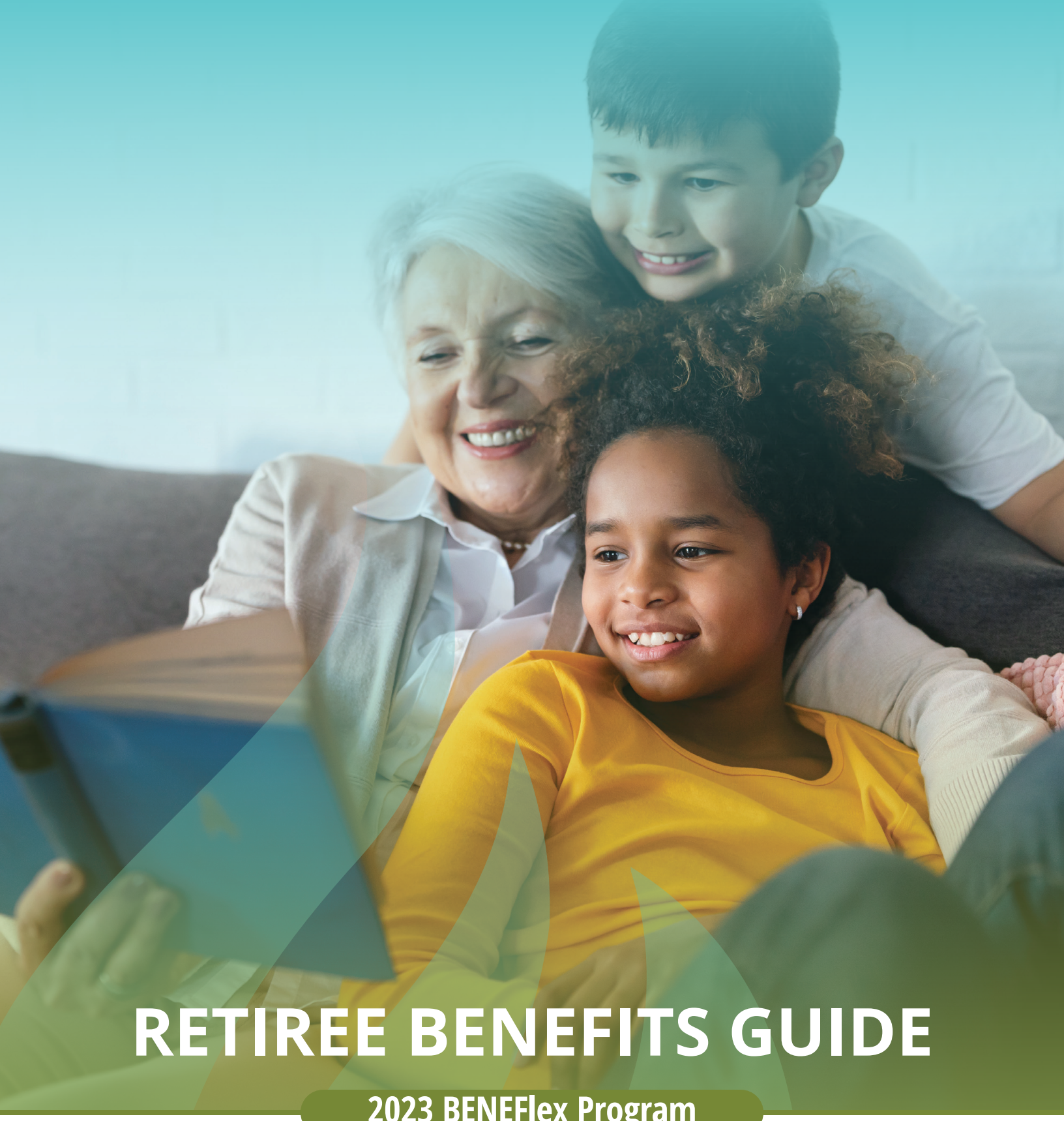


RETIREE BENEFITS GUIDE

2023 BENEFlex Program

PINELLAS COUNTY SCHOOLS

PINELLAS COUNTY SCHOOLS

TABLE OF CONTENTS

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

CONTACTS ?

Risk Management Retirement Team | P.O. Box 2942, Largo, FL 33779

PLANS AND PROVIDERS	TELEPHONE	WEBSITE/EMAIL
RISK MANAGEMENT AND INSURANCE		
Risk Management Retirement Team	727-588-6214	risk-retirement@pcsb.org
Risk Management and Insurance	727-588-6195	Fax: 727-588-6182
ONSITE REPRESENTATIVES		
Aetna (Claims and Account Advisor)	727-588-6367	www.pcsb.org/healthinsurance
Aetna (Health & Wellness)	727-588-6137	www.pcsb.org/wellness
INSURANCE CARRIERS		
MEDICAL		
Aetna Concierge Customer Service	866-253-0599	www.aetnapcsb.com
Aetna Pharmacy Mail Order Prescriptions	888-792-3862	www.aetnapcsb.com
Healthcare Bluebook	888-316-1824	www.pcsb.org/healthcarebluebook
VISION		
EyeMed Vision (#9856857)	866-299-1358	www.eyemedvisioncare.com
DENTAL		
Humana Dental Advantage Plus 2S Plan (Group #548085)	800-979-4760	www.myhumana.com
MetLife Dental PDP (#G95682)	800-942-0854	www.metlife.com/dental
MedCom (Enrollment and Billing questions)	800-523-7542	email: retireeservices@medcom.net
LIFE INSURANCE		
The Standard Life Insurance Company (Group #92959)	800-628-8600	www.pcsb.org/risk-benefits
MEDICARE ADVANTAGE PLAN		
Humana Medicare Advantage Plans	727-792-2103	www.humana.com
NON-PCS PROGRAMS AND OTHER RESOURCES		
Florida Retirement (FRS) Pension Plan	844-377-1888	https://frs.fl.gov
Florida Retirement (FRS) Investment Plan	844-377-1888	www.myfrs.com
Medicare Services (800-MEDICARE) You must contact the appropriate provider 3 months prior to being eligible for Medicare	800-633-4227	www.medicare.gov
SHINE—Serving Health Insurance Needs of Elders Non-profit Medicare Counseling	800-963-5337	www.floridashine.org

OVERVIEW

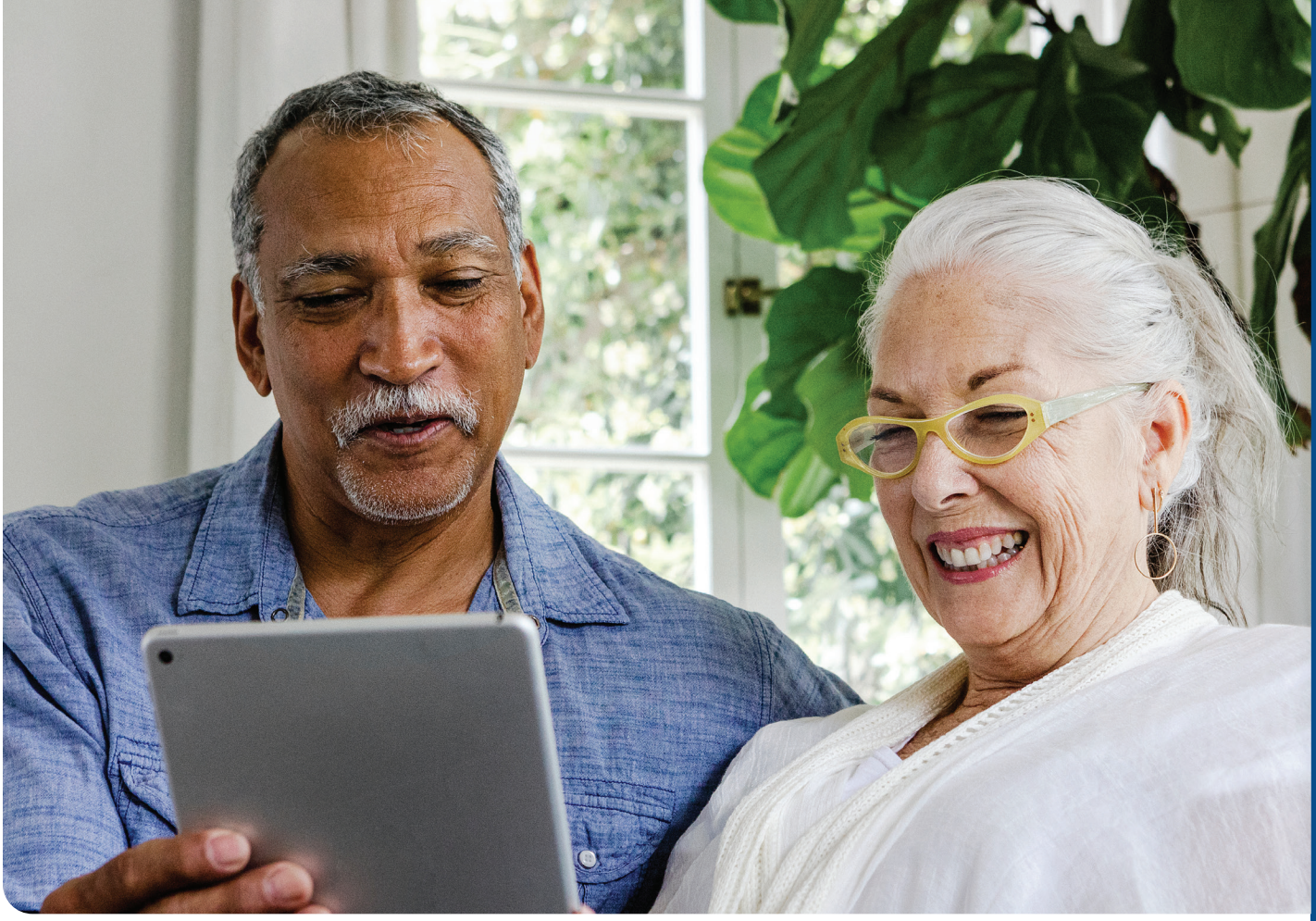
BENEFlex Retiree Insurance

As a new retiree of Pinellas County Schools, you are eligible to continue the following insurance benefits. **NOTE:** If you cancel any of your PCS-sponsored coverage when you retire, you cannot re-enroll, unless otherwise stated.

Benefit Plan	Enrolled at Time of Retirement?*	Can You Continue after You Retire?
Medical	Yes	If you are enrolled at time of retirement, you can continue your coverage under any of these plans
Dental	Yes	
Vision	Yes	
Basic Term Life Insurance	Yes	Minimum $10,000 Basic Board Term Life Insurance coverage required to continue this coverage
Family Term Life Insurance	Yes	Fixed $5,000
Optional Term Life Insurance (you and your spouse)	Yes	You may convert your or your spouse's Optional Term Life coverage to individual policies directly through The Standard
Accidental Death & Dismemberment (AD&D)	Yes	No
Disability Insurance	Yes	No
MetLife Legal or Pet Insurance	Yes	No
MetLife HIP	Yes	MetLife will send you a Continuation of Coverage (COC) letter to the address on file with the District. Or you can call MetLife at 1-866-626-3705.
Be SMART Wellness Program	Available to all employees	Yes, you are still eligible for certain programs offered through this program.

* If you are not enrolled in coverage at the time of retirement, you cannot enroll when you retire or during any subsequent Annual Enrollment.

Each year during Annual Enrollment, you will have the opportunity to review your benefit elections and make limited changes. This guide provides information about your and your dependents' eligibility and coverage options. If you have questions, you may call the Risk Management Retirement Team at **727-588-6214**.



New Retiree Insurance Eligibility

You may participate in the retiree BENEFlex program if you have six years of service and were hired before July 1, 2011.

Members starting employment after July 1, 2011, will need eight years of service to participate in the retiree BENEFlex program. All members must:

- Receive a Florida Retirement System check, or
- Be at least 59 1/2 with eight years of service or have completed 30 years of service and be eligible for withdrawals under the State Investment Plan.

Retirees fall into two categories:

- Under age 65: PCS medical plans
- Over age 65: Medicare options

Re-Employment after Retirement Guidelines for Health Insurance

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

Official retirement includes early retirement, retirement from DROP, normal retirement from the Pension Plan, or retirement from the Investment Plan.

OVERVIEW

PCS Be Smart Wellness

The Be SMART Wellness Program is available throughout the year to PCS retirees who elect to continue their medical plan coverage with Aetna. Starting March 1, 2021, the wellness program will include many initiatives. For information on the programs, visit **pcsb.org/risk-benefits**.

Diabetes Care Program

The wellness program included the Diabetes CARE Program. When you or a covered dependent enroll in this program and complete the requirements, your co-pay is waived for diabetic supplies.* For more information, visit **pcsb.org/diabetes-care-program**.

Be Smart Contact Information	
PCS Wellness Coordinator	727-588-6031
Employee Wellness Specialist	727-588-6151
Resources for Living Employee Assistance Program	727-588-6507
Aetna Claims Advisor	727-588-6367
Aetna Wellness Specialist	727-588-6134
PCS Retirement Team	727-588-6214

*Available to PCS retirees and their dependents enrolled in a PCS-sponsored Aetna medical plan.

2023 Monthly Insurance Rates

Medical, Vision, and Life Insurance Payments: Your monthly rates will be deducted from your monthly FRS pension check. If you do not receive an FRS pension check, payment coupons will be sent to you. Please note, if your annual premiums total $200 or less for dental or vision, you will need to make one annual payment.

Dental Insurance Payments: If you have Humana Advantage or MetLife Dental, they will bill you directly for your dental insurance. Dental insurance cannot be deducted from your FRS pension check.

Aetna Medical Plans	Retiree	Retiree + Spouse	Retiree + Children	Retiree + Family
Select Open Access	$835.33	$1,657.67	$1,474.34	$2,384.33
Choice POS II	$852.00	$1,692.67	$1,509.34	$2,454.33
CDHP + HRA	$802.00	$1,586.00	$1,402.67	$2,286.00
Basic Essential	$738.67	$1,462.67	$1,301.00	$2,104.33

Humana Dental Advantage 25 Plus Plan	Retiree	Retiree + 1	Retiree + Family
	$23.22	$39.27	$57.12

MetLife Dental Plan	Retiree	Retiree + 1	Retiree + Family
	$34.89	$60.60	$87.49

EyeMed Vision Care Plan	Retiree	Retiree + 1	Retiree + Family
	$3.65	$8.37	$13.51

The Standard Life Insurance Rates (Board Life)

Age	Rate	Age	Rate
35-39	$0.11	**55-59**	$0.51
40-44	$0.14	**60-64**	$0.98
45-49	$0.21	**65-69**	$1.55
50-54	$0.35	**70+**	$2.27

The life insurance rates are per $1,000 of coverage, based on your age as of January 1, and are subject to reduction at age 70.

The Standard Dependent Term Life

Dependent Rate	$1.50 for $5,000 of coverage

AETNA MEDICAL PLANS

How Much You Have to Pay

Health Reimbursement Account (HRA) (CDHP only)

Use your HRA to pay your deductible, coinsurance, and Rx co-pays, reducing your out-of-pocket costs. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified.

Medical Plan Deductible (Choice POS II, CDHP + HRA, and Basic Essential)

This is the amount you pay for medical expenses before the plan begins paying benefits.

Coinsurance (Choice POS II, CDHP + HRA, and Basic Essential)

This is 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. With the Aetna Prescription Drug Program, you pay co-pays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay co-pays.

Out-of-Pocket (OOP) Maximums

This is the most you will pay for deductibles (if applicable), co-pays, and/or coinsurance in a plan year. There are two OOPs, one for medical expenses and one for Rx. When you reach an OOP maximum, the plan will pay 100% of those eligible expenses for the remainder of the plan year.

Coordination of Medical Benefits

If you, your spouse, or your child(ren) have 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" of 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.

If you or one of your covered dependents has Medicare, generally Medicare will be your primary health plan. Your PCS health plan will coordinate benefits with Medicare if your provider is an Aetna contracted in-network provider. For example, if you are a retiree, have Medicare and are enrolled in the Aetna Select Open Access or the CDHP + HRA plan, Aetna will coordinate with Medicare only if your provider is an Aetna contracted in-network provider.

If you have questions about your specific situation or claims, please call Aetna Concierge Customer Service at 866-253-0599.

Routine Eye Exam Not Covered

Routine eye exams are not covered under the Aetna medical plans.
If you are enrolled in the EyeMed Vision Care Plan, routine eye exams are covered.

AETNA MEDICAL PLANS

Aetna Medical Coverage

- You and your eligible dependents must be enrolled in a PCS medical plan at the time of your retirement to continue medical coverage.
- You must remain in that plan or elect to terminate your coverage. If you remain in the plan, you can change your election at the next Annual Enrollment. Your change will be effective on January 1 of the following year.
- You may continue to cover your enrolled dependents or cancel their coverage. In some instances, newborns may be added, subject to state legislation and carrier requirements. Please contact the Risk Management and Insurance Department Retirement Team for information.

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 specialty drug. Call Aetna's Concierge Customer Service at 866-253-0599 if you have questions.

Maintenance drugs are filled under the Maintenance Choice Program, which requires that your physician write a 90-day prescription for all maintenance medications. You must fill the 90-day supply through CVS Caremark mail order or at your local CVS Pharmacy retail locations. You will only pay two co-pays for a 90-day supply.

AETNA MEDICAL PLANS

TELADOC®

Your cost copay depends on the Aetna medical plan in which you are enrolled: $25 co-pay for Select Open Access, Choice POS II, and CDHP; $40 co-pay for Basic Essential.

After registering, you can talk to a doctor by phone or video 24/7 who can treat colds, sore throats, flu symptoms, allergies and sinus infections, earaches, and more.

- Call 855-835-2362 to register by phone.
- Go to **www.Teladoc.com/Aetna**, click "set up account."
- Download the mobile app, click "activate account."

Healthcare Bluebook.

Available to all Aetna medical plan members, 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** to learn more.

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aetna®

The Aetna In Touch Care program offers personal, ongoing support to help you manage a health event or chronic condition. Offering both digital and nurse support, the program allows you to easily move between the two. The program is easy to access from your secure member website at **aetnapcsb.com**. And, it comes as part of your benefits plan, so there is no additional cost to you. Aetna will reach out to members who may benefit from extra support, so please answer your phone when they call.

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

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

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

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

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

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

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

Questions?

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

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

Visit **www.prudentrx.com**

AETNA MEDICAL PLAN COMPARISONS

	Select Open Access	Choice POS II	
Benefit	**In-Network Only**	**In-Network**	**Out-of-Network[1]**
Service Areas/Networks	Any provider in the Aetna Select Open Access national network	Any provider in the Choice POS II Network (national network)	Any Provider
Health Reimbursement Account (HRA)—Individual/Family HRA funds can only be used for medical plan and prescription drug expenses.	N/A	N/A	N/A
Deductibles—Individual/Family	N/A	$500 individual; $1,000 family (combined in– and out-of-network)	
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or co-pays	$5,000 individual; $10,000 family	$5,000 individual; $10,000 family (combined in– and out-of-network)	
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible	$2,000 individual; $4,000 family	$2,000 individual; $4,000 family (combined in– and out-of-network)	
Lifetime Maximum	Unlimited	Unlimited	
Physician Office Visits	**You Pay**	**You Pay**	**You Pay**
Primary Care Physician (PCP)	$35 co-pay	20% after deductible	40% after deductible
Specialist (SPC)	$60 co-pay	20% after deductible	40% after deductible
Teladoc: Doctor	$25 co-pay	$25 co-pay	N/A
Teladoc: Behavioral Health	$25 co-pay	20% after deductible	N/A
Preventative Adult Physical Exams	No co-pay	0%	40% after deductible
Preventative GYN Care (including Pap test) (direct access to participating providers)	No co-pay	0%	40% after deductible
Mammography Preventive Screening	No co-pay	0%	40% after deductible
Immunizations	No co-pay	0%	40% after deductible
Allergy Injections	Co-pay waived for allergy injections billed separately	20% after deductible	40% after deductible
Allergy Tests Lab X-Ray Outpatient Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)	$50 co-pay $25 co-pay $50 co-pay $250 co-pay	20% after deductible	40% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	No co-pay	0%	40% after deductible
Chiropractic Services (limits apply) (direct access to participating providers)	$60 co-pay, 20 visits per calendar year	20% after deductible	40% after deductible
		20 visits per calendar year combined in– or out-of-network	
Hearing Exam	$25 co-pay	20% after deductible	40% after deductible

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

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

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

AETNA MEDICAL PLANS

	CDHP + HRA	Basic Essential
Benefit	**In-Network Only**	**In-Network Only**
Service Areas/Networks	Any provider in the Aetna Select Open Access national network	Any provider in the Choice POS II Network (national network)
Health Reimbursement Account (HRA)—Individual/Family HRA funds can only be used for medical plan and prescription drug expenses.	$500 individual $750 employee + child(ren) $750 employee + spouse $1,000 family HRA contributions are prorated based on your date of hire	N/A
Deductibles—Individual/Family	$1,500 individual; $3,000 family	$2,300 individual, $6,900 family
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or co-pays	$5,000 individual; $10,000 family	$8,550 individual; $17,100 family
Rx Out-of-Pocket Maximum—Includes Rx co-pays and deductible	$2,000 individual; $4,000 family	Combined with medical
Lifetime Maximum	Unlimited	Unlimited
Physician Office Visits	**You Pay**	**You Pay**
Primary Care Physician (PCP)	20% after deductible	$50 co-pay
Specialist (SPC)	20% after deductible	30% after deductible
Teladoc: Doctor	$25 co-pay	$40 co-pay
Teladoc: Behavioral Health	20% after deductible	0%, no deductible
Preventative Adult Physical Exams	0%, no deductible	0%, no deductible
Preventative GYN Care (including Pap test) (direct access to participating providers)	0%, no deductible	0%, no deductible
Mammography Preventive Screening	0%, no deductible	0%, no deductible
Immunizations	0%, no deductible	0%, no deductible
Allergy Injections	20% after deductible	30% after deductible
Allergy Tests Lab X-Ray Outpatient Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)	20% after deductible	30% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	0%, no deductible	0%
Chiropractic Services (limits apply) (direct access to participating providers)	20% after deductible; 20 visits per calendar year	30% after deductible; 20 visits per calendar year
Hearing Exam	20% after deductible	30% after deductible

Understanding How Much You Have to Pay

Health Reimbursement Account (HRA) (CDHP only)

Use your HRA to pay your deductible, coinsurance, and Rx co-pays, reducing your out-of-pocket costs. The amount deposited in your HRA is prorated based on your benefits effective date. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified.

Medical Plan Deductible (Choice POS II, CDHP + HRA, Basic Essential)

The amount you pay for medical expenses before the plan begins paying benefits.

Coinsurance (Choice POS II, CDHP + HRA, Basic Essential)

The percentage of eligible medical expenses you pay after paying the deductible for most services.

Co-Pays

The fixed amount you pay for medical care and prescriptions.

Aetna Prescription Drug Program

You pay co-pays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay co-pays. The deductible does not apply to the non-preferred brand drugs. More information can be found on page 9.

AETNA MEDICAL PLAN COMPARISONS

	Select Open Access	Choice POS II	
Hospital	**In-Network Only**	**In-Network**	**Out-of-Network**
Inpatient (Includes maternity and newborn services)	$500 co-pay per day; up to 5-day maximum	$500 co-pay per day; up to 5-day maximum	40% after deductible
Outpatient Surgery (including facility charges)	$500 co-pay	20% after deductible	40% after deductible
Emergency Room Services	$500 co-pay	20% after deductible	20% after deductible
Ambulance	No co-pay	20% after deductible	20% after deductible
Urgent Care Facility	$50 co-pay	20% after deductible	40% after deductible
Maternity Care/OB Visits	$50 co-pay for initial visit only	20% after deductible	40% after deductible
Mental Health Services			
Outpatient Mental Health Services	$25 co-pay	20% after deductible	40% after deductible
Inpatient Mental Health Services	$500 co-pay per day; up to 5-day maximum [2]	$500 co-pay per day; up to 5-day maximum [2]	40% after deductible
Miscellaneous			
Home Health Care (limits apply)	$25 co-pay	20% after deductible	40% after deductible
Hospice—Inpatient (limits apply)	$500 co-pay per day; up to 5-day maximum [2]	$500 co-pay per day; up to 5-day maximum [2]	40% after deductible; 30-day lifetime maximum
Skilled Nursing Facility (limits apply)	$500 co-pay per day; up to 5-day maximum; up to 120-visit limit per calendar year	$500 co-pay per day after deductible; up to 120-visit per calendar year	40% after deductible, 120-visit limit per calendar year
Short-Term Rehabilitation/ Outpatient Therapy (speech, physical, occupational)	$25 co-pay per visit, 60-visit limit per calendar year for all therapies combined	20% after deductible; 60-visit limit per calendar year for all therapies combined	40% after deductible, 60-visit per calendar year for all therapies combined
Diabetic Supplies (syringes, test strips)	See prescription drugs below	See prescription drugs below	See prescription drugs below
Durable Medical Equipment (DME)	$50 co-pay	20% after deductible	40% after deductible
Aetna Prescription Drug Program— Some Drugs may be Subject to Step-Therapy or Precertification [3]			
Up to 30-day supply: Generic Preferred Brand Non-Preferred Brand Specialty—PrudentRx*	Mandatory Generics Unless Dispensed As Written $15 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written $15 co-pay, no Rx deductible $60 co-pay, no Rx deductible 30% coinsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written NOT COVERED
90-day Supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.) Generic Preferred Brand Non-Preferred Brand Specialty—PrudentRx	Mandatory Generics Unless Dispensed As Written $30 co-pay, no Rx deductible $120 co-pay, no Rx deductible $180 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written $30 co-pay, no Rx deductible $120 co-pay, no Rx deductible $180 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written NOT COVERED

AETNA MEDICAL PLANS

	CDHP + HRA	Basic Essential
Hospital	**In-Network Only**	**In-Network Only**
Inpatient (Includes maternity and newborn services)	20% after deductible	30% after deductible
Outpatient Surgery (including facility charges)	20% after deductible	30% after deductible
Emergency Room Services	20% after deductible	30% after deductible
Ambulance	20% after deductible	30% after deductible
Urgent Care Facility	20% after deductible	30% after deductible
Maternity Care/OB Visits	20% after deductible	30% after deductible
Mental Health Services	**You Pay**	**You Pay**
Outpatient Mental Health Services	20% after deductible	0% no deductible
Inpatient Mental Health Services	20% after deductible	30% after deductible
Miscellaneous		
Home Health Care (limits apply)	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Hospice—Inpatient (limits apply)	20% after deductible	30% after deductible
Skilled Nursing Facility (limits apply)	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Short-Term Rehabilitation / Outpatient Therapy (speech, physical, occupational)	20% after deductible; 60-visit limit per calendar year for all therapies combined	30% after deductible
Diabetic Supplies (syringes, test strips)	See prescription drugs below	N/A
Durable Medical Equipment (DME)	20% after deductible	30% after deductible
Aetna Prescription Drug Program— Some Drugs may be Subject to Step-Therapy or Precertification [3]		
Up to 30-day supply: Generic Preferred Brand Non-Preferred Brand Specialty—PrudentRx*	Mandatory Generics Unless Dispensed As Written $15 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written $25 co-pay, no Rx deductible $60 co-pay, no Rx deductible $90 co-pay, no Rx deductible 30% coinsurance, $0 if enrolled
90-day Supply (maintenance medications) at CVS retail or mail order (mail order must be through CVS Caremark mail order delivery.) Generic Preferred Brand Non-Preferred Brand Specialty—PrudentRx*	Mandatory Generics Unless Dispensed As Written $30 co-pay, no Rx deductible $120 co-pay, no Rx deductible $180 co-pay, after Rx deductible 30% coinsurance, $0 if enrolled	Mandatory Generics Unless Dispensed As Written $50 co-pay, no Rx deductible $120 co-pay, no Rx deductible $180 co-pay, no Rx deductible 30% coinsurance, $0 if enrolled

Aetna Concierge (Group #109718) Customer Service

Please Note:
The dollar amounts are co- pays, deductibles, and maximums, which you pay; the percentages are coinsurance amounts, which you pay after you meet applicable deductibles. The amount the plan pays may be based on usual, reasonable, and customary (URC) fees for out-of-network services only. This chart provides a brief outline of the medical coverage options available to you through Aetna. Complete details are in the official plan documents. In any conflict between the plan documents and this basic comparison chart, the plan documents will control.

See the Diabetes CARE Program information on page 6 for details about free diabetic testing supplies.

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

[2] Waived if transferred from hospital

[3] See page 9 for Aetna Prescription Drug Program and step-therapy information.

* May be eligible for $0 co-pay under PrudentRx program, see page 11 for details. Some exclusions apply. Any specialty prescriptions not eligible under PrudentRx will fall to applicable tier for that drug.

AETNA MEDICAL PLANS

Health Care Reform and Your Medical Plan Choice

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

Children: Florida KidCare is the state-sponsored health care program for children from birth through age 18 who meet specific eligibility requirements. For more information, call 888-540-5437 or visit **floridakidcare.org**.

Spouse and/or child(ren): You can consider your spouse's employer-sponsored plans. If your spouse is not employed or his or her employer doesn't offer health insurance, the federal Health Insurance Marketplace may offer cost-effective alternatives. You can also enroll your child(ren) in a federal Marketplace plan. For more information about health care reform, go to: **pcsb.org/affordable-care-act**.

Enrollment in a Federal Health Insurance Marketplace Plan

You can enroll in a medical plan through the Federal Health Insurance Marketplace. If you enroll in a medical plan through the Market Place after the PCS annual enrollment window, you must contact us within 31 days of your enrollment to discontinue your PCS group coverage. Your request to discontinue your coverage will be effective the first of the month following receipt of your enrollment and change form by PCS.

If, within 12-months after enrolling in a plan through the marketplace, you are not happy with your decision and would like to re-enroll in a PCS medical plan, please contact us at 727-588-6140 during the next annual enrollment and we can reinstate your coverage in an equivalent plan. You will be responsible for the applicable rates.

Medicare Eligibility

Generally, you are eligible for Medicare, if you:

- Or your spouse worked for at least 10 years in Medicare-covered employment, AND
- Are 65 years old or older, AND
- Are a citizen or permanent resident of the United States, OR
- Are a younger person with a disability or with end-stage renal disease (permanent kidney failure requiring dialysis or transplant)

Medicare Coordination through Aetna

If you are eligible for Medicare due to kidney dialysis and/or transplant, Medicare becomes your primary coverage when the 30-month coordination period has end-ed. If you are a retiree and on Medicare, Medicare is always primary.

Resources for Medicare-Eligible Retirees

You must contact the appropriate provider directly to enroll in a plan, make changes, access provider directories, and get information.

SHINE – Serving Health Insurance Needs of Elders

800-963-5337 | **floridashine.org**

SHINE is a free program offered by the Florida Department of Elder Affairs and your local Area Agency on Aging. Specially trained volunteers can assist you with your Medicare, Medicaid, and health insurance questions by providing one-on-one counseling and information.

Medicare

For general Medicare inquiries, contact:
1-800-MEDICARE (800-633-4227)
TYY/TDD# 877-486-2048 | **medicare.gov**

DENTAL BENEFITS

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

CAUTION: If you cancel your and/or your dependent's dental coverage as a new retiree, during the year, during annual enrollment or discontinue your payment, you will not be able to re-enroll. If you elect either dental plan, you will be billed by the carrier and will be required to pay them directly.

	Humana Dental (#548085) 800-979-4760 | www.myhumana.com	MetLife Preferred Dental Program (#95682) 1-800-GET-MET8 | www.metlife.com/dental
	State of Florida Service Area. In-network only. This is an Open Access Dental HMO.	In or out-of-network. Save the most when you choose a participating In-network provider.
Network	Humana Dental Advantage Plus 2S Plan	MetLife Preferred Dentist Program (PDP Plus)
Primary Care Dentist and Specialist Referrals	Not required	Not required
Deductible	None	$50/individual; $150/family (Applies to Type B and C Services)
Calendar Year Maximum	None	$1,250 per person
Preventative Services	No charge	No charge, no deductible (Type A)
Basic Services	No charge	20% coinsurance after deductible (Type B)
Major Services	Scheduled co-pays	50% coinsurance after deductible (Type C)
Orthodontia	Scheduled co-pays (Adult and child)	50% (up to age 19)
Lifetime Orthodontia Limit	N/A	$1,000 individual

Humana Dental Advantage Plus 2S Plan (Group #548085)

You and your eligible enrolled dependents may continue participation in the Humana Dental Advantage Plus 2S Plan if you are a Florida resident. Make sure your dentist is in the Advantage Plus 2S Plan network.

If, at the time of retirement, you are enrolled in the Humana Dental Plan and are planning on moving out of Florida, you are eligible to enroll in the MetLife Dental Plan.

If you move out of Florida at a later date and would like to change your enrollment to the MetLife Dental Plan, you will need to contact the retirement team and submit a PCS Enrollment and Change form with your new address within 31 days of your relocation.

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.

DENTAL BENEFITS

Humana Dental Plan Highlights

The Humana Dental 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.

Humana Dental 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.

Humana Dental 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. The total number of periodontal maintenance and all other prophylaxis treatments combined are limited to two (2) per member every twelve (12) months.

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 BENEFITS

MetLife Dental (Group #G95682)

You and your eligible enrolled dependents may continue participation in MetLife Dental Plan. Enrollment and monthly billing for MetLife is processed through MedCom, a third-party administrator.

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.

MetLife 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.

MetLife 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.)

	In-Network or Out-of-Network		In-Network or Out-of-Network
Basis of Reimbursement	Negotiated PDP Fee*	**Individual Deductible (Annual)**	$50
Type A—Preventative	100%	**Family Deductible (Annual)**	$150
Type B — Basic	80%	**Deductible Applies To**	Basic and Major
Type C — Major	50%	**Calendar Year Maximum**	$1,250 per person
Type D — Orthodontia	50%	**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 over-view and the certificate of insurance and group insurance policy.

DENTAL BENEFITS

MetLife Dental: 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.

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

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

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

DENTAL BENEFITS

Type C (Major) cont.

- 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 Dental 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 non-covered services, such as cosmetic dentistry or orthodontia, providing plan participants with savings on these non-covered 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.

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.

EYEMED VISION CARE PLAN

If you are enrolled in the vision plan, you may continue your and your dependent's coverage when you retire. If you cancel your and/or your dependent's vision coverage or discontinue your payment, you will not be able to re-enroll. Your monthly rates will be deducted from your monthly FRS pension check.

Who Is Eligible?

All retirees who meet the eligibility criteria listed on page 5 are eligible for vision coverage. Eligible dependents include your spouse and/ or your eligible children through the end of the year in which they reach age 26.

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.

EyeMed Vision Care Plan Benefits

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

When You Use Participating In-Network Providers	
Frequency (Based on Calendar year)	
Vision Exam	Once per calendar year
Lenses or Contact Lenses	Once per calendar year
Frame	Every other calendar year
Benefits	**In-Network Providers**
Exam with Dilation (as needed)	$10 co-pay
Eyeglass Lenses (Single vision, bifocal, or trifocal)	$15 co-pay
Standard Progressive	$50 co-pay
Frames	$110 allowance (20% off the balance over $110)
Contact Lenses, conventional	$110 allowance (15% off the balance over $110)
Disposable	$110 allowance (full amount over $110)
Medically Necessary	Paid in full

EYEMED VISION CARE PLAN

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.

- 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

Additional Plan Costs and Discounts

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

- UV coating or 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.

EYEMED VISION CARE PLAN

When You Visit a Nonparticipating Provider

Eligible retirees 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
Lenses or Contact Lenses	Once per calendar year
Frame	Every other calendar year
Benefits	**Reimbursement**
Exam with Dilation (as needed)	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."

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.

Benefits	Benefit Amount
Hospital Admission Benefits	**$500**
Hospital Confinement Benefits	**$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 during the first 12 months for each person covered under the plan.
If you are concerned about a pre-existing condition, please call MetLife at 800-438-6388.
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.

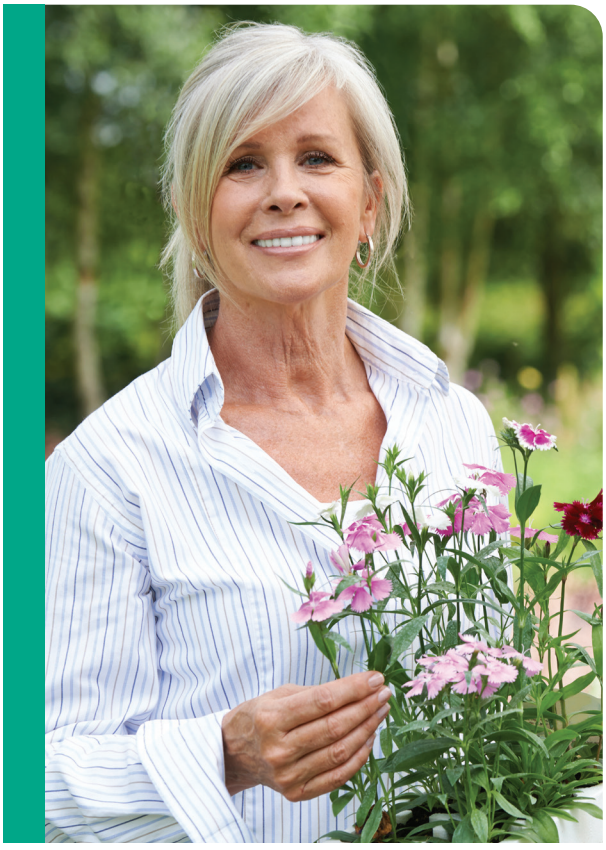
Income Tax Considerations for HIP

When you enroll in the MetLife Hospital Indemnity Plan, you will pay MetLife Voluntary Plans directly. Any payments you receive will be made on a post-tax basis, you will not have to pay federal income tax on any HIP benefit payments you may receive.

Continuation of Coverage

When your active employment ends, MetLife will send a Certificate of Coverage (COC) Letter to the address on file with the District. If you complete and submit the COC, the policy will become an individual policy with direct billing. The premiums will remain the same as the active plan. However you will be billed at a quarterly rate.

Contact MetLife at 800-438-6388 for more information.



LIFE INSURANCE

- Life insurance includes Basic, Optional, and Family (spouse/children) Term Life insurance.
- The coverage you have in effect at the time of your retirement can be continued or decreased but may not be increased.
- You can convert your coverage to an individual policy directly through The Standard.
- Retiree life insurance benefits are subject to a reduction formula.

Who's Eligible?

As a PCS retiree, you are eligible to continue your Basic Term Life insurance in effect at the time of your retirement. Your legal spouse and/or children are eligible for Family Term Life insurance, provided they are enrolled in this coverage at the time of your retirement.

Eligible dependents include:

- Your legal spouse as defined by the laws of the state of Florida.
- Your children beginning at live birth to the end of the year in which they reach age 26.

If your spouse is also a Pinellas County Schools retiree and has elected his or her own retiree life insurance, you may not elect Family Term Life insurance.

Basic Life Term Insurance

You may continue the amount of your Board Term Life insurance in effect at the time of your retirement. This life insurance policy is a Term Life insurance policy and has no cash value.

Optional Term Life Insurance Conversion

You can convert the amount of your Optional Term Life in effect at the time of your retirement to a Whole Life individual policy with The Standard within 31 days of retirement. You may elect less coverage, but under no circumstances may you elect more coverage than what is in effect at the time of your retirement.

Family Term Life Insurance—(Spouse/Children)

This policy covers your legal spouse and eligible children for $5,000 per person. You may continue this coverage if it is in effect at the time of your retirement. Florida's Department of Insurance guidelines state that you, the retiree, must have a minimum of $10,000 of Basic Term Life insurance to continue this coverage.

Reduction of Coverage

Your life insurance death benefit reduces beginning at age 70. Here is an example of how a $100,000 life insurance election is affected. Please note that your premium will be reduced based on the amount of insurance in force. We recommend that if you are over age 70, you review the reduced benefit payable to determine if your reduced life insurance benefit is appropriate.

Age	Percent of Policy Value	Death Benefit
69 or younger	100%	$100,000
70-74	65%	$65,000
75-79	45%	$45,000
80 or older	30%	$30,000

CAUTION! You will not be eligible to re-enroll in the life insurance program if you cancel your life insurance or your coverage is terminated for failure to make timely premium payments.

LIFE INSURANCE

Coverage Amount and Premium Payment Retiree Back Term Life

Your coverage amount cannot exceed your Basic Term Life insurance amount in force immediately prior to your retirement.

If you do not elect this coverage when you retire, you will not be eligible to re-enroll at a later date.

Dependents: Family Term Life (Spouse/Child)

This includes $5,000 for each dependent (includes your spouse and/or all eligible children).

One premium covers all your eligible dependents.

If you do not elect this coverage when you retire, you will not be eligible to re-enroll at a later date.

If you have Family Term Life insurance in effect at the time of your retirement and you wish to continue this coverage, you must elect a minimum of $10,000 of Basic Term Life coverage.

Premium Payment

Life insurance premiums will automatically be deducted from your retirement check—just like your medical and vision premiums—after you complete and return the Florida Retirement System Insurance Payroll Authorization Form. The form can be found in your retiree enrollment packet. Be sure to sign this form and return it along with two months of premium payment to the Risk Management and Insurance Department within 30 days prior to your coverage effective date.

This excludes FRS Investment Plan participants with 30 years of service with Pinellas County Schools or who are age 591⁄2.

PLEASE NOTE: Special provisions apply to life insurance participants who retired prior to March 1, 1992. Life insurance coverage is issued by Standard Insurance Company.

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 Basic Term life insurance benefit while still living. This benefit is only available once and is payable in a lump sum or six equal monthly installments. The death benefit payable to your beneficiary will be reduced by the amount you elect under this option.

Questions?

A Life Insurance Certificate of Coverage from The Standard Insurance Company which includes the entire plan provisions, exclusions, and limitations, is available at **pcsb.org/certificates** or by contacting the Risk Management and Insurance Retirement Team directly.

Retirement Guidelines for Life Insurance

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 fail to enroll in life insurance at the time you retire and your PCS group life insurance coverage lapses, you will not be permitted to re-enroll in a PCS-sponsored retiree life insurance plan at a later date. It is your responsibility to contact the PCS retirement team when and if you return to work or leave employment with Pinellas County Schools.

*Official retirement includes early retirement, retirement from DROP, normal retirement from the Pension Plan, or retirement from the Investment Plan. If you return to work in a benefit-eligible position, you may **not** continue life insurance coverage as a retiree.

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 a retiree status.

LEGAL NOTICES & DISCLOSURES

LEGAL NOTICES & DISCLOSURES

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please call the Risk Management Department.

Newborns' and Mothers' Health Protection Act

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP 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, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

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: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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+: https://www.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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

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: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
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

LEGAL NOTICES & DISCLOSURES

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

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-442-6003 TTY: Maine relay 711

Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa

Phone: 1-800-862-4840

TTY: (617) 886-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633 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/programs-services/medicaid/health-insurance-premium-program

Phone: 603-271-5218

Toll free number for the HIPP program: 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/Services/Assistance/Pages/HIPP-Program.aspx

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov

Phone: 1-888-549-0820

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

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

Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp

Medicaid Phone: 1-800-432-5924

CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone: 1-800-251-126

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
***www.dol.gov/agencies/ebsa* • 1-866-444-EBSA (3272)**

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
***www.cms.hhs.gov* • 1-877-267-2323, Menu Option 4, Ext. 61565**

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

HIPAA

HIPAA Notice Of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Pinellas County Schools is committed to the privacy of your health information. The administrators of the PCS Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting the Personnel Department. The notice also is available online at pcsb.org/page/464.

HIPAA Special Enrollment Rights

Pinellas County Schools Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

LEGAL NOTICES & DISCLOSURES

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact April Paul at 727-588-6136.

Notice of Creditable Coverage

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:

1. **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.**
2. **Pinellas County Schools has determined that the prescription drug coverage offered by the medical plan 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 to 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 (2) 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, your current Pinellas County Schools coverage will be affected.

LEGAL NOTICES & DISCLOSURES

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).

If you do decide to join a Medicare drug plan and drop your current Pinellas County School 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 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 nineteen 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 October to join.

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this 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 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER:
Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2023
Name of Entity/Sender: Pinellas County Schools
Contact: April Paul, SPHR
Position Director
Office: Risk Management & Insurance
Office Address: 301 4th Street SW
Largo, FL 33770
Phone Number: (727) 588-6136

LEGAL NOTICES & DISCLOSURES

Wellness Program Disclosures

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Personnel Department and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE REGARDING WELLNESS PROGRAM

The Pinellas County Schools' wellness program, 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 will 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 never 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.

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

LEGAL NOTICES & DISCLOSURES

When Can COBRA Coverage Be Elected? (Change in Status Event)	Who Can Elect COBRA Coverage?	How Long Can Coverage Be Continued?
Termination of employment of gross misconduct) or reduction in covered employee (other than for 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

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.

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.

LEGAL NOTICES & DISCLOSURES

Workers' Compensation

Basic Facts

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

How to Get Medical Care and Benefits

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

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

If you have any questions, please contact Risk Management, Workers' Compensation at 727-588-6196.

Payment For Lost Wages

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

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

Pinellas County Schools Modified Alternative Duties Program

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

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

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

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

QUESTIONS ABOUT ENROLLMENT:
Call 727-588-6214, 727-588-6141 or
727-588-6140 to speak with a Risk Management and Insurance Retirement team member.

pcs
PINELLAS COUNTY SCHOOLS