



EMPLOYEE BENEFITS GUIDE

2024 BENeflex Program





Questions?

**Call the Benefits Team:
727-588-6197**

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

Departments • Human Resources • Risk Management

Risk Management and Insurance
301 - 4th Street S.W.
Largo, FL 33770

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

TABLE OF CONTENTS

OVERVIEW

Contact Information	1
2024 Benefit Plans Summaries	2
Payroll Deduction Rate Chart	6
New Hire Enrollment Information	8
General Enrollment Information	9
Eligibility	9
Enrollment and Effective Dates	9
Dependent Coverage and Eligibility	10
Changes in Coverage	11
Coordination of Benefits	11
Termination of Coverage	12
Annual Enrollment	12
Board Contribution	12
Two Board Employees	13
Change in Two Board Status	13
Payroll Deductions	14
Leave of Absence (LOA)	14
Continuation or Waiver of Insurance Premium	16
Retiree Insurance	16
Disability Form Information	18
Life Insurance Medical History Information	19

FINANCIAL WELLBEING

The FLEX Plan	20
Premium Conversion	20
Change in Status Events	21

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs)	23
-----------------------------------	----

MEDICAL BENEFITS

Medical Plans	26
Hospital Indemnity Plan (HIP)	45

EMPLOYEE WELLNESS

Employee Assistance Program (EAP)	46
Drug- and Alcohol-Free Workplace	47
The Be SMART Wellness Program	48

DENTAL BENEFITS

Dental Plans	52
--------------	----

VISION BENEFITS

EyeMed Vision Plan	62
--------------------	----

LIFE AND AD&D INSURANCE

Life and AD&D Insurance	65
-------------------------	----

DISABILITY INSURANCE

Disability Insurance Plans	73
----------------------------	----

VOLUNTARY BENEFITS

Voluntary Benefits	80
--------------------	----

RETIREMENT PLANS

Retirement Savings Program	83
Florida Retirement System (FRS)	87

2024 ANNUAL ENROLLMENT NOTICES & DISCLOSURES

Plan Administration... Your Rights and Responsibilities	89
--	----



CONTACT INFORMATION

PLANS AND PROVIDERS	TELEPHONE	WEBSITE
RISK MANAGEMENT AND INSURANCE		
Main Number	727-588-6195 (Fax) 727-588-6182	www.pcsb.org/risk-benefits
Insurance Benefits and Deductions	727-588-6197	www.pcsb.org/risk-benefits
Retirement (Insurance Benefits/DROP)	727-588-6214	www.pcsb.org/retirement www.myfrs.com
Retirement Savings Program	727-588-6141	www.tsacg.com/individual/plan-sponsor/florida/pinellas-county-schools/
Wellness for Employees	727-588-6031	www.pcsb.org/wellness
Workers' Compensation	727-588-6196	www.pcsb.org/risk-benefits
ONSITE REPRESENTATIVES		
Aetna (Claims Advisor)	727-588-6367	www.pcsb.org/healthinsurance
Aetna (Wellness)	727-588-6134	www.pcsb.org/wellness
Standard Insurance Company (Disability Claims)	727-588-6197	www.pcsb.org/disability
INSURANCE CARRIERS		
Aetna Concierge Customer Service	866-253-0599	www.aetnapcsb.com
EyeMed Vision (#9856857)	866-299-1358	www.eyemedvisioncare.com
Farmers Insurance Auto & Home	800-438-6381	www.myautohome.farmers.com
Healthcare Bluebook	888-316-1824	www.pcsb.org/healthcarebluebook
Horace Mann Auto	727-576-5555	www.floridaeducatorsinsurance.com
Humana Advantage Dental (#548085)	800-979-4760	www.myhumana.com
MetLife Dental (#G95682)	800-942-0854	www.metlife.com/dental
MetLife Voluntary Benefits	800-438-6388	www.metlife.com/mybenefits
PayFlex/Inspira Financial (FSA/HRA)	888-678-8242	www.mypayflex.com
Resources for Living (RFL) Employee Assistance Program (EAP)	800-848-9392	www.resourcesforliving.com username: pcsb; password: eap
Standard Insurance Company Life Insurance	800-628-8600	www.standard.com
Teladoc	855-835-2362	www.teladoc.com/aetna
NON-PCS PROGRAMS		
Florida Retirement System (FRS)	866-446-9377	www.myfrs.com
Florida KidCare	888-540-5437	www.floridakidcare.org
Federal Health Insurance Marketplace	800-318-2596	www.healthcare.gov

QUESTIONS?

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

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





2024 BENEFIT PLANS SUMMARIES

Introduction

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

This guide contains details about the BENEFlex program, including eligibility, plan features and provisions, and their associated costs—everything you need to know to make informed choices.

Please take the time to review this guide carefully and use the contact information printed on the inside front cover if you have any questions or would like additional information. The decisions you make will remain in effect through December 31, 2024.

Medical Plans

- Choose from four Aetna medical plans: Select Open Access, Choice POS II (Point of Service II), CDHP + HRA (Consumer Directed Health Plan + Health Reimbursement Account), and Basic Essential.
- Enroll your legal spouse, and/or your children who may be eligible for coverage through the end of the year in which they turn age 26 (see pages 10-11 for information about dependent coverage and eligibility).
- The medical plans offered by PCS meet or exceed the affordability and coverage requirements.
- Medical Plan members can use the Healthcare Bluebook, a free online and mobile resource that offers rewards up to a maximum of \$200 when you use a Fair Price provider. See page 37 for details.

MetLife Hospital Indemnity Plan (HIP)

HIP pays a daily amount for hospital confinement. See page 45 for details about this plan.

Be SMART Wellness Programs

- Participate in district-sponsored programs for physical activity, nutrition, tobacco cessation, flu shots, financial wellness, resiliency, and many more throughout the year.
- Choose from programs offered at your school based upon employee interest, such as walking programs, yoga, softball competitions, informative speakers, and other creative opportunities.

Board Contribution Credit

- If you do not enroll in a PCS-sponsored medical plan, you are eligible to use up to a \$75 per-pay-period Board Contribution credit toward the purchase of eligible supplemental benefits. Eligible benefits are marked on the rate sheets and Enrollment & Change form with a diamond (◆). Enrollment in these supplemental benefits is not automatic. You must complete an Enrollment & Change form and elect them. If you do not elect supplemental benefits, you forfeit the \$75 per-pay-period credit.
- The Board Contribution credit may be applied to your payroll deductions for dental, vision, AD&D, disability, and/or the Hospital Indemnity Plan (HIP). The contribution cannot be used to purchase Optional Term Life insurance or be contributed to a Dependent Care FSA.
- If you are not enrolled in a medical plan and you enroll in a Healthcare FSA, you can deposit from \$10 to \$25 of your Board Contributions credits into your Healthcare FSA. This is not automatic—you must actively enroll in a Healthcare FSA to receive the credits the first year you enroll. In subsequent years, your FSA contribution amount will continue unless you change it during Annual Enrollment. See page 23 for more information.
- Board Contribution credits do not accumulate and are not automatic. You must enroll for the benefits listed above and any amount not used will be forfeited.





2024 BENEFIT PLANS SUMMARIES

DENTAL PLANS

HumanaDental Advantage Plus 2S Plan

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

See pages 52–57 for details.

MetLife® Preferred Dentist Program (PDP)

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

See pages 58-61 for details.



Vision Plan

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

See pages 62–64 for details.

Life Insurance

- Receive Basic Life insurance coverage, paid by the Board, at one times your annual base salary rounded up to the next \$1,000, with a coverage minimum of \$15,000. Coverage amounts in excess of \$50,000 are subject to taxation under Section 79 of the Internal Revenue Code.
- At retirement, you can continue Board Life insurance and convert Optional Term Life coverage to an individual policy.
- Select additional coverage, if needed:
 - **Optional Employee Term Life insurance:** up to \$500,000 (guaranteed coverage available up to \$250,000, if you enroll within 31 days of becoming eligible).
 - **Spouse:** up to \$100,000, not to exceed the employee's total life insurance coverage (basic plus any optional employee life). (Guaranteed coverage available up to \$30,000, if you enroll within 31 days of becoming eligible.)
 - **Child(ren):** up to \$10,000 (no medical underwriting).
 - **Optional Family Term Life insurance:** \$5,000 per dependent.
 - Disabled employees can apply for a continuation of benefits to age 65.

See pages 65-69 for details.





2024 BENEFIT SUMMARIES

Accidental Death & Dismemberment (AD&D) Plan

- Receive Board-paid Basic AD&D coverage of \$2,000.
- Select Optional AD&D coverage for employee and family, if needed.
- Choose from employee coverage amounts of \$50,000, \$100,000, \$200,000, or \$300,000. Coverage amounts for spouse and/or child(ren) are a percentage of the employee's coverage.

See pages 70-72 for details.

DISABILITY INSURANCE PLANS

Disability insurance

Choose from the following:

- **Preferred Monthly Benefit:** Choose an amount between \$400 and \$5,000 (up to 66 2/3% of your salary).
- **Benefit Duration:**
 - Two years OR
 - Up to the Social Security Normal Retirement Age (SSNRA).
- **Waiting Period:** Choose 14, 30, or 60 days until the plan starts paying benefits.

See pages 73-79 for details.

Voluntary Benefits

- Auto and Home Insurance* through Horace Mann and Farmers Insurance.
- MetLife Legal Plan offered by Hyatt Legal Plans (a MetLife company).
- MetLife Veterinary (VPI®) Pet Insurance.

See pages 80-82 for details.

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

Retirement Savings Program

- Pre-tax plans: 403(b) or 457(b).
- After-tax plan: Roth 403(b).
- Make deposits via easy payroll deductions.
- Choose from a variety of investment programs.
- Change your salary reduction amount up to four times per calendar year.
- Enroll or cancel participation anytime during the calendar year.

See pages 83-86 for details.

Employee Discount Program

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





PAYROLL DEDUCTION RATE CHART

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

Rates Subject to Union Ratification and Board Approval

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

Aetna Medical Plans - 2024

Coverage Level	Select Open Access	Choice POS II	CDHP + HRA	Basic Essential
Employee	\$93.00	\$104.00	\$72.00	\$32.00
Employee + Spouse	\$249.00	\$272.00	\$204.00	\$127.00
Employee + Child(ren)	\$227.00	\$249.00	\$182.00	\$118.00
Employee + Family	\$330.00	\$374.00	\$268.00	\$154.00
Two Board Family ¹	\$231.00	\$275.00	\$169.00	\$55.00

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

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

◆ Humana or MetLife Dental Plans

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

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

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

◆ EyeMed Vision Plan

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

◆ MetLife Hospital Indemnity Plan (HIP)

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

MetLife Legal Plan

Call MetLife (800-438-6388) to Enroll

\$11.85
(no coverage level
selection required)

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





PAYROLL DEDUCTION RATE CHART

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

Standard Insurance Company Life Insurance Plans³

Basic Employee Term Life Insurance¹

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

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

Optional Employee and Dependent Term Life

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

³ Keep in mind that the amount of coverage you elect will be reduced at certain ages. The \$12.36 contribution shown for age 70 and above actually buys coverage of \$6,500 at ages 70-74, \$4,500 at ages 75-79, and \$3,000 at age 80 and above.

- ¹ This coverage is "guarantee issue" and no evidence of good health is required.
- ² Optional Employee Term Life: \$10,000 minimum, up to \$200,000 in \$10,000 increments or \$250,000, up to \$500,000 maximum in \$50,000 increments; "guarantee issue" (new hire only) to \$250,000 or your current coverage amount; for additional amounts, you must provide evidence of good health; subject to reduction schedules at age 70.
- ³ Optional Dependent Term Life for Spouse: \$10,000 increments to \$100,000; (Guaranteed coverage available up to \$30,000, if you enroll within 31 days of becoming eligible); coverage terminates at age 70.
- ⁴ Optional Dependent Term Life for Child(ren): \$2,000 increments to \$10,000; one premium covers all eligible child(ren).
- ⁵ Optional Family Term Life: One premium covers spouse and eligible child(ren).

◆ Standard Insurance Company Optional Accidental Death & Dismemberment Insurance

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

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

◆ Standard Insurance Company Disability

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

If Your Annual Base Salary is at Least:	Monthly Disability Benefit	Two Year Plan and Waiting Periods			To SSNRA ⁴ Plan and Waiting Periods		
		14 Days	30 Days	60 Days	14 Days	30 Days	60 Days
\$ 7,200	\$ 400	\$5.81	\$3.72	\$2.07	\$7.52	\$4.99	\$3.15
10,800	600	\$8.71	\$5.58	\$3.10	\$11.28	\$7.48	\$4.72
14,400	800	\$11.61	\$7.44	\$4.14	\$15.03	\$9.97	\$6.29
18,000	1,000	\$14.51	\$9.31	\$5.17	\$18.79	\$12.47	\$7.87
21,600	1,200	\$17.42	\$11.17	\$6.21	\$22.55	\$14.96	\$9.44
25,200	1,400	\$20.32	\$13.03	\$7.24	\$26.31	\$17.46	\$11.01
28,800	1,600	\$23.22	\$14.89	\$8.28	\$30.07	\$19.95	\$12.59
32,400	1,800	\$26.13	\$16.75	\$9.31	\$33.83	\$22.44	\$14.16
37,800	2,100	\$30.48	\$19.54	\$10.86	\$39.46	\$26.18	\$16.52
43,200	2,400	\$34.83	\$22.33	\$12.41	\$45.10	\$29.92	\$18.88
48,600	2,700	\$39.19	\$25.13	\$13.96	\$50.74	\$33.66	\$21.24
54,000	3,000	\$43.54	\$27.92	\$15.52	\$56.38	\$37.40	\$23.60
63,000	3,500	\$50.80	\$32.57	\$18.10	\$65.77	\$43.64	\$27.53
72,000	4,000	\$58.06	\$37.22	\$20.69	\$75.17	\$49.87	\$31.46
81,000	4,500	\$65.31	\$41.88	\$23.27	\$84.56	\$56.11	\$35.40
90,000	5,000	\$72.57	\$46.53	\$25.86	\$93.96	\$62.34	\$39.33

Pre-existing conditions, including pregnancy, apply during the first year of new or increased coverage. See page 73 and the online BENEFlex Guide for full details.

⁴ Social Security Normal Retirement Age (SSNRA)





NEW HIRE ENROLLMENT INFORMATION

WELCOME TO PINELLAS COUNTY SCHOOLS!

As a new employee, this is your opportunity to enroll in the benefit plans of your choice. Making benefit choices is easy when you take the time to read the general enrollment information and review the benefit plan highlights in this guide.

PLEASE REMEMBER: When you are enrolling

- Your enrollment forms must be received by the Risk Management and Insurance Department no later than 31 days from your date of hire or date of change to eligible status. Insurance coverage begins the first day of the month following 60 days of employment in an eligible status. See page 9 of this BENEFlex Guide.
- We recommend you read this BENEFlex Guide, rather than ask questions of your coworkers, as they may not have the answers that best meet your or your family's benefit or financial needs. You may also contact the Risk Management and Insurance Department Benefits Team.
- Pinellas County Schools' Enrollment and Change form highlights important areas that must be completed as you select your benefit options. If you enroll in the optional term life plan, you are required to submit the online Medical History Statement when you elect more than \$250,000 of employee and/or more than \$30,000 of spouse term life insurance coverage. See page 17 for Life Insurance Form instructions.

When you can make benefit changes Annual Enrollment

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

Change in Status Event

- During the calendar year, you may only make benefit changes if you have a change in status event, which is explained on page 11 in this BENEFlex Guide. Per IRS regulations, you must request the change within 31 days of your change in status event. The change will be effective the first of the month following the status event effective date and the receipt of the enrollment form.



Be sure to visit
www.pcsb.org/new-hire
for more information.

Please see pages 17-19 for
information on how to
complete the new hire forms.





GENERAL ENROLLMENT INFORMATION

ELIGIBILITY

WHO	Full-time, regular employees who work at least 30 hours per week. Job-sharing employees. Part-time, regular employees in two or more authorized positions who work at least 30 hours per week.
HOW	You must complete and return an Enrollment and Change form to the Risk Management and Insurance Department. Return your form within 31 days from your date of hire or date of change to eligible status.
WHEN	Benefits are effective the first day of the month following 60 days of employment in an eligible status or change to eligible status.
WHAT	It is your responsibility to read the benefit information provided, complete the required enrollment forms, and ensure that they are received by the Risk Management and Insurance Department on or before your enrollment due date.
LATE?	If you fail to submit the required enrollment forms by the enrollment due date, you will have to wait until the next Annual Enrollment to enroll in our benefit programs.

Enrollment and Effective Dates

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

New Coverage

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

Enrolling a Newborn Child



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

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

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





GENERAL ENROLLMENT INFORMATION

Dependent Coverage and Eligibility

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

- Your legal spouse as defined by the state of Florida.
- Your children, including natural, foster, step, legally adopted children, children proposed for adoption, and children for whom you have been appointed permanent legal guardian.
- Medical, Dental, and/or Vision Plan Coverage for Children: Your eligible children can be covered under a PCS medical, dental, and/or vision plan through the end of the calendar year in which they reach age 26, regardless of marital, financial, or student status. A covered child's spouse is not eligible for coverage. **Please note, as allowed by Florida law, you may cover a grandchild from birth to age 18 months provided your child was covered under your PCS medical plan when your grandchild was born.**
- **Handicapped Dependents.** There is no age limitation for an unmarried handicapped dependent child provided the following requirements are met:
 - The dependent must be chiefly dependent upon the employee for support and maintenance, and be incapable of self-support due to mental or physical incapacity, either of which commenced prior to reaching a limiting age.
 - The dependent had continuous coverage under a Pinellas County Schools group health insurance plan.
 - The employee must submit proof of the handicapped dependent's condition and eligibility to the Risk Management and Insurance Department and the appropriate health plan(s) within 31 days after the end of the year in which the dependent reaches a limiting age.
- **Dependent Life Insurance.** You can purchase dependent life insurance for your legally married spouse up to age 70. You may also cover your dependent children up to the end of the calendar year in which they reach age 26 (unmarried).

Spouse and Dependent Certification Required

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

- For your legal spouse: Submit a copy of your marriage license or other documentation as requested.
- **Note:** A former spouse (divorced) is not eligible.
- For children (including legally adopted children, stepchildren, and children for whom you have been appointed a permanent legal guardian): Submit birth certificates, adoption certificates, and/or guardianship certificates.

Why are you being asked to do this? PCS periodically performs dependent eligibility audits. It is illegal to enroll ineligible dependents. It also drives up the plan costs for all of us.

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

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

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

**Source: Business Insurance Magazine*



CAUTION!

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





GENERAL ENROLLMENT INFORMATION

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

Capturing Dependents' Social Security Numbers

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

Changes in Coverage

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

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

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

Coordination of Benefits

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

Medicare Coordination of Benefits

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

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

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





GENERAL ENROLLMENT INFORMATION

Termination of Coverage

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

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

Disability coverage will terminate on the date your employment ends.

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

Please see pages 97-98 to find important information about your rights and responsibilities for continuation of insurance coverage through COBRA.

Board Contribution

Each pay period during the school year, the Board contributes toward the cost of your benefits. The Board Contribution is earned each pay period in which you receive a Board paycheck. In any pay period in which you do not receive a paycheck, you will owe both the Board Contribution amount and your normal insurance deduction(s) unless you are on an approved family medical leave. (See page 14.)

If you choose medical insurance, the rates reflected on the Payroll Deduction Rate Chart (on page 6) are the amounts that will be deducted from your check. The Board Contribution has already been applied toward the full rate.

"No Health" Board Contribution

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

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

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

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

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

ANNUAL ENROLLMENT

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





GENERAL ENROLLMENT INFORMATION

Two Board Employees

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

- You both want to be covered under the same medical plan, AND
- You are covering one or more dependents (for a total of three or more covered individuals).

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

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

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

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

Change in Two Board Status

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

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

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

- **Note:** if you and your spouse are not covering dependents, you are not eligible for two-board coverage and each of you must enroll in employee-only coverage.





GENERAL ENROLLMENT INFORMATION

Payroll Deductions

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

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

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



PAYROLL DEDUCTION RATES

Please see the Payroll Deduction Rate Chart on page 6.

Your rates are based upon 20 deductions and should not be compared to insurance plans where rates are based upon 24 or 26 deductions.

LEAVE OF ABSENCE (LOA)

Family and Medical Leave of Absence

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

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

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

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

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





GENERAL ENROLLMENT INFORMATION



LEAVE OF ABSENCE

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

If you have any questions or want more information about leaves of absence, please contact the Risk Management and Insurance Department.

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

Insurance Billing—Leave of Absence

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

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

If you are no longer eligible for the Two Board Family option (see page 13), you will need to complete an Enrollment and Change form within 31 days of the change in status event. Please contact the Risk Management and Insurance Department if you have any questions.

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

**If you are on a family medical leave, you will only be billed for your regular employee deductions.*





GENERAL ENROLLMENT INFORMATION

Continuation or Waiver of Insurance Premium

While on a Regular, Unpaid Leave of Absence

Premium Continuation of Term Life Insurance

You may continue Basic and Optional Employee Term Life with premium payments if you become disabled prior to age 60. Please refer to page 65 for details.

Waiver of Disability Premium

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

Retiree Insurance

You may participate in the Retiree Insurance program if you meet the following criteria at the time of your termination of employment.

If you are hired prior to July 1, 2011, and you retire with six or more years of creditable service, OR you are hired on July 1, 2011, or after and you retire with eight or more years of service and you either:

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

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

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

Basic and Optional Term Life insurance benefits may be continued within 60 days of your retirement date as an individual contract subject to insurance company procedures. Disability coverage ends upon retirement.

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

Re-employment after Retirement

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

Life Insurance Guidelines Upon Re-employment

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

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





ENROLLMENT INFORMATION

ENROLLMENT AND CHANGE FORM

HOW TO COMPLETE ENROLLMENT

BENEFICIARY INFORMATION									
Board paid Life Insurance and AD & D Beneficiary(ies) - Required Information									
Name _____					SSN Last 4 Digits _____				
Your primary beneficiary is first in line to receive your death benefit. If the primary beneficiary dies before you, a secondary or contingent beneficiary is the next in line. Percentages must equal 100%.									
PRIMARY									
BENEFICIARY NAME				RELATIONSHIP		ADDRESS		BIRTHDATE	
<div style="float: left; width: 20%;"> FOR OFFICE USE ONLY Effective Date ____ / ____ / ____ <i>Print or Type Clearly. Use Black Ink.</i> </div> <div style="float: right; width: 80%; text-align: center;"> PINELLAS COUNTY SCHOOLS BENEFLEX INSURANCE ENROLLMENT AND CHANGE FORM 2024 EMPLOYEE </div>									
NAME (Last, First, M.I.)					SSN LAST FOUR				
ADDRESS (No. Street)					CITY	STATE	ZIP CODE	HOME PH.	
SEX	DATE OF BIRTH	EMPLOYMENT DATE	POSITION	SCHOOL/DEPT.	WORK PH.				
Rates Listed are Per-Pay Deductions for 20 Pay Periods									
1. MEDICAL		REFUSAL		EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE + CHILD(REN)	2 BOARD EMPLOYEES + CHILD(REN)	SPOUSE OF 2 BOARD
• AETNA SELECT OPEN ACCESS		___ 93.00	___ 249.00	___ 227.00	___ 330.00	___ 231.00	___ No Charge		
• AETNA CHOICE POS II		___ 104.00	___ 272.00	___ 249.00	___ 374.00	___ 275.00	___ No Charge		
• AETNA CDHP (Consumer Directed Health Plan)		___ 72.00	___ 204.00	___ 182.00	___ 268.00	___ 169.00	___ No Charge		
• AETNA BASIC ESSENTIAL		___ 32.00	___ 127.00	___ 118.00	___ 154.00	___ 55.00	___ No Charge		
2. DENTAL		REFUSAL		EMPLOYEE	EMPLOYEE+1	EMPLOYEE+FAMILY	2 BOARD EMPLOYEES + CHILD(REN)	SPOUSE OF 2 BOARD	
• HUMANA ADVANTAGE		___ 7.93	___ 14.56	___ 21.27	___ 19.27	___ No Charge			
• METLIFE PDP		___ 14.93	___ 27.36	___ 39.49	___ 37.49	___ No Charge			
3. EYEMED VISION				REFUSAL		4. METLIFE HOSPITAL INCOME PLAN			
Employee NO COST		Employee+1 2.83	Employee+Family 5.92	Employee 8.00	Employee+Spouse 13.00	Employee+Children 17.00	Employee+Family 21.00		
DEPENDENT INFORMATION									
Please list each family member below you wish to ENROLL IN OR DELETE FROM MEDICAL, DENTAL, VISION, OR HIP .									
<input type="checkbox"/> Add <input type="checkbox"/> Delete See additional dependent criteria regarding this section.									
LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SSN	GENDER	BIRTHDATE	MED	DEN	VIS HIP
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
5. ACCIDENTAL DEATH & DISMEMBERMENT		REFUSAL		6. DISABILITY		REFUSAL		10. EMPLOYEE OPTIONAL TERM LIFE	
				SEPARATE APPLICATION REQUIRED				Employee Guaranteed Issue - NEW HIRE ONLY	
Employee		Employee + Family		PLAN 1 (2 YEARS)		___ 10,000		___ 20,000 ___ 30,000 ___ 40,000 ___ 50,000 ___ 60,000 ___ 70,000	
\$50,000 ___ 0.60		___ 1.05		PLAN 2 (TO SSNRA)		___ 80,000		___ 90,000 ___ 100,000 ___ 110,000 ___ 120,000 ___ 130,000 ___ 140,000	
\$100,000 ___ 1.20		___ 2.10		7. FAMILY TERM LIFE		___ 150,000		___ 160,000 ___ 170,000 ___ 180,000 ___ 190,000 ___ 200,000 ___ 250,000	
\$200,000 ___ 2.40		___ 4.20		___ \$0.90 - I wish to enroll all eligible dependents for one premium amount.		___ Employee Election over \$250,000 requires online application subject to medical approval.			
\$300,000 ___ 3.60		___ 6.30							
8. HEALTHCARE FLEXIBLE SPENDING				REFUSAL		11. SPOUSE OPTIONAL TERM LIFE			
Deduction per paycheck \$ _____ Minimum deduction \$10. Must be in whole dollars. May not exceed \$2,700 per calendar year.						Guaranteed Issue - NEW HIRE ONLY. Not to exceed employee election			
						___ 10,000 ___ 20,000 ___ 30,000			
9. DEPENDENT CARE FLEXIBLE SPENDING				REFUSAL		___ Spouse Election over \$30,000 requires online application subject to medical approval.			
Deduction per paycheck \$ _____ Minimum deduction \$10. Must be in whole dollars. May not exceed \$5,000 per calendar year. NOTE: This account is not for healthcare expenses						12. CHILDREN OPTIONAL TERM LIFE			
						___ 2,000 ___ 4,000 ___ 6,000 ___ 8,000 ___ 10,000			
PRE-TAX PREMIUM PLAN - By signing below I elect to have premiums for my medical, dental, vision, HIP, disability, and flexible spending account(s) deducted from my pay on a pre-tax basis. Premiums will continue unless noted otherwise.									
INSURANCE PREMIUMS - Premiums are due in advance, therefore deductions begin the month before the effective date of coverage. Deductions are taken over 20 pay periods. I understand that I pay for coverage over a 10 month period, but I am covered for the entire year. Premium for summer coverage may be an additional amount owed upon initial enrollment or if a change is made during the year.									
SIGNATURE _____					E-MAIL _____ DATE _____				
ELIGIBLE FOR "NO HEALTH - BOARD CONTRIBUTION" PCS Form 3-2247-C24 (Rev. 10/23) Review Date 10/24									
					Category Z CC# 5310				





ENROLLMENT INFORMATION

SAMPLE SUPPLEMENTAL FORM

Complete this form **ONLY** if you are applying for coverage under the **DISABILITY PLAN**

Standard Insurance Company

Standard Insurance Company		To Be Completed By Risk Management & Insurance		Disability Plan Enrollment and Change Form	
Group Number 755556		Employer Name The School Board of Pinellas County, Florida		Date of Employment	

To Be Completed By Applicant <input type="checkbox"/> Apply for Coverage <input type="checkbox"/> New Hire <input type="checkbox"/> Change in Coverage <input type="checkbox"/> Life Event					
Your Name (Last, First, Middle)		Your Social Security Number		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address		City	State	ZIP	
Job Title/Occupation				Phone Number	
Hours Worked Per Week		Annual Earnings \$ _____			

Coverage
The Standard Educator Disability Plan

Refer to the enrollment materials provided when completing the following:

Maximum Benefit Period (choose one):

☐ 2 Year Option

☐ Social Security Normal Retirement Age (SSNRA) Option

Benefit Waiting Period (choose one): **Benefit Amount/Per Pay Cost**

☐ 14/14 \$ _____ Monthly Benefit

☐ 30/30 \$ _____ Per Pay Period 20 salary deductions per year

☐ 60/60

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

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Initials: _____	I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction.
Initials: _____	I understand that the insurance applied for contains exclusions and limitations.

To be completed by Risk Management & Insurance		
Reviewer Signature _____		Date (Mo/Day/Yr) _____
Effective Date	First Deduction Date	Per Pay Cost

Return completed form to Risk Management & Insurance.

Please keep a copy for your records.

1 of 1

SI 75533

D-755556-DIS
(9/19)

See page 7 for disability rates.





ENROLLMENT INFORMATION

SAMPLE SUPPLEMENTAL FORM

Complete the online Medical History Statement if you are applying for coverage requiring this for these plans (see guidelines below).

Optional Employee and Family Term Life Insurance Plans

Standard Insurance Company

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

You must submit your Medical History Statement using Standard Insurance Company's online statement.

This statement is only required if you are requesting employee life insurance coverage greater than \$250,000 or spouse term life insurance greater than \$30,000.

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

Go to www.standard.com/mybenefits/pinellas/eeoi and check the "I Agree" button located at the bottom of the page to get started.

FOLLOW THESE STEPS:

1. Answer the Initial Questions. Enter the applicant's name. This is the person applying for coverage, i.e., employee or spouse. Enter address information.
2. Demographic Questions. Select an applicant type. This is the person applying for coverage. The applicant's date of birth is a required field. All other fields on this page are optional.
3. Employment Questions. Your policy number of 755556 is prefilled. All other fields are optional.
4. Coverage Questions. Indicate the type of application. As a new hire, you will select "Initial."
5. Medical Questions. You must answer all of the health questions in order to advance to the next screen.
6. Notices and Signatures. After reading all of the information, click the "I Agree" button to go to the next screen.
7. Submit Form. You now have the option to make changes or print a copy of your Medical History Statement and submit your statement. If you do not click the "Submit" button, your application will not be received by Standard Insurance Company.
8. Application Confirmed. When you receive this notification, you have successfully submitted your application.

Standard Insurance Company		Supplemental Additional Life Enrollment and Change Form	
To Be Completed By Risk Management & Insurance			
Group Number 755556	Date of Enrollment		
To Be Completed By Applicant			
<input type="checkbox"/> Apply for Coverage <input type="checkbox"/> Add or <input type="checkbox"/> Delete Dependent Date of add/delete			
Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address	City	State	ZIP
Former Name (Last, First, Middle) Complete only if name change		Phone Number	
Employer Name The School Board of Pinellas County, Florida		Job Title/Occupation	
Hours Worked Per Week			
Coverage Check with Risk Management & Insurance about coverage options available to you and Evidence Of Insurability requirements.			
Life Insurance			
<input type="checkbox"/> Additional Life requested amount \$			
Dependents Life Insurance			
<input type="checkbox"/> Spouse Life requested amount \$			
Spouse Name		Date of Birth	
Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.			
Member/Employee Signature Required		Date (Mo/Da/Yr)	
To be completed by Risk Management & Insurance			
Reviewer Signature		Date (Mo/Da/Yr)	
<p>This form should be completed if you are electing over \$250,000 for yourself and/or electing over \$30,000 of coverage for your spouse.</p> <p>Please go to the following website to complete the Medical History Statement: https://www.standard.com/mybenefits/pinellas/eeoi.html</p> <p>As a New Hire, you may elect up to the Guaranteed Issue amount of \$250,000 of employee coverage or \$30,000 for spouse coverage without having to submit a Medical History Statement.</p>			
<small>Return completed form to Risk Management & Insurance. Please keep a copy for your records. 1 of 1</small>			



THE FLEX PLAN

Premium Conversion

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

Eligibility

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

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

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

There is no effect on your earnings base for Florida Retirement System (FRS) Pension Plan calculations and minimal effect on Social Security benefits.

We recommend you speak with a tax professional if you have any questions or concerns about pre-tax deductions.

How to Elect After-Tax Deductions

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

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

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

	NO FLEX	WITH FLEX	NOTE: If you are a FLEX Plan participant and enroll in a Disability plan, any disability payments you receive will be considered taxable income for the calendar year in which they are received and subject to FICA for the first six months for which you receive benefits.
Gross Income	\$30,000	\$30,000	
Annual Insurance Premiums	– 1,780	– 1,780	
Taxable Income	\$30,000	28,220	
Federal Income and Social Security Taxes	– 2,684	– 2,163.46	
Take-home Pay \$23,756	\$25,536	\$26,056.54	

\$520.54 Saved!

Assumptions: \$30,000 gross income • Select Health Plan Employee Only Coverage 2022 tax tables.
This chart is for illustrative purposes only.





THE FLEX PLAN

Change in Status Events

Life changes. People get married, have babies, get divorced or change jobs and may need to change their benefit elections during the year. According to IRS regulations, you cannot change your benefit elections during the year unless you experience a qualified change in status event (also called life event).

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

To change your benefit elections, you must submit an Enrollment and Change Form to Risk Management within 31 days of the qualified change in status event. If you are benefits-eligible and have not met the required waiting period, you may be eligible to change your benefit elections.

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

Change in Status FAQs

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

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

How do I notify Risk Management?

You must submit an Enrollment and Change Form (PCS 3-2247) along with the documentation required consistent with your life event. Changes in coverage are effective the first day of the month following the change in status event and receipt of the forms by Risk Management.

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

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

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

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

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

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

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

Can I cancel my benefits while on leave?

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

When and how can I re-enroll?

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

GRANDCHILDREN —

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





THE FLEX PLAN

Qualifying Events to ADD Medical, Dental, or Vision

Qualifying Event	Documentation Required
Marriage	Copy of marriage certificate
Divorce	Copy of divorce decree
Death	Copy of death certificate when available
Birth of a Child	Copy of birth certificate when available: <ul style="list-style-type: none"> • Within 31 days to avoid paying first month's additional premium • Within 60 days or coverage will be allowed and billed from date of birth
Legal Adoption or intent to adopt	Copy of adoption paperwork
Permanent Legal Guardianship	Copy of permanent legal guardianship paperwork
Judgment, decree or order requiring you to provide health coverage for dependent child	Copy of judgment, decree, or order
Grandchild	Copy of birth certificate identifying covered dependent as parent
Return to work from unpaid leave	Return to Work notification (received from Personnel)
Loss of benefits from employer group plan, federal or state sponsored plan	HIPAA letter or statement from other coverage sponsor stating why coverage was terminated. Dropping coverage voluntarily or cancellation of coverage for non-payment is NOT a qualifying life event
Loss of COBRA benefits	COBRA termination letter showing end of eligibility
Significant premium cost change attributable to employee or dependents benefit plan	Statement from other coverage sponsor stating cost change and effective date

Qualifying Events to DROP Medical, Dental, or Vision

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

Healthcare Flexible Spending Accounts (FSA)

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





FLEXIBLE SPENDING ACCOUNTS

Increase Your Take-Home Pay with Flexible Spending Accounts

Would you like to save money this year? You can when you enroll in the Healthcare FSA and/or the Dependent Care FSA. Flexible spending accounts (FSAs) allow you to pay for certain eligible expenses with tax-free dollars.

Keep More Money in Your Pocket

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

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

Make FSAs Work for You

- **PayFlex** is the administrator of the Flexible Spending Accounts for Pinellas County Schools. In early 2024, they will be changing their name to **Inspira Financial**.
- **Estimate Your Expenses**—Take the time to estimate your health care and/or dependent care needs for the year. Use the Healthcare FSA and Dependent Care FSA planners at www.aetnapcsb.com, where you can link to PayFlex.
- **Decide How Much to Contribute**
 - Healthcare FSA = \$200 to \$2,700
 - Dependent Care FSA = \$200 to \$5,000 (\$2,500 if married and filing separately)
- **Board Contribution Credits Count!** If you do not enroll in a medical plan, you can enroll in a Healthcare FSA and authorize from \$10 up to \$25 of your Board Contribution Credits to be deposited in your account each payday.
- **WARNING! Estimate Carefully**—The IRS “use it or lose it” rule says you must use all of the money you deposit into your FSA(s) by the end of the plan year or you will forfeit any remaining balance in your account(s).
- **Enjoy Your Tax Savings**—The chart below shows how much three employees could save on taxes.





FLEXIBLE SPENDING ACCOUNTS

Changing Your FSA Elections

You cannot change your elections during a plan year unless you experience a qualifying change in status event. Your change must be a direct result of and consistent with the event.

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

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

Accessing Your FSA Funds Healthcare FSA

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

When you enroll in a Healthcare FSA, you will receive the PayFlex debit card loaded with an amount equal to your annual election. Note: You may be required to submit receipts to support the eligibility of your debit card purchases. If you remain enrolled in a Healthcare FSA from year to year, your debit card will automatically renew and reload with your annual election amount on January 1. You cannot use your debit card to pay prior year expenses (i.e., you go to the doctor on January 5, 2024, and have a balance due from a December 2023 visit. You cannot use your debit card to pay the December 2023 expense).

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

Dependent Care FSA

Your Dependent Care FSA funds cannot be used until they have been deducted from your paycheck and deposited into your account. Please take this into account as you budget for your dependent care expenses. You will have to file manual claims for Dependent Care FSA reimbursements—you cannot use the debit card to pay dependent day care expenses. Your reimbursement claims will be paid via direct deposit or by check through the mail. Claims are generally processed in five to seven business days of receipt by PayFlex. Reimbursement checks are processed and mailed on a daily basis.

FSA Eligible Expenses Healthcare FSA

- Eligible medical, dental, and vision plan deductibles, coinsurance, or copays.
- Prescription eyeglasses, contact lenses, and supplies.
- LASIK and other surgery to correct or improve vision.
- Smoking cessation programs.
- See IRS Publication 502 for a list of eligible expenses.

Dependent Care FSA

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





FLEXIBLE SPENDING ACCOUNTS

PayFlex Makes Managing Your FSAs Easy

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

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

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

The IRS "use it or lose it" rule states that any FSA balance not used by the end of the plan year must be forfeited. You have 90 days after the end of the plan year, or date of termination, to submit receipts for reimbursement of services received during the plan year or employment period.

FSA Expenses:

Unsubstantiated claims will be reflected as taxable income.

PayFlex/Inspira Financial Contact Information

Inspira Financial (FSA / HRA)
www.mypayflex.com
 888-678-8242

or

Aetna Concierge Customer Service
www.aetnapcsb.com
 866-253-0599

Keep It Simple with the Aetna PayFlex Mobile® App

Manage your account and view alerts. Snap a photo of your receipts to submit claims. View common eligible expense items, and more.

Attention CDHP Members Enrolled in the CDHP+HRA and a Healthcare FSA?

- If you are enrolled in the CDHP with a Health Reimbursement Account (HRA) and a Healthcare FSA, you will receive two PayFlex debit cards—one for your HRA and one for your Healthcare FSA.
- Because FSAs are subject to the "use it or lose it" rule, you may want to use the money in your Healthcare FSA first to avoid losing any money in your FSA at the end of the plan year.

Healthcare Flexible Spending Accounts (FSA)

May only be dropped or decreased due to these qualifying events: death, divorce, or unpaid leave of absence.

Save Your Receipts for the FSA and HRA

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



Once you are enrolled in a plan, you and your covered dependents will have access to Aetna's services and programs described on pages 38–39 and at www.aetnapcsb.com.

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

- If your spouse is not employed or his or her employer doesn't offer group health insurance, the federal Health Insurance Marketplace may offer cost effective alternatives. You can also enroll your child(ren) in a Marketplace plan.

Search for your doctors and providers:

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

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



AETNA MEDICAL PLANS

AETNA RESOURCES

Important Information for Women

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

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

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

Choosing the Right Medical Plan

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

	Select Open Access	Choice POS II	CDHP	Basic Essential
Do I have to stay in-network to receive plan benefits?	YES	NO	YES	YES
What is the coverage area?	National	National	National	National
Do I have to select a PCP?	Not Required	Not Required	Not Required	Not Required
Do I need a referral to see specialists?	NO	NO	NO	NO
What do I pay for medical services?	Copays for all services, no deductible	Deductible, coinsurance and copays	Deductible and coinsurance	PCP copay; Deductible and coinsurance on all other services
Is preventive care covered at 100%?	YES In-network only	YES In-network only	YES In-network only	YES In-network only
Is there a Health Reimbursement Account (HRA)?	NO	NO	YES (see pages 28-29)	NO
Is there prescription drug coverage?	All four plans offer the Aetna Prescription Drug Program. Details are provided on pages 30-31.			





AETNA MEDICAL PLANS

AETNA RESOURCES

Aetna Select Open Access

In-Network Only Coverage: Aetna Select Open Access

- You can visit any doctor in the network. There is no out-of-network coverage except for emergencies as defined by the plan.
- You don't have to select a PCP or get referrals to specialists.
- You will have a higher copay to visit specialists. (A specialist is a doctor who focuses only on treating certain conditions or diseases.)

Choice POS II

Network: Choice POS II

- You don't have to select a PCP or get referrals to specialists.
- You can visit licensed providers who are not in the network. Going out-of-network may cost you more.
- Out-of-network doctors and hospitals do not contract with Aetna and can charge more for their services, and you may have to pay the difference between what the plan pays for services and the amount the out-of-network provider charges.
- Out-of-network providers may not submit claims or get approval for coverage when needed—this means you may need to handle these details on your own.

CDHP + HRA

In-Network Only Coverage: Aetna Select Open Access

- You can visit any doctor in the network. There is no out-of-network coverage except for emergencies as defined by the plan.
- You don't have to select a PCP or get referrals to specialists.
- When you enroll in the Consumer Driven Health Plan with Health Reimbursement Account (CDHP + HRA) PCS will fund an Aetna PayFlex Card® with up to \$500 (employee), \$750 (employee + spouse), \$750 (employee + children), or \$1,000 (family) each year. See "How the CDHP + HRA Works" for details.

NOT REQUIRED: PCP Designation or Specialist Referrals

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

You can visit any network doctor or specialist without a referral. Network doctors contract with Aetna to offer rates often lower than their regular fees. The network doctor or specialist will provide care, get approval from Aetna before giving you certain services, file claims for you, search for a doctor or facility, find urgent care centers and walk-in clinics, view claims, and more.

How the CDHP + HRA Works

- When you enroll in the Consumer Driven Health Plan with Health Reimbursement Account (CDHP + HRA) PCS will fund an Aetna PayFlex Card® with up to \$500 (employee), \$750 (employee + spouse), \$750 (employee + children), or \$1,000 (family) each year.
- You choose when to use the HRA. Aetna will not automatically apply your HRA funds when they process your claims.
- When you use your HRA PayFlex Card, you can pay the first \$500 (individual) or \$1,000 (family) of your eligible medical and/or prescription drug expenses. (You may also submit claim forms and receipts for reimbursement.)
- Any funds over and above the Rollover Maximum that remain in your HRA will not roll over to the next year.
- Although you can use your HRA card to pay eligible expenses at the time of your visit, we recommend you wait until you receive your explanation of benefits (EOB) from Aetna. Pay the balance due based on your EOB to ensure you do not overpay.





AETNA MEDICAL PLANS

AETNA RESOURCES

CDHP Health Reimbursement Account Contributions

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

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

HRA Rollover Maximum

Effective January 1, 2024, the amount of HRA funds you can carryover from one year to another will be subject to the new maximum.

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

Any funds in your account in excess of the maximum will be forfeited as of December 31, 2023.

Important Information About the PayFlex HRA and Healthcare FSA Cards

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

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

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

Basic Essential Plan

In-Network Only Coverage: Aetna Select Open Access

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

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





AETNA MEDICAL PLANS

AETNA RESOURCES

Aetna Prescription Drug Program

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

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

See the medical plan comparison chart on pages 38–39 for your out-of pocket-costs.

Understanding the Drug Classification			
Generic Drugs Lowest Cost	Preferred Brand Drugs Higher Cost	Non-Preferred Brand Drugs Higher Cost	Specialty Drugs — PrudentRx Highest Cost
The least expensive drugs, such as generics and select brand-name drugs.	Brand-name drugs that have proven to be the most effective in their class.	Non-preferred brand drugs are higher cost and often have a generic or preferred brand alternative that can save you money.	Specialty drugs are the most expensive, high-technology and self-administered injectable medications not available on other levels. May be eligible for \$0 copay under PrudentRx program. If not enrolled, 30% coinsurance applies. See page 31 for details.
<div> Maintenance Choice Program: 90-day supply for two copays after applicable deductibles at a CVS Pharmacy, CVS Caremark mail order, or Costco Pharmacy. Brand specialty drugs are not available through this program. See next page for details.</div>			Not available





AETNA MEDICAL PLANS

AETNA RESOURCES



PrudentRx helps you manage your specialty prescription benefit coverage.

In-Network —

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 —

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

How to get started —

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

Specialty Prescriptions —

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

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

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



QUESTIONS?

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

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

Visit www.prudentrx.com





AETNA MEDICAL PLANS

AETNA RESOURCES

Restrictions

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

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

Precertification

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

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



LOCATE A PARTICIPATING PHARMACY

You can use all major retail pharmacies as well as many independent pharmacies participating in the Aetna Pharmacy Management (APM) National Retail Pharmacy Network.

Go to aetnapcsb.com to find a pharmacy.





AETNA MEDICAL PLANS

AETNA RESOURCES

Maintenance Choice Program

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

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

Maintenance Choice Program Transition Period

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

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

1. Switch to a 90-day supply and fill your order through CVS or Costco Pharmacies. Have your 90-day prescription transferred to a CVS or Costco location.
 - You will need to ask your doctor for a 90-day prescription for your maintenance medicines if you refill every 30 days. Your doctor may require you to schedule a visit before he or she will write a prescription.
 - Switch to a 90-day supply of maintenance drugs at CVS Caremark mail-order pharmacy, CVS Pharmacy retail location, including CVS Pharmacies located inside Target stores, as well as Costco Locations.
 - Need help? Contact Aetna Pharmacy Management to access the Aetna Rx Courtesy StartSM program. A representative will contact your doctor to attempt to help you get the prescription. Please allow up to seven days for the process to work. To help this process move quickly, please let your doctor know to expect a call from Aetna.

2. Opt out of the program and fill your maintenance drugs with a 30-day supply at CVS, Costco, or other network pharmacies.
 - You must call Aetna Pharmacy Management at 1-888-RX AETNA (1-888-792-3862) or TDD: 1-800-823-6373 and opt out of the Maintenance Choice Program. You can call Monday-Friday, 8:00 a.m.-6:00 p.m. to opt out (even from the pharmacy) and an override will be placed immediately.
 - With the override, you can continue to fill 30-day prescription(s) of maintenance medicine(s) at any pharmacy in the Aetna network. The override will include all maintenance medicines you are taking for the remainder of the calendar year.
3. Pay the full cost of your prescriptions, if you do nothing.
 - If you do not choose one of the first two options before the transitional period has ended, your claim will be rejected, and you will pay the full cost of the prescription (not just the copays!)

SAVE ON MAINTENANCE MEDICATIONS!



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





AETNA MEDICAL PLANS

AETNA RESOURCES

How to Save with the Maintenance Choice Program

CVS or Costco Pharmacy retail location near you

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

CVS Caremark mail-order pharmacy

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



MAINTENANCE CHOICE PROGRAM FREQUENTLY ASKED QUESTIONS (FAQ) AVAILABLE ON DISTRICT WEBSITE

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



Scan here or visit
pcsb.org/Pharmacy!





AETNA MEDICAL PLANS

AETNA RESOURCES

Aetna Specialty Pharmacy®

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

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

Compound Medications

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

Rx Cost Savings Tips

Pay less when you use generic and lower-cost brand-name medications. Be sure to take a copy of the Aetna drug list to your doctor and request a lower-cost alternative whenever possible.

- Take advantage of free and low-cost options at retail and grocery store pharmacies, including those offered by the preferred pharmacies.
- Consider an over-the-counter (OTC) alternative, available for many common conditions.





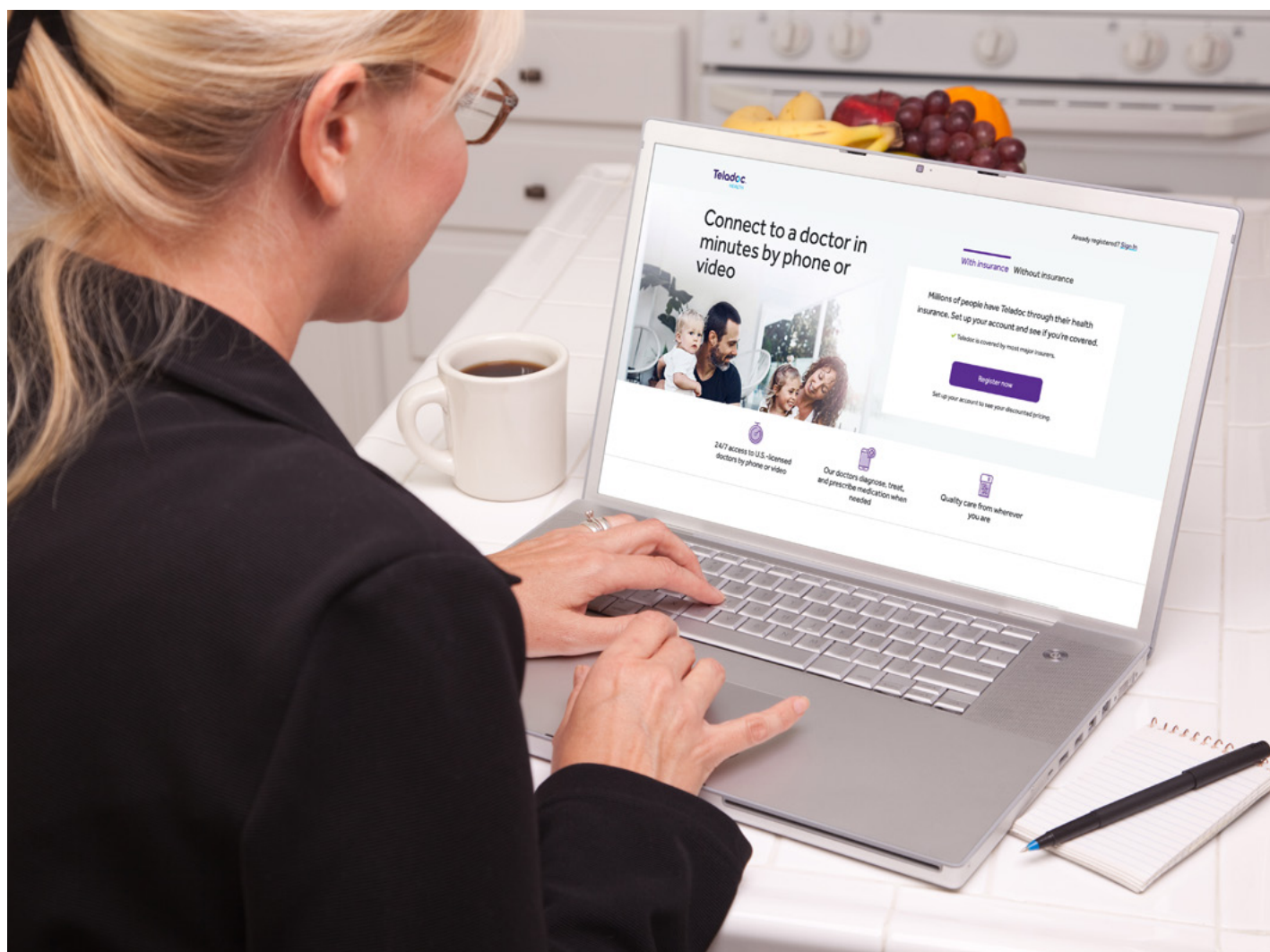
AETNA MEDICAL PLANS

AETNA RESOURCES

Teladoc

Teladoc provides access 24 hours, 7 days a week to a U.S. board-certified doctor by phone, video, or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away. Aetna members also have access to Teladoc Behavioral Health. Employees and eligible dependents (age 18 or older) may have appointments with psychiatrists, psychologists, and licensed therapists by video.

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





AETNA MEDICAL PLANS

AETNA RESOURCES

Healthcare Bluebook: Compare, Choose, Save

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

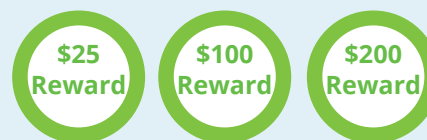
Go Green to Get Green

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

Start Saving Now

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

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



Go Green to Get Green

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

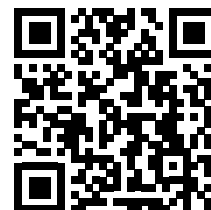
HEALTHCARE BLUEBOOK TOP ELIGIBLE SERVICES

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



Scan to download
the mobile
app and get
started today!

Mobile code: PCSB



QUESTIONS?

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

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





AETNA MEDICAL PLANS

COMPARISON CHART

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 supercede.

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

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

Understanding How Much You Have to Pay

- **Health Reimbursement Account (HRA) (CDHP only).** Use your HRA to pay your deductible, coinsurance, and Rx copays, reducing your out-of-pocket costs. The amount deposited in your HRA is prorated based on your benefits effective date. See page 28-29 in the 2024 BENEFlex Guide. Note the IRS requires that 100% of disbursements made from your HRA be substantiated or verified. See page 29 in the 2024 BENEFlex Guide for the HRA rollover maximum, effective January 1, 2024.
- **Medical Plan Deductible** (Choice POS II, CDHP + HRA and Basic Essential). The amount you pay for medical expenses before the plan begins paying benefits.
- **Coinsurance** (Choice POS II, CDHP + HRA and Basic Essential). The percentage of eligible medical expenses you pay after paying the deductible for most services.
- **Copays** The fixed amount you pay for medical care and prescriptions.
- **Aetna Prescription Drug Program** (all plans). You pay copays for generic and preferred brand drugs. For non-preferred brand and specialty drugs, you pay the Rx deductible before you pay copays. In the Basic Essential plan, the deductible does not apply to the non-preferred brand drugs.

Benefit	Aetna Concierge (Group #109718) Customer Service 866-253-0599		Select Open Access		Choice POS II		CDHP + HRA	Basic Essential
	In-Network Only		In-Network Only		Out-of-Network ¹		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)		Any provider		Any provider in the Aetna Select Open Access national network	Any provider in the Aetna Select Open Access national network
Health Reimbursement Account (HRA)—Individual/Family HRA funds can only be used for medical plan and prescription drug expenses.	N/A		N/A		N/A		\$500 Individual; \$750 Employee + Child(ren) or Employee + Spouse; \$1,000 Family. HRA contributions are prorated based on your date of hire.	N/A
Deductibles—Individual/Family	N/A		\$500 Individual; \$1,000 Family (combined in- and out-of-network)		\$1,500 Individual; \$3,000 Family		\$2,300 Individual; \$6,900 Family	
Medical Out-of-Pocket Maximum—Includes medical deductible, coinsurance, and/or copays	\$5,000 Individual; \$10,000 Family		\$5,000 Individual; \$10,000 Family (combined in- and out-of-network)		\$5,000 Individual; \$10,000 Family		\$8,550 Individual; \$17,100 Family	
Rx Out-of-Pocket Maximum—Includes Rx copays and deductible	\$2,000 Individual; \$4,000 Family		\$2,000 Individual; \$4,000 Family (combined in- and out-of-network)		\$2,000 Individual; \$4,000 Family		Combined with medical	
Lifetime Maximum	Unlimited		Unlimited		Unlimited		Unlimited	
Physician Office Visits	You Pay:		You Pay:		You Pay:		You Pay:	You Pay:
Primary Care Physician (PCP)	\$35 copay		20% after deductible		40% after deductible		20% after deductible	\$50 copay
Specialist (SPC)	\$60 copay		20% after deductible		40% after deductible		20% after deductible	30% after deductible
Teladoc: Doctor	\$25 copay		\$25 copay		N/A		\$25 copay	\$40 copay
Teladoc: Behavioral Health	\$25 copay / \$60 Specialist		20% after deductible		N/A		20% after deductible	0% no deductible
Preventive Adult Physical Exams	No copay		0%		40% after deductible		0% no deductible	0% no deductible
Preventive GYN Care (including Pap test) (direct access to participating providers)	No copay		0%		40% after deductible		0% no deductible	0% no deductible
Mammography Preventive Screening	No copay		0%		40% after deductible		0% no deductible	0% no deductible
Immunizations	No copay		0%		40% after deductible		0% no deductible	0% no deductible
Allergy Injections	Copay waived for allergy injections billed separately		20% after deductible		40% after deductible		20% after deductible	30% after deductible
Allergy Tests	\$50 copay		20% after deductible		40% after deductible		20% after deductible	30% after deductible
Lab	\$25 copay		20% after deductible		40% after deductible		20% after deductible	30% after deductible
X-Ray Outpatient	\$50 copay		20% after deductible		40% after deductible		20% after deductible	30% after deductible
Advanced Outpatient Radiology Services (MRI, CAT scan, PET scan, etc.)	\$250 copay		20% after deductible		40% after deductible		20% after deductible	30% after deductible
Colonoscopy Screenings—Preventive and Diagnostic	No copay		0%		40% after deductible		0% no deductible	0% no deductible
Chiropractic Services (limits apply) (direct access to participating providers)	\$60 copay 20 visits per calendar year		20 visits per calendar year combined in- or out-of-network		20% after deductible 20 visits per calendar year		20% after deductible	30% after deductible 20 visits per calendar year
Hearing Exam	\$25 copay		20% after deductible		40% after deductible		20% after deductible	30% after deductible



AETNA MEDICAL PLANS

COMPARISON CHART

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 supercede.

*Some drugs may be subject to step-therapy or precertification.
**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.

Please note: The dollar amounts are copays, 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.

Diabetes CARE |

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

Important Rx Information

Maintenance Choice Program

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

Rx Deductible May Apply

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

Benefit	Aetna Concierge (Group #109718) Customer Service 866-253-0599	Select Open Access	Choice POS II		CDHP + HRA	Basic Essential
		In-Network Only	In-Network	Out-of-Network ¹	In-Network Only	In-Network Only
Hospital						
Inpatient (Includes maternity and newborn services)		\$500 copay per day; up to 5-day maximum	\$500 copay per day; up to 5-day maximum	40% after deductible	20% after deductible	30% after deductible
Outpatient Surgery (including facility charges)		\$500 copay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Emergency Room Services		\$500 copay	20% after deductible	20% after deductible	20% after deductible	30% after deductible
Ambulance		No copay	20% after deductible	20% after deductible	20% after deductible	30% after deductible
Urgent Care Facility		\$60 copay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Maternity Care/OB Visits		\$50 copay for initial visit only	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Mental Health Services						
Outpatient Mental Health Services		\$25 copay	20% after deductible	40% after deductible	20% after deductible	0% no deductible
Inpatient Mental Health Services		\$500 copay per day; up to 5-day maximum	\$500 copay per day after deductible; up to 5-day maximum	40% after deductible	20% after deductible	30% after deductible
Miscellaneous						
Home Health Care (limits apply)		\$25 copay	20% after deductible	40% after deductible	20% after deductible; 120-visit limit per calendar year	30% after deductible; 120-visit limit per calendar year
Hospice—Inpatient (limits apply)		\$500 copay per day; up to 5-day maximum ²	\$500 copay per day after deductible; up to 5-day maximum ²	40% after deductible; 30-day lifetime maximum	20% after deductible	30% after deductible
Skilled Nursing Facility (limits apply)		\$500 copay per day; up to 5-day maximum ² up to 120-visit limit per calendar year	\$500 copay per day after deductible; up to 5-day maximum ² 120-visit limit per calendar year	40% after deductible	20% after deductible up to 120-visit limit per calendar year	30% after deductible up to 120-visit limit per calendar year
Short-Term Rehabilitation/Outpatient Therapy (speech, physical, occupational)		\$25 copay 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	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	See prescription drugs below	See prescription drugs below	See prescription drugs below	N/A
Durable Medical Equipment (DME)		\$50 copay	20% after deductible	40% after deductible	20% after deductible	30% after deductible
Aetna Prescription Drug Program*		Mandatory Generics Unless Dispensed As Written	Mandatory Generics Unless Dispense As Written		Mandatory Generics Unless Dispense As Written	Mandatory Generics Unless Dispense As Written
Up to 30-day supply:	Generic Preferred Brand Non-Preferred Brand Specialty—PrudentRx**	\$15 copay, no Rx deductible \$60 copay, no Rx deductible \$90 copay, after Rx deductible 30% coinsurance, \$0 if enrolled	\$15 copay, no Rx deductible \$60 copay, no Rx deductible \$90 copay, after Rx deductible 30% coinsurance, \$0 if enrolled	NOT COVERED	\$15 copay, no Rx deductible \$60 copay, no Rx deductible \$90 copay, after Rx deductible 30% coinsurance, \$0 if enrolled	\$25 copay, no Rx deductible \$60 copay, no Rx deductible \$90 copay, no Rx deductible 30% coinsurance, \$0 if enrolled
90-day Supply (maintenance medica-tions) at CVS and Costco or mail order (mail order must be through CVS Caremark mail order delivery.)		Mandatory Generics Unless Dispensed As Written	Mandatory Generics Unless Dispense As Written		Mandatory Generics Unless Dispense As Written	Mandatory Generics Unless Dispense As Written
Preferred Brand Non-Preferred Brand Specialty—PrudentRx*		\$30 copay, no Rx deductible \$120 copay, no Rx deductible \$180 copay, after Rx deductible N/A	\$30 copay; no Rx deductible \$120 copay; no Rx deductible \$180 copay; after Rx deductible N/A	NOT COVERED	\$30 copay, no Rx deductible \$120 copay, no Rx deductible \$180 copay, after Rx deductible N/A	\$50 copay, no Rx deductible \$120 copay, no Rx deductible \$180 copay, no Rx deductible N/A



AETNA MEDICAL PLANS

TOOLS & RESOURCES TO MAXIMIZE YOUR COVERAGE

Aetna Maternity Program

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

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

Start with Your Secure Member Website

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

Download the Aetna Mobile App

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

TO YOUR BENEFIT— AETNA'S DIGITAL PROGRAMS AND RESOURCES

Log in to your secure member website to access:

Personal health record.

Organize and store your health history and information so you can share it with your doctor.

Health assessment.

Get a step-by-step plan for better health.

Health decision support.

Learn about your health care and treatment options.

Online programs.

Find health coaching programs that offer personalized support.

Personal health database.

View hundreds of on-demand videos for health and wellness programs and resources.





AETNA MEDICAL PLANS

TOOLS & RESOURCES TO MAXIMIZE YOUR COVERAGE

CALL CONCIERGE MEMBER SERVICES—866-253-0599

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

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

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

Need Help Planning for Health Care Expenses?

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

WE'VE ALL BEEN THERE—NEEDING HELP WITH OUR HEALTH PLAN AND NOT KNOWING WHERE TO TURN.

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

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

Estimate Costs

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





AETNA MEDICAL PLANS

TOOLS & RESOURCES TO MAXIMIZE YOUR COVERAGE

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

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

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

Aetna One Choice Program

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

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

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

Member Discounts

Once you're an Aetna member, just log in to your secure member website at www.aetnapcsb.com, and select "Aetna Member Website" at the top of the page. It's the place to take care of your benefits. Your place to save, too. You can:

- Find a vision, hearing, or natural therapy professional
- Sign up for a weight-loss program
- Buy health products
- Find a gym
- And more

Savings on Hearing Aids and Exams

Hearing Care Solutions

- Discounts on a large choice of hearing aids
- A nationwide network of hearing care providers to choose from
- A 60-day trial period with a money-back guarantee
- Ongoing care, 1 year of free follow-up visits, a 3-year warranty and 2 years of free batteries

Amplifion Hearing Health Care

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

AMPLIFION HEARING HEALTH CARE WEBSITE:

www.hearingcaresolutions.com





AETNA MEDICAL PLANS

WHAT IS NOT COVERED

The following services and items is a list of the general exclusions under your medical plans. This is not a comprehensive list; a full list of plan exclusions is available in your plan documents.

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





METLIFE HOSPITAL INDEMNITY PLAN (HIP)

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

Plan Highlights

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

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

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

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

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

Enrolling in the MetLife HIP

When you enroll as a new employee, you and your eligible family members are guaranteed acceptance¹. You also have the benefits of competitive group rates and convenient payroll deductions that ensure continuous, worry-free coverage.

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

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

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

INCOME TAX CONSIDERATIONS FOR HIP

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





EMPLOYEE ASSISTANCE PROGRAM (EAP)

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

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

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

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

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

Identity Theft Services

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

MindCheck

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

Discount Center

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

Fitness Discounts

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

EAP FAQs

How do I access the EAP?

Call Resources for Living at 800-848-9392 and a client services team member will make every effort to address your needs and match you with an EAP counselor located near your home or work. All counselors are licensed, seasoned professionals with broad expertise. Counselors are available 24 hours a day.

How does the EAP work?

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

What is the cost?

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

Will I be required to use the EAP?

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

Who will know that I have used the EAP?

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

TO ACCESS EAP SERVICES:
1-800-848-9392

resourcesforliving.com
Username: pcsb
Password: eap





EMPLOYEE ASSISTANCE PROGRAM (EAP)

Aetna Behavioral Health Plan Benefit

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

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

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

Drug- and Alcohol-Free Workplace

Pinellas County Schools is committed to maintaining a drug- and alcohol-free workplace.

Employees are prohibited from manufacturing, distributing, dispensing, possessing, being under the influence of, or using alcohol or a controlled substance in the workplace, during the workday, on duty, or in the presence of students' families as part of any school or work-related activities.

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

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

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

Keep in mind:

- The EAP is available to all full- and part-time employees and members of their households
- Mental health and substance abuse benefits are available to all employees and their dependents enrolled in any of the BENEFlex medical plans

Employee Assistance Plan (EAP)

800-848-9392

Prevention Office (formerly Safe and Drug Free Schools)

727-588-6130

Risk Management and Insurance Department

727-588-6195

Office of Professional Standards

727-588-6471 or 727-588-6470

Human Resources

727-588-6000 ext.1936





THE BE SMART WELLNESS PROGRAM

Wellness programs change lives.

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

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

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

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

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

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



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

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

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

Limeade — Participate to earn points & incentives throughout the year by creating new healthy habits. Visit page 49 and 51 to learn more.

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





THE BE SMART WELLNESS PROGRAM

limeade

Limeade is an app and web-based for Pinellas County School employees enrolled in the health plan and their dependent spouses!

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

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

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

PHYSICAL	EMOTIONAL	FINANCIAL
Completing your annual wellness preventative exam and tests.	Finding new approached to decrease stress.	Learning about building and committing to a budget.
Syncing your fitness device to track steps.	Learning techniques to help build and maintain relationships.	Contributing to your retirement plan.

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

- Amazon
- Walmart
- Target
- Starbucks
- And more!

MORE INFORMATION?
Visit www.pcsb.org/limeade

QUESTIONS?
Call the Limeade Customer Support Team at 866-762-6293.

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





THE BE SMART WELLNESS PROGRAM

Resources for Living®

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

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

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

To access EAP services, call 1-800-848-9392 or visit resourcesforliving.com (username: pcs, password: eap)



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

Visit pcs.org/eap for more information on how to use and access Talkspace.



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

Visit aetnapcsb.com for additional information.



CVS Health Hubs provide medical and behavioral health services on-site or telephonically. Check your HealthHUB to verify they have a therapist on staff. Cost is subject to Aetna Member's plan selection. Aetna members may also utilize their EAP benefit for behavioral health visits. Prior authorization from EAP is required.

Visit cvs.com/healthhub or contact the Aetna Concierge Customer Service at 866-253-0599 for additional information.



Teladoc is Aetna's telemedicine provider for both medical and behavioral health benefits. Teladoc provides access 24 hours a day, 7 days a week to a U.S. board-certified doctor by phone, video, or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away. Aetna members also have access to Teladoc Behavioral Health. Employees and eligible dependents (age 18 or older) may have appointments with psychiatrists, psychologists, and licensed therapists by video

Visit www.teladoc.com/aetna and click "set up account" or, download the mobile app available in your phone's app store, or call 855-835-2362 for additional information.





THE BE SMART WELLNESS PROGRAM

- **Telephonic or Online Health Coaching**
Work with a health coach to help you set goals and explore ways to increase activity, improve eating habits, reduce stress, improve back care, or stop smoking. Free to you and anyone on your health plan.
- **Aetna One Choice Program:**
877-243-2752
- **Aetna On-site Health & Wellness Advocate**
Speak to an Aetna on-site representative at 727-588-6134 about ongoing wellness programs:
 - Incentive Program
 - Free Diabetic Supplies
 - Quit Tobacco Resources
- **Corporate Fitness & Weight Loss Discounts**
Discounts available to any PCS employee.

For More Information visit www.pcsb.org/wellness

Contact	Phone	Email
Employee Wellness Coordinator, Caleigh Hill	727-588-6031	hillca@pcsb.org
Employee Assistance Program (Resources for Living) On-site Representative, Darlene Rivers	727-588-6507	pcs.riversd@pcsb.org
Aetna Wellness Specialist, Jessica O'Connell	727-588-6134	pcs.oconnellj@pcsb.org
PCS Benefits Team	727-588-6197	





DENTAL PLANS

HUMANADENTAL ADVANTAGE PLUS 2S PLAN

Plan Highlights

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

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

Dependent Eligibility

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

Please see pages 10–11 for comprehensive eligibility information.



Frequently Asked Questions

How do I make an appointment?

Call the participating provider you chose on or after the date you enroll in coverage.

How do I pay for services?

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

How many times a year can I visit a dentist?

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

Must I choose a primary provider?

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

What if I need a specialty dentist?

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

Does coverage include corrective braces?

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

Is there any maximum coverage limitation?

There are no limitations on benefits.

How can I get more information?

You can contact Member Services at 800-979-4760, Monday through Friday, 8:00 a.m. – 6:00 p.m. Member Services can provide you with plan information or help you obtain emergency services. You can also access information online at [MyHumana.com](https://www.mychumana.com)





DENTAL PLANS

HUMANADENTAL ADVANTAGE PLUS 2S PLAN

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

Office visit copay

☐ \$0/\$0

Annual maximum

☐ No annual maximum

Summary of services

Preventive		Member pays			
D0120 ^a	Periodic oral examination.....	no charge	D1515	Space maintainer—fixed, bilateral (limited to child <14)	no charge
D0140 ^a	Limited oral evaluation—problem focused ...	no charge	D1520	Space maintainer—removable, unilateral (limited to child <14)	no charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver (limit 1 every 12 months)	no charge	D1525	Space maintainer—removable, bilateral (limited to child <14)	no charge
D0150	Comprehensive oral evaluation—new/established patient (limit 1 every 24 months) .	no charge	D1550	Re-cement or re-bond space maintainer	no charge
D0160	Limited/comprehensive/detailed and extensive oral eval (limit 1 every 12 months) .	no charge	D2140	Amalgam—one surface primary or permanent. .	no charge
D0170	Re-evaluation—limited problem focused (limit 1 every 12 months)	no charge	D2150	Amalgam—two surfaces primary or permanent	no charge
D0180	Comprehensive periodontal eval—new/established patient (limit 1 every 24 months) .	no charge	D2160	Amalgam—three surfaces primary or permanent	no charge
D0210	X-ray intraoral—complete series (limit 1 every 3 years)	no charge	D2161	Amalgam—four/more surfaces primary/permanent	no charge
D0220	X-ray intraoral—periapical, first radiographic image (limit 9 every 12 months includes D0230)	no charge	D2330	Resin based composite—one surface, anterior .	no charge
D0230	X-ray intraoral—periapical, each additional radiographic image (limit 9 every 12 months includes D0220)	no charge	D2331	Resin based composite—two surfaces, anterior .	no charge
D0240	X-ray intraoral—occlusal radiographic image	no charge	D2332	Resin based composite—three surfaces, anterior	no charge
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	no charge	D2335	Resin based composite —four or more surfaces, involving incisal angle.....	no charge
D0270 ^a	Bitewing—single radiographic image	no charge	D2390	Resin based composite—crown anterior	no charge
D0272 ^a	Bitewings—two radiographic images	no charge	D2391	Resin based composite—one surface, posterior .	no charge
D0273 ^a	Bitewings—three radiographic images.....	no charge	D2392	Resin based composite—two surfaces, posterior	no charge
D0274 ^a	Bitewings—four radiographic images.....	no charge	D2393	Resin based composite—three surfaces, posterior	no charge
D0277 ^a	Vertical bitewings—7 to 8 radiographic images.	no charge	D2394	Resin based composite—four or more surfaces, posterior	no charge
D0330	Panoramic radiographic image (limit 1 every 3 years)	no charge	D4341	Periodontal scaling and root planing—per quadrant, four or more teeth (limit 1 per quad every 12 months)	no charge
D0470	Diagnostic casts.....	no charge	D4342	Periodontal scaling and root planing—per quadrant, 1-3 teeth (limit 1 per quad every 12 months).....	no charge
D1110 ^a	Prophylaxis—adult (inclusive of D4910)	no charge	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis (limit 1 every 5 years).....	no charge
D1120 ^a	Prophylaxis—child (inclusive of D4910)	no charge	D4910	Periodontal maintenance (limit 1 every 6 months, inclusive of D1110 and D1120)	no charge
D1206 ^a	Topical application of fluoride varnish (for child <16)	no charge	D7111	Extraction coronal remnants deciduous tooth.	no charge
D1208 ^a	Topical application of fluoride – excluding varnish (for child <16)	no charge	D7140	Extraction erupted tooth or exposed root . . .	no charge
D1351	Sealant—per tooth (limit 1 per tooth every 12 months for child <14) .	no charge			
Basic		Member pays	Major		Member pays
D1510	Space maintainer—fixed, unilateral (limited to child <14)	no charge	D2510 ^b	Inlay—metallic, one surface.....	\$313.00
			D2520 ^b	Inlay—metallic, two surfaces.....	\$355.00
			D2530 ^b	Inlay—metallic, three or more surfaces	\$410.00





DENTAL PLANS

HUMANADENTAL ADVANTAGE PLUS 2S PLAN

D2542 ^b	Onlay—metallic, two surfaces	\$402.00	D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	\$680.00
D2543 ^b	Onlay—metallic, three surfaces.	\$420.00	D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	\$354.00
D2544 ^b	Onlay—metallic, four or more surfaces.	\$437.00	D5110 ^d	Complete denture—maxillary	\$498.00
D2610 ^b	Inlay—porcelain/ceramic, one surface	\$368.00	D5120 ^d	Complete denture—mandibular	\$642.00
D2620 ^b	Inlay—porcelain/ceramic, two surfaces	\$389.00	D5130 ^d	Immediate denture—maxillary	\$700.00
D2630 ^b	Inlay—porcelain/ceramic, three or more surfaces	\$414.00	D5140 ^d	Immediate denture—mandibular	\$700.00
D2642 ^b	Onlay—porcelain/ceramic, two surfaces	\$403.00	D5211 ^d	Maxillary partial denture—resin base	\$542.00
D2643 ^b	Onlay—porcelain/ceramic, three surfaces.	\$434.00	D5212 ^d	Mandibular partial denture—resin base	\$629.00
D2644 ^b	Onlay—porcelain/ceramic, four or more surfaces.	\$461.00	D5213 ^d	Maxillary partial denture—cast metal—resin base	\$709.00
D2650 ^b	Inlay—resin based composite, one surface.	\$242.00	D5214 ^d	Mandibular partial denture—cast metal—resin base	\$709.00
D2651 ^b	Inlay—resin based composite, two surfaces	\$288.00	D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$700.00
D2652 ^b	Inlay—resin based composite, three or more surfaces	\$303.00	D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$700.00
D2662 ^b	Onlay—resin based composite, two surfaces.	\$263.00	D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$700.00
D2663 ^b	Onlay—resin based composite, three surfaces	\$310.00	D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$700.00
D2664 ^b	Onlay—resin based ccomposite, four or more surfaces	\$332.00	D5410 ^c	Adjust complete denture—maxillary.	\$ 35.00
D2710 ^b	Crown—resin based composite, indirect	\$187.00	D5411 ^c	Adjust complete denture—mandibular	\$ 35.00
D2720 ^b	Crown—resin with high noble metal	\$461.00	D5421 ^c	Adjust partial denture—maxillary.	\$ 35.00
D2721 ^b	Crown—resin with predominantly base metal.	\$432.00	D5422 ^c	Adjust partial denture—mandibular	\$ 35.00
D2722 ^b	Crown—resin with noble metal	\$441.00	D5510	Repair broken complete denture base	\$ 70.00
D2740 ^b	Crown—porcelain/ceramic substrate	\$411.00	D5520	Replace missing/broken teeth—complete denture	\$ 59.00
D2750	Crown—porcelain fused to high noble metal	\$405.00	D5610	Repair resin denture base.	\$ 76.00
D2751 ^b	Crown—porcelain fused predom base metal	\$434.00	D5620	Repair cast framework.	\$ 82.00
D2752 ^b	Crown—porcelain fused to noble metal.	\$445.00	D5630	Repair or replace broken clasp—per tooth.	\$100.00
D2790 ^b	Crown—full cast high noble metal	\$450.00	D5640	Replace broken teeth—per tooth	\$ 64.00
D2791 ^b	Crown—full cast predom base metal.	\$426.00	D5650	Add tooth to existing partial denture.	\$ 88.00
D2792 ^b	Crown—full cast noble metal	\$434.00	D5660	Add clasp to existing partial denture—per tooth	\$105.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$ 41.00	D5710 ^e	Rebase complete maxillary denture.	\$261.00
D2920	Re-cement or re-bond crown	\$ 36.00	D5711 ^e	Rebase complete mandibular denture	\$249.00
D2929	Crown—prefabricated porcelain/ceramic crown - primary tooth	\$115.00	D5720 ^e	Rebase maxillary partial denture.	\$246.00
D2930	Crown—prefabricated stainless steel, primary tooth	\$115.00	D5721 ^e	Rebase mandibular partial denture	\$246.00
D2931	Crown—prefabricated stainless steel, permanent tooth	\$131.00	D5730 ^e	Reline complete maxillary denture.	\$147.00
D2932	Crown—prefabricated resin.	\$142.00	D5731 ^e	Reline complete mandibular denture	\$147.00
D2940	Sedative filling	\$ 44.00	D5740 ^e	Reline maxillary partial denture	\$135.00
D2950	Core buildup including any pins	\$ 94.00	D5741 ^e	Reline mandibular partial denture	\$135.00
D2951	Pin retention—per tooth addition restoration.	\$ 23.00	D5750 ^e	Reline complete maxillary denture.	\$196.00
D2952	Cast post and core in addition to crown	\$168.00	D5751 ^e	Reline complete mandibular denture	\$196.00
D2954	Prefabricated post and core in addition to crown	\$139.00	D5760 ^e	Reline maxillary partial denture	\$193.00
D3220	Therapeutic pulpotomy.	\$ 75.00	D5761 ^e	Reline mandibular partial denture	\$193.00
D3310	Root canal therapy—anterior.	\$315.00	D5850	Tissue conditioning maxillary.	\$ 61.00
D3320	Root canal therapy—bicuspid.	\$385.00	D5851	Tissue conditioning mandibular.	\$ 61.00
D3330	Root canal therapy—molar	\$428.00	D6092	Recement implant/abutment supported crown	\$ 42.00
D3346	Previous root canal therapy—anterior.	\$424.00	D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	\$ 57.00
D3347	Previous root canal therapy—bicuspid	\$500.00	D6210	Pontic—cast high noble metal.	\$378.00
D3348	Previous root canal therapy—molar	\$601.00	D6211 ^f	Pontic—cast predominantly base metal	\$404.00
D3410	Apicoectomy/periradicular surgery—anterior	\$361.00	D6212 ^f	Pontic—cast noble metal.	\$420.00
D3421	Apicoectomy/periradicular surgery—bicuspid	\$394.00	D6240 ^f	Pontic—porcelain fused to high noble metal	\$426.00
D3425	Apicoectomy/periradicular surgery—molar	\$445.00			
D3426	Apicoectomy/periradicular surgery—each addtl root	\$148.00			
D3430	Retrograde filling—per root.	\$109.00			
D4210 ^c	Gingivectomy/gingivoplasty—four or more teeth, quad	\$278.00			
D4211 ^c	Gingivectomy/gingivoplasty—1 to 3 teeth, quad	\$153.00			
D4240 ^c	Gingival flap proc—four or more teeth,quad.	\$421.00			
D4241 ^c	Gingival flap proc—1 to 3 teeth,quad	\$217.00			
D4249	Clinical crown lengthening – hard tissue.	\$481.00			





DENTAL PLANS

HUMANADENTAL ADVANTAGE PLUS 2S PLAN

D6241 ^f	Pontic—porceln fused predom base metal ...	\$393.00
D6242 ^f	Pontic—porcelain fused to noble metal	\$415.00
D6250 ^f	Pontic—resin with high noble metal	\$420.00
D6251 ^f	Pontic—resin with predominantly base metal .	\$388.00
D6252 ^f	Pontic—resin with noble metal	\$400.00
D6600 ^f	Retainer inlay—porcelain/ceramic, two surfaces	\$355.00
D6601 ^f	Retainer inlay—porcelain/ceramic, three or more surfaces.....	\$373.00
D6602 ^f	Retainer inlay—cast high noble metal, two surfaces	\$380.00
D6603 ^f	Retainer inlay—cast high noble metal, three or more surfaces	\$418.00
D6604 ^f	Retainer inlay—cast predom base metal, two surfaces.....	\$372.00
D6605 ^f	Retainer inlay—cast predom base metal, three or more surfaces	\$394.00
D6606 ^f	Retainer inlay—cast noble metal, two surfaces	\$366.00
D6607 ^f	Retainer inlay—cast noble metal, three or more surfaces.....	\$406.00
D6608 ^f	Retainer onlay—porcelain/ceramic, two surfaces	\$386.00
D6609 ^f	Retainer onlay—porcelain/ceramic, three or more surfaces.....	\$403.00
D6610 ^f	Retainer onlay—cast high noble metal, two surfaces	\$409.00
D6611 ^f	Retainer onlay—cast high noble metal, three or more surfaces	\$448.00
D6612 ^f	Retainer onlay—cast predom base metal, two surfaces	\$407.00
D6613 ^f	Retainer onlay—cast predom base metal, three or more surfaces	\$426.00
D6614 ^f	Retainer onlay—cast noble metal, two surfaces	\$399.00
D6615 ^f	Retainer onlay—cast noble metal, three or more surfaces.....	\$414.00
D6720 ^f	Retainer crown—resin with high noble metal.	\$474.00
D6721 ^f	Retainer crown—resin with predom base metal.....	\$450.00
D6722 ^f	Retainer crown—resin with noble metal.....	\$458.00
D6740 ^f	Retainer crown—porcelain/ceramic.....	\$499.00
D6750 ^f	Retainer crown—porcelain fused to high noble metal.....	\$426.00
D6751 ^f	Retainer crown—porcelain fused to predom base metal	\$453.00
D6752 ^f	Retainer crown—porcelain fused to noble metal.....	\$464.00
D6780 ^f	Retainer crown—3/4 cast high noble metal ..	\$458.00
D6790 ^f	Retainer crown—full cast high noble metal. .	\$469.00
D6791 ^f	Retainer crown—full cast predom base metal	\$445.00
D6792 ^f	Retainer crown—full cast noble metal	\$461.00
D6930 ^f	Re-cement or re-bond fixed partial denture ..	\$ 57.00
D7210	Surgical removal—erupted tooth	\$ 91.00
D7220	Removal of impacted tooth—soft tissue	\$135.00

D7230	Removal of impacted tooth—partially bony .	\$179.00
D7240	Removal of impacted tooth—completely bony.	\$211.00
D7241	Remove impacted tooth—completely bony w/comp	\$265.00
D7250	Surgical removal of residual tooth roots	\$114.00
D7310	Alveoloplasty in conjunction w/extractions—per quad	\$125.00
D7311	Alveoloplasty in conjunction w/extractions—1-3 teeth.....	\$ 97.00
D7320	Alveoloplasty not conjunction w/extractions—per quad.....	\$181.00
D7321	Alveoloplasty not conjunction w/extractions—1-3 teeth	\$153.00
D7510	Incision and drainage of abscess—intraoral ..	\$120.00
D7520	Incision and drainage of abscess—extraoral .	\$570.00
D7960	Frenulectomy—separate procedure.....	\$111.00
D7970	Excision of hyperplastic tissue—per arch	\$272.00
D9110	Palliative treatment dental pain—minor procedure	\$ 45.00
D9215	Local anesthesia	no charge
D9310	Professional consultation by non-treating dentist	no charge
D9951	Occlusal adjustment—limited	\$ 58.00
D9952	Occlusal adjustment—complete	\$326.00

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





DENTAL PLANS

HUMANADENTAL ADVANTAGE PLUS 2S PLAN

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

HumanaDental

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

Member Services

800-979-4760

www.MyHumana.com

Go to Basic Links, then search
or click on "Provider Search"

Note:

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

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

MetLife® Preferred Dentist Program (PDP) #95682

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

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

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

In-Network or Out-of-Network

Basis of Reimbursement	Negotiated PDP fee*
Type A – Preventive	100%
Type B – Basic	80%
Type C – Major	50%
Type D – Orthodontia	50%
Individual Deductible (Annual)	\$50
Family Deductible (Annual)	\$150
Deductible Applies To	Basic and Major
Calendar Year Maximum	\$1,250 per person
Lifetime Orthodontia Maximum	\$1,000 per person

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

Allocation of Services: Primary Plans

Type A Preventive	Type B Basic	Type C Major	Type D Orthodontia
<ul style="list-style-type: none"> • Oral Exams • Full mouth X-Rays • Bitewing X-Rays • Prophylaxis/Cleaning • Fluoride Treatments • Sealants • Space Maintainers • Palliative Care 	<ul style="list-style-type: none"> • Periapicals and other X-Rays • Labs and other tests • Fillings • Pulp Capping/Pulpal Therapy • Periodontal Maintenance • General Anesthesia 	<ul style="list-style-type: none"> • Inlays/Onlays • Crowns • Endodontics/Root Canal • Periodontics • Rebases/Relines • Repairs • Dentures • Bridges • Simple Extractions • Surgical Extractions • Oral Surgery • Consultations • Implants 	<ul style="list-style-type: none"> • Child Only (up to age 19) • OrthodonticDiagnostics • Orthodontic Treatment





DENTAL PLANS

METLIFE® PREFERRED DENTIST PROGRAM (PDP)

Dependent Eligibility

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

Please see pages 9-10 for comprehensive eligibility information.

Plan Highlights:

- You may visit the dentist of your choice, no primary dentist selection requirement.
- There are no specialist referrals.

- Reduced out-of-pocket expenses on covered services and on services not covered by your benefit plan when you use a participating PDP dentist. (For example, if you or your covered dependent over age 19 visit a participating PDP orthodontist, the orthodontist will extend a negotiated fee for a full course of orthodontic treatment. Contact MetLife for the current rate.)
- Coverage provided for most preventive and routine services.
- Choice of over 100,000 participating PDP dentists who agree to accept our negotiated fees as payment in full.
- A \$1,000 maximum orthodontic benefit for dependent children under age 19.

An Example of Savings When You Visit a Participating PDP Dentist

Take a look, the example below shows how receiving services from a PDP dentist can save you money: Your dentist says you need a crown—a Type C service:

PDP Negotiated Fee: \$649.00		Dentist's Usual Fee: \$989.00	
Please note: This example assumes that your annual deductible has been met.			
In-Network		Out-of-Network	
When you receive care from a participating PDP dentist...		When you receive care from a non-participating dentist...	
Negotiated PDP Fee:	\$649.00	Dentist's Usual Fee:	\$989.00
Plan Pays: (50% of \$649.00 PDP Fee)	\$324.50	Plan Pays: (50% of \$649.00 PDP Fee)	\$324.50
Your Out-of-Pocket Cost:		Your Out-of-Pocket Cost:	
\$324.50		\$664.50	
In this example, you save \$340.00 (\$664.50–\$324.50) by using a participating PDP dentist.			

Limitations, Exclusions, and other Provisions by Type:

Type A (Preventive)

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

Type B (Basic)

- Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery such as osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such 12-month period.

Type C (Major)

- Adjustment of dentures (no earlier than six months after initial installation)
- Initial installation of fixed bridgework
- Initial installation of partial or full removable dentures
- Initial installation of crowns, inlays, and onlays (cast restorations): once every five years

- Dentures and bridgework replacement: 10 years
- Immediate denture replacement: 12 months
- Crown replacement: five years
- Periodontal surgery, including gingivectomy or gingivoplasty, gingival curettage, osseous surgery, bone replacement graft, and guided tissue regeneration once per quadrant every 36 months
- Root canal treatment is limited to once per tooth in a 24-month period
- Surgical Extractions including impactions/Oral Surgery

- Relines and rebases to dentures are limited to one per 24 months (no earlier than six months after initial installation)
- Consultations are limited to once in any six consecutive month period

Type D (Orthodontia) Child Only

- All dental procedures performed in connection with orthodontic treatment are payable as orthodontia
- Initial payment due upon installation of the orthodontic appliance; repetitive payments for the orthodontic adjustments will be made quarterly at the end of the quarter based on the Orthodontic Lifetime Maximum Benefits end at cancellation





DENTAL PLANS

METLIFE® PREFERRED DENTIST PROGRAM (PDP)

Frequently Asked Questions

What is a participating PDP dentist?

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

How do I find a participating PDP dentist?

There are over 100,000 participating PDP dentist locations nationwide, including over 22,000 specialist locations. You can get a list of these participating PDP dentists online at www.metlife.com/dental or call 800-942-0854 to have a list faxed or mailed to you.

What services are covered by the PDP?

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

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

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

May I choose a nonparticipating dentist?

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

NO METLIFE ID CARDS

MetLife does not issue ID cards.

The Group Number is G95682.

For more information, call MetLife Dental customer service at 800-942-0854 or go to metlife.com/dental.

Can my dentist apply for PDP participation?

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

How are claims processed?

The dentist may submit your claims for you, which helps to reduce your paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, you can find one online at www.metlife.com/dental or request one by calling 800-942-0854.





DENTAL PLANS

METLIFE® PREFERRED DENTIST PROGRAM (PDP)

FUN FACTS

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

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

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

Dental Exclusions

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





DENTAL PLANS

METLIFE® PREFERRED DENTIST PROGRAM (PDP)

Covered Benefits Limitations

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

Coordination of Benefits

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

Cancellation/Termination of Benefits

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





VISION PLAN

EYEMED ADVANTAGE PLAN (GROUP #9856857)

The Vision of Good Health

Periodic eye examinations are an important part of routine preventive health care. Because many eye and vision conditions have no obvious symptoms, employees may be unaware they have problems. Early detection and treatment is critical for maintaining good vision and preventing permanent vision loss. Eye exams can detect symptoms for diseases such as diabetes, hypertension, glaucoma, cataracts, and macular degeneration.

This is why Pinellas County Schools offers quality vision care for you and your family through the EyeMed Vision Care Plan.

Who Is Eligible?

All employees who meet the eligibility criteria listed on page 9 are eligible for vision coverage. During your initial enrollment period as a new employee, you can enroll in free employee-only vision coverage. You can enroll your eligible dependents and pay the additional cost for their coverage. Or, if you decline medical coverage and enroll yourself and your dependents in vision coverage, you can offset the cost of dependent vision coverage with Board credits.

Eligible dependents include your spouse and/or your eligible children through the end of the year in which they reach age 26. See pages 9-10 for more information about dependent coverage and eligibility.

How Does the Plan Work?

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

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

The vision benefits are detailed on the next page.

QUESTIONS?

Call EyeMed Vision Care Customer Service
866-299-1358

Monday – Saturday,
7:30 a.m. – 11:00 p.m. ET
Sunday, 11:00 a.m. – 8:00 p.m. ET

Or

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





VISION PLAN

EYEMED ADVANTAGE PLAN

EyeMed Vision Care Plan Benefits

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

When You Use Participating In-Network Providers

Basic Benefits

	Frequency (based on calendar year)
Vision Exam	Once per calendar year
Lenses or Contact Lenses	Once per calendar year
Frame	Every other calendar year
Benefit	In-Network Provider
Exam with Dilation As necessary	\$10 copay
Eyeglass Lenses Single Vision, Bifocal, or Trifocal Standard Progressive	\$15 copay \$50 copay
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

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

Contact Lenses

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

- Disposable
- Conventional
- Daily
- Replacement

Premium contact lens fit—More complex applications, including but not limited to toric (astigmatism .62D or higher), bifocal/multifocal, cosmetic color, postsurgical, and gas-permeable—does include extended/overnight wear for any prescription. Premium fit includes:

- Cosmetic color
- Toric
- Multifocal; includes monovision
- Continuous wear
- RGP (Rigid Glass Permeable) lens
- Post-surgical and gas-permeable

In-Network Discounts

EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the plan at in-network providers





VISION PLAN

EYEMED ADVANTAGE PLAN

Additional Plan Costs and Discounts

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

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

LASIK Benefits

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

When You Visit a Nonparticipating Provider

Eligible employees and their covered dependents may receive the following features and be reimbursed

Reimbursement Benefits

	Frequency (based on calendar year)
Vision Exam	Once per calendar year
Eyeglass or Contact Lenses	Once per calendar year
Frame	Every other calendar year
Benefit	Reimbursement
Exam with Dilation As necessary	Up to \$35
Eyeglass Lenses Single Vision	
Bifocal	Up to \$35
Trifocal	Up to \$40
	Up to \$55
Frames	Up to \$55
Contact Lenses	
Elective (conventional or disposable)	\$90
Medically Necessary	\$210

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.”

Nonparticipating provider
claims can be mailed to:

EyeMed Vision Care

P.O. Box 8504

Mason, OH 45040-7111





LIFE AND AD&D INSURANCE

INTRODUCTION

Life Insurance

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

Your BENEFlex life insurance program includes:

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

Pinellas County Schools provides Basic Employee Life insurance coverage—through Standard Insurance Company—of one times your annual base salary, rounded up to the next \$1,000, with minimum coverage of \$15,000. For example:

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

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

Life insurance coverage is issued by The Standard.

AD&D Insurance

Each year, more than 95,000 Americans lose their lives to accidents, the fourth leading cause of death in this country. For workers under age 38—when they are at their peak earning years for establishing a comfortable standard of living—accidents are the leading cause of death.

Even if you are extremely careful and safety-conscious—on the job, on the road, at home, or on vacation—you cannot always control the circumstances that could place you in danger of an accident. Furthermore, it is very difficult to evaluate in advance the extent to which an accident could affect your family's financial security.

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

Your AD&D insurance includes:

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

More Information...

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

AD&D insurance coverage is issued by The Standard.

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

For Life insurance:

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





LIFE AND AD&D INSURANCE

Life Insurance—Employee	
Covers	Employee
Amount of Coverage ¹	Basic Employee Term Life: One times your annual base salary, rounded up to the next \$1,000 with a minimum benefit of \$15,000 and maximum benefit of \$200,000 Optional Employee Term Life: \$10,000 minimum, up to \$200,000 in \$10,000 increments, or \$250,000 up to \$500,000 maximum in \$50,000 increments (guaranteed coverage available up to \$250,000, if you enroll within 31 days of becoming eligible)
Cost	Basic Employee Term Life: None Optional Employee Term Life: Age based, see the rate schedule on page 6, premiums are based on your age as of January 1
Actively at Work	Yes
Medical Evidence	Basic Employee Term Life: Health questions not required Optional Employee Term Life: Medical history questionnaire required; new hires may select up to \$250,000 with no questions during the initial new hire enrollment period only
Life Insurance—Dependents	
Optional Family Term Life	
Covers	Spouse and eligible children (see page 10 for eligibility requirements)
Amount of Coverage	\$5,000/dependent
Cost	See rate schedule on page 6
Board Contribution	You may not use
Actively at Work	Yes
Medical Evidence	Spouse: No health questions required Child(ren): No health questions required
Optional Dependent Term Life (Spouse and/or Child[ren])	
Covers	Spouse ² and/or child(ren)
Amount of Coverage	Spouse: \$10,000 increments up to the \$100,000 maximum.* Child(ren): \$2,000 increments up to the \$10,000 maximum
Cost	See rate schedule on page 6; premiums for spouse coverage are based on the individual's age as of January 1
Board Contribution	You may not use
Actively at Work	Yes
Medical Evidence	Spouse: Medical history questionnaire required on any amount over \$30,000 Child(ren): No health questions required
Beneficiaries must be listed on the Enrollment and Change form and may be changed at any time by submitting a new Enrollment and Change form online. ¹ Amounts of employer-provided insurance in excess of \$50,000 are subject to taxation under Section 79 of the Internal Revenue Code. The tax is based on the value of the coverage as determined by rates established in the Internal Revenue Code. ² Optional spouse coverage may be written without employee enrollment. * The total amount of spouse coverage cannot exceed the employee's total life insurance coverage (basic plus any optional employee life).	





LIFE AND AD&D INSURANCE

Accidental Death & Dismemberment Insurance	
Basic Employee AD&D	
Covers	Employee
Amount of Coverage ¹	\$2,000
Cost	None
Optional AD&D - Employee Only	
Covers	Employee
Amount of Coverage	\$50,000, \$100,000, \$200,000, or \$300,000
Cost	See rate schedule on page 6
Board Contribution	You may use
Optional AD&D - Employee and Family	
Covers	Employee and Family
Amount of Coverage	Employee: \$50,000, \$100,000, \$200,000, or \$300,000 Spouse only: 50% of employee's coverage Child(ren) only: 15% of employee's coverage Spouse and Child(ren): 40% and 10%, respectively, of employee's coverage
Cost	See rate schedule on page 6
Board Contribution	You may use





LIFE AND AD&D INSURANCE

LIFE INSURANCE—EMPLOYEE

Employee Term Life Insurance

Basic Employee Term Life

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

Optional Employee Term Life

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

Eligibility to Participate

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

Coverage Amounts

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

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

Reduction/Termination of Coverage

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

Accelerated Benefit Option

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

Premium Continuation

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

Guaranteed Coverage/Medical Evidence Requirements

(Optional Employee Term Life Only)

New Hires: Certain coverage is available without providing evidence of good health. If you enroll within 31 days of your date of eligibility, your guaranteed coverage amount is \$250,000. You must provide evidence of good health for coverage amounts greater than \$250,000.

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

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

Imputed Income

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

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

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

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





LIFE AND AD&D INSURANCE

LIFE INSURANCE—EMPLOYEE AND DEPENDENTS

Life Insurance for Your Dependents

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

Dependents are your legally married spouse (not separated or divorced) and eligible unmarried children beginning at live birth up to the end of the calendar year in which they reach age 26. Eligible children include your legally adopted children, stepchildren, and foster children who depend on you for support.

Handicapped dependents may continue to be covered under the life insurance plan if they are on the plan at age 26. Verification forms to verify eligibility can be found on the Annual Enrollment page at **www.pcsb.org/annual-enrollment**. If your spouse or dependent child is confined for medical care or treatment at home or elsewhere, coverage will begin when confinement ends.

If your spouse is an employee, or a Pinellas County Schools retiree, he/she cannot be covered as a dependent. Spouse coverage will terminate at age 70.

If your employment ends, your spouse and dependent children may receive similar Optional Dependent Term Life coverage under the portability provision. You must purchase portable group life insurance coverage for yourself in order to purchase any other insurance for your dependents. You will be advised of the cost of this coverage.

Optional Family Term Life

Eligibility to Participate

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

Coverage Amounts

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

Guaranteed Coverage/Medical Evidence Requirements

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

Optional Dependent Term Life (Spouse and/or Child)

Eligibility to Participate

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

Coverage Amounts

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

Guaranteed issue up to \$30,000 if you enroll within 31 days of becoming eligible.

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

Medical Evidence Requirements

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

Living Benefit Option

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

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

LIFE AND AD&D INSURANCE

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

Eligibility to Participate

Coverage Amounts

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

Spouse Only: 50% of your coverage amount.

Spouse and Children: 40% of your coverage amount for your spouse and 10% of your coverage amount for each child.

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



LIFE AND AD&D INSURANCE

AD&D INSURANCE

Standard Benefits

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

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

Seat Belt Benefit

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

Air Bag Benefit

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

Loss Due to Coma

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

Occupational Assault Benefit

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

Career Adjustment Benefit

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

Higher Education Benefit

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

Child Care Benefit

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





LIFE AND AD&D INSURANCE

AD&D INSURANCE

Disappearance

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

Exposure

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

Common Accident Benefit

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

Exclusions

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

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

Life Insurance Certificate of Coverage Insured by Standard Insurance Company

A Certificate of Coverage, which includes the entire plan provisions, exclusions, and limitations, is available on the Risk Management and Insurance Department website (www.pcsb.org/risk-benefits) or by contacting the Risk Management and Insurance Department directly.

Policy #755556

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

Contract series 83500.

IFS A108213 Ed. 8/05





DISABILITY INSURANCE PLANS

The Standard Educator Disability Plan

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

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

Monthly Benefit	Benefit Duration
Choose a preferred monthly benefit amount between \$400 and \$5,000 (to up to 66⅔% of your salary)	Choose a benefit duration: Two years OR up to the Social Security Normal Retirement Age (SSNRA)
Waiting Period	
Choose 14, 30, or 60 days until the plan starts paying benefits (14- and 30-day waiting periods are waived with hospital admission)	

Highlights

- Evidence of Insurability (EOI) is not required. You do not have to fill out a medical questionnaire to be approved.
- Pre-existing conditions will apply. Please refer to “Pre-existing Condition Exclusion” section in the sidebar.
- If a claim is submitted in the first 12 months of the policy effective date, a minimum benefit of \$400 will be paid for the first 90 days after the waiting period. A review will be conducted to determine if the claim is subject to pre-existing conditions. If the claim is determined to be a pre-existing condition, then benefits will stop after the 90-day payment. If not, and there is no pre-existing condition, then benefits will continue based on the disability amount you selected, and any retro payment owed by The Standard will also be paid.
- First Day Hospital Benefit on 14- and 30-day plans. If you have a claim for a hospital admission/ confinement, the 14- and 30-day waiting period will be waived.

- Lifetime Security Benefit. This only applies to the benefit duration of up to SSRNA. Your disability benefit (amount in effect when the claim closes) could continue beyond your Social Security normal retirement age if you are unable to perform two or more activities of daily living or are suffering from severe cognitive impairment.
- Disability coverage will end on the date your employment terminates.
- Please call The Standard at 800-628-8600 for more information.

Important Information About Disability Benefits

Preexisting Condition Limitation

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

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

Disability Benefits During Pregnancy

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





DISABILITY INSURANCE PLANS

Eligibility

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

Effective Date

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

Premium

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

Plan Benefits

A. Plan Maximum Monthly Benefit

The lesser of \$5,000 or 66⅔% of your predisability earnings.

B. Plan Minimum Monthly Benefit

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

C. Benefit Waiting Period

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

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

D. Plan Schedule of Benefits

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

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

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

E. Own Occupation Definition

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

E. Any Occupation Definition

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





DISABILITY INSURANCE PLANS

Integration — Deductible Income

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

During the First 24 Months of Disability:

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

After You Have Been Disabled for 24 months:

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

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

If any of these plans has two or more payment options, the option which comes closest to providing you a monthly income for life with no survivors benefit will be deductible income, even if you choose a different option.

- Any earnings or compensation included in predisability earnings which you receive or are eligible to receive while LTD benefits are payable.
- Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.
- Any amount you receive or are eligible to receive from or on behalf of a third party because of your disability, whether by judgement, settlement, or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as deductible income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees.
- Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.





DISABILITY INSURANCE PLANS

Additional Plan Features

24-Hour Coverage

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

Rehabilitation Plan

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

Reasonable Accommodation Expense

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

Survivors Benefit

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

Waiver of Premium

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

Life Time Security Benefit — SSNRA Plan Only

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

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

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





DISABILITY INSURANCE PLANS

Maximum Benefit Duration Period

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

Option 1: Two Years	
If you become disabled before age 66, disability benefits may continue during disability for two years. If you become disabled at age 66 or older, the benefit duration is determined by your age when disability begins:	
Age	Maximum Benefit Period
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Income Tax Consideration	
When you enroll in disability insurance, your payroll deductions are automatically deducted on a pre-tax basis, along with all of your other benefit deductions (except Optional Life Insurance). This means that any disability benefit you receive will be subject to federal income taxes, unless you elect to have your premiums deducted on an after-tax basis, in which case all your payroll deductions for all benefits will be taken on an after-tax basis.	

Option 2: SSNRA	
If you become disabled before age 62, disability benefits may continue during disability until age 65 or to the Social Security Normal Retirement Age (SSNRA) or three years and six months, whichever is longer. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:	
Age	Maximum Benefit Period
62	To SSNRA, or 3 years 6 months, whichever is longer
63	To SSNRA, or 3 years, whichever is longer
64	To SSNRA, or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year





DISABILITY INSURANCE PLANS

OTHER IMPORTANT INFORMATION

Other Important Information Exclusions

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

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

Preexisting Conditions

A preexisting condition is a mental or physical condition:

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

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

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

Limitations

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

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





DISABILITY INSURANCE PLANS

OTHER IMPORTANT INFORMATION

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

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

Mental or Emotional Disorder Defined

Disability benefits due to a mental or emotional disease or disorder of any kind will be limited to a period not to exceed two years.

Waiver of Premium

Under the Base Plan, if you are disabled and entitled to payment of benefits under the plan for three consecutive months, your premium, which becomes due during the remaining compensable period of disability, will be waived. Waiver of premium will cease on the earlier of (1) the date disability ceases, or (2) the date the maximum benefit period has expired.

When Benefits End

LTD benefits end automatically on the earliest of:

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

When Insurance End

Insurance ends automatically on the earliest of the following:

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

Group Insurance Certificate

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





VOLUNTARY BENEFITS

VOLUNTARY PRODUCTS

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

- MetLife Hospital Indemnity Plan (HIP)
- Farmers Insurance Auto & HomeTM
- MetLife Legal Plan
- MetLife My Pet Protection
- Horace Mann Auto Payroll Deduction Plan

Enrolling in MetLife Voluntary Plans



MetLife

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

MetLife Hospital Indemnity Plan (HIP)	Enroll as a new hire, during annual enrollment for the next plan year, or when you experience a qualified change in status.	New employee: Enroll using the PCS Enrollment and Change Form.
MetLife Legal Plan	Enroll as a new hire or during annual enrollment for the next plan year. For more information, go to info.legalplans.com and use the Access Code: PCS.	To enroll in any of the MetLife voluntary plans (except for MetLife HIP) call the toll-free number or visit the MetLife website. 800-GETMet8 (800-438-6388) To enroll in auto & home and legal plans, go to www.metlife.com/mybenefits
Farmers Insurance Auto & HomeTM	You may apply for coverage at any time. Visit www.myautohome.farmers.com for more information.	With the Farmers Insurance Auto & Home* program, you have access to quality auto and home insurance, as well as a full range of other personal insurance policies, including renters, condo, boat, and personal excess liability (also referred to as "umbrella" coverage). You can also save with our special discounts, including a group discount, and other money-saving discounts, if you pay your premium through automatic payroll deductions. The Farmers Auto & Home program also offers 24-hour claim reporting, extended customer service hours, and flexible payment options. The program is available to PCS employees and their dependents. <i>*Subject to underwriting approval. Some areas of Florida may not be eligible for home insurance.</i>





VOLUNTARY BENEFITS

VOLUNTARY PRODUCTS

MetLife Pet Insurance (Pet First)

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

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

Why Is Pet Insurance Important?

- A small monthly payment can help you prepare for unexpected vet expenses down the road.
- More than 6 in 10 pet owners said their pet has had an emergency medical expense.²
- 24% of pet parents have credit card or personal loan debt to cover pet health and vet costs.³
- The average annual cost for a routine vet visit is \$212 for a dog and \$160 for a cat; and the average annual cost for a surgical vet visit is \$426 for a dog and \$214 for a cat.⁴
- Pet insurance may not cover pre-existing conditions. You may contact MetLife at 1-800-GETMET8 for more information or to enroll. You may enroll at any time. Note that rates are only provided when you call to enroll in or renew your policy.

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

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

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

4 2019-2020 APPA National Pet Owners Survey.

MetLife Legal Plan

With MetLife Legal Plan, you'll have easy access to a nationwide network of participating attorneys who can provide you with a wide range of legal services—for a fraction of the regular cost.

No matter how many times you use a participating attorney over the course of the year for covered legal matters, all you pay is your monthly premium, no copayments and no deductibles. Just your legal plan premium, which can be conveniently deducted from your paycheck. Your spouse and dependent children also have access to the plan benefits.

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

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

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

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

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



Continued on next page





VOLUNTARY BENEFITS

VOLUNTARY PRODUCTS

Eligibility and Enrollment

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

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

Farmers Insurance Auto & Home™

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

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

Horace Mann Auto Payroll Deduction Plan

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

- 12-month policy terms and no bills to pay—your premiums are deducted from each paycheck.*
- Discounted coverage:
 - Payroll deduction discount.
 - Member discounts, including FACA, PASA, NEA.
 - Special educator rates.
- Educator Advantage® benefits and features at no additional cost.
- Customer service available 24/7, 365 days a year, and online claims service.
- Licensed agents available 24/7 at three local offices.

For more information call 727-474-8000 or 727-576-5555. Visit www.floridaeducatorsinsurance.com for a free quote.

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





RETIREMENT SAVINGS PROGRAM

PRE-TAX AND AFTER-TAX OPTIONS

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

How the Plans Work

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

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

After-Tax Roth 403(b) Plan

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

QUICKENROLL

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

www.myquickenroll.com

Maximum Allowable Contributions

You can participate in one, two, or all three of the plans. However, federal regulations limit the amount you can defer during a calendar year. These limits are determined by Maximum Allowable Contribution (MAC) calculations. The MAC is calculated on a calendar year basis from January 1 through December 31. The limit for 2023 is \$20,500. The 2024 limits were not available at the time this guide was printed. (If you turn age 50 or older during the year, you can contribute an additional \$6,500 for a total of \$27,000.) You are responsible for making sure that the amount deferred each year does not exceed IRS limits. MAC calculation estimates and retirement benefit handbooks are available online during the first quarter of each calendar year to help you determine the amount of your annual retirement account contribution.





RETIREMENT SAVINGS PROGRAM

PRE-TAX AND AFTER-TAX OPTIONS

Enrolling in the Plans

To participate, you must select an investment plan from the list of authorized investment providers below. Check the list to determine whether the provider you select offers the plan(s) you want. Carefully compare investment products before you select a provider and take the time to understand the investments you are choosing and the implications of your investment decision. If you do not understand the information presented to you by a sales representative or are unsure about a product, do not complete the online payroll deduction authorization.

The authorized list does not reflect any opinion as to financial strength or the quality of the product or service for any company. The products that these companies provide are typically standard-interest annuities, variable annuities, and mutual funds. Payroll deductions are permitted for those vendors who have made proper application and are on Pinellas County Schools' list of authorized vendors. Pinellas County Schools does not endorse or recommend any product or vendor and does not offer financial advice.

403(B) AND 457(B) DISTRIBUTION TRANSACTIONS

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



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

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

**Florida Department of Financial Services
Consumer Helpline
(800) 342-2762**

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

**Florida Office of
Financial Regulations
[www.flofr.com/sitePages/
fileacomplaint](http://www.flofr.com/sitePages/fileacomplaint)**



RETIREMENT SAVINGS PROGRAM

PRE-TAX AND AFTER-TAX OPTIONS

Other Information

To use the ART system you will need to establish your initial ART system login, visit the secure ART login website: www.tsacg.com/individual/art-help.

Retirement Savings Program				
List of Authorized Investment Providers				
COMPANY NAME	PRODUCTS AVAILABLE			TELEPHONE
	403(B)	457	ROTH 403(b)	
AIG Retirement Services (Valic)	X	X	X	813-269-3362
Equitable**	X	X	X	888-890-0013, Ext 195
Fidelity Funds (No Load)*	X	X	X	800-343-0860
Franklin Templeton	X	X	X	727-588-6140
Horace Mann	X	X	X	727-497-7701
Lincoln Investment	X	X	X	800-771-7732
Suncoast Credit Union	X	X	X	866-300-9382, Option
VOYA/Aetna	X	X	X	813-281-3743



RETIREMENT SAVINGS PROGRAM

PRE-TAX AND AFTER-TAX OPTIONS

Resources

For more information about the PCS Retirement Savings Program:

Call

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

Visit

- <https://www.tsacg.com/individual/plan-sponsor/florida/pinellas-county-schools/>

The following websites offer relevant information

Social Security Administrationwww.ssa.gov

Find answers to your questions concerning Social Security.

Administration on Agingwww.usa.gov

Information on retirement, Medicare, and other issues for retirees.

Internal Revenue Servicewww.irs.gov

Source for tax information, including changes to the tax code.

U.S. Department of Laborwww.dol.gov

Information for the workforce.

Morningstarwww.morningstar.com

Information on stocks, funds, and factors affecting the stock market.

A.M. Best Companywww.ambest.com

Information on company ratings, products, and news.

Standard and Poor's Companywww.standardandpoors.com

Information on company ratings, fund information, indices, and more.

American Savings Education Councilwww.choosetosave.org/asec

Information about saving for retirement.

Employee Benefit Research Institutewww.ebri.org

Information on employee benefit programs.

Employee Benefits Security Administrationwww.dol.gov/ebsa/

Information on pensions, COBRA, plan sponsors, compliance, fraud, and more.





FLORIDA RETIREMENT SYSTEM (FRS)

Key Differences Between FRS Plans

Pension Plan

A traditional retirement plan designed for longer-service career employees.

You qualify for a benefit after eight¹ years of service. You are always fully vested in your own contributions as long as you remain in the Pension Plan².

PCS contributes the majority of your FRS retirement plan contribution based on a fixed percentage of your gross salary as determined by the state legislature. A mandatory 3% pre-tax contribution is deducted from your paycheck and deposited into the Pension Plan trust fund³.

Pays a guaranteed lifetime monthly benefit using a formula based on the service and salary while you are working for an FRS employer. Plan underfunding or future cost increases could make it necessary for the Florida Legislature to reduce benefits.

Investment Plan

A retirement plan designed for shorter service and more mobile employees.

PCS contributes the majority of your FRS retirement plan contribution based on a fixed percentage of your gross salary. A mandatory 3% pre-tax contribution is deducted from your paycheck and deposited into your retirement account³.

Your benefit depends on the amount of money contributed to your account and its growth over time. You decide how to allocate the money in your account among the available investment funds. Future plan cost increases could make it necessary for the Florida Legislature to reduce the amount that employers contribute to the plan, which may result in a lower benefit.

Your benefit depends on the amount of money contributed to your account and its growth over time. You decide how to allocate the money in your account among the available investment funds. Future plan cost increases could make it necessary for the Florida Legislature to reduce the amount that employers contribute to the plan, which may result in a lower benefit.

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

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

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

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

About the DROP Option

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





FLORIDA RETIREMENT SYSTEM (FRS)

About the MyFRS Financial Guidance Program

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

You can speak with a financial planner about:

- Retirement planning
- Investment planning, including investments outside the FRS, such as the PCS Retirement Savings Program.
- Investment fund performance
- Estate planning
- Debt, spending, and credit issues

The **www.MyFRS.com** website serves as your gateway to a host of tools and information about the FRS Pension Plan and Investment Plan.

For more information about the Florida Retirement System, the MyFRS Financial Guidance Program, and DROP.

CALL:
The PCS Retirement Team:
727-588-6214

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

VISIT:
www.MyFRS.com





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

LEGAL NOTICES & DISCLOSURES (INCLUDES TO WHOM THEY APPLY)

- Women's Health & Cancer Rights Act (Employees and Retirees)
- Newborns' and Mothers' Health Protection Act (Employees and Retirees)
- Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) (Employees and Retirees)
- HIPAA Notice of Privacy Practices Reminder (Employees and Retirees)
- HIPAA Special Enrollment Rights (Employees and Retirees)
- Notice of Creditable Coverage (Employees and Retirees)
- Wellness Program Disclosures (Employees Only)
- COBRA (Employees and Retirees)
- Patient Protection and Affordable Care Act (PPACA, or Health Care Reform) (Employees and Retirees)
- Family and Medical Leave of Absence (Employees and Retirees)
- Workers' Compensation (Employees Only)
- How to Get Medical Care and Benefits (Employees and Retirees)
- Payment for Lost Wages (Employees Only)
- Pinellas County Schools Modified Alternative Duties Program (Employees Only)

Women's Health and Cancer Rights Act

(Employees and Retirees)

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

(Employees and Retirees)

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).





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

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

(Employees and Retirees)

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)**.





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

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, 2023. 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://hcpf.colorado.gov/child-health-plan-plus>
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): <https://www.mychohibi.com/>
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.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
HIPP Phone: 1-800-766-9012

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: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>
Phone: 1-877-524-4718
Kentucky Medicaid Website: <https://chfs.ky.gov>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: <https://www.mymaineconnection.gov/benefits/s/>
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofl/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: HSHIPPProgram@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





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

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
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

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

TEXAS – Medicaid

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

UTAH – Medicaid and CHIP

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

VERMONT– Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>
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/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: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023,
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.





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

HIPAA

(Employees and Retirees)

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

(Employees and Retirees)

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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

NOTICE OF CREDITABLE COVERAGE

(Employees and Retirees)

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.

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.





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

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, 2024

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





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

WELLNESS PROGRAM DISCLOSURES

(Employees Only)

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 ever disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

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

(Employees and Retirees)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (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

PLEASE REVIEW THE FOLLOWING SECTIONS CAREFULLY.

They contain important information about your rights and responsibilities as a Pinellas County Schools employee.

- COBRA
- Family Medical and Leave of Absence
- Workers' Compensation

- 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).

Retirees Only: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Pinellas County Schools, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

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 (or reduction in covered employee)	Employee, spouse, and dependent children	18 months
Death of covered employee	Spouse and dependent children	36 months
Divorce or legal separation*	Spouse and dependent children	36 months
Covered employee becomes eligible for Medicare	Spouse and dependent children	36 months
Loss of child's dependent status	Dependent child	36 months
Qualifying disability	Employee	29 months

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

How to Obtain Continued Coverage

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

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

Premium Payment

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

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

All subsequent payments must be made the first of each month. If these payments are not received on

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

When Continued Coverage Ceases

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

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

If You Have Questions

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





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA, OR HEALTH CARE REFORM)

(Employees and Retirees)

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 PCS 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

(Employees Only)

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.





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

WORKERS' COMPENSATION

(Employees Only)

Basic Facts

- Workers' Compensation coverage is paid by Pinellas County Schools at no cost to you.
- It is your responsibility to report a work-related accident to administration within 24 hours.
- 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.
- Pinellas County Schools has the right to choose the medical providers who will treat you.
- 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

(Employees and Retirees)

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

(Employees Only)

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

(Employees Only)

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.





PLAN ADMINISTRATION

YOUR RIGHTS AND RESPONSIBILITIES

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.







Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department. 04655-PCS-Beneflex-BG