00 a.m.–6:00 p.m. EST and Friday 8:00 a.m.–4:00 p.m. EST.

### 2017–2018 Voluntary Retirement Program

#### List of Authorized Investment Providers

<table>
<thead>
<tr>
<th>COMPANY NAME</th>
<th>PRODUCTS AVAILABLE</th>
<th>AGENT OF RECORD</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieva</td>
<td>X</td>
<td>Pat Leach</td>
<td>727-431-7358</td>
</tr>
<tr>
<td>Aetna-VOYA</td>
<td>X</td>
<td>Diane Pelitta</td>
<td>813-281-3751</td>
</tr>
<tr>
<td>American Century (No Load)</td>
<td>X</td>
<td><a href="http://www.americancentury.com/florida">www.americancentury.com/florida</a></td>
<td>800-345-3533</td>
</tr>
<tr>
<td>AXA Advisors</td>
<td>X</td>
<td>Ryan Lau</td>
<td>813-466-3195</td>
</tr>
<tr>
<td>Fidelity Funds (No Load)*</td>
<td>X</td>
<td><a href="http://www.fidelity.com/atwork">www.fidelity.com/atwork</a></td>
<td>800-343-0860</td>
</tr>
<tr>
<td>Franklin Templeton</td>
<td>X</td>
<td>Andrew Aiello</td>
<td>727-299-4624</td>
</tr>
<tr>
<td>Horace Mann</td>
<td>X</td>
<td>Gary Cucchi</td>
<td>813-600-3268</td>
</tr>
<tr>
<td>Lincoln Investment</td>
<td>X</td>
<td>Brett Smith</td>
<td>800-771-7732</td>
</tr>
<tr>
<td>Northern-VOYA</td>
<td>X</td>
<td>Keista Ransom</td>
<td>813-281-3743</td>
</tr>
<tr>
<td>Plan Member Services</td>
<td>X</td>
<td>Richard Rush</td>
<td>800-874-6910</td>
</tr>
<tr>
<td>Security Benefits</td>
<td>X</td>
<td>Jacob Moore</td>
<td>727-543-5098</td>
</tr>
<tr>
<td>The Legend Group</td>
<td>X</td>
<td>Steven Fisher</td>
<td>727-578-2828</td>
</tr>
<tr>
<td>Valic</td>
<td>X</td>
<td>Chris Brown</td>
<td>813-269-3362</td>
</tr>
<tr>
<td>Waddell &amp; Reed</td>
<td>X</td>
<td>Todd A. Mazur</td>
<td>813-286-9196 x126</td>
</tr>
</tbody>
</table>

* 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.

Continued on next page
Voluntary Retirement Programs
Pre-Tax and After-Tax Options

Resources
For more information about the PCS Voluntary Retirement Program:

Call
• Your investment provider representative, or
• The PCS Retirement Team: 727-588-6141

Visit
• [https://www.tsacg.com/employee_site/districts/florida/pinellas.htm](https://www.tsacg.com/employee_site/districts/florida/pinellas.htm)

The following websites offer relevant information

<table>
<thead>
<tr>
<th>Website</th>
<th>Website URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Administration</td>
<td><a href="http://www.ssa.gov">www.ssa.gov</a></td>
</tr>
<tr>
<td>Administration on Aging</td>
<td><a href="http://www.usa.gov">www.usa.gov</a></td>
</tr>
<tr>
<td>U.S. Department of Labor</td>
<td><a href="http://www.dol.gov">www.dol.gov</a></td>
</tr>
<tr>
<td>Morningstar</td>
<td><a href="http://www.morningstar.com">www.morningstar.com</a></td>
</tr>
<tr>
<td>A.M. Best Company</td>
<td><a href="http://www.ambest.com">www.ambest.com</a></td>
</tr>
<tr>
<td>Standard and Poor's Company</td>
<td><a href="http://www.standardandpoors.com">www.standardandpoors.com</a></td>
</tr>
<tr>
<td>American Savings Education Council</td>
<td><a href="http://www.choosetosave.org/asec">www.choosetosave.org/asec</a></td>
</tr>
<tr>
<td>Employee Benefit Research Institute</td>
<td><a href="http://www.ebri.org">www.ebri.org</a></td>
</tr>
</tbody>
</table>
### Key Differences Between FRS Plans

<table>
<thead>
<tr>
<th>Pension Plan</th>
<th>Investment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>A traditional retirement plan designed for longer-service career employees.</td>
<td>A retirement plan designed for shorter service and more mobile employees.</td>
</tr>
<tr>
<td>You qualify for a benefit after eight years of service. You are always fully vested in your own contributions as long as you remain in the Pension Plan.</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>PCS contributes the majority of your FRS retirement plan contribution based on a fixed percentage of your gross salary (total employee and employer rate is 6.3% for Regular Class employees). A mandatory 3% pre-tax contribution is deducted from your paycheck and deposited into your retirement account.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

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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.

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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.

### 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
• MyFRS Financial Guidance Line:
   866-446-9377 Option 2
   (TRS 711)

Visit • www.MyFRS.com
COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) requires employers who sponsor group health plans to offer employees and their families the opportunity to purchase medical, vision, or dental coverage at group rates. This section is to notify you of your rights and obligations to continue coverage under this law. We urge both you and your spouse to read this notice carefully.

This federal law provides qualified beneficiaries the same health benefits as active employees, including the right to participate in Annual Enrollment and continue participation in the Healthcare FSA.

School Board employees whose medical, vision, or dental coverage ends due to reduction in work hours or termination of employment for reasons other than gross misconduct have the right to continue the above-mentioned coverage.

Spouses of covered employees who are on the employee’s policy(ies) have the right to continue coverage for any of these reasons:

- Death of your spouse who was a covered School Board employee,
- Termination of your spouse’s employment for reasons other than gross misconduct,
- Reduction in your spouse’s work hours,
- Divorce or legal separation* from your spouse, and
- Your spouse becomes eligible for Medicare.

Dependent children of covered employees who are on the employee’s policies may continue coverage for any of these reasons:

- Death of a parent who was a covered School Board employee,
- Termination of parent’s employment for reasons other than gross misconduct,
- Reduction in parent’s work hours,
- Parent becomes eligible for Medicare, and
- Loss of child’s dependent status (e.g., age limitation).

Please review the following sections carefully. They contain important information about your rights and responsibilities as a Pinellas County Schools employee.

- COBRA
- HIPAA
- Family Medical and Leave of Absence
- Workers’ Compensation

<table>
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<tr>
<th>When Can COBRA Coverage Be Elected? (Change in Status Event)</th>
<th>Who Can Elect COBRA Coverage? (Qualified Beneficiaries)</th>
<th>How Long Can Coverage Be Continued?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Termination of employment of covered employee (other than for gross misconduct) or reduction in work hours of covered employee</td>
<td>Employee, spouse, and dependent children</td>
<td>18 months</td>
</tr>
<tr>
<td>Death of covered employee</td>
<td>Spouse and dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Divorce or legal separation*</td>
<td>Spouse and dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Covered employee becomes eligible for Medicare</td>
<td>Spouse and dependent children</td>
<td>36 months</td>
</tr>
<tr>
<td>Loss of child’s dependent status</td>
<td>Dependent child</td>
<td>36 months</td>
</tr>
<tr>
<td>Qualifying disability</td>
<td>Employee</td>
<td>29 months</td>
</tr>
</tbody>
</table>

* Only divorce is recognized by the state of Florida, not legal separation.
How to Obtain Continued Coverage

You or your family are responsible for notifying the Risk Management and Insurance Department of a divorce or a child losing dependent status (or other change in status event) within 60 days of the qualifying event. The Personnel Department is responsible for notifying the Risk Management and Insurance Department in the case of death, termination of employment, or reduction in work hours.

When Risk Management and Insurance is notified that a qualifying event has occurred, Risk Management and Insurance will notify you of your right to continue group insurance coverage. You have 60 days from the notice to submit an enrollment form for continued coverage. Payment and coverage will be retroactive. If you wait longer than 60 days, your eligibility to continue medical, vision and/or dental coverage, or participate in your Healthcare FSA, your coverage or participation will end.

Premium Payment

To extend coverage for yourself or your family, you are required to pay the entire cost of coverage plus administrative costs. The law states that this premium can be 102% of Pinellas County Schools’ cost of providing benefits. This amount will be calculated yearly, and may vary from year to year.

Your initial premium payment must be paid no later than 45 days after you enroll. Your initial payment amount is retroactive, may cover more than one month, and will be larger than your remaining monthly payments. If your initial payment is late, you will not be able to continue coverage.

All subsequent payments must be made the first of each month. If these payments are not received on time, coverage will end. For this reason, you should be careful that all premium payments are made on time. If the premium payment is not paid by the end of the grace period, your continued coverage will end on the last day of the month for which a timely payment was received and you may not re-enroll.

When Continued Coverage Ceases

The COBRA law states that your continued coverage as a qualified beneficiary may be cancelled for any of the following reasons:

• Pinellas County Schools no longer provides coverage to any of its employees
• The premium for your continued coverage is not paid on time
• You or your dependents become eligible for coverage under another group plan (if you have a pre-existing condition not covered under your new plan, you may continue your old plan to cover that pre-existing condition)
• You or your dependents enroll in:
  — Medicare—Part A, Part B, or both
  — Medicare + Choice HMO
• You were divorced or widowed from a covered employee and later remarry and are eligible under your new spouse’s group plan.

If You Have Questions

If you have any questions about this law, please contact Risk Management and Insurance at 727-588-6197, Monday through Friday, 8:00 a.m. to 4:30 p.m. ET.
Plan Administration
Your Rights and Responsibilities

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

Starting in 2019, most Americans are no longer required to purchase health insurance coverage or pay a penalty.

However, whether you are eligible for a premium subsidy depends on the plans offered by your employer. The medical plans offered by PSC meet the affordability and coverage requirements.

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

Medical Plans

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.

Continued on next page
Plan Administration
Your Rights and Responsibilities

Family and Medical Leave of Absence

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

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

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

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

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

Workers’ Compensation

Basic Facts

1. Workers’ Compensation coverage is paid by Pinellas County Schools at no cost to you.
2. It is your responsibility to report a work-related accident to administration within 24 hours.
3. This coverage will pay for the most reasonable and necessary medical care if you have an illness or injury arising out of or in the course of your employment.
4. Pinellas County Schools has the right to choose the medical providers who will treat you.
5. Workers’ Compensation coverage also will replace part of your lost wages if your doctor says you must be out of work for a certain length of time because of a work-related injury or illness.

How to Get Medical Care and Benefits

If you require medical attention due to your work-related illness or injury, please notify your supervisor. You must obtain treatment from a provider who is on the list of Workers’ Compensation providers, posted at your work site. The list of providers is also available on the PCS Risk Management website at pcsb.org/risk-benefits. (For serious emergencies or for urgent care after hours, please proceed to the nearest emergency facility.)

Unauthorized absences and treatment received outside the PCS Workers’ Compensation provider network are not covered.

If you have any questions, please contact Risk Management, Workers’ Compensation at 727-588-6196.
Payment for Lost Wages

If your earnings are lower because of a work-related injury or illness, you may be able to receive some cash benefits (indemnity benefits). Your first 10 lost workdays will be covered by Pinellas County Schools, payable at 100% (maximum of 10 days paid per fiscal year). After this period, your wages will be paid through our Workers’ Compensation carrier.

Your compensation rate will be based on 66\(\frac{2}{3}\)% of your average weekly wage, up to a yearly state maximum. You will be eligible for this benefit if you have a doctor’s statement that indicates you are unable to return to work as a result of the accident or illness. (Physician must be an approved doctor from the Workers’ Compensation network.)

Pinellas County Schools Modified Alternative Duties Program

Pinellas County Schools has developed a program designed to assist you while you are temporarily disabled due to a work-related injury or occupational disease. The Modified Alternative Duties Program is designed to offer a temporary (up to a maximum of 90 days) alternative work site or position where you can function during the healing and rehabilitation process.

Each placement is made considering all medical restrictions recommended by authorized Workers’ Compensation providers. Please be assured, it is our intent to work closely with you and your physician on this matter.

If you have any questions concerning this program, please call the Personnel Department.

Women’s Health and Cancer Rights Act

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

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

Maternity and Newborn Length of Stay

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

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

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

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

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Pinellas County Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, no one will ever disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.
Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Aetna’s patient advocate in order to provide you with services under the wellness program.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact April Paul at 727-588-6136.
Important Notice from Pinellas County Schools
About Your Prescription Drug Coverage and Medicare

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 costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

• Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

• Pinellas County Schools has determined that the prescription drug coverage offered by the Aetna Prescription Drug Program is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When 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.

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.

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.

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).
Plan Administration
Your Rights and Responsibilities

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

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

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

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

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

- •  www.cms.hhs.gov  •  877-267-2323, Menu Option 4, Ext. 61565
- •  307-777-7531
- •  https://wyequalitycare.acs-inc.com/
- •  1-800-362-3002
- •  Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
- •  Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
- •  Phone: 1-800-362-3002 ext. 15473
- •  West Virginia – Medicaid
  Website: http://mywvhipp.com/
  Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
- •  Wisconsin – Medicaid
  Website: https://www.dhs.wisconsin.gov/publications/s/1/p10095.pdf
  Phone: 1-800-362-3002
This guide describes Pinellas County Schools employee benefit programs that will be effective for the plan year beginning January 1, 2019. This is only a summary of the benefit programs. Additional restrictions and/or limitations not included in this guide may apply. In the event of a conflict between this guide and the plan documents, the plan documents will control.

Risk Management and Insurance
301 - 4th Street S.W.
Largo, FL 33770
Questions?
Call the Benefits Team:
727-588-6197
or visit our website at www.pcsb.org/risk-benefits

Departments • Human Resources • Risk Management