START

BENEFlex

2021 EMPLOYEE BENEFITS GUIDE

pcs
PINELLAS COUNTY SCHOOLS

Contact Information

Onsite Representatives

Aetna (Claims Advisor)	727-588-6367
Aetna (Medical—Patient Advocate)	727-588-6137
Aetna (Health & Wellness Advocate)	727-588-6134
Standard Insurance Company (Disability Claims)	727-588-6444

Risk Management and Insurance

Main Number	727-588-6195 • (Fax) 727-588-6182
Insurance Benefits and Deductions—Employee	727-588-6197
Retirement (Insurance Benefits, DROP)	727-588-6214
Tax-Deferred Accounts	727-588-6141
Wellness	727-588-6031
Workers' Compensation	727-588-6196

Insurance Carriers

Aetna Concierge Customer Service • Member Services • Aetna Mail Order Pharmacy • Aetna PayFlex FSA Administration	866-253-0599 www.aetnapcsb.com
EyeMed Vision Care	866-299-1358 eyemed.com
Healthcare Bluebook	888-316-1824 pcsb.org/healthcarebluebook
Humana Advantage Dental (548085)	800-979-4760 www.MyHumana.com
MetLife® Dental Plan—PDP (G95682)	800-942-0854 metlife.com/dental
MetLife® Voluntary Benefits (HIP, Auto, Legal, Pet Insurance, etc.)	800-438-6388 metlife.com/mybenefits
Resources for Living (RFL) Employee Assistance Program (EAP)	800-848-9392 resourcesforliving.com • username: pcsb; password: eap
Standard Insurance Company (Life, AD&D, Disability Claims) Christine D'Angelo	800-325-5757 Christine.D'Angelo@standard.com
Teladoc	855-835-2362 teladoc.com/aetna

Non-PCS Programs

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

This guide describes Pinellas County Schools employee benefit programs that will be effective for the plan year beginning January 1, 2021. 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.

Contents

Contact Information
2021 Benefit Plans Summaries 2
Payroll Deduction Rate Chart 6
New Hire Enrollment Information 8
General Enrollment Information 9
- Eligibility 9
- Enrollment and Effective Dates 9
- Dependent Coverage and Eligibility 10
- Changes in Coverage 12
- Coordination of Benefits 12
- Termination of Coverage 13
- Annual Enrollment 13
- Board Contribution 13
- Two Board Employees 14
- Change in Two Board Status 14
- Payroll Deductions 15
- Leave of Absence (LOA) 15
- Continuation or Waiver of Insurance Premium 17
- Retiree Insurance 17
- Disability Form Information 18
- Life Insurance Medical History Information 19

The FLEX Plan 20
- Premium Conversion 20
- Change in Status Events 21
- Flexible Spending Accounts (FSAs) 23

Aetna Medical Plans 26–42
- Medical Plans Comparison Chart 34–37

Hospital Indemnity Plan (HIP) 43

Employee Assistance Program (EAP) 44
Drug- and Alcohol-Free Workplace 45
The Be SMART Wellness Program 46

Dental Plans 48

EyeMed Vision Plan 58

Life and AD&D Insurance 61

Disability Insurance Plans 69

Voluntary Benefits 76

Voluntary Retirement Programs 79
Florida Retirement System (FRS) 83

Plan Administration...*Your Rights and Responsibilities* 85

2021 Benefit Plans Summaries

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, 2021.

Medical Plans

- Choose from four Aetna medical plans: Select Open Access, Choice POS II (Point of Service II), CDHP + HRA (Consumer Driven Health Plan + Health Reimbursement Account), and Basic Essential.
- 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.
- 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 43 for details about this plan.

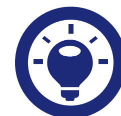
Be SMART Wellness Programs

- 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.

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, 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 credits into your Healthcare FSA. **This is not automatic**—you must actively enroll in a Healthcare FSA to receive the credits the first year you enroll. In subsequent years, your FSA contribution amount will continue unless you change it during Annual Enrollment. 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.

2021 Benefit Plans Summaries



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 $2,700 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.

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.

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 44).
- 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 Aetna Resources for Living® at 800-848-9392 for help and information.

2021 Benefit Plans Summaries

Dental Plans

HumanaDental 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.

2021 Benefit Plans Summaries

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.

Disability Insurance Plans

Disability insurance

Choose from the following:

- **Preferred Monthly Benefit:** Choose an amount between $400 and $5,000 (up to 66⅔% of your salary).
- **Benefit Duration:**
  - — Two years OR
  - — Up to the Social Security Normal Retirement Age (SSNRA).
- **Waiting Period:** Choose 14, 30, or 60 days until the plan starts paying benefits.

Voluntary Benefits

- Auto and Home Insurance* through Horace Mann and MetLife.
- MetLife Legal Plan offered by Hyatt Legal Plans (a MetLife company).
- MetLife Veterinary (VPI®) Pet Insurance.
- See pages 78–81 for details.

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

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 82–85 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

Rates Subject to Union Ratification and Board Approval

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

Payroll Deduction Rate Chart

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

Aetna Medical Plans

Coverage Level	Select Open Access	Choice POS II	CDHP + HRA	Basic Essential
Employee	$89.00	$99.00	$69.00	$31.00
Employee + Spouse	$238.00	$259.00	$195.00	$121.00
Employee + Child(ren)	$217.00	$238.00	$174.00	$113.00
Employee + Family	$315.00	$357.00	$256.00	$147.00
Two Board Family[1]	$220.00	$262.00	$161.00	$52.00

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

[1] To be eligible for Two Board Family, three or more individuals must be covered under the plan and your legal spouse must be a benefits-eligible employee of the School Board.

◆ Humana or MetLife Dental Plans

Coverage Level	Humana Advantage	MetLife® PDP
Employee	$7.93	$14.93
Employee + 1	$14.56	$27.36
Employee + Family	$21.27	$39.49
Two Board Family[2]	$19.27	$37.49

◆ EyeMed Vision Plan

Coverage Level	EyeMed
Employee	No Charge
Employee + 1	$2.83
Employee + Family	$5.92
Two Board Family	$5.92

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

[2] To be eligible for Two Board Family, three or more individuals must be covered under the plan and your legal spouse must be a benefits-eligible employee of the School Board.

◆ MetLife Hospital Indemnity Plan (HIP)

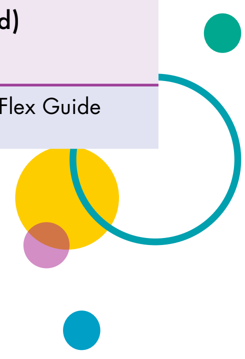
Coverage Level	Hospital Indemnity Plan (HIP)
Employee Only	$8.00
Employee + Spouse	$13.00
Employee + Children up to age 26	$17.00
Employee + Family	$21.00

MetLife Legal Plan

Call MetLife (800-438-6388) to Enroll

$11.85
(no coverage level selection required)

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



Payroll Deduction Rate Chart

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

Standard Insurance Company Life Insurance Plans[3]

Basic Employee Term Life Insurance[1]

One times base annual earnings rounded up to next $1,000 is provided for all eligible PCS employees at no cost to you.

Minimum: $15,000
Maximum: $200,000

Optional Employee and Dependent Term Life

Employee[2] & Spouse[3]		Children[4]	Family[5] Formerly "Dependent Life"
Age (as of effective date of coverage)	Rates (per $10,000)	Rates (per $2,000)	Rates (per family unit)
under 30	$ 0.34	$0.24	$0.90
30–34	0.48		
35–39	0.54		
40–44	0.60		
45–49	0.90		
50–54	1.38		
55–59	2.58		
60–64	3.96		
65–69	7.62		
70+	12.36		

[3] 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.

1. This coverage is "guarantee issue" and no evidence of good health is required.
2. Optional Employee Term Life: $10,000 minimum, up to $200,000 in $10,000 increments or $250,000, up to $500,000 maximum in $50,000 increments; "guarantee issue" (new hire only) to $100,000 or your current coverage amount; for additional amounts, you must provide evidence of good health; subject to reduction schedules at age 70.
3. Optional Dependent Term Life for Spouse: $10,000 increments to $100,000; evidence of good health is required; **coverage terminates at age 70.**
4. Optional Dependent Term Life for Child(ren): $2,000 increments to $10,000; one premium covers all eligible child(ren).
5. Optional Family Term Life: One premium covers spouse and eligible child(ren).

◆ Standard Insurance Company Optional Accidental Death & Dismemberment Insurance

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

Benefit Amount	Employee Only	Employee + Family	Benefit Amount	Employee Only	Employee + Family
$50,000	$0.60	$1.05	$200,000	$2.40	$4.20
$100,000	$1.20	$2.10	$300,000	$3.60	$6.30

◆ Standard Insurance Company Disability

An eligible employee may select one plan and one waiting period, outlined below, provided the Monthly Disability Benefit does not exceed 66²/₃% of the person's regular monthly base salary.

If Your Annual Base SalaryIsatLeast	Monthly Disability Benefit	Two Year Plan and Waiting Periods			To SSNRA[4] Plan and Waiting Periods		
		14 Days	30 Days	60 Days	14 Days	30 Days	60 Days
$ 7,200	$ 400	$ 5.28	$ 3.38	$ 1.88	$ 6.83	$ 4.54	$ 2.86
10,800	600	7.91	5.08	2.82	10.25	6.80	4.29
14,400	800	10.55	6.77	3.76	13.67	9.07	5.72
18,000	1,000	13.19	8.46	4.70	17.08	11.33	7.15
21,600	1,200	15.83	10.15	5.65	20.50	13.60	8.58
25,200	1,400	18.47	11.84	6.59	23.92	15.87	10.01
28,800	1,600	21.11	13.54	7.52	27.33	18.13	11.44
32,400	1,800	23.75	15.23	8.47	30.75	20.40	12.88
37,800	2,100	27.71	17.77	9.88	35.87	23.80	15.02
43,200	2,400	31.67	20.30	11.29	41.00	27.20	17.17
48,600	2,700	35.62	22.84	12.70	46.12	30.60	19.31
54,000	3,000	39.58	25.38	14.11	51.25	34.00	21.46
63,000	3,500	46.18	29.61	16.46	59.79	39.67	25.03
72,000	4,000	52.78	33.84	18.82	68.33	45.34	28.61
81,000	4,500	59.38	38.07	21.17	76.87	51.01	32.18
90,000	5,000	65.97	42.30	23.52	85.41	56.67	35.76

Pre-existing conditions, including pregnancy, apply during the first year of new or increased coverage. See page 25 and the online BENEFlex Guide for full details.

[4] Social Security Normal Retirement Age (SSNRA)

New Hire Enrollment Information

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 optional term life plan, you are required to submit the online Medical History Statement when you elect more than $100,000 of employee and/or spouse optional term life insurance coverage. See page 19 for details.**

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. Per IRS regulations, 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* 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 31and 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.

General Enrollment Information

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 natural, foster, step, legally adopted children, children proposed for adoption, and children for whom you have been appointed legal guardian.
- **Medical, Dental, and/or Vision Plan Coverage for Children**
  Your 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 been appointed a legal guardian): 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.

General Enrollment Information

Termination of Coverage

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

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

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

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

Please see pages 88–90 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, 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.

If you subsequently elect medical insurance and you were using your board contribution toward a Healthcare FSA plan, you may be responsible for the final month of premiums for the FSA.

* ***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 retires 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.

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 65 for details.

Waiver of Disability Premium

Under the disability plan, if you are disabled and entitled to payment of benefits under the policy for three consecutive months, your premium will be waived. Waiver of premium will begin on the first day of the month following 90 days of disability..

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.

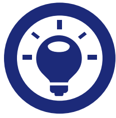
Re-employment after Retirement

It is your responsibility to contact the PCS retirement team when and if you return to work or leave employment with Pinellas County Schools.

Life Insurance Guidelines Upon Re-employment

When you officially retire, you may enroll in the same amount (one times your salary) of Basic Term Life insurance benefit that was in effect at the time of your retirement. If you return to a benefit eligible position with Pinellas County Schools, you cannot continue the Board Life insurance that you continued as a retiree. You will need to cancel this coverage since you will be covered by the district with Board life that is one times your new annual salary.

In the event you return to work in a position that offers a lesser amount of Board-paid life insurance, you will only be eligible for the most recent and lower amount of the Basic Term life insurance when you return to retiree status.



Enrollment Information

Sample Supplemental Form

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

Disability Plan

Standard Insurance Company

Standard Insurance Company — **Disability Plan Enrollment and Change Form**

To Be Completed By Risk Management & Insurance

Group Number	Employer Name	Date of Employment
755556	The School Board of Pinellas	

To Be Completed By Applicant ☐ Apply for Coverage ☒ New Hire ☐ Change in Coverage ☐ Life Event

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	
Smith, Mary A.	000-00-0000	10/3/86	☐ Male ☒ Female

Your Address	City	State	ZIP
123 Main Street North	St. Petersburg	FL	33702

Job Title/Occupation	Phone Number
Teacher	727-555-5678

Hours Worked Per Week	Annual Earnings $
40	45,000

Coverage

The Standard Educator Disability Plan

Refer to the enrollment materials provided when completing the following:

Maximum Benefit Period ***(choose one):***

☒ 2 Year Option

☐ Social Security Normal Retirement Age (SSNRA) Option

Benefit Waiting Period ***(choose one):***

☒ 14/14

☐ 30/30

☐ 60/60

Benefit Amount/Per Pay Cost

$ 2,400 Monthly Benefit

$ 35.62 Per Pay Period 20 salary deductions per year

Signature I wish to make the choices indicated on this form. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change

Member/Employee Signature Required Mary A. Smith Date (Mo/Day/Yr) 10/13/19

Initials: MAS — I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction.

Initials: MAS — I understand that the insurance applied for contains exclusions and limitations.

To be completed by Risk Management & Insurance

Reviewer Signature ____________________ Date (Mo/Day/Yr) __________

Effective Date	First Deduction Date	Per Pay Cost

Return completed form to Risk Management & Insurance.
Please keep a copy for your records.

SI 7533D-755556 (9/19) 1 of 1 (2/11)

See page 7 for 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 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 Insurance Company.**
8. **Application Confirmed.** When you receive this notification, you have successfully submitted your application.

The FLEX Plan

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.

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

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**.

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

	NO FLEX	WITH FLEX
Gross Income	$30,000	$30,000
Annual Insurance Premiums	– 3,560	– 3,560
Taxable Income	30,000	26,440
Federal Income and Social Security Taxes	– 2,684	– 2,027
Take-home Pay	**$23,756**	**$24,413**

NOTE: If you are a FLEX Plan participant and enroll in a 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.

$657 Saved!

Assumptions: $30,000 gross income • Consumer Directed Health Plan Employee + Family Coverage
2020 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.

The FLEX Plan

Qualifying Events to ADD Medical, Dental, or Vision

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

Qualifying Events to DROP Medical, Dental, or Vision

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

Healthcare Flexible Spending 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.*

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 $2,700
  - **Dependent Care FSA** = $200 to $5,000 ($2,500 if married and filing separately)
- **Board Contribution 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 Contribution 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.

Kirin Saved $1,651 — Her savings equaled a mortgage payment

Dave Saved $303 — His savings paid for eight tanks of gas

Tonya Saved $757 — Her savings paid for a new laptop computer

	Kirin	Dave	Tonya
Annual Salary	**$35,000**	**$22,000**	**$42,000**
FSA Payroll Deductions:			
Healthcare FSA	-$450	-$1,000	-$2,500
Dependent Care FSA	-$5,000	$0	$0
Taxable Salary	**$29,550**	**$21,000**	**$39,500**
Taxes on Annual Salary	$6,494	$2,555	$8,615
Reduced Taxes on Taxable Salary	$4,843	$2,252	$7,858
Total Tax Savings	**$1,651**	**$303**	**$757**
Tax Status	*Single with 3 exemptions*	*Single with 1 exemption*	*Married with 3 exemptions*

The FLEX Plan
Flexible Spending Accounts (FSAs)

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.
- See 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 four Aetna medical plans.

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

Each plan offers a network of doctors and other health care providers who offer their services at a reduced or specified rate. Using in-network providers lowers your out-of-pocket expenses.

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.

	Select Open Access	Choice POS II	CDHP	Basic Essential
Do I have to stay in-network to receive plan benefits?	YES	NO	YES	YES
What is the coverage area?	National	National	National	National
Do I have to select a PCP?	Not Required	Not Required	Not Required	Not Required
Do I need a referral to see specialists?	NO	NO	NO	NO
What do I pay for medical services?	Co-pays for all services, no deductible	Deductibles, coinsurance and co-pays	Deductibles and coinsurance	PCP co-pay; Deductible and coinsurance on all other services
Is preventive care covered at 100%?	YES In-network only	YES In-network only	YES In-network only	YES In-network only
Is there a Health Reimbursement Account (HRA)?	NO	NO	YES (see page 28)	NO
Is there prescription drug coverage?	All four plans offer the Aetna Prescription Drug Program. Details are provided on pages 30–31.			

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 (employee), $750 (employee + spouse), $750 (employee + children), 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.

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

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).

PayFlex Card		Eligible Out-of-Pocket Expenses
HRA PayFlex Card (for CDHP + HRA Plan members only)	→	Pay for Medical/Rx Expenses Only
Healthcare FSA PayFlex Card	→	Pay for Medical/Rx, Dental, and Vision Expenses

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

New HRA Rollover Maximum

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

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

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

Basic Essential Plan

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 Primary Care Physician (PCP) or get referrals to specialists.
- You will pay a higher individual deductible* and out-of-pocket maximum compared to the other medical plans offered by PCS.
- You pay a co-pay for PCP visits, TelaDoc visits and prescriptions (expect brand specialty drugs) that are not subject to the deductible.

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

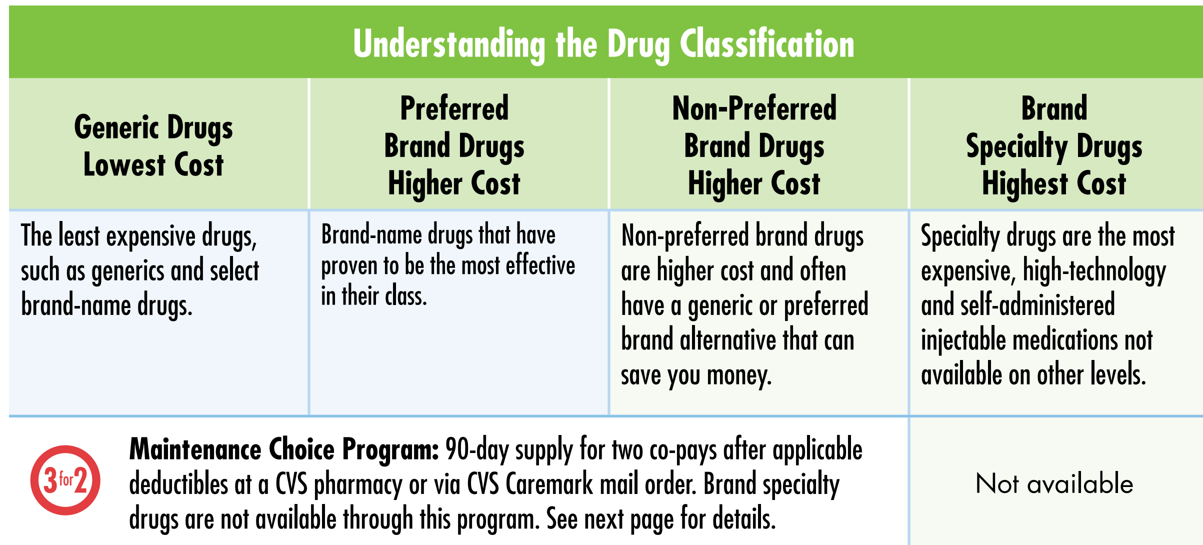
Aetna Medical Plans
Aetna Resources

Aetna Prescription Drug Program

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

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

See the medical plan comparison chart on pages 36–37 for your out-of pocket-costs.



Understanding the Drug Classification

Generic Drugs Lowest Cost	Preferred Brand Drugs Higher Cost	Non-Preferred Brand Drugs Higher Cost	Brand Specialty Drugs Highest Cost
The least expensive drugs, such as generics and select brand-name drugs.	Brand-name drugs that have proven to be the most effective in their class.	Non-preferred brand drugs are higher cost and often have a generic or preferred brand alternative that can save you money.	Specialty drugs are the most expensive, high-technology and self-administered injectable medications not available on other levels.
3 for 2 **Maintenance Choice Program:** 90-day supply for two co-pays after applicable deductibles at a CVS pharmacy or via CVS Caremark mail order. Brand specialty drugs are not available through this program. See next page for details.			Not available

Restrictions

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

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

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

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

Locate a Participating Pharmacy

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

Maintenance Choice Program

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

Maintenance Choice gives members a choice to fill a 90-day supply of their maintenance medicine either through CVS Caremark mail order delivery or at their local CVS Pharmacy retail locations. The member only pays two co-pays for a 90-day supply when obtaining those maintenance prescriptions through CVS.

Maintenance Choice Program Transition Period

A transition period is available for members who are currently filling maintenance prescriptions with a 30-day supply and for members who are filling 90-day maintenance drugs at non-CVS pharmacies.

Each prescription you fill will have a transition period. You will be able to obtain your maintenance drug at any pharmacy in the network for a 30-day supply **(not 90 days)** up to two retail fills per maintenance drug. Once you have completed the transitional period, you will have three options:

1. **Switch to a 90-day supply and fill your order through CVS or have your 90-day prescription transferred to a CVS.**
   - You will need to ask your doctor for a 90-day prescription for your maintenance medicines if you refill every 30 days. Your doctor may require you to schedule a visit before he or she will write a prescription.
   - Switch to a 90-day supply of maintenance drugs at CVS Caremark mail-order pharmacy or at a CVS Pharmacy retail location, including CVS Pharmacies located inside Target stores.
   - **Need help?** Contact Aetna Pharmacy Management to access the Aetna Rx Courtesy StartSM program. A representative will contact your doctor to attempt to help you get the prescription. Please allow up to seven days for the process to work. To help this process move quickly, please let your doctor know to expect a call from Aetna.
2. **Opt out of the program and fill your maintenance drugs with a 30-day supply at CVS or other network pharmacies.**
   - **You must call** Aetna Pharmacy Management at 1**-888-RX AETNA (1-888-792-3862)** or **TDD: 1-800-823-6373** and **opt out** of the Maintenance Choice Program. You can call Monday–Friday, 8:00 a.m.–6:00 p.m. to opt out (even from the pharmacy) and an override will be placed immediately.
   - With the override, you can continue to fill 30-day prescription(s) of maintenance medicine(s) at any pharmacy in the Aetna network. The override will include all maintenance medicines you are taking for the remainder of the calendar year.
3. **Pay the full cost of your prescriptions, if you do nothing.**

   If you do not choose one of the first two options before the transitional period has ended, your claim will be rejected, and you will pay the full cost of the prescription (not just the co-pays!)

Save on Maintenance Medications!

Please read this carefully to make sure you are not paying more for maintenance drugs than you need to! The Maintenance Choice Program is required if you want to save by paying two co-pays instead of three for a 90-day prescription.

Aetna Medical Plans

Aetna Resources

How to Save with the Maintenance Choice Program

CVS Pharmacy retail location near you

- Pick up your medicine at a CVS Pharmacy retail location that is convenient for you.
- Enjoy same-day prescription availability and the ability to talk with a pharmacist face-to-face.

CVS Caremark mail-order pharmacy

- Reorder only once every three months — online, by phone, or by mail.
- Receive your medicine in private, secure packaging.
- Talk to a pharmacist by phone, any time of the day or night.
- Easily order refills and manage your prescriptions when you log in to *www.aetnanavigator.com*, your secure member website.
- Choose from two delivery options:
  - On-Demand Delivery. Four-hour delivery offered within 10 miles of any CVS Pharmacy location; you pay up to $7 per delivery.
  - One- to two-day U.S. mail delivery at no extra cost to you, and your prescriptions arrive every 90 days anywhere in the U.S., at no extra cost to you.

Maintenance Choice Program Frequently Asked Questions (FAQ) Available on District Website

You may visit *pcsb.org/Pharmacy* for answers to frequently asked questions and additional information on Aetna's formulary, the CVS Caremark mail-order option, and available retail pharmacy discount programs.

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.

Healthcare Bluebook: Compare, Choose, Save

When you are enrolled in a PCS Aetna medical plan you and your enrolled dependents can access the Healthcare Bluebook. This free online and mobile resource makes it easy to shop for affordable high-quality health care—from diagnostics and imaging to outpatient surgery—at a fair price.

Go to *pcsb.org/healthcarebluebook* or download the free Healthcare Bluebook mobile app and start shopping for a Fair Price provider while you are with your doctor. 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.

$25 Reward | $100 Reward | $200 Reward

Go Green to Get Green

You can earn a reward for selecting a Fair Price provider for select procedures.

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.*

Teladoc

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. Aetna members also have access to Teladoc Behavioral Health. Employees and eligible dependents (age 18 or older) may have appointments with psychiatrists, psychologists, and licensed therapists by video.

Online	Go to ***www.Teladoc.com/Aetna*** and click "set up account."
Mobile app	Download the app and click "Activate account." Visit *www.teladoc.com/mobile* to download the app.
Call	855-Teladoc (835-2362) Teladoc can help you register your account over the phone.
Pay less ...	***... than a visit to an urgent care: $25 co-pay for Open Access Select, Choice POS II and CDHP; $40 co-pay for Basic Essential.***

Aetna Medical Plans Comparison Chart

The amount the plan pays may be based on usual, reasonable, 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.

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 28. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified. See page 29 for the HRA rollover maximum, effective January 1, 2023.
- Medical Plan Deductible (Choice POS II and CDHP + HRA). The amount you pay for medical expenses before the plan begins paying benefits.
- Coinsurance (Choice POS II and CDHP + HRA). The percentage of eligible medical expenses you pay after paying the deductible for most services.
- Co-pays The fixed amount you pay for medical care and prescriptions.
- Aetna Prescription Drug Program (all plans). You pay co-pays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay co-pays. In the Basic Essential plan, the deductible does not apply to the non-preferred brand drugs.

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

Benefit	Select Open Access In-Network Only
Service Areas/Networks	Any provider in the Aetna Select Open Access national network
Health Reimbursement Account (HRA)—Individual/ Family HRA funds can only be used for medical plan and prescription drug expenses.	N/A
Deductibles—Individual/Family	N/A
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or co-pays	$5,000 Individual; $10,000 Family
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible	$2,000 Individual; $4,000 Family
Lifetime Maximum	Unlimited
Physician Office Visits	**You Pay:**
Primary Care Physician (PCP)	$35 co-pay
Specialist (SPC)	$60 co-pay
Teladoc: Doctor/Behavioral Health	$25 co-pay/$25 co-pay
Preventive Adult Physical Exams	No co-pay
Preventive GYN Care (including Pap test) (direct access to participating providers)	No co-pay
Mammography Preventive Screening	No co-pay
Immunizations	No co-pay
Allergy Injections	Co-pay waived for allergy injections billed separately
Allergy Tests Lab X-Ray Outpatient Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)	$50 co-pay $25 co-pay $50 co-pay $250 co-pay
Colonoscopy Screenings—Preventive and Diagnostic	No co-pay
Chiropractic Services (limits apply) (direct access to participating providers)	$60 co-pay 20 visits per calendar year
Hearing Exam	$25 co-pay

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

Aetna Medical Plans Comparison Chart

Choice POS II		CDHP + HRA	Basic Essential
In-Network	**Out-of-Network[1]**	**In-Network Only**	**In-Network Only**
Any provider in the Choice POS II Network (national network)	Any provider	Any provider in the Aetna Select Open Access national network	Any provider in the Aetna Select Open Access national network
N/A	N/A	$500 Individual; $750 Employee + Child(ren) or Employee + Spouse; $1,000 Family (No maximum rollover amount) HRA contributions are prorated based on your date of hire.	N/A
$500 Individual; $1,000 Family (combined in- and out-of-network)		$1,500 Individual; $3,000 Family	$2,300 Individual; $8,900 Family
$5,000 Individual; $10,000 Family (combined in- and out-of-network)		$5,000 Individual; $10,000 Family	$8,550 Individual; $17,100 Family
$2,000 Individual; $4,000 Family (combined in- and out-of-network)		$2,000 Individual; $4,000 Family	Combined with medical
Unlimited		Unlimited	Unlimited
You Pay:	**You Pay:**	**You Pay:**	**You Pay:**
20% after deductible	40% after deductible	20% after deductible	$50 co-pay
20% after deductible	40% after deductible	20% after deductible	30% after deductible
$25 co-pay/20% after deductible	N/A	$25 co-pay/20% after deductible	$40 co-pay/0% no deductible
0%	40% after deductible	0% no deductible	0% no deductible
0%	40% after deductible	0% no deductible	0% no deductible
0%	40% after deductible	0% no deductible	0% no deductible
0%	40% after deductible	0% no deductible	0% no deductible
20% after deductible	40% after deductible	20% after deductible	30% after deductible
20% after deductible 20% after deductible 20% after deductible 20% after deductible	40% after deductible 40% after deductible 40% after deductible 40% after deductible	20% after deductible 20% after deductible 20% after deductible 20% after deductible	30% after deductible 30% after deductible 30% after deductible 30% after deductible
0%	40% after deductible	0% no deductible	0% no deductible
20% after deductible	40% after deductible	20% after deductible 20 visits per calendar year	30% after deductible 20 visits per calendar year
20 visits per calendar year combined in- or out-of-network			
20% after deductible	40% after deductible	20% after deductible	30% after deductible

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

Continued on next page

Aetna Medical Plans Comparison Chart—continued

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.

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.

Diabetes CARE

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

Important Rx Information

Maintenance Choice Program

Pay two co-pays for a 90-day supply only when you fill your maintenance prescriptions through CVS Caremark mail order delivery or at a CVS Pharmacy retail location.

Rx Deductible May Apply

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

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

Benefit		Select Open Access In-Network Only
Hospital		
Inpatient (Includes maternity and newborn services)		$500 co-pay per day; up to 5-day maximum
Outpatient Surgery (including facility charges)		$500 co-pay
Emergency Room Services		$500 co-pay
Ambulance		No co-pay
Urgent Care Facility		$50 co-pay
Maternity Care/OB Visits		$50 co-pay for initial visit only
Mental Health Services		
Outpatient Mental Health Services		$25 co-pay
Inpatient Mental Health Services		$500 co-pay per day; up to 5-day maximum
Miscellaneous		
Home Health Care (limits apply)		$25 co-pay
Hospice—Inpatient (limits apply)		$500 co-pay per day; up to 5-day maximum[2]
Skilled Nursing Facility (limits apply)		$500 co-pay per day; up to 5-day maximum[2] 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)		$25 co-pay per visit 60-visit limit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)		See prescription drugs below
Durable Medical Equipment (DME)		$50 co-pay
Aetna Prescription Drug Program *Some drugs may be subject to step-therapy or precertification*		***Mandatory Generics Unless Dispensed As Written***
Up to 30-day supply	**Generic**	$15 co-pay; no Rx deductible
	Preferred Brand	$60 co-pay; no Rx deductible
	Non-Preferred Brand	$90 co-pay; after Rx deductible
	Brand Specialty	$120 co-pay; after Rx deductible
90-day Supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.)		***Mandatory Generics Unless Dispensed As Written***
	Generic	$30 co-pay; no Rx deductible
	Preferred Brand	$120 co-pay; no Rx deductible
	Non-Preferred Brand	$180 co-pay; after Rx deductible
	Brand Specialty	N/A

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

Aetna Medical Plans Comparison Chart

Choice POS II		CDHP + HRA	Basic Essential
In-Network	**Out-of-Network[1]**	**In-Network Only**	**In-Network Only**
$500 co-pay per day; up to 5-day maximum	40% after deductible	20% after deductible	30% after deductible
20% after deductible	40% after deductible	20% after deductible	30% after deductible
20% after deductible	20% after deductible	20% after deductible	30% after deductible
20% after deductible	20% after deductible	20% after deductible	30% after deductible
20% after deductible	40% after deductible	20% after deductible	30% after deductible
20% after deductible	40% after deductible	20% after deductible	30% after deductible
20% after deductible	40% after deductible	20% after deductible	0% no deductible
$500 co-pay per day after deductible; up to 5-day maximum	40% after deductible	20% after deductible	30% after deductible
20% after deductible	40% after deductible	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
$500 co-pay per day after deductible; up to 5-day maximum[2]	40% after deductible; 30-day lifetime maximum	20% after deductible	30% after deductible
$500 co-pay per day after deductible; up to	40% after deductible	20% after deductible 120-visit limit per calendar year	30% after deductible 120-visit limit per calendar year
120-visit limit per calendar year			
20% after deductible	40% after deductible	20% after deductible 60-visit limit per calendar year for all therapies combined	30% after deductible
60-visit limit per calendar year for all therapies combined			
See prescription drugs below	See prescription drugs below	See prescription drugs below	N/A
20% after deductible	40% after deductible	20% after deductible	30% after deductible
Mandatory Generics Unless Dispense As Written		***Mandatory Generics Unless Dispense As Written***	***Mandatory Generics Unless Dispense As Written***
$15 co-pay; no Rx deductible $60 co-pay; no Rx deductible $90 co-pay; after Rx deductible $120 co-pay; after Rx deductible	**NOT COVERED**	$15 co-pay; no Rx deductible $60 co-pay; no Rx deductible $90 co-pay; after Rx deductible $120 co-pay; after Rx deductible	$25 co-pay; no Rx deductible $60 co-pay; no Rx deductible $90 co-pay; no Rx deductible 30% after medical deductible
Mandatory Generics Unless Dispense As Written		***Mandatory Generics Unless Dispense As Written***	***Mandatory Generics Unless Dispense As Written***
$30 co-pay; no Rx deductible $120 co-pay; no Rx deductible $180 co-pay; after Rx deductible N/A	**NOT COVERED**	$30 co-pay; no Rx deductible $120 co-pay; no Rx deductible $180 co-pay; after Rx deductible N/A	$50 co-pay; no Rx deductible $120 co-pay; no Rx deductible $180 co-pay; no Rx deductible N/A

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.

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*.

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.

Aetna Medical Plans

Tools and Resources to Maximize Your Coverage

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.

Aetna Medical Plans

Tools and Resources to Maximize Your Coverage

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.aetnapcsb.com*, and select "Aetna Member Website" at the top of the page to explore the resources available to you.

With one simple call, you can:

- Learn 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**.

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

Aetna Medical Plans
What Is Not Covered

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

MetLife Hospital Indemnity Plan (HIP)

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

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.

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

Pre-existing conditions limitations apply. Benefits will not be payable for pre-existing conditions for which, in 12 months before an insured becomes covered they received medical advice, treatment, or care from a physician; or the covered person had symptoms, or any medical or physical conditions that would cause an ordinarily prudent person to seek diagnosis, care, or treatment. If you are concerned about a pre-existing condition, please call MetLife at 800-438-6388 to understand how this may or may not affect you.

Benefits reduced 25% for ages 65 to 69. Benefits reduced 50% for age 70+.

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

Enrolling in the MetLife HIP

When you enroll as a new employee, you and your eligible family members are guaranteed acceptance[1]. 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

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

Employee Assistance Program (EAP)

The EAP provides short-term problem resolution to help you deal with life challenges. Resources For Living (RFL) is an employer sponsored program, available at no cost to you, family members living in your household, and dependent children up to age 26, no matter where they live. Services are confidential and available 24 hours a day, seven days a week.

You are eligible for up to eight counseling sessions per issue. You can call 24 hours a day for in-the-moment emotional well-being support. Counseling sessions are available face to face or online with televideo. Services are free and confidential.

Call for personalized guidance or help finding the resources you need. RFL also offers carekits related to growing families, child care, caregiving, and more.

Your member website offers a full range of tools and resources to help with emotional well-being and work/life balance. We're always here to help with a wide range of issues, including:

- **Emotional well-being support**
- **Daily life assistance**
- **Online resources**
- **Legal services**
- **Financial services**
- **Other services**

Identity Theft Services

Phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

MindCheck

Online tools and resources that make it easy to improve your emotional well-being, measure your mindset, and maintain a positive outlook.

Discount Center

Find deals on brand-name products and services including electronics, entertainment, gifts and flowers, travel, and more.

Fitness Discounts

Save on gym memberships at over 9,000 locations nationwide and home fitness equipment.

EAP FAQs

How do I access the EAP?

Call Resources for Living at 800-848-9392 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.

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?

Resources for Living adheres to the confidentiality guidelines mandated by law. PCS receives a report that contains only collective statistical information.

To access EAP services:
1-800-848-9392

resourcesforliving.com

Username: pcsb
Password: eap

EAP continued on next page

Aetna Behavioral Health Plan Benefit

- Accessibility to psychologists, psychiatrists, or licensed mental health counselors to treat more complex mental health issues or long-term problem resolution through your health plan benefit.
- Testing administered through psychologists. Medications administered through psychiatrists.

COST: Employee cost share for face-to-face Behavioral Health Services is based upon your Aetna plan selection.

Appointment assistance is available through our on-site Aetna representatives Jessica at 727-588-6134 or Gina at 727-588-6137. They can assist you by doing the appointment legwork on your behalf.

Drug- and Alcohol-Free Workplace

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:

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

Employee Assistance Plan (EAP) • 800-848-9392
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 Be SMART Wellness Program

Wellness programs change lives—that's why Pinellas County Schools supports the Be SMART Wellness Program. In addition to providing employees and their family members opportunities to make positive behavior changes, our wellness program also boosts morale, improves quality of life, increases productivity and job performance, and saves money from reduced health claims, turnover, absenteeism/ substitute pay, disability, and workers compensation costs.

The end result…higher student achievement when employees are present, happy, and healthy! Your participation in the PCS Be SMART program is critical to the District's vision of 100% student success.

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

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

- **Employee Assistance Program**
  Free, confidential 24-hour assistance with depression, finances, alcohol/ drug abuse, conflicts, stress, parenting, and other personal concerns. Also have services for legal and financial concerns. Available to you and your household. Call 800-848-9392 or visit *resourcesforliving.com* (username: pcsb | password: eap).

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

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

The Be Smart Wellness Program

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

- **Aetna On-site Health & Wellness Advocate**
  Speak to an Aetna on-site representative at 727-588-6134 about ongoing wellness programs:
  - Incentive Program
  - Free Diabetic Supplies
  - Quit Tobacco Resources

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

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

	Phone	Email
Employee Wellness Coordinator, Caleigh Bean	727-588-6031	beanc@pcsb.org
Employee Wellness Specialist, Dawn Handley	727-588-6151	handleyd@pcsb.org
Employee Assistance Program (Resources for Living) On-site Representative, Darlene Rivers	727-588-6507	pcs.riversd@pcsb.org
Aetna Claims Advisor, Janet Lang	727-588-6367	pcs.langj@pcsb.org
Aetna Patient Advocate, Gina DeOrsey	727-588-6137	pcs.deorseyg@pcsb.org
Aetna Wellness Specialist, Jessica O'Connell	727-588-6134	pcs.oconnellj@pcsb.org
PCS Benefits Team	727-588-6197	

Dental Plans

PCS offers two dental plans, the HumanaDental Advantage Plus 2S Plan and the MetLife Preferred Dentist Program. The chart below compares the plan benefits. All services are subject to plan limits, exclusions and other provisions. Read the following pages to learn more about each plan or call the insurance carrier with questions.

HumanaDental
800-979-4760
www.MyHumana.com

MetLife Preferred Dental Program (PDP Plus)
800-GET-MET8
www.metlife.com/dental

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.

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

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*

Dental Plans

HumanaDental Advantage Plus 2S Plan

Advantage Plus plans are network-based dental plans that emphasize prevention and cost containment. Members select any participating general dentist in HumanaDental's Advantage Plus network. Care received from an out-of-network dentist (except emergency care) is not a covered benefit. S plan copayments for listed procedures are applicable only at participating General Dentist. To find a dentist, call 1-800-979-4760 or look on **HumanaDental.com**.

Office visit copay

☐ $0/$0

Annual maximum

☐ No annual maximum

Summary of services

Preventive		Member pays
D0120[a]	Periodic oral examination	no charge
D0140[a]	Limited oral evaluation—problem focused	no charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver (limit 1 every 12 months)	no charge
D0150	Comprehensive oral evaluation—new/established patient (limit 1 every 24 months)	no charge
D0160	Limited/comprehensive/detailed and extensive oral eval (limit 1 every 12 months)	no charge
D0170	Re-evaluation—limited problem focused (limit 1 every 12 months)	no charge
D0180	Comprehensive periodontal eval—new/established patient (limit 1 every 24 months)	no charge
D0210	X-ray intraoral—complete series (limit 1 every 3 years)	no charge
D0220	X-ray intraoral—periapical, first radiographic image (limit 9 every 12 months includes D0230)	no charge
D0230	X-ray intraoral—periapical, each additional radiographic image (limit 9 every 12 months includes D0220)	no charge
D0240	X-ray intraoral—occlusal radiographic image	no charge
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	no charge
D0270[a]	Bitewing—single radiographic image	no charge
D0272[a]	Bitewings—two radiographic images	no charge
D0273[a]	Bitewings—three radiographic images	no charge
D0274[a]	Bitewings—four radiographic images	no charge
D0277[a]	Vertical bitewings—7 to 8 radiographic images	no charge
D0330	Panoramic radiographic image (limit 1 every 3 years)	no charge
D0470	Diagnostic casts	no charge
D1110[a]	Prophylaxis—adult (inclusive of D4910)	no charge
D1120[a]	Prophylaxis—child (inclusive of D4910)	no charge
D1206[a]	Topical application of fluoride varnish (for child <16)	no charge
D1208[a]	Topical application of fluoride - excluding varnish (for child <16)	no charge
D1351	Sealant—per tooth (limit 1 per tooth every 12 months for child <14)	no charge

Basic		Member pays
D1510	Space maintainer—fixed, unilateral (limited to child <14)	no charge
D1515	Space maintainer—fixed, bilateral (limited to child <14)	no charge
D1520	Space maintainer—removable, unilateral (limited to child <14)	no charge
D1525	Space maintainer—removable, bilateral (limited to child <14)	no charge
D1550	Re-cement or re-bond space maintainer	no charge
D2140	Amalgam—one surface primary or permanent.	no charge
D2150	Amalgam—two surfaces primary or permanent	no charge
D2160	Amalgam—three surfaces primary or permanent	no charge
D2161	Amalgam—four/more surfaces primary/permanent	no charge
D2330	Resin based composite—one surface, anterior	no charge
D2331	Resin based composite—two surfaces, anterior	no charge
D2332	Resin based composite—three surfaces, anterior	no charge
D2335	Resin based composite —four or more surfaces, involving incisal angle	no charge
D2390	Resin based composite—crown anterior	no charge
D2391	Resin based composite—one surface, posterior	no charge
D2392	Resin based composite—two surfaces, posterior	no charge
D2393	Resin based composite—three surfaces, posterior	no charge
D2394	Resin based composite—four or more surfaces, posterior	no charge
D4341	Periodontal scaling and root planing—per quadrant, four or more teeth (limit 1 per quad every 12 months)	no charge
D4342	Periodontal scaling and root planing—per quadrant, 1-3 teeth (limit 1 per quad every 12 months)	no charge
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis (limit 1 every 5 years)	no charge
D4910	Periodontal maintenance (limit 1 every 6 months, inclusive of D1110 and D1120)	no charge
D7111	Extraction coronal remnants deciduous tooth	no charge
D7140	Extraction erupted tooth or exposed root	no charge

Major		Member pays
D2510[b]	Inlay—metallic, one surface	$313.00
D2520[b]	Inlay—metallic, two surfaces	$355.00
D2530[b]	Inlay—metallic, three or more surfaces	$410.00

Code	Procedure	Fee
D2542[b]	Onlay—metallic, two surfaces	$402.00
D2543[b]	Onlay—metallic, three surfaces	$420.00
D2544[b]	Onlay—metallic, four or more surfaces	$437.00
D2610[b]	Inlay—porcelain/ceramic, one surface	$368.00
D2620[b]	Inlay—porcelain/ceramic, two surfaces	$389.00
D2630[b]	Inlay—porcelain/ceramic, three or more surfaces	$414.00
D2642[b]	Onlay—porcelain/ceramic, two surfaces	$403.00
D2643[b]	Onlay—porcelain/ceramic, three surfaces	$434.00
D2644[b]	Onlay—porcelain/ceramic, four or more surfaces	$461.00
D2650[b]	Inlay—resin based composite, one surface	$242.00
D2651[b]	Inlay—resin based composite, two surfaces	$288.00
D2652[b]	Inlay—resin based composite, three or more surfaces	$303.00
D2662[b]	Onlay—resin based composite, two surfaces	$263.00
D2663[b]	Onlay—resin based composite, three surfaces	$310.00
D2664[b]	Onlay—resin based ccomposite, four or more surfaces	$332.00
D2710[b]	Crown—resin based composite, indirect	$187.00
D2720[b]	Crown—resin with high noble metal	$461.00
D2721[b]	Crown—resin with predominantly base metal	$432.00
D2722[b]	Crown—resin with noble metal	$441.00
D2740[b]	Crown—porcelain/ceramic substrate	$411.00
D2750	Crown—porcelain fused to high noble metal	$405.00
D2751[b]	Crown—porcelain fused predom base metal	$434.00
D2752[b]	Crown—porcelain fused to noble metal	$445.00
D2790[b]	Crown—full cast high noble metal	$450.00
D2791[b]	Crown—full cast predom base metal	$426.00
D2792[b]	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 tooth	$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	Sedative filling	$ 44.00
D2950	Core buildup including any pins	$ 94.00
D2951	Pin retention—per 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
D3220	Therapeutic pulpotomy	$ 75.00
D3310	Root canal therapy—anterior	$315.00
D3320	Root canal therapy—bicuspid	$385.00
D3330	Root canal therapy—molar	$428.00
D3346	Previous root canal therapy—anterior	$424.00
D3347	Previous root canal therapy—bicuspid	$500.00
D3348	Previous root canal therapy—molar	$601.00
D3410	Apicoectomy/periradicular surgery—anterior	$361.00
D3421	Apicoectomy/periradicular surgery—bicuspid	$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[c]	Gingivectomy/gingivoplasty—four or more teeth, quad	$278.00
D4211[c]	Gingivectomy/gingivoplasty—1 to 3 teeth, quad	$153.00
D4240[c]	Gingival flap proc—four or more teeth,quad	$421.00
D4241[c]	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
D5110[d]	Complete denture—maxillary	$498.00
D5120[d]	Complete denture—mandibular	$642.00
D5130[d]	Immediate denture—maxillary	$700.00
D5140[d]	Immediate denture—mandibular	$700.00
D5211[d]	Maxillary partial denture—resin base	$542.00
D5212[d]	Mandibular partial denture—resin base	$629.00
D5213[d]	Maxillary partial denture—cast metal—resin base	$709.00
D5214[d]	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
D5410[c]	Adjust complete denture—maxillary	$ 35.00
D5411[c]	Adjust complete denture—mandibular	$ 35.00
D5421[c]	Adjust partial denture—maxillary	$ 35.00
D5422[c]	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 clasp to existing partial denture—per tooth	$105.00
D5710[e]	Rebase complete maxillary denture	$261.00
D5711[e]	Rebase complete mandibular denture	$249.00
D5720[e]	Rebase maxillary partial denture	$246.00
D5721[e]	Rebase mandibular partial denture	$246.00
D5730[e]	Reline complete maxillary denture	$147.00
D5731[e]	Reline complete mandibular denture	$147.00
D5740[e]	Reline maxillary partial denture	$135.00
D5741[e]	Reline mandibular partial denture	$135.00
D5750[e]	Reline complete maxillary denture	$196.00
D5751[e]	Reline complete mandibular denture	$196.00
D5760[e]	Reline maxillary partial denture	$193.00
D5761[e]	Reline mandibular partial denture	$193.00
D5850	Tissue conditioning maxillary	$ 61.00
D5851	Tissue conditioning mandibular	$ 61.00
D6092	Recement implant/abutment supported crown	$ 42.00
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$ 57.00
D6210	Pontic—cast high noble metal	$378.00
D6211[f]	Pontic—cast predominantly base metal	$404.00
D6212[f]	Pontic—cast noble metal	$420.00
D6240[f]	Pontic—porcelain fused to high noble metal	$426.00

Dental Plans
HumanaDental Advantage Plus 2S Plan

Code	Procedure	Member pays
D6241[f]	Pontic—porceln fused predom base metal	$393.00
D6242[f]	Pontic—porcelain fused to noble metal	$415.00
D6250[f]	Pontic—resin with high noble metal	$420.00
D6251[f]	Pontic—resin with predominantly base metal	$388.00
D6252[f]	Pontic—resin with noble metal	$400.00
D6600[f]	Retainer inlay—porcelain/ceramic, two surfaces	$355.00
D6601[f]	Retainer inlay—porcelain/ceramic, three or more surfaces	$373.00
D6602[f]	Retainer inlay—cast high noble metal, two surfaces	$380.00
D6603[f]	Retainer inlay—cast high noble metal, three or more surfaces	$418.00
D6604[f]	Retainer inlay—cast predom base metal, two surfaces	$372.00
D6605[f]	Retainer inlay—cast predom base metal, three or more surfaces	$394.00
D6606[f]	Retainer inlay—cast noble metal, two surfaces	$366.00
D6607[f]	Retainer inlay—cast noble metal, three or more surfaces	$406.00
D6608[f]	Retainer onlay—porcelain/ceramic, two surfaces	$386.00
D6609[f]	Retainer onlay—porcelain/ceramic, three or more surfaces	$403.00
D6610[f]	Retainer onlay—cast high noble metal, two surfaces	$409.00
D6611[f]	Retainer onlay—cast high noble metal, three or more surfaces	$448.00
D6612[f]	Retainer onlay—cast predom base metal, two surfaces	$407.00
D6613[f]	Retainer onlay—cast predom base metal, three or more surfaces	$426.00
D6614[f]	Retainer onlay—cast noble metal, two surfaces	$399.00
D6615[f]	Retainer onlay—cast noble metal, three or more surfaces	$414.00
D6720[f]	Retainer crown—resin with high noble metal	$474.00
D6721[f]	Retainer crown—resin with predom base metal	$450.00
D6722[f]	Retainer crown—resin with noble metal	$458.00
D6740[f]	Retainer crown—porcelain/ceramic	$499.00
D6750[f]	Retainer crown—porcelain fused to high noble metal	$426.00
D6751[f]	Retainer crown—porcelain fused to predom base metal	$453.00
D6752[f]	Retainer crown—porcelain fused to noble metal	$464.00
D6780[f]	Retainer crown—3/4 cast high noble metal	$458.00
D6790[f]	Retainer crown—full cast high noble metal	$469.00
D6791[f]	Retainer crown—full cast predom base metal	$445.00
D6792[f]	Retainer crown—full cast noble metal	$461.00
D6930[f]	Re-cement or re-bond fixed partial denture	$ 57.00
D7210	Surgical removal—erupted tooth	$ 91.00
D7220	Removal of impacted tooth—soft tissue	$135.00
D7230	Removal of impacted tooth—partially bony	$179.00
D7240	Removal of impacted tooth—completely bony	$211.00
D7241	Remove impacted tooth—completely bony w/comp	$265.00
D7250	Surgical removal of residual tooth roots	$114.00
D7310	Alveoloplasty in conjunction w/extractions—per quad	$125.00
D7311	Alveoloplasty in conjunction w/extractions—1-3 teeth	$ 97.00
D7320	Alveoloplasty not conjunction w/extractions—per quad	$181.00
D7321	Alveoloplasty not conjunction w/extractions—1-3 teeth	$153.00
D7510	Incision and drainage of abscess—intraoral	$120.00
D7520	Incision and drainage of abscess—extraoral	$570.00
D7960	Frenulectomy—separate procedure	$111.00
D7970	Excision of hyperplastic tissue—per arch	$272.00
D9110	Palliative treatment dental pain—minor procedure	$ 45.00
D9215	Local anesthesia	no charge
D9310	Professional consultation by non-treating dentist	no charge
D9951	Occlusal adjustment—limited	$ 58.00
D9952	Occlusal adjustment—complete	$326.00

Orthodontics		Member pays
D8070	Comprehensive Orthodontic treatment of the transitional/adolescent dentition; Children up to 19 years of age; Up to 24 months of routine orthodontic treatment for Class I and Class II cases	
	Consultation	no charge
	Evaluation	$ 35.00
	Records/Treatment Planning	$ 250.00
	Orthodontic treatment	$2100.00
D8080	Comprehensive Orthodontic treatment of the transitional/adolescent dentition; Children up to 19 years of age; Up to 24 months of routine orthodontic treatment for Class I and Class II cases	
	Consultation	no charge
	Evaluation	$ 35.00
	Records/Treatment Planning	$ 250.00
	Orthodontic treatment	$2100.00
D8090	Comprehensive Orthodontic treatment of the transitional/adult dentition; Adults 19 years of age and older; Up to 24 months of routine orthodontic treatment for Class I and Class II cases.	
	Consultation	no charge
	Evaluation	$ 35.00
	Records/Treatment Planning	$ 250.00
	Orthodontic treatment	$2300.00
D8680	Retention	$ 450.00

HumanaDental Advantage Plus 2S Plan

LIMITATIONS AND EXCLUSIONS

a Limit of one every six months
b Limit one per tooth every eight years
c Limit one every 12 months
d Limit one every five years
e Limit of one every three years
f Limit of one every eight years

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"

NOTE:

- Your participating general dentist and participating specialist office visit co-payment amounts, if applicable, are shown on your ID card.
- Your office visit co-payment is applicable for all dates of service and is in addition to the co-payment amounts listed for covered dental care services.
- Not all participating dentists perform all listed procedures, including amalgams. Please consult your dentist prior to treatment for availability of services.
- Unlisted procedures may be eligible to receive up to a 20% discount. Members may contact their participating provider to determine if any discounts apply. Visit *MyHumana.com* to find a participating dentist.
- Additional exclusions and limitations are listed along with full plan information in your Certificate of Benefits.

Insured or administered by Humana Insurance Company, The Dental Concern, Inc., CompBenefits Dental, Inc., CompBenefits Company, HumanaDental Insurance Company, or CompBenefits Insurance Company.

MetLife® Preferred Dentist Program (PDP) #95682

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.

	In-Network or Out-of-Network
Basis of Reimbursement	Negotiated PDP fee*
Type A – Preventive	100%
Type B – Basic	80%
Type C – Major	50%
Type D – Orthodontia	50%
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

Type A Preventive

- Oral Exams
- Full mouth X-Rays
- Bitewing X-Rays
- Prophylaxis/Cleaning
- Fluoride Treatments
- Sealants
- Space Maintainers
- Palliative Care

Type B Basic

- Periapicals and other X-Rays
- Labs and other tests
- Fillings
- Pulp Capping/Pulpal Therapy
- Periodontal Maintenance
- General Anesthesia

Type C Major

- Inlays/Onlays
- Crowns
- Endodontics/Root Canal
- Periodontics
- Rebases/Relines
- Repairs
- Dentures
- Bridges
- Simple Extractions
- Surgical Extractions
- Oral Surgery
- Consultations
- Implants

Type D Orthodontia

- Child Only (up to age 19)
- Orthodontic Diagnostics
- Orthodontic Treatment

Dental Plans
MetLife® Preferred Dentist Program (PDP)

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:

PDP Negotiated Fee: $649.00		Dentist's Usual Fee: $989.00	

Please note: This example assumes that your annual deductible has been met.

In-Network		Out-of-Network	
When you receive care from a participating PDP dentist…		When you receive care from a non-participating dentist…	
Negotiated PDP Fee:	$649.00	Dentist's Usual Fee:	$989.00
Plan Pays: (50% of $649.00 PDP Fee)	$324.50	Plan Pays: (50% of $649.00 PDP Fee)	$324.50
Your Out-of-Pocket Cost:	**$324.50**	*Your Out-of-Pocket Cost:*	**$664.50**

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

Limitations, Exclusions, and other Provisions by Type:

Type A (Preventive)

- Oral exams: twice in a year
- Two fluoride treatments, for dependent child to age 16, twice in a year
- Cleaning of teeth (oral prophulaxis): twice in a year
- Full mouth and panorex X-rays: once every 36 months
- Bitewing X-rays: twice in a year
- Space maintainers: limitation of one space maintainer per lifetime per area for premature loss of primary teeth for dependent children to age 19
- Sealants: limitation of one application of sealant material for each non-restored permanent 1st and 2nd molar tooth of a dependent child to age 13, once every 12 months

Type B (Basic)

- 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 such 12-month period.

Type C (Major)

- Adjustment of dentures (no earlier than six months after initial installation)
- Initial installation of fixed bridgework
- Initial installation of partial or full removable dentures
- Initial installation of crowns, inlays, and onlays (cast restorations): once every five years
- Dentures and bridgework replacement: 10 years
- Immediate denture replacement: 12 months
- Crown replacement: five years
- Periodontal surgery, including gingivectomy or gingivoplasty, gingival curettage, osseous surgery, bone replacement graft, and guided tissue regeneration once per quadrant every 36 months
- Root canal treatment is limited to once per tooth in a 24-month period
- Surgical Extractions including impactions/Oral Surgery
- Relines and rebases to dentures are limited to one per 24 months (no earlier than six months after initial installation)
- Consultations are limited to once in any six consecutive month period

Type D (Orthodontia) Child Only

- All dental procedures performed in connection with orthodontic treatment are payable as orthodontia
- 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

MetLife® Preferred Dentist Program (PDP)

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.metdental.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.

Dental Plans
MetLife® Preferred Dentist Program (PDP)

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]

[1] *www.dentalgentlecare.com/fun_dental_facts.htm, accessed February 2006.*

[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

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.

Vision Plan
EyeMed Advantage Plan

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.

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

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

Contact Lenses Allowance

If you prefer contact lenses instead of eyeglasses, a contact lens allowance is provided instead of (not in addition to) your eyeglass lens benefit.

In addition to your $10 co-pay for your comprehensive eye exam, you are responsible for the contact lens fitting fees up to $40. If your contact lens fitting is more extensive, you will receive a 10% discount on the cost of a premium fitting.

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

Vision Plan
EyeMed Advantage Plan

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

Frequency (based on calendar year)	
Vision Exam	Once per calendar year
Eyeglass or Contact Lenses	Once per calendar year
Frame	Every other calendar year

Benefit	Reimbursement
Exam with Dilation	
As necessary	Up to $35
Eyeglass Lenses	
Single Vision	Up to $35
Bifocal	Up to $40
Trifocal	Up to $60
Frames	Up to $55
Contact Lenses	
Elective (conventional or disposable)	$90
Medically Necessary	$210

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®, Target 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.

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

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

Annual salary	Basic coverage is:
$12,000	$15,000 *(minimum $15,000 coverage)*
$25,000	$25,000 *(one times your annual base salary)*
$27,750	$28,000 *(rounded up to next $1,000)*

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

Covers	**Employee**
Amount of Coverage[1]	**Basic Employee Term Life:** One times your annual base salary, rounded up to the next $1,000 with a minimum benefit of $15,000 and maximum benefit of $200,000 **Optional Employee Term Life:** $10,000 minimum, up to $200,000 in $10,000 increments, or $250,000 up to $500,000 maximum in $50,000 increments (guaranteed coverage available up to $100,000, if you enroll within 31 days of becoming eligible)
Cost	**Basic Employee Term Life:** None **Optional Employee Term Life:** Age based, 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

Life Insurance—Dependents

Optional Family Term Life

Covers	**Spouse and eligible children** (see page 65 for eligibility requirements)
Amount of Coverage	$5,000/dependent
Cost	See rate schedule on page 6
Board Contribution	You may **not** use
Actively at Work	**Yes**
Medical Evidence	**Spouse:** No health questions required **Child(ren):** No health questions required

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

Covers	**Spouse[2] and/or child(ren)**
Amount of Coverage	**Spouse:** $10,000 increments up to the $100,000 maximum.* **Child(ren):** $2,000 increments up to the $10,000 maximum
Cost	See rate schedule 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

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

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

[2] Optional spouse coverage may be written without employee enrollment.

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

Accidental Death & Dismemberment Insurance

Basic Employee AD&D

Covers	**Employee**
Amount of Coverage	**$2,000**
Cost	**None**

Optional AD&D—Employee Only

Covers	**Employee**
Amount of Coverage	$50,000, $100,000, $200,000, or $300,000
Cost	See rate schedule on page 6
Board Contribution	You may use

Optional AD&D—Employee and Family

Covers	**Employee and Family**
Amount of Coverage	**Employee:** $50,000, $100,000, $200,000, or $300,000 **Spouse only:** 50% of employee's coverage **Child(ren) only:** 15% of employee's coverage **Spouse and Child(ren):** 40% and 10%, respectively, of employee's coverage
Cost	See rate 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.

Life and AD&D Insurance

Life Insurance—Employee (continued) and Dependents

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.

Handicapped dependents may continue to be covered under the life insurance plan if they are on the plan at age 26. Verification forms to verify eligibility can be found on the Annual Enrollment page at *www.pcsb.org/annual-enrollment*. 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.

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.

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.

Life and AD&D Insurance
Dependents (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.

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.

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

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.

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):

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

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.

Life and AD&D Insurance
AD&D Insurance

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 Insurance Certificate of Coverage Insured by 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 Standard Insurance Company. This section is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. If there is a discrepancy between this document and the Group Contract/Booklet-Certificate issued by Standard Insurance Company, the terms of the Group Contract will govern. Contract provisions may vary by state. Contract series 83500. IFS A108213 Ed. 8/05

Disability Insurance Plans

The Standard Educator Disability Plan

What would you do if illness or injury kept you out of work for a long time without pay? Disability insurance provides replacement income to help pay your bills.

The disability plan allows you to choose a monthly benefit, a benefit duration, and a waiting period.

Monthly Benefit	Benefit Duration
Choose a preferred monthly benefit amount between $400 and $5,000 (to up to 66⅔% of your salary)	Choose a benefit duration: Two years OR up to the Social Security Normal Retirement Age (SSNRA)

Waiting Period

Choose 14, 30, or 60 days until the plan starts paying benefits (14- and 30-day waiting periods are waived with hospital admission)

Highlights

- Evidence of Insurability (EOI) is not required. You do not have to fill out a medical questionnaire to be approved.
- Pre-existing conditions will apply. Please refer to "Pre-existing Condition Exclusion" section in the sidebar.
- If a claim is submitted in the first 12 months of the policy effective date, a minimum benefit of $400 will be paid for the first 90 days after the waiting period. A review will be conducted to determine if the claim is subject to pre-existing conditions. If the claim is determined to be a pre-existing condition, then benefits will stop after the 90-day payment. If not, and there is no pre-existing condition, then benefits will continue based on the disability amount you selected, and any retro payment owed by The Standard will also be paid.
- **First Day Hospital Benefit on 14- and 30-day plans.** If you have a claim for a hospital admission/confinement, the 14- and 30-day waiting period will be waived.
- **Lifetime Security Benefit.** This only applies to the benefit duration of up to SSRNA. Your disability benefit (amount in effect when the claim closes) could continue beyond your Social Security normal retirement age *if* you are unable to perform two or more activities of daily living or are suffering from severe cognitive impairment.
- Disability coverage will end on the date your employment terminates.
- Please call The Standard at 800-325-5757 or email *Christine.D'Angelo@standard.com* for more information.

Important Information About Disability Benefits

Preexisting Condition Limitation

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

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

Disability Benefits During Pregnancy

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

Disability Insurance Plans

Eligibility

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

Effective Date

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

Premium

This is a voluntary benefit and you pay 100% of the premium for coverage through payroll deductions and/or flex credits.

Plan Benefits

A. Plan Maximum Monthly Benefit

The lesser of $5,000 or 66²/₃% of your predisability earnings.

B. Plan Minimum Monthly Benefit

The greater of $100 or 25% of your disability benefit before reduction by deductible income.

C. Benefit Waiting Period

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

Accidental Injury	Other Disabilities
14 days	14 days
30 days	30 days
60 days	60 days

D. Plan Schedule of Benefits

You may select one of the benefit levels outlined below, provided the Monthly disability Benefit does not exceed 66²/₃% of your regular monthly salary.*

If Your Annual Base Salary Is at Least	You Are Eligible for a Maximum Disability Benefit
$ 7,200	$ 400
10,800	600
14,400	800
18,000	1,000
21,600	1,200
25,200	1,400
28,800	1,600
32,400	1,800
37,800	2,100
43,200	2,400
48,600	2,700
54,000	3,000
63,000	3,500
72,000	4,000
81,000	4,500
90,000	5,000

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

E. Own Occupation Definition

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

E. Any Occupation Definition

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

Integration — Deductible Income

Deductible income is income you receive under any state disability income benefit law or similar law.

During the First 24 Months of Disability:

1. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:
   a. A workers' compensation law;
   b. The Jones Act;
   c. Maritime Doctrine of Maintenance, Wages, or Cure;
   d. Longshoremen's and Harbor Worker's Act; or
   e. Any similar act or law.
2. Your Work Earnings, as described in the Return To Work Provisions.
3. Any amount you receive by compromise, settlement, or other method.

After You Have Been Disabled for 24 months:

1. Your Work Earnings, as described in the Return To Work Provisions.
2. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:
   a. A workers' compensation law;
   b. The Jones Act;
   c. Maritime Doctrine of Maintenance, Wages, or Cure;
   d. Longshoremen's and Harbor Worker's Act; or
   e. Any similar act or law.
3. Any amount you, your spouse, or your child under age 18 receive or are eligible to receive because of your disability or retirement under:
   a. The Federal Social Security Act;
   b. The Canada Pension Plan;
   c. The Quebec Pension Plan;
   d. The Railroad Retirement Act; or
   e. Any similar plan or act.

   Full offset: Both the primary benefit (the benefit awarded to you) and dependents benefit are deductible income.

   Benefits your spouse or a child receives or are eligible to receive because of your disability are deductible income regardless of marital status, custody, or place of residence. The term "child" has the meaning given in the applicable plan or act.
4. Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.
5. Any amount you receive or are eligible to receive because of your disability under another group insurance coverage.
6. Any disability or retirement benefits you receive or are eligible to receive under your employer's retirement plan, including a public employee retirement system, a state teacher retirement system, and a plan arranged and maintained by a union or employee association for the benefit of its members. You and your employer's contributions will be considered as distributed simultaneously throughout your lifetime, regardless of how funds are distributed from the retirement plan.

   If any of these plans has two or more payment options, the option which comes closest to providing you a monthly income for life with no survivors benefit will be deductible income, even if you choose a different option.
7. Any earnings or compensation included in predisability earnings which you receive or are eligible to receive while LTD benefits are payable.
8. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.
9. Any amount you receive or are eligible to receive from or on behalf of a third party because of your disability, whether by judgement, settlement, or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as deductible income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees.
10. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

Disability Insurance Plans

Additional Plan Features:

24-Hour Coverage

24-hour disability plans provide coverage for disabilities occurring on or off the job.

Rehabilitation Plan

If you are participating in an approved rehabilitation plan, The Standard may include payment of some of the expenses you incur in connection with the plan, including but not limited to: training and education expenses, family (child and elder) care expenses, job related expenses, and job search expenses.

Reasonable Accommodation Expense

The Standard will reimburse your employer up to a pre-approved amount for some or all of the cost of the modification, which enables you to return to work while disabled.

Survivors Benefit

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

Waiver of Premium

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

Life Time Security Benefit – SSNRA Plan Only

Your disability benefit (amount in effect when the claim closes) payments will continue beyond the regular plan Maximum Benefit Period if you are unable to perform two or more Activities of Daily Living or are suffering severe cognitive impairment. You are eligible for this benefit only if you elected the SSNRA duration plan.

First Day Hospital Benefit – Plans with Waiting Periods of 14 or 30 days Only

If you are hospital confined for at least four hours during the benefit waiting period, the following will apply: the remainder of your benefit waiting period will be waived, disability benefits will become payable on the first day you are hospital confined, and your maximum benefit period will begin on the date your disability benefits are payable. "Hospital confined" means you are admitted to a hospital as an in-patient, and for which you are charged for room and board. You are eligible for this benefit only if your elected a benefit waiting period of 14 or 30 days.

Maximum Benefit Duration Period

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

Option 1: Two Years

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

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

Income Tax Consideration

When you enroll in disability insurance, 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.

Option 2: SSNRA

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

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

Disability Insurance Plans
Other Important Information

Exclusions

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

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

Preexisting Conditions

A preexisting condition is a mental or physical condition:

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

Preexisting Condition Period	The 180-day period just before your insurance becomes effective or any insurance increases become effective
Specified Exclusion and Limitation Period	12 months

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

Limitations

Disability benefits are not payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Able to work and earn at least 20% of your indexed predisability earnings, but you elect not to work; throughout the own occupation period months after the end of the benefit waiting period the responsibility to work is limited to work in your own occupation; thereafter, the responsibility to work includes work in any occupation

In addition, payment of disability benefits is limited in duration:

- If you reside outside the United States or Canada
- If applicable, if your disability is caused or contributed by a preexisting condition or the medical or surgical treatment of a preexisting condition unless on the date you become disabled, you have been continuously insured under the group policy for the specified exclusion and limitation period, and you have been actively at work for at least one full day after the end of the specified exclusion and limitation period
- If your disability is caused or contributed to by mental disorders or substance abuse

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.

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.

When Benefits End

LTD benefits end automatically on the earliest of:

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

When Insurance End

Insurance ends automatically on the earliest of the following:

- The last day of the last period for which you make a premium contribution (except if premiums are waived while disabled)
- The date your employment terminates
- The date the group policy terminates
- The date you cease to meet the eligibility requirements (coverage may continue for limited periods under certain circumstances)
- If applicable, the date your employer ceases to participate under the group policy

Group Insurance Certificate

If coverage becomes effective, and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions, and terminating events. The controlling provisions will be in the group policy. Neither the information presented in this summary nor the certificate modifies the group policy or the insurance coverage in any way.

Voluntary Benefits
Voluntary Products

Voluntary Products

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®
- MetLife Legal Plan
- MetLife My Pet Protection
- Horace Mann Auto Payroll Deduction Plan

Enrolling in MetLife Voluntary Plans

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 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.
MetLife 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* 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) To enroll in auto & home and legal plans, go to *www.metlife.com/mybenefits*
MetLife Auto & Home®	You may enroll in this plan anytime during the year.	

MetLife Pet Insurance (Pet First)

Now more than ever, pets are playing a significant role in our lives, and it is important to keep them safe and healthy. Help make sure your furry family members are protected in case of an accident or illness with pet insurance offered by MetLife.[1]

With their deep understanding of pet owners' needs, they have designed a plan that better serves those needs—providing enhanced coverage that is simple and easy to use. Pet insurance can help you manage the high cost of veterinary services for your pet. Go to *www.metlife.com/mybenefits* for further information.

Why Is Pet Insurance Important?

- A small monthly payment can help you prepare for unexpected vet expenses down the road.
- More than 6 in 10 pet owners said their pet has had an emergency medical expense.[2]
- 24% of pet parents have credit card or personal loan debt to cover pet health and vet costs.[3]
- The average annual cost for a routine vet visit is $212 for a dog and $160 for a cat; and the average annual cost for a surgical vet visit is $426 for a dog and $214 for a cat.[4]
- Pet insurance may not cover pre-existing conditions.

You may contact MetLife at 1-800-GETMET8 for more information or to enroll. You may enroll at any time. Note that rates are only provided when you call to enroll in or renew your policy.

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

[2] *Delfino, Devon. "42% of Millennials Have Been in Debt for Their Pet," lendingtree,* https://www.lendingtree.com/personal/pet-financing/average-pet-debt/. *Accessed 22 April 2020.*

[3] *2019 Employee Benefits Adviser "5 benefit perks to entice top millennial talent to your clients."*

[4] *2019-2020 APPA National Pet Owners Survey.*

MetLife Legal Plan

With MetLife Legal Plan, 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.

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 legal plan 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.

Continued on next page

Voluntary Benefits

Voluntary Products

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.

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* for a free quote.

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

Voluntary Retirement Programs

Pre-Tax and After-Tax Options

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
- 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.

Pre-Tax Savings Example
Traditional 403(b) or 457(b) Voluntary Retirement Deduction (VRD)

	Gross Pay	Federal Income Tax*	Social Security	Deduction to Savings Account / "Reduction" to Tax Shelter	Take-Home Net Pay
No VRD	$500.00	$34.91	$38.25	Deduction to Savings Account: $25.00	$401.84
With VRD	$500.00	$31.16	$38.25	"Reduction" to Tax Shelter: $25.00	$405.59

* *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.*

Voluntary Retirement Programs
Pre-Tax and After-Tax Options

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 2020 is $19,500. The 2021 limits were not available at the time this guide was printed. (If you turn age 50 or older during the year, you can contribute an additional $6,500 for a total of $26,000.) **You are responsible for making sure that the amount deferred each year does not exceed IRS limits.** MAC calculation estimates and retirement benefit handbooks are available online during the first quarter of each calendar year to help you determine the amount of your annual retirement account contribution.

403(b) and 457(b) Distribution Transactions

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

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.

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:

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

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.

As of March 1, 2019, Achieva, American Century, Plan Member, Security Benefit, The Legend Group, and Waddell & Reed have been placed in an inactive status. Their existing clients have been grandfathered in.

2020–2021 Voluntary Retirement Program
List of Authorized Investment Providers

COMPANY NAME	PRODUCTS AVAILABLE 403(B)	457	ROTH 403(b)	AGENT OF RECORD	TELEPHONE
Aetna	X	X	X	Diane Petitta	813-281-3751
AXA Advisors	X	X	X	Ryan Lau	813-466-3195
Fidelity Funds (No Load)*	X	X		www.fidelity.com/atwork	800-343-0860
Franklin Templeton	X		X	John Kelley	727-299-7143
Horace Mann	X	X	X	Gary Cucchi	813-600-3268
Lincoln Investment	X	X	X	Brett Smith	800-771-7732
VOYA	X	X	X	Keista Ransom	813-281-3743
AIG Retirement Services (Valic)	X	X	X	Chris Brown	813-269-3362

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

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/individual/plan-sponsor/florida/pinellas-county-schools/***

The following websites offer relevant information

- **Social Security Administration** *www.ssa.gov*
  Find answers to your questions concerning Social Security.
- **Administration on Aging** *www.usa.gov*
  Information on retirement, Medicare, and other issues for retirees.
- **Internal Revenue Service** *www.irs.gov*
  Source for tax information, including changes to the tax code.
- **U.S. Department of Labor** *www.dol.gov*
  Information for the workforce.
- **Morningstar** *www.morningstar.com*
  Information on stocks, funds, and factors affecting the stock market.
- **A.M. Best Company** *www.ambest.com*
  Information on company ratings, products, and news.
- **Standard and Poor's Company** *www.standardandpoors.com*
  Information on company ratings, fund information, indices, and more.
- **American Savings Education Council** *www.choosetosave.org/asec*
  Information about saving for retirement.
- **Employee Benefit Research Institute** *www.ebri.org*
  Information on employee benefit programs.
- **Employee Benefits Security Administration** *www.dol.gov/ebsa/*
  Information on pensions, COBRA, plan sponsors, compliance, fraud, and more.

Florida Retirement System (FRS)

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

1 If you have any Pension Plan service prior to July 1, 2011, you are subject to six-year vesting. If you join the Pension Plan on or after July 1, 2011 and have no previous Pension Plan service, you are subject to eight-year vesting.

2 How your employee contributions are distributed or refunded to you depends on a number of factors, especially if you use your 2nd Election to switch Plans in the future. You can call the MyFRS Financial Guidance Line at 1-866-446-9377, Option 2, for information.

3 Contribution rates are fixed by law, and the Florida Legislature can increase or decrease the amount that you and your employer contribute to your account.

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.

Florida Retirement System (FRS)

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*

Plan Administration
Your Rights and Responsibilities

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**

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

** Only divorce is recognized by the state of Florida, not legal separation.*

Plan Administration

Your Rights and Responsibilities

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.

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 66⅔% 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).

Continued on next page

Plan Administration
Your Rights and Responsibilities

Notice Regarding the Wellness Program

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

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

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

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

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.

Continued on next page

Plan Administration
Your Rights and Responsibilities

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

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

- Visit *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).*

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

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

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

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

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

ALABAMA – Medicaid

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

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx

Phone: 916-440-5676

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

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711

CHP+: Colorado.gov/pacific/ HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

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

GEORGIA – Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162 ext 2131

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479

All other Medicaid Website:
http://www.indianamedicaid.com
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Website: http://dhs.iowa.gov/hawki
Phone: 1-800-257-8563

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328 • Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium
Webpage: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740. TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

Continued on next page

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345 ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid

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

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/

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

VERMONT– Medicaid

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

VIRGINIA – Medicaid and CHIP

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

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid

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

WISCONSIN – Medicaid and CHIP

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

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any more states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa • 866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov • 877-267-2323

BENEFlex 2021

Questions?

Call the Benefits Team: 727-588-6197

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

Departments • Human Resources • Risk Management

This guide describes Pinellas County Schools employee benefit programs that will be effective for the plan year beginning January 1, 2021. 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

BENEFlex

Questions?

Call the Benefits Team:
727-588-6197

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

Departments • Human Resources • Risk Management

pcs PINELLAS COUNTY SCHOOLS