CONTRACT ADMINISTRATOR

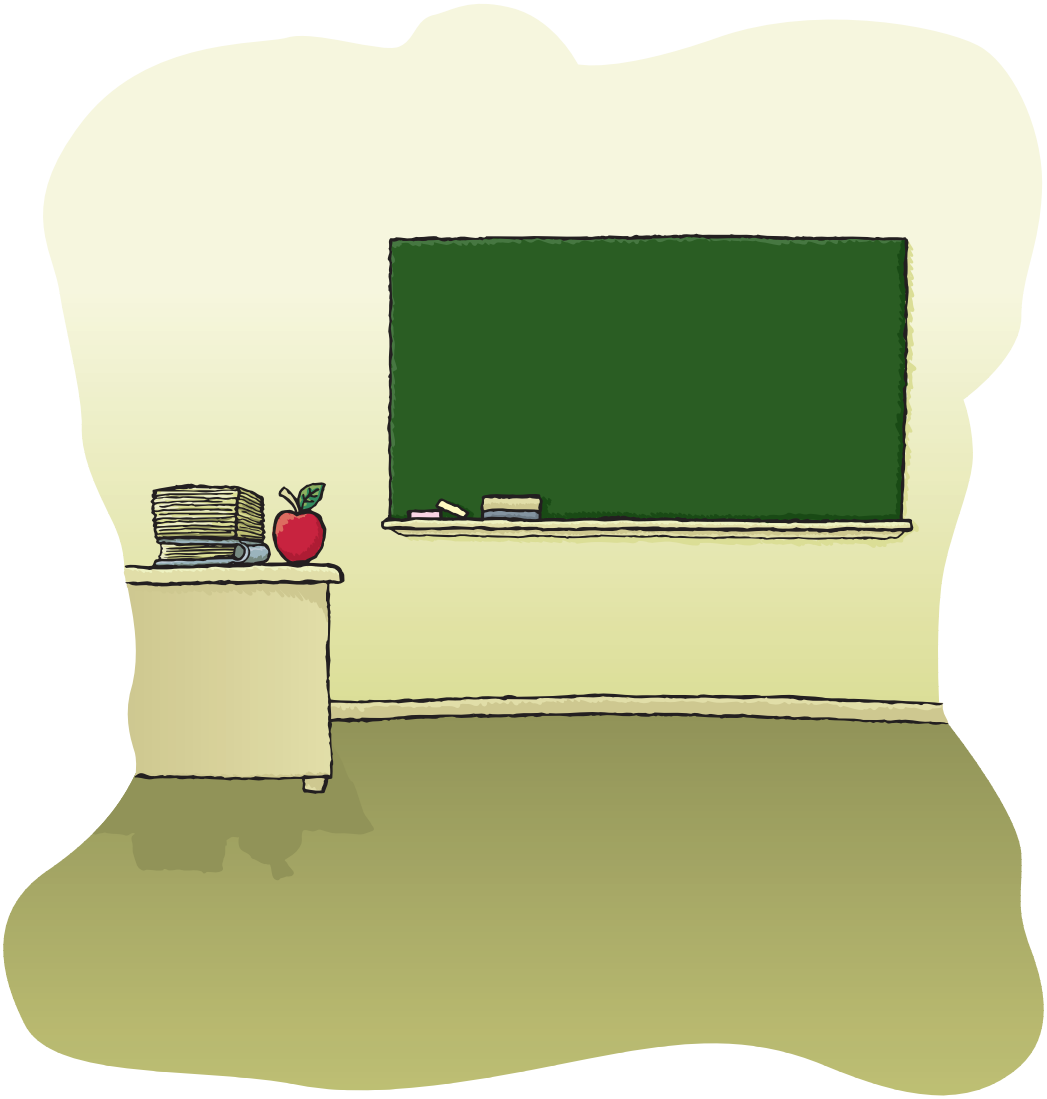
Sunbelt Worksite Marketing, Inc.
PO Box 1287
Auburndale, Fl 33823-1287
Customer Service 1.800.822.8045

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

2010 FLEXIBLE BENEFITS PLAN

Benefits Enrollment Guide

District School Board of Pasco County



THINK ABOUT YOUR BENEFITS

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Customer Service Information

Company	Department	Hours	Phone / Web Address
Employee Benefits Department	Customer Service	Mon-Fri 8:00am-4:30pm	813-794-2253 727-774-2253 352-524-2253 ebarm.pasco.k12.fl.us
Blue Cross Blue Shield *Medical Plans – Dependent Children Only / HMO / BlueOptions / PPO Low Option / MyBlueService*	Customer Service	Mon-Thur 8:00 am - 6:00 pm Friday 9:00 am – 6:00 pm	1-800-507-9820 www.bcbsfl.com
Medco *Prescription Drug Plan*	Customer Service	24 hours a day 7 days a week	1-800-207-2568 www.medco.com
Horizon Health *Mental Health & Substance Abuse*	Customer Service	24 hours a day 7 days a week	1-866-882-9791 http://horizoncarelink.com/login.aspx Login – pascoschools Password - worklife
Employee Assistance Program *Employee Counseling*	Appointments	8:00 am – 4:30 pm	813-794-2366 727-774-2366 352-524-2366 ebarm.pasco.k12.fl.us/pages/eap.html
Minnesota Life *Basic Core Life and Supplemental Life*	Customer Service	Mon – Fri 8:00 am-5:00 pm	1-866-293-6047 www.lifebenefits.com
Safeguard/DHMO Dental	Customer Service	Mon – Fri 8:00 am – 9:00 pm	1-800-880-1800 www.safeguard.net
MetLife *PPO – Dental*	Customer Service	Mon – Fri 8:00 am – 9:00 pm	1-800-942-0854 www.metlife.com/mybenefits
Ameritas/VSP *Vision Plan*	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-800-877-7195 www.vsp.com
Unum *Long and Short Term Disability*	Customer Service Claims	Mon- Fri 9:00 am– 8:00 pm 24 hours a day 7 days a week	1-800-421-0344 www.unum.com
Cornerstone Flex Account *Flexible Spending Accounts*	Customer Service	Mon-Fri 8:00 am – 5:00 pm	1-800-422-4661 www.teamcornerstone.com/pasco
ARAG *Legal Services*	Customer Service	Mon – Fri 8:00 am 8:00 pm	1-800-247-4184 members.araggroup.com/pasco
Allstate *Critical Illness* *Accident* *Hospital Income* *Cancer*	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-800-521-3535 www.allstate.com
Transamerica *Universal Life*	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-800-400-3042 prompt 4
Life Insurance Company of North America (LINA) *Group Term Life Insurance*	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-800-822-8045 www.cigna.com
Sunbelt Worksite Marketing	Customer Service	Mon – Fri, 8:00 am – 5:00 pm	1-800-822-8045

Board-Provided Benefits

WHO IS ELIGIBLE?

The District School Board of Pasco County provides the following coverage to each benefits-eligible employee: Full-time employees who have completed one month of continuous employment are eligible for coverage. Employees must work a specified minimum of 20 to 30 hours per week, depending on their job and duration of employment. New employees hired in a benefit-earning position are eligible for health coverage on the first day of the month following one month of continuous employment. For example if your date of hire is March 15th, you are eligible for coverage on May 1st.

MID-YEAR CHANGE IN STATUS EVENT

The School Board has one Open Enrollment period per year in which you can elect new coverage. However, when you have a change in status, such as marriage, divorce, spouse has a job change, childbirth or adoption, you may need coverage more appropriate to your new situation. You need to contact the Employee Benefits, Assistance and Risk Management Department (EBARM) for the proper forms and select new coverage within 30 days of the change.

WHAT HAPPENS IF I DON'T ENROLL?

- If you fail to enroll, you will keep your current benefits, but your participation in any medical/dependent flexible spending accounts will be waived. Also if you have DHMO dental you will be auto-assigned to a dental facility.

Below you will find a list of the Board-Provided Benefits (no cost to the employee):

- BlueCross BlueShield Medical Coverage
  - HMO BlueCare Plan
  - Blue Options Plan
  - Alternate PPO BlueChoice Plan 329
- Health Opt-Out Plan
- Medco's Prescription Drug Benefit
- Dental
  - Safeguard – DHMO
  - MetLife – PPO
- $35,000 Group term life insurance coverage
- Mental Health/Substance Abuse
- Employee Assistance Program and
- Voluntary Benefits Options (Employer Provides $150 towards the purchase of these options).

VOLUNTARY BENEFITS

You will be able to use your Board provided $150 towards reducing the cost of dependent medical coverage or purchasing voluntary benefits. You may not use your $150 to reduce the cost of Minnesota Life Supplemental Insurance. Once you have used your Board contribution of $150, you may also purchase additional products through payroll deduction; most are pre-tax, saving you money on FICA and withholding tax. If you do not use your additional $150 towards voluntary benefits, that money will be put into an HRA (Health Reimbursement Account) for your use.

SELECTING BENEFITS OR OPTING OUT FOR CASH

All eligible employees have the option of enrolling in the Board's health plan or "opting out" for cash.

Employees electing coverage under the Board's health plan receive a paid in full benefit package that includes:

- HMO BlueCare or Blue Options PPO
- Medco Prescription Drug Benefit
- Safeguard/MetLife Dental (HMO or PPO)
- $35,000 Group Term Life
- Employee Assistance Program
- Mental Health/Substance Abuse and
- Flexible Benefit Credit

Employees electing to decline health coverage and enroll in the "Health Opt Out" plan will receive:

- Receive $1,200 annual taxable income paid over the course of the year (24-deduct employees receive $50 per pay; 20-deduct employees receive $60 per pay)
- Receive $35,000 Group Term Life
- Be eligible to use the Board-provided $150 to purchase voluntary benefits
- Be eligible for the Employee Assistance Program
- Be eligible for a Flexible Spending Account at your own expense.
- Be eligible to purchase dental coverage for yourself and your dependents

An employee who has medical coverage through his/her spouse's plan may want to consider this option.

Board-Provided Benefits

If you enroll in the Health Opt Out plan, you can enroll in dental insurance on a voluntary basis for yourself and your family. Plan information is included in this Reference Guide. You may also use your Board Provided $150 Credit to purchase or off-set the cost of any voluntary benefits you would like to purchase, excluding Minnesota Supplemental Life.

HOW DO I ENROLL IN MY BENEFITS?

The District has moved to a paperless enrollment system. You will have 3 ways to enroll in your 2010 benefits:

1. Contact the Sunbelt Call Center at 1-800-822-8045
2. Meet with a benefits enroller at your worksite
3. Self-enroll by logging onto the Employee benefits website at www.mypascodsbbenefits.com

After you have enrolled with the Sunbelt Call Center, you may view your benefit elections and print and ***election summary*** by visiting the following website: www.mypascodsbbenefits.com

Please be sure to print out a benefit summary sheet and review your benefit selections for accuracy regardless of what method you choose for enrollment. If there is an error with your selection you will be required to produce a copy of your summary sheet.

COORDINATION OF BENEFITS

The medical, dental, mental health and substance abuse plans all offer coordination of benefits provisions. If you are covered by an additional insurance policy or other benefits such as Medicare, that insurance carrier and your School Board insurer will combine their benefits to help pay for coverage. However, no more than 100% of your incurred costs will be reimbursed through the coordination of benefits.

Several factors determine which policy pays how much of the cost. Dependent benefits can also be coordinated. Please see the insurance company plan booklet for more details.

BENEFIT RECORD ACCESS

To access your benefit record and make changes you must enter a username and password. This required information is as follows:

Online ID: first letter of your first name, first letter of your last name and last seven digits of your social security number.

Password: your birth date mmddyy

After the initial login, you will be asked to change your password. Follow the instructions given.

Insurance Dependent Coverage

DEPENDENT COVERAGE

You may purchase medical, dental, or vision coverage for your dependents using your Board-provided $150 and pre-tax payroll deduction. Eligible dependents for coverage under the Board's plans include:

- Your legal spouse
- Your own unmarried child under the age 19 who lives in your household
- Your own child may be covered until the end of calendar-year in which the child reaches 25, if the child depends on you for support and lives in your household or is a full or part-time student.
- Stepchildren and legally adopted children who meet the above requirements are also eligible for coverage
- Your child of any age who is disabled and dependent upon you for support
- You may be asked to complete a dependent verification form and provide verification of eligibility for a dependent age 19 or over
- Newborns, adopted children and children in the process of adoption will be covered from the moment of birth, adoption, or placement for adoption if you choose to enroll them in the Board's health plan. If you enroll your newborn or adopted child within the first 30 days, you will not be required to pay any additional premiums (if applicable) for the first month of coverage. If you enroll after 30 days (60 days maximum), you will be required to pay premium retroactive to the date of birth, adoption, or placement for adoption. If you do not enroll your new dependent within 60 days, you must wait for the next open enrollment for benefits effective the next calendar year.

DEPENDENT CHILD AGES 26-30

The policy must insure a dependent child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches 30, if the child:

- Is unmarried and does not have a dependent of his or her own;
- Is a resident of this state (Florida) or a full-time or part-time student; and
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

DEPENDENT RATES FOR TWO MARRIED EMPLOYEES OF THE SCHOOL BOARD

There are many married couples that are employed by the District School Board of Pasco County. As employees of the School Board, the group benefits are available to both spouses. Therefore, when they need dependent coverage, they are entitled to use the "two married employees of the School Board 'children only' option." The use of "children only" option requires that certain conditions be met:

- The "children only" rate will only apply in those situations where both employees, a married couple, are covered under the same Medical and Dental plans. If you and your spouse elect coverage under different health plans, the spouse who carries the dependents will be charged the full "one dependent" or full "family" rate, as applicable.
- If you and your spouse are covered under different plans, but currently have no dependent coverage and anticipate the addition of a dependent during the year, you should plan ahead at this time, and choose the same Medical and Dental plans, since you can only change your Medical and Dental plans during the Open Enrollment period.

The addition of a newborn or adopted child or any other dependent as the result of a change in status will result in the full dependent rate being charged to the spouse who elects to carry the new dependent. The lesser "children only" rate would be available if both spouses were under the same health plan.

- Two married employees of the School Board are no longer eligible for the "children only" rate when either spouse loses his/her eligibility (goes on an unpaid leave, a divorce occurs, resigns/terminates employment, etc.) for benefits. If the paying spouse remains an active employee of the School Board, the dependent premiums will automatically change to the applicable premium: one (1) dependent or family rate.

Medical Insurance Overview

As you consider your choices for Medical coverages, make an "apples-to-apples" comparison to best understand how the plans differ. Examining these three points will show you the basic differences and you can decide how important these differences are to you:

COST

The Board pays the entire premium for Employee Only coverage. The cost of dependent(s) coverage depends on the selected Medical plan, Dental plan and Sunbelt options. Do I want to pay for medical-only or medical and dental benefits for my dependent(s)?

TYPE OF PLAN

Should I choose an HMO with good in-network coverage, but no out-of-network benefits?

Would I prefer the BlueOptions Plan that includes good in-network coverage and reduced benefits out of network?

CHOICE OF DOCTORS AND HOSPITALS

Is my current doctor in the plan's network?

How would I feel about choosing a new doctor?

Are the plan-approved hospitals convenient for me?

One or two of the questions may jump out as the most important and help you make a decision.

MEDICAL PREMIUMS

A premium is the per-pay-period cost of your benefits. The School Board will fully fund the employee-only premium. If you choose dependent coverage, you will pay an additional premium. Dependent coverage may be purchased to include medical-only, dental-only or medical and dental coverage. See the Dependent Premium Rate Chart. Premiums will be deducted pretax.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association Serving Residents and Businesses of Florida.

Medical Insurance Overview

HMO BASICS

A health maintenance organization (HMO) provides comprehensive medical services to enrolled members for a fixed prepayment. You must choose a Primary Care Physician (PCP). Usually the service provider files claims for the patient. Patients pay only a co-payment. Because costs are fixed, patients avoid the sometimes high cost of traditional fee-for-service medical care.

MEDICAL HMO REFERRALS

If you are in the HMO plan, it will not be necessary to obtain a referral from your primary care physician (PCP) to see an in-network specialist. However, you must still select a PCP if you are in the HMO plan.

Note: If your PCP, pediatrician or specialist elects to leave the network during the plan year, you may not change plans until the next Open Enrollment period. You may select a new PCP from the network by contacting BlueCross BlueShield.

BLUEOPTIONS BASICS

Plan members receive comprehensive health benefits and can use either in-network providers or out-of-network providers. However, there will be higher out of pocket expenses if using out-of-network providers. You do not have to choose a primary care physician, and you do not need referrals and authorizations. Refer to the list of plan providers by calling Customer Service at 1-800-507-9820 to see if your current doctor is in-network or out-of-network. This information is also available on the BCBSFL website: www.bcbsfl.com

CO-PAYMENT

A co-payment is the portion of the cost of a covered service, which you pay. This is usually a per-visit flat fee. Co-payments (except prescriptions) count toward your maximum out-of-pocket responsibility. Out-of-pocket maximum is the most you are required to pay in a single year over and above your premium. Once you have paid the maximum, the insurer assumes the cost of any additional care, with certain exceptions.

PRIMARY CARE PHYSICIAN

After you select a primary care physician (PCP) (required under the HMO plan only) you are encouraged to establish a relationship with him/her. By sharing your lifestyle practices and health history with your primary physician, he or she can best coordinate all of your medical care. Family Practitioners, Internists, General Practitioners and Pediatricians are all considered primary care physicians.

PREAUTHORIZATION

Certain services, such as advanced imaging services and selected outpatient services (outpatient physical therapy), require prior authorization. When you receive these services through participating providers, your PCP or physician will perform the necessary notification.

HOSPITALIZATION/MEDICAL EMERGENCY

In case of an emergency, first seek treatment and then contact your primary care physician and the insurance company within 24 to 48 hours, depending on your plan's requirements. Anyone can call; friend, family or hospital however, you, the employee, are ultimately responsible.

RECEIVING CARE AWAY FROM HOME

If you are enrolled in the HMO BlueCare Medical plan, you have access to health care benefits around the world. To meet the different health care needs of members and dependents that are away from home, your HMO offers separate benefits for short trips and long-term stays.

For shorter trips (less than 90 days) the BlueCard Program gives you access to doctors and hospitals almost anywhere, giving you the peace of mind that you'll have access to the care you need.

For longer trips (90 consecutive days or longer), the Guest Membership benefit is available for you and your covered dependents in most states. This benefit is designed to bring you peace of mind if you have a dependent attending school out of state, family members living in different service areas or a long-term work assignment in another state. Whatever the reason, you're eligible for this benefit when you're away from home for at least 90 days. For eligibility information and specific locations where the Guest membership benefit is available, please contact BlueCross BlueShield customer service @ 800-810-2583.

WELLNESS PROGRAM

Insurance companies set up wellness programs to help provide preventive care. Programs will vary, but may include regular checkups, as well as special programs, classes and health screenings. Some examples of BlueCross BlueShield disease management programs are: asthma, cancer care, congestive heart failure and diabetes.

BCBSFL also offers Health Dialog which is your pathway to free educational materials: pre-printed, online, videotapes and over 300 audio tapes you can listen to. Employees can also talk with one of Health Dialog's experienced coaches 24 hrs a day. For more information call 877-789-2583.

Medical Insurance Basics About BlueOptions PPO

At Blue Cross Blue Shield of Florida (BCBSF), we have designed our BlueOptions plans to provide you with access to a wide variety of health care providers. Even though your BlueOptions coverage offers you the freedom to select any provider, you can lower your out-of-pocket costs if you use providers who are part of the BlueOptions/NetworkBlue network.

HOW BLUEOPTIONS WORKS

1. Under the BlueOptions plan you will only have to pay a Co-payment for certain covered services rendered by health care providers. A co-payment is the specific dollar amount which the insured is required to pay to the health care providers at the time services are rendered by that provider.

2. Under the BlueOptions plan you will have an Individual Calendar-Year Deductible for Out-of-Network services only. This requirement must be satisfied by each insured each calendar year before any payment will be made by BCBSF for any claim that is out of the network. Only those charges indicated on claims received by BCBSF for covered services will be credited by BCBSF toward the individual out-of-network calendar-year deductible requirement and only up to the applicable Allowed Amount.

   • Allowed Amount means the maximum Usual, Reasonable and Customary amount, by region, as determined by BCBSF.

3. Your BlueOptions plan will also have a Family Calendar-Year Deductible for Out-of-Network services only, which is the maximum amount of deductible that as a family you will need to pay in each calendar year. Once this amount has been satisfied, no insured in that family will have any additional calendar-year deductible responsibility for the remainder of that calendar year. The maximum amount that any insured in the family can contribute toward the family calendar-year deductible requirement is the amount applied toward the individual calendar-year deductible amount.

4. After the insured has satisfied the applicable deductible responsibility for Out-of-Network services, BCBSF will pay for claims for covered services at the Coinsurance percentage. The unpaid percentage of the allowed amount is the insured's coinsurance responsibility.

   • Out-of-Pocket Maximum is the maximum amount an individual insured can reach as set forth in the Schedule of Benefits. With the BlueOptions product it includes Deductible, Coinsurance and Non-rx Co-pays. Once an insured reaches this amount, there is no additional responsibility out of pocket for the remainder of the calendar year and BCBSF will pay for covered services at 100 percent of the **allowed amount.** This does not apply to prescriptions. (Please note that under your plan there are separate In- Network and Out-of-Network – Out-of-Pocket Maximums to be met.)

   • Out-of-Pocket Maximum Family is the maximum amount a enrolled member's family can reach as set forth in the Schedule of Benefits. With the BlueOptions product it includes Deductible, Coinsurance and Non-rx Co-pays. Once the member's family reaches this amount, no insured in the certificate holder's family will have any additional out-of-pocket responsibility for the remainder of that calendar year and BCBSF will pay for covered services at 100 percent of the **allowed amount**. The maximum amount any insured can contribute to the family Out-of-pocket Family Maximum limit is the amount applied toward the Individual maximum out-of-pocket responsibility limit amount.

5. If you or a member of your family requires hospitalization, you will have to satisfy a Hospital Per-Admission Co-pay. This co-pay covers the facility charge and is the same whether you are there for 1 day or 10 or more days. The BlueOptions participating hospitals are on a tiered system. Option 1 Hospitals are: Lower Cost, Community hospitals, Option 2 Hospitals are Higher cost Hospitals, Research Facilities and Specialty Hospitals. Based upon the hospital you go to, you will have a different co-pay. The co-pays are progressively higher for Option II hospitals. This tiered hospital system applies to In-patient as well as Outpatient. You will be responsible to meet your out-of-network deductible and coinsurance for out-of-network hospitals.

6. If you or a member of your family require emergency services, you will have an Emergency Room Co-pay. The emergency room per-visit co-pay applies regardless of the reason for the visit and applies in and outside the state of Florida and it covers the Facility charge. The emergency room per-visit co-pay must be satisfied by each insured for each visit. If the insured is admitted to the hospital at the time of the emergency room visit, the emergency room co-pay will be waived and the in-patient facility co-pay will apply.

Please refer to the Benefit Summary of the plan that you have selected.

UNDERSTANDING YOUR BLUEOPTIONS PLAN

Choosing the BlueOptions health plan that works best for you and your family was just the beginning. You still have more choices, which is one of the great things about BlueOptions. You choose your doctors, hospitals and other facilities. The following sections may help you in making your decisions. In the end, the choice is yours.

CHOOSING A PROVIDER

Probably the most important choice you're going to make is choosing your provider. Before you make your decision, there are some specifics we'd like you to know.

VALUE OF A FAMILY PHYSICIAN

Although BlueOptions doesn't require selection of a primary care physician, we encourage you to develop a relationship with a NetworkBlue* family physician. There are several advantages to selecting a family physician:

(1) They are trained to provide a broad range of medical care

(2) They can be a valuable resource to help coordinate your over all health care needs; and

(3) They can help you determine when you need to see a specialist. With BlueOptions, a family physician is any doctor whose primary specialty is family practice, general practice, internal medicine or pediatrics.

(4) If you require hospitalization or Advanced Imaging Services your physician will contact BlueCross to obtain authorizations before you receive this care. Covered services are provided at the respective co-payments shown on the Summary of Benefits.

LOWERING YOUR OUT-OF-POCKET COSTS

NetworkBlue is the PPO provider network designated as "in-network" for BlueOptions plans. When you see a provider who participates in NetworkBlue, your expenses for covered services should be lower. When you use out-of-network providers, your out-of-pocket costs for covered services may be higher. Please see your Schedule of Benefits for your costs for Covered Services.

FINDING A PROVIDER

We encourage you to determine whether a provider is a NetworkBlue in-network or out-of-network provider before you receive services so you'll know your out-of-pocket costs up front. You can find out if your physician is a NetworkBlue provider by visiting www.bcbsfl.com, by calling the customer service number on your BlueOptions ID card or by calling the physician's office.

Whether you choose to see a physician who is in or out of NetworkBlue, choosing a physician is an important part of your health care experience.

If you scheduled appointments with health care providers before you enrolled with BlueOptions, be sure to notify the providers that you've changed your health insurance.

SELECTING A HOSPITAL

You will find a wide variety of hospitals available in NetworkBlue from local hospitals to ones that offer specialized services like children's and teaching hospitals.

Your BlueOptions plan features a two-tier design of participating NetworkBlue hospitals. Both options represent varying cost levels for hospital services, so you are aware of how your out-of-pocket costs could be affected based on what option a hospital is in. Typically, Option 1 hospitals are less costly than Option 2 hospitals. Having this information can help you plan for potential out-of-pocket expenses.

One of the factors that determine a hospital's option is our ability to negotiate payment amounts with area hospitals some are lower than others. Because of this, in-network hospitals are divided into two groups: Option 1 and Option 2. If you choose an out-of-network hospital, the out-of-pocket costs will be higher and you might not have balance billing protection.

It is important to note that the option ranges do not reflect the quality of the facility. Your Schedule of Benefits shows the copay amount for each hospital option.

Since not all physicians admit patients to every hospital, it is important when choosing a physician that you determine the hospitals where your physician has admitting privileges. Contact the physician's office to learn about their admitting privileges, so you can plan for your out-of-pocket costs in the event you're hospitalized.

LOCATION OF SERVICE

Where you receive your services can also affect the amount you pay. For example, the amount you are responsible for paying will vary whether you receive services in a hospital, a provider's office, or an ambulatory surgical center. Please refer to your Schedule of Benefits for specific information regarding your expenses for services at different locations. You should also consult with your physician to determine the most appropriate setting based on you health care and financial needs.

* *NetworkBlue is one of our preferred provider networks made up of independent hospital, physicians and ancillary providers.*

Medical Insurance BlueOptions PPO Q & A

Q WILL I GET AN ID CARD?

A Yes, after your enrollment process has been completed, a health benefit plan package will be sent to you. Your Blue Cross and Blue Shield of Florida (BCBSF) member ID card will be included in this package. You will receive a card with a magnetic strip on the back. We call this the "card for life".

Q HOW DO I FIND A PARTICIPATING PROVIDER?

A Please feel free to use the online provider search capability to determine if a provider is participating in NetworkBlue*, the provider network for BlueOptions. Simply log on to www.bcbsfl.com. You can access our provider directory right from the home page by clicking on the "Find a Doctor or More" tab. You may also call the number on the back of your member ID card and speak to a Customer Service Representative. New providers are being added to NetworkBlue on a regular basis, so if you do not find the provider you are looking for right away, you may want to check again in the near future.

Q HOW ARE HOSPITAL TIERS DETERMINED?

A One of the factors that determines a hospital's option level is our ability to negotiate payment amounts with area hospitals – some lower than others. Because of this, in-network hospitals have been divided into two groups: Option 1 and Option 2. It is important to note that the option ranges do not reflect on the quality of the facility. Hospitals in Option 1 have the lowest facility copayment amount. Hospitals in Option 2 have a slightly higher facility copayment amount. When visiting a hospital that is not part of NetworkBlue, there may not be protection from balance billing, and you will have higher out-of-pocket expenses.

Q DO I HAVE TO SELECT A PRIMARY CARE PHYSICIAN (PCP)?

A No. Under the BlueOptions health benefit plan, you are free to see any Participating Physician in NetworkBlue. If you've already scheduled appointments with providers, be sure to notify them that you'll be changing your health coverage. We encourage you to inquire about the provider's participation status in NetworkBlue. That way, you'll be able to determine how the change in your health benefit plan will, if at all, affect your out-of-pocket costs.

Q DO I HAVE TO SUBMIT CLAIMS?

A No. As long as you choose a provider from within NetworkBlue, your provider should process all claim submission paperwork on your behalf.

Q WHOM CAN I CALL IF I HAVE A QUESTION BEFORE I RECEIVE MY HEALTH INSURANCE BENEFIT PACKAGE?

A You can speak with our on site BCBSF Representative for additional information at 1-813-794-2492.

Q WHOM CAN I CALL AFTER I HAVE ENROLLED IF I HAVE QUESTIONS ABOUT MY PLAN?

A The number to the Customer Service area is 1-800-507-9820. They are available to take your calls Monday through Thursday from 8 a.m. until 6 p.m. and on Fridays from 9 a.m. until 6 p.m. or contact the BCBSF on site representative at the number above.

Q DO I HAVE BENEFITS IF I RECEIVE SERVICES FROM AN OUT-OF-NETWORK PROVIDER?

A Covered services rendered by an out-of-network provider are included under the BlueOptions health benefit plan. In most cases, you will be subject to a deductible and pay a higher coinsurance and/or co-payment for out-of-network covered services. The out-of-network benefit level can be determined by reviewing the benefit booklet included in the enrollment package.

Q HOW AM I COVERED IF I TRAVEL OUTSIDE THE STATE OF FLORIDA?

A When traveling outside the State of Florida, BlueOptions members are covered under the BlueCard® Program. The BlueCard® Program provides access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country and worldwide. BlueOptions members receive in-network benefits and are protected from balance billing when receiving covered services from a BlueCard® participating provider. If services are rendered in a BlueCard® participating hospital outside of Florida, the member pays the Option 2 co-payment. To find a BlueCard participating provider, visit www.bcbsfl.com and click on "Find a Doctor and More" tab, then click on "Doctors and Hospitals Nationally" link on the right margin or call 1-800-810-BLUE.

**** NetworkBlue is one of our preferred provider networks made up of independent hospitals, physicians and ancillary providers.***

Blue Options PPO Plan

BlueOptions
PPO Plan

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Please note this plan has a 6/12 pre-existing condition clause. See page 19.

Benefits for Covered Services	*Amount Member Pays*
Office Services	
Physician Office Services In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit	 $20 Copayment $35 Copayment DED [1] + 40% Coinsurance $10 Copayment DED + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network Out-of-Network	 $150 Copayment DED + 40% Coinsurance
Maternity Initial Visit In-Network Specialist Out-of-Network	 $35 Copayment DED + 40% Coinsurance
Allergy Injections (rendered by an In-Network Physician)	$10 Copayment
Preventive Care	
Adult Wellness Benefit Maximum (PBP [2]) (In-Network)	No Maximum
Out-of-Network Routine Adult Physical Exam and Immunizations Benefit Maximum (PBP)	$150
Routine Adult Physical Exam and Immunizations In-Network Family Physician In-Network Specialist Out-of-Network	 $20 Copayment $35 Copayment 40% Coinsurance
Well Woman Exam (e.g. Annual GYN) In-Network Family Physician In-Network Specialist Out-of-Network	 $20 Copayment $35 Copayment 40% Coinsurance
Mammograms (Covered at 100% of Allowed Amount, In- and Out-of-Network)	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies) (Covered at 100% of Allowed Amount, In- and Out-of-Network)	$0
Well Child (No PBP Max) In-Network Family Physician In-Network Specialist Out-of-Network	 $20 Copayment $35 Copayment 40% Coinsurance
Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	 $45 Copayment DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network / Out-of-Network	 $100 Copayment / $200 Copayment
Ambulance Services In-Network/Out-of-Network (Ground, air and water travel, combined per day maximum)	DED+ 20% Coinsurance/DED+40% Coinsurance $5,000
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (except *AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Out-of-Network	 $50 Copayment $150 Copayment DED + 40% Coinsurance
Independent Clinical Lab (e.g. Blood Work) In-Network / Out-of-Network	$0 for Quest Diagnostics only/ DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network (Option 1 / Option 2) Out-of Network	 $200 Copayment / $300 Copayment DED + 40% Coinsurance

*AIS = Advanced Imaging Services

Blue Options PPO Plan

Other Provider Services	
Provider Services at Hospital and ER In-Network and Out-of-Network	 $0
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network and Out-of-Network	 $35 Copayment
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 $20 Copayment $35 Copayment DED + 40% Coinsurance
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP Max) In-Network Locations other than Hospital and Physician's Office Out-of-Network Locations other than Hospital Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services (Option 1 / Option 2) Out-of-Network	 $2,500 $35 Copayment DED + 40% Coinsurance $35 Copayment / $60 Copayment DED + 40% Coinsurance
Durable Medical Equipment In-Network Out-of-Network	 20% Coinsurance DED + 40% Coinsurance
Home Health Care (PBP Max) In-Network Out-of-Network	$2,500 20% Coinsurance DED + 40% Coinsurance
Skilled Nursing Facility (PBP Max) In-Network Out-of-Network	60 days 20% Coinsurance DED + 40% Coinsurance
Hospice (Lifetime Max) In-Network Out-of-Network	No Maximum 20% Coinsurance DED + 40% Coinsurance
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $100 Copayment DED + 40% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network	Rehabilitation Services limit - 21 days (PBP) $600 Copayment / $1,000 Copayment DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All other Services (Option 1 / Option 2) Out-of-Network	 $45 Copayment / $60 Copayment $200 Copayment / $300 Copayment DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network / Out-of-Network	 $100 Copayment / $200 Copayment
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before BCBSF pays)	 $0 / $0 $500 / $1,500
Coinsurance In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	 20% / 40%
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	 $2,500 / $5,000 $5,000 / $10,000
Total Lifetime Maximum Benefit	$5,000,000

Blue Options PPO Plan

Benefits for Covered Services *Amount Member Pays*

An Array of Value-Added Programs and Services*

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***www.bcbsfl.com*** and other interactive web-based support tools
- **MyBlueService**, our 24/7 online member self-service, where you can request extra ID cards, review benefits, check claims status, print forms and more
- **Discounts** on vision care, hearing care, alternative care, fitness clubs, and more through our member discount program; Blue365.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more**
- BlueOptions members receive a **Member Health Statement** that summarizes your health care activity for the preceding month

Access to Our Strong Networks

NetworkBlue[SM] is the Preferred Provider Network designated as "In-Network" for BlueOptions. However, you will have **protection from balance billing** when you receive covered services from a provider in our Traditional Program Network. You may also receive **out-of-state coverage through the BlueCard**[®] Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, BCBSF does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at **www.bcbsfl.com.**

* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has entered into arrangements with various vendors to provide value-added features that include care decision support tools and services to its members. These programs are not part of insurance coverage. All decisions that members make pertaining to medical/clinical judgment should be made in conjunction with their Physician since neither BCBSF nor its vendors provide medical care or advice.

** As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

Blue Cross Blue Shield HMO Plan

BLUECARE - HMO

BlueCare is a Health Maintenance Organization (HMO) plan. It provides high-quality, cost-effective health care coverage, with emphasis on preventative care. BlueCare offers families the kind of coverage they really need today from routine doctor office visits, as well as coverage while traveling. BlueCare also offers convenient and affordable coverage that includes access to an extensive network of independent, contracting physicians and hospitals.

HOW THE HMO WORKS

1. At the time you enroll in the BlueCare HMO, each member enrolling will select a Primary Care Physician (PCP) who functions as a family doctor, managing the individual family member's health care. You will select your Primary Care Physician from the list of Family Practice, General Practice, Internal Medicine or Pediatricians by calling Customer Services at 1-800-507-9820 or on our Web site, www.bcbsfl.com. All services must be provided or arranged by the PCP. Covered services, including preventive care, are provided by the PCP at the co-payment amounts shown on the Summary of Benefits.

2. If you require hospitalization or Advanced Imaging Services your PCP will contact BlueCross to obtain authorizations before you receive this care. Covered services are provided at the respective co-payments shown on the Summary of Benefits.

3. For a listing of contracting providers visit us online at www.bcbsfl.com or call your dedicated customer service unit at 1-800-507-9820.

4. Once your enrollment is completed, you will receive Identification (ID) Cards. Call your PCP when you need health care and present your membership card. Remember, you do not have to wait until you're sick to get to know your new PCP. You can make an appointment any time with your PCP so that he or she can get to know you and your medical history. By doing this, you and your PCP can build a sound relationship, which is the first step in assuring your good health.

5. Services rendered outside of the service area that are not an emergency, must be authorized in advanced by BlueCross BlueShield in order to be covered.

SELECT EXCLUSIONS AND LIMITATIONS

The following is a partial listing of services that are excluded from coverage under this agreement, but only if, and to the extent that, such exclusion is permitted under law.

For a complete listing, please refer to the Master Policy. Exclusions include:

- All services not specifically listed in the schedule of benefits or in any rider or endorsement, unless such services are specifically required by state or federal law
- Elective cosmetic surgery
- Hearing aids or eyeglasses, dental care, or oral appliances
- Routine Physical for insurance, licensing, school, or recreational purposes
- Elective abortions
- Workers' Compensation Injuries
- Prescription drugs (unless included through BlueCare Rx)
- Complementary and Alternative Healing Methods (CAM)

The co-payments are the responsibility of the Member and must be paid to the provider at the time service is rendered, unless you have met your out-of-pocket maximum. (See page 15).

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.

This summary is only a partial description of the many benefits and services covered by Health Options, the HMO subsidiary of BlueCross and BlueShield of Florida, Inc. These benefits apply only to groups of 51 or more employees. Health Options, Inc. and BlueCross and BlueShield of Florida, Inc. are independent licensees of the BlueCross and BlueShield Association. This does not constitute a contract. For a complete description of benefits and exclusions, please see Master Policy 86002 R0399 SR; its terms prevail.

BlueCare
HMO

Care must be received from or arranged by your Health Options contracting primary care physician.

Benefits	Cost to You
Physician Office Services	
Primary care physician office services	$20 copay per visit
Contracting specialist office services	$35 copay per visit
One annual self-referral to contracting GYN for well-woman exam	$35 copay per visit
These office services may include: • Pediatric and well-baby care • Periodic health evaluation and immunizations • Other diagnostic services • Health education • Professional counseling (family planning, nutritional and medical social services) • Vision and hearing screening • Family planning services • In-office surgery	
Additional Services (Office or Outpatient Facility)	
Allergy testing	No copay
Allergy injection, including serum	$10 copay per visit
Outpatient physical, speech, cardiac and occupational therapies	$20 copay per visit
Diagnostic lab and X-ray	No copay
Hospital Services (Inpatient Facility)	
Room and board	$400/day, days 1-5
These inpatient hospital services may include: • Anesthesia, use of operating and recovery rooms, oxygen, drugs and medications • Intensive Care Unit and other special units • Laboratory and X-ray services • Inpatient physical, speech, cardiac and occupational therapies	
Hospital or Ambulatory Surgical Center (Outpatient Facility)	
Outpatient and outpatient surgical services may include: Anesthesia, use of operating and recovery rooms, oxygen, drugs and medications, including: • Hospital or surgical center • Surgeon's fees • Outpatient laboratory, X-ray and other tests	$300 copay
Emergency Services (Hospital)	
Use of emergency rooms and emergency services at contracting hospitals	$200 copay per visit
Use of emergency rooms and emergency services outside of service area or at non-contracting hospitals	$200 copay per visit

Blue Cross Blue Shield HMO Plan

Maternity Services	
Primary care physician office services	$20 copay
Contracting specialist office services – initial OB visit only	$35 copay
Certified nurse midwife or midwife	No copay
Inpatient hospital services	$400/day, days 1-5
Birthing center services	No copay
Infertility Services	
Primary care physician	$20 copay per visit
Contracting specialist	$35 copay per visit
Special Services	
Hospice care	No copay
Skilled nursing facility – 90 days per calendar year	No copay
Home health care - $10,000 calendar year maximum	No copay
Ambulance (medically necessary)	$100 copay
Durable medical equipment	
• Motorized wheelchairs	$500 copay
• All other durable medical equipment	No copay
Prosthetics and orthotics	No copay
Maximum Out-of-Pocket	$2,000 per member $6,000 per family

Additional information related to access to providers can be found on www.bcbsfl.com.

Select Exclusions and Limitations

The following is a partial listing of services that are excluded from coverage under the Master Policy. For a complete listing please refer to the Master Policy.

- All services not specifically listed in the Covered Services section of your Member Handbook or in any rider or endorsement, unless such services are specifically required by state or federal law
- Elective cosmetic surgery
- Hearing aids or eyeglasses, dental care or oral appliances
- Physical for insurance, licensing, school or recreational purposes
- Elective abortions
- Workers' compensation
- Prescription drugs (unless included through BlueCare Rx)
- Complementary and Alternative Healing Methods (CAM)

The copayments are the responsibility of the Member and must be paid to the provider at the time service is rendered.

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.

Health care services must be provided or authorized by your primary care physician. This summary is only a partial description of the many benefits and services covered by Health Options, Inc., an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. These benefits apply only to groups of 51 or more employees. Health Options, Inc. and Blue Cross and Blue Shield of Florida, Inc. are independent licensees of the Blue Cross and Blue Shield Association. This does not constitute a contract. For a complete description of benefits and exclusions, please see Master Policy *86002*; its terms prevail.

Blue Cross Blue Shield Low Option PPO Plan

With this BlueChoice PPO Family Physician Plan, you get the freedom to choose between convenient, affordable care from your PPO network Family Physician, or other providers for care as you see fit. In order to take advantage of lower out-of-pocket costs, simply choose a PPO physician who specializes in Family Practice, Internal Medicine or Pediatrics.

This is not an insurance contract or Certificate of Coverage. The above Benefit Summary is only a partial description of the many benefits and services covered by BlueCross and BlueShield of Florida, Inc., an independent licensee of the BlueCross and BlueShield Association. For a complete description of benefits and exclusions, please refer to your Certificate of Coverage.

Low Option PPO Plan (BlueChoice PPO)

With the BlueChoice® PPO Family Physician Plan, you get the freedom to choose between convenient, affordable care from your PPO network Family Physician, or other providers for care as you see fit. In order to take advantage of lower out-of-pocket costs, simply choose a PPO physician who specializes in Family Practice, General Practice, Internal Medicine or Pediatrics.

Benefits

Financial Responsibilities for Covered Services

Deductibles	
Individual Calendar Year Deductible	$5,000 Per Person
Family Calendar Year Deductible	None
Hospital Per Admission Deductible	
• PPO Hospitals	$150
• Hospitals Not Participating in PPO	$300
Emergency Room Per Visit Deductible (waived if admitted)	$50

Note: The Hospital Per Admission Deductible and the Emergency Room Per Visit Deductible is in addition to the Calendar Year Deductible.

Coinsurance Percentage Payable by BCBSF	
PPO Providers – Allowed Amount	70%
Providers Not Participating in PPO – Allowance	50%
• Ambulance Services – Allowance	70%

Your Coinsurance Responsibility Per Calendar Year	
Individual Coinsurance Limit	$10,000
Family Coinsurance Limit	None

Office Services	
PPO Family Physician:	
• Office services by a PPO Family Physician (Co-payment Only)	$20
• Allergy Injections per visit (Co-payment only)	$5

All Other Providers

- Office services provided by any provider other than a PPO Family Physician is subject to the Individual Calendar Year Deductible and Coinsurance.

Note: Durable Medical Equipment, Prosthetics and Orthotics are always subject to the Individual Calendar Year Deductible and Coinsurance; no Copayment applies.

Low Option PPO Plan (BlueChoice PPO)

Benefit Maximums

Calendar Year Maximums Per Insured	
Home Health Care Benefit Maximum	$2,500
Skilled Nursing Facility Days Benefit Maximum	60
Enteral Formula (Low Protein Food Products) Benefit Maximum	$2,500
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations Benefit Maximum	$2,500
Adult Wellness Benefit Maximum Per Insured Per Calendar Year Covered Services for an adult (i.e., age 17 and older) Includes the following: • Annual physical and gynecological exam (including family planning/contraceptive services); • Related wellness services (e.g., Pap smears, Prostate Specific Antigen [PSA], X-rays, laboratory services, and immunizations). Routine vision and hearing examinations and screening are not covered.	$150

Because we want to make sure you take advantage of these important Benefits, adult wellness services are not subject to the Individual Calendar Year Deductible. You'll only need to meet the Copayment, or applicable Coinsurance, depending on where you receive care and the participating status of your chosen Provider.

Lifetime Maximums Per Insured	
Total Lifetime Maximum Benefit	$2,000,000
Hospice Benefit Maximum	$7,500

Pre-existing Conditions Limitation
This plan has a 6/12 pre-existing condition clause. See page 19.

This is not an insurance contract or Certificate of Coverage. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's BlueChoice Certificate of Coverage and Schedule of Benefits; its terms prevail.

Blue Cross Blue Shield Dependent Child(ren) Only Plan

BlueOptions
Dependent Child(ren) Only Plan

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Benefits for Covered Services	*Amount Member Pays*
This is a limited benefit plan, so please carefully review what the plan covers. With these plans, you and your covered dependents will have medical benefits for your routine health care, **up to** the maximum number of office services/visits allowed under the health plan each calendar year. And **BCBSF will only pay up to the Annual Benefit Maximum** of the health plan per calendar year for covered services.	
Office Services	
Physician Office Services In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Out-of-Network e-Office Visit ***This plan has a six- (6) physician office visit per person, per calendar year maximum. e-Office Visits do not count toward your office visit maximum.*** **Note:** Visits considered as Adult Wellness*, Well Child, Mental Health*, Substance Dependency*, Maternity Services and Outpatient Therapy* & Spinal Manipulation* are **not** subject to the six physician office visit maximum. (*These benefits have separate benefit maximums.)	 $25 Copay $40 Copay CYD[1] + 50% AA Coinsurance* $10 Copay CYD + 50% AA Coinsurance*
Maternity Initial Visit In-Network Specialist Out-of-Network	 $40 Copay CYD + 50% AA Coinsurance*
Allergy Injections In-Network Out-of-Network	 $10 Copay CYD + 50% AA Coinsurance*
Preventive Care	
Adult Wellness Benefit Maximum (PCY[2] max, includes Well Woman and Routine Adult Physical Exam and Immunizations)	$150
Routine Adult Physical Exam and Immunizations (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	 $25 Copay $40 Copay 50% AA Coinsurance*
Well Woman Exam (Annual GYN) (Applies towards Adult Wellness PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	 $25 Copay $40 Copay 50% AA Coinsurance*
Mammograms In-Network / Out-of-Network	 100% AA*
Well Child (No PCY max) In-Network Family Physician In-Network Specialist Out-of-Network	 $25 Copay $40 Copay 50% AA Coinsurance*
Prescription Drug Program (BlueScript)	
Generic / Brand / Non-Preferred	$15 / Not Covered*
Mail Order (90-day supply) Generic / Brand / Non-preferred	Not Applicable
BlueScript Pharmacy benefit also provides coverage for Prescription oral contraceptives, Prescription diaphragms and diabetic equipment and supplies. *Brand drugs are not covered under this plan, however you can take advantage of the BlueSaver savings program designed to give you special discounted pricing on brand name prescription drug purchases when you show your BlueSaver ID card at participating pharmacies. The BlueSaver savings program is administered by Medical Security Card Company (MCS) of Tucson, Arizona and is not an insurance product or part of your BlueOptions health plan.	

Blue Cross Blue Shield Dependent Child(ren) Only Plan

*PLEASE NOTE, THIS BLUEOPTIONS PLAN HAS A 6/12 PRE-EXISTING CONDITIONS CLAUSE.

Pre-existing conditions which existed within 6 months prior to date of hire (for new hires or new dependents) or effective date of coverage for existing employees are excluded for 12 months with credit given for the 12 month period for creditable coverage the member may have had.

Pre-existing Waiting Period – A pre-existing condition is any condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the Enrollment Date. Participants must satisfy a 12-month waiting period from the Enrollment date before becoming eligible to receive benefits for pre-existing conditions.

This provision will not apply to newborns or children who are adopted or placed for adoption and enrolled in the plan within 30 days. Pregnancy is not considered a pre-existing condition.

The period of pre-existing condition exclusion will be reduced by prior periods of Creditable Coverage under another plan or health coverage applicable to the Participant as of the Enrollment Date, if such coverage was earned without a Significant Break in Coverage (not more than 63 days). The Participant must show proof of prior creditable coverage. A Certificate of Coverage may be used for this purpose.

Please call BCBSFL for further explanation at 1-800-507-9820.

This does not constitute a contract and is only a summary of benefits. For a complete description of benefits and exclusions, please see your Master Policy; its terms prevail.

Benefits for Covered Services	*Amount Member Pays*
Emergency Medical Care	
Urgent Care Centers In-Network / Out-of-Network	$40 Copay / CYD + 50% AA Coinsurance*
Emergency Room Facility Services (per visit) (Copay waived if admitted) In-Network / Out-of-Network	$150 Copay / $300 Copay
Ambulance Services (Ground travel / Air and water travel, per day maximum)	CYD + 30% Coinsurance* $400 / $4,000*
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Out-of-Network	 CYD + 30% Coinsurance CYD + 50% AA Coinsurance*
Independent Clinical Lab In-Network / Out-of-Network	$0 / CYD + 50% AA Coinsurance*
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	$300 Copay / $300 Copay CYD + 50% AA Coinsurance*
Mental Health & Substance Dependency	
HORIZON HEALTH	1-866-882-9791
Other Provider Services	
Provider Services at Hospital and ER In-Network and Out-of-Network	CYD + 30% Coinsurance*
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 CYD + 30% Coinsurance CYD + 30% Coinsurance CYD + 50% AA Coinsurance*

1 CYD = Calendar Year Deductible
2 PCY = Per Calendar Year
Note: Out-of-Network services may be subject to balance billing.

BlueOptions
Dependent Child(ren) Only Plan

Benefits for Covered Services	*Amount Member Pays*
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations In-Network Locations other than Hospital and Physician's Office Out-of-Network Locations other than Hospital Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network	$1,500 **(PCY maximum)** $40 Copay CYD + 50% AA Coinsurance* $300 Copay / $300 Copay CYD + 50% AA Coinsurance*
Durable Medical Equipment In-Network Out-of-Network	**$1,000 (PCY maximum)** CYD + 30% Coinsurance CYD + 50% AA Coinsurance*
Home Health Care In-Network Out-of-Network	**$2,500 (PCY maximum)** CYD + 30% Coinsurance CYD + 50% AA Coinsurance*
Skilled Nursing Facility In-Network Out-of-Network	**60 days (PCY maximum)** CYD + 30% Coinsurance CYD + 50% AA Coinsurance*
Hospice In-Network Out-of-Network	**$5,200 (Lifetime maximum)** CYD + 30% Coinsurance CYD + 50% AA Coinsurance*
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	$100 Copay / CYD + 50% AA Coinsurance*
Inpatient Hospital Facility and Rehabilitation Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network	**Rehabilitation Services limit - 21 days PCY** $750 Copay / $750 Copay CYD + 50% AA Coinsurance*
Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network	$300 Copay / $300 Copay CYD + 50% AA Coinsurance*
Emergency Room Facility Services (per visit) (Copay waived if admitted) In-Network / Out-of-Network	$150 Copay / $300 Copay
Financial Features	
Annual Benefit Maximum (The Annual Benefit Maximum is the maximum amount BCBSF will pay in benefits for each covered member, each calendar year)	$25,000
Calendar Year Deductible (CYD) (per person / family aggregate) In-Network Out-of-Network (CYD is the amount the member is responsible for before BCBSF pays for covered services)	 $1,000 (Individual) $2,000 (Family) $3,000 (individual) $6,000 (Family)
Coinsurance In-Network / Out-of-Network (Coinsurance is the percentage the member pays for covered services)	30% / 50%*
Out-of-Pocket Maximum	Not Applicable
Total Lifetime Maximum Benefit	Unlimited

Blue Cross Blue Shield Dependent Child(ren) Only Plan

BlueOptions
Dependent Child(ren) Only Plan

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

***OUT-OF-NETWORK SERVICES BASED ON ALLOWED AMOUNTS AND MAY BE SUBJECT TO BALANCE BILLING.**

ALLOWED AMOUNTS FOR IN-NETWORK SERVICES BASED ON CONTRACTED FEES.
ALLOWED AMOUNTS FOR OUT-OF-NETWORK SERVICES BASED ON UCR (USUAL REASONABLE AND CUSTOMARY) FEES.

PCY = Per Calendar Year
CYM = Calendar Year Maximum
AA = Allowed Amount
CYD = Calendar Year Deductible

An Array of Value-Added Programs and Services*

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***www.bcbsfl.com*** and other interactive web-based support tools
- **MyBlueService**, our 24/7 online member self-service, where you can request extra ID cards, review benefits, check claims status, print forms and more
- **Discounts** on vision care, hearing care, alternative care, fitness clubs and more through our Discount Blue365 program
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more**
- A quarterly **Personal Health Report**, and **programs to reward you for staying healthy and participating in sports**

Access to Our Strong Networks

NetworkBlue℠ is the Preferred Provider Network designated as "In-Network" for BlueOptions. However, you will have **protection from balance billing** when you receive covered services from a provider in our Traditional Program Network. You may also receive **out-of-state coverage through the BlueCard®** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, BCBSF does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at **www.bcbsfl.com.**

* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has entered into arrangements with various vendors to provide value-added features that include care decision support tools and services to its members. These programs are not part of insurance coverage. All decisions that members make pertaining to medical/clinical judgment should be made in conjunction with their Physician since neither BCBSF nor its vendors provide medical care or advice.
** As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

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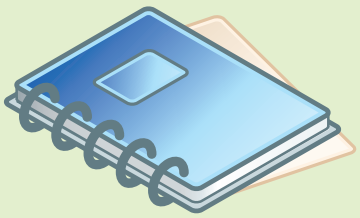
Medical Insurance Self-Service Website

MYBLUESERVICE (MBS)

BLUECROSS BLUESHIELD OF FLORIDA ONLINE MEMBER SELF-SERVICE

MyBlueService is BlueCross BlueShield of Florida's self-service Web site for our members. It gives members the ability to:

- Check claim status
- Request ID cards and benefit booklets
- View your benefit election, demographics and dependent status.
- Web Chat Feature: Receive real-time on-line help with login or technical problems
- Print a Temporary ID Card (10-day effective date)
- Change your PCP (HMO only)
- Search provider directories
- Submit general inquiries
- Download forms and search Frequently Asked Questions and review dependent eligibility verification
- Available in English and en Espanol.



HOW DO I REGISTER FOR MYBLUESERVICE (MBS)?

1. Go to www.bcbsfl.com. Click on link under "New Member?" to register.
2. Complete the following information requested: Social Security number, date of birth, and verification
3. Click on continue button.
4. Create your User ID, using 6-8 numbers.
5. Create personal identification number (PIN) using 6 numbers.

You will have access to your own claims as well as claims for any dependents under the age of 18. Anyone on the policy over the age of 18 must create his/her own PIN and User ID to access MyBlueService.

Questions regarding use of MyBlueService should be directed to Customer Service, or contact your on-site representative at (813) 794-2492.

Prescription Drug Plan

PRESCRIPTION DRUG PLAN

Medco is the new administrator of the the Prescription Drug Program for the District School Board of Pasco County. All employees enrolled in a medical plan automatically receive pharmacy benefits.

As a new employee, your Personal Plan Description booklet and ID card will be delivered to your home on or before your effective date of coverage. If you misplace your ID card, call Customer Service at 1-800-711-0917 to request a new one.

The program has two parts:

- Retail Pharmacy Benefit – choose from thousands of participating pharmacies nationwide and
- Mail Service Pharmacy Benefit – order your prescriptions and have them delivered right to your door.

YOUR COST

When your covered prescriptions are filed under this program, you share a portion of the cost; the plan pays for the rest. Please see chart on next page for your costs for the program.

It is standard pharmacy practice (and in some states, it is even required by law) to substitute generic equivalents for brand name drugs whenever possible. When you use the mail service or a participating retail pharmacy, you will receive generic equivalents whenever available and allowable.

Under your benefit plan you will be responsible for the generic co-payment, plus the difference between the brand and generic price of each drug whenever a brand-name drug is dispensed, when a generic equivalent is available and allowable.

A formulary is a list of medications that can help you maximize your benefit by minimizing your prescription costs. These formulary medications have received FDA approval as safe and effective. To determine a medication's status, please visit www.medco.com or call Medco Member Services.

CLINICAL PRIOR AUTHORIZATION PROGRAM (CPA)

Certain prescriptions require "clinical prior authorization" or approval from your plan, before they will be covered. The categories/medications that require clinical prior authorization may include, but are not limited to: Acne (topical-after age 24), ADHA/Narcolepsy (after age 19), Anabolic Steroids (all types), Antiemetics (oral-after 7-day supply per 25 days), Butorphanol (after two 5 ml bottles per 25 day supply), Crinone (8%), Diflucan (150 mg after two per 25 day supply), Impotency (after 8 qty. per 25 day supply, then CPA), Insomnia (after 90 day qty. per 144 day supply) and Migraine (after 8 injectables, 8 nasal or 18 oral per 25 day supply).

To confirm whether you need clinical prior authorization and/or to request approval, call 1-800-711-0917. Please have available the name of your medication, physician's name, phone (and fax number, if available), your member ID number and your group number (from your ID card).

STEP THERAPY

This program generally requires utilization of an effective first-line agent before other alternative therapies may be covered. Your benefit plan requires this program to be in place for the following categories: COX-2 Inhibitors, Leuko trienes, Prilosec (OTC), Proton Pump Inhibitors. For more information, call 1-800-711-0917.

SPECIALTY PHARMACY

Certain medications used for treating complex health conditions must be obtained through the Specialty Pharmacy program. The following conditions may require drugs that fall under Specialty Pharmacy which include, but are not limited to: Cystic Fibrosis, Growth Hormone Deficiency, Multiple Sclerosis, Rheumatoid Arthritis and Viral Hepatitis. Please call 1-800-711-0917 to enroll in this program.

COVERED DRUGS

Please refer to your Summary Plan Description for details about covered and non-covered drugs. For specific drug inquiries, contact MedCo Member Services at 1-800-711-0917.

NON-COVERED DRUGS

- Cosmetic drugs
- Infertility drugs
- Over-the-counter (OTC) items

This is a partial listing of non-covered drugs. Certain prescriptions may require a physician confirmation of medical necessity. Please refer to your plan document for details.

Prescription Drug Plan

PARTICIPATING PHARMACIES

You can choose from more than 62,000 participating pharmacies. Below are just some of the many pharmacies participating in our nationwide retail network. For additional participating pharmacies, call Medco Member Services at 1-800-711-0917 or visit our Web site at www.medco.com.

Acme	Osco Drug
Albertsons	Publix
Brooks Pharmacy	Rite Aid
Costco	Sam's Club
CVS	Sav-on Drugs
Duane Reade	Target
Eckerd	Thrifty Drug
Kerr Drug	Walgreens
Kmart	Wal-Mart
Kroger	Winn Dixie

If you have a question regarding your pharmacy program, please visit the Medco's Web site, www.medco.com, or if you would like to speak to a representative you may contact Customer Service 24 hours a day, toll-free at 1-800-711-0917.

RETAIL PHARMACY

(Short-term medications):

Up to 30-day supply

Generic:	$10.00
Preferred Brand:	$25.00
Non-Preferred Brand:	$40.00

Retail Pharmacy Advantage 90*

(Long-term medications):
90-day supply

Generic:	$25.00
Preferred Brand:	$62.50
Non-Preferred Brand:	$100.00

Mail Service

(Long-term medications):
Up to 90-day supply

Generic:	$20.00
Preferred Brand:	$50.00
Non-Preferred Brand:	$80.00

**Only available at select retail pharmacies*

NEW MANDATORY 90 DAY PHARMACY PRESCRIPTION REFILLS FOR 2009.

If you take a daily medication you will be required to refill for a 90 day supply. Daily or maintenance medications are medications taken on a regular, continuous daily basis. You will have 2 ways to save money if you take daily medications: the Advantage 90 program from selected pharmacies, or with Medco's Mail Service pharmacies.

If you do not fill for a 90 day supply you will be required to pay a double co-pay for your prescriptions for non-compliance with the Mandatory 90 day Prescription Program.

FILLING PRESCRIPTIONS AT THE MAIL SERVICE PHARMACY

Through the Prescription Drug Program, you can take advantage of convenient delivery of your covered maintenance medications to your home or other specified address.

- Complete and return the Registration & Prescription Order Form provided in your patient information packet.
- Visit the Medco Web site at www.medco.com to download the "Registration & Order Form." Print it out, complete it and mail it with your prescription order.
- Visit the Medco Web site at www.medco.com to complete and submit the Online Registration Form. This form allows for online registration only. Your registration will be active within 48 hours.

REFILL PRESCRIPTIONS

- If you have a current prescription with valid refills, you will not need to obtain a new prescription.
- You can refill your prescription(s) by mail, telephone, or through the Internet at www.medco.com with your co-payment information.
- The pharmacist will process and fill your prescription(s) and mail it to your home or office.

NEW PRESCRIPTIONS

- Mail your new prescription(s) to the Medco Mail Service Pharmacy with your co-payment.
- The pharmacist will process and fill the prescription(s) and mail it to your home or office.

If you have a question regarding your mail service pharmacy order, please visit the Medco Web site www.medco.com or if you would like to speak to a pharmacy representative or a pharmacist, you may contact Customer Service at 1-800-711-0917 Monday – Friday, 8:00 a.m. – 8:00 p.m. ET, Saturday, 8:00 a.m. – Noon ET.

Employee Assistance Program

THE EMPLOYEE ASSISTANCE PROGRAM (EAP)

This benefit program is intended to ensure a healthy work environment for all staff. The services include counseling and referral for personal issues, wellness initiatives, financial advisement, and other specialized services.

Employees of the District School Board have access to this valuable service. The District will provide up to five (5) free, confidential counseling sessions for each employee and retiree. All services are totally confidential.

- No information on clients is available to anyone except the EAP counselor, except with the client's written authorization.
- Only the employee may choose to share information with a supervisor.
- All counseling offices are located separate from any school or school board property.
- The employee never needs to go to the District Office for service.
- No record of EAP services is kept in personnel files.

The EAP can help assist employees with many issues that affect their well being, job attendance or job performance. Twelve licensed professionals are available in offices throughout the county (Hudson/Bayonet Point, New Port Richey, Tarpon Springs, Land O'Lakes, Lutz, Dade City, and Zephyrhills), all in offices completely separate from School Board properties. All appointments are scheduled through the Land O'Lakes office.

Use or nonuse of the EAP is voluntary and cannot be construed as negative during performance evaluations. An employee cannot be required to use or be coerced into using the Employee Assistance Program. Employees may choose to seek counseling services or supplement their EAP services by accessing counseling through their insurance plan (Comprehensive Behavioral Care).

WHAT TYPES OF ISSUES ARE ADDRESSED BY THE EAP COUNSELING AND REFERRAL SERVICES?

- Marital and Relationship Issues
- Family/Child Adjustment Issues
- Issues Relating to Elder Care
- Job-related Stress
- Stress/Burnout
- Depression
- Anxiety/Panic Attacks
- Alcohol/Substance Abuse
- Eating Disorders
- Tobacco Addiction
- Personal Finance Issues
- Wellness
- Family Mediation

Two of our providers are Supreme Court Certified Family Mediators. Mediation, an alternative to formal court divorce/custody proceedings, allows couples to negotiate and resolve disputes with an emphasis on cooperation. By accessing these services through your Employee Assistance Program, some of the cost of mediation can be deferred. Please contact the EAP for further information.

To schedule an appointment or to request additional information, please contact the EAP scheduling office (8:00 AM – 4:30 PM) at:

727/774-2366 (west)
813/794-2366 (central)
352/524-2366 (east)

Mental Health and Substance Abuse Benefits

COMPREHENSIVE BEHAVIORAL CARE

Horizon Health is working closely with community-based behavioral health care providers to ensure that members have:

- Around-the-clock access to comprehensive compassionate behavioral health services.

If you're having difficulty handling day-to-day responsibilities because of feelings like:

- Anger
- Sadness
- Depression
- Stress
- Anxiety

The program can help if you have a problem and want to talk. It offers you and your family members a full range of behavioral health care services.

ACCESSING CARE

By calling Horizon Health's toll-free number (866-882-9791), you or a family member can receive a referral for treatment. A licensed care manager is available 24 hours a day, seven days a week, to assess your needs and refer you to the appropriate behavioral health care professional.

If you experience a life-threatening emergency, call 911 or go to your nearest hospital emergency room, then call the program within 24 hours. Your mental health and substance abuse benefits provide for in-network and out-of-network benefits.

Horizon Health
Mental Health & Substance Abuse
866-882-9791
http://horizoncarelink.com/login.aspx
Login – pascoschools
Password – worklife

OBTAINING AUTHORIZATION

Your in-network benefits require you to see a Horizon Health network provider and to obtain pre-approval from the program before receiving treatment, except in the case of an emergency (as explained above). Even if your primary care physician has given you a referral, you still must call the program for pre-approval. Additionally, you have out-of-network benefits that you may use, but your co-payments and deductibles will vary and may be at a higher rate.

CONFIDENTIALITY

Employers are not informed when employees seek treatment. All behavioral health records are strictly private and confidential, as required by federal and state laws.

CHOOSING YOUR DOCTOR OR THERAPIST

Simply call Horizon Health and a representative will assist you in selecting a network doctor, therapist, or facility close to your home or place of work. Most behavioral health care treatment takes place in an outpatient setting, such as a doctor's office or clinic. More intensive treatment may require more frequent outpatient visits, partial hospitalization or inpatient admission at a hospital. The program will work with you and your doctor or therapist to see that your treatment is tailored to your specific needs.

WorkLife Benefit Options at a Glance

Toll-Free Number – (866) 882-9791	▪ Confidential consultation and resource services at no cost to you! ▪ Immediate access to all WorkLife benefits.
Telephonic Intervention	▪ 24/7 telephonic assessment and triage ▪ Immediate assistance from a qualified member advocate ▪ Monthly email communications
WorkLife Benefits	▪ Eldercare, childcare, and dependent care consultation and referral - unlimited number of issues per year ▪ Convenience services - unlimited number of issues per year
Financial Consultation	▪ One free 30-minute telephonic initial consultation per each new issue with a financial counselor on topics including credit counseling, debt and budgeting, mortgages, retirement planning, and tax questions with local referrals and web access - unlimited number of issues per year. ▪ Library of forms, articles, FAQ's, calculators
Legal Consultation	▪ One free 30-minute telephonic or face-to-face consultation with a network attorney or mediator per each new issue - unlimited number of issues per year. ▪ 25% discount off usual rates for subsequent work with network attorney or mediator. ▪ Free simple will preparation ▪ 10% discount off usual rates for telephonic and online assistance to help prepare legal documents such as divorce forms, estate planning forms, immigration forms, and others. ▪ Library of forms, articles, FAQ's, calculators.

Mental Health and Substance Abuse Benefits

WorkLife Benefit Options at a Glance

Identity Theft Consultation	▪ One free 60-minute telephonic consultation per each new issue with a fraud resolution specialist - unlimited number of issues per year. ▪ Specialist assists employees with restoring their identity and good credit. ▪ Free "ID Theft Emergency Response Kit." ▪ Specialist advises client on how to dispute fraudulent debts due to ID theft. ▪ Counselor follows up with the member and monitors progress.
HorizonCareLink™ Online EAP Services	▪ Child and elder care searches and resources ▪ School and college tools ▪ Adoption resources ▪ Veterinarian and pet care searches ▪ Psychological health resources ▪ Assessments and wellness resources ▪ Money and time-saving resources ▪ Free live webinars on timely topics such as: - Housing in Today's Economy - Strategies for Building Self Esteem - Living Green Made Easy - The ABCs of Estate Planning - Managing Holiday Stress

Behavioral Health Benefit Options at a Glance

Toll-Free Number – (866) 882-9791	▪ Immediate access to behavioral health and convenience service benefits ▪ Contact Horizon to access premier benefit coverage options
Outpatient Mental Health	▪ $35 co-pay when approved by Horizon (In-Network) ▪ 40% coinsurance without approval by Horizon after deductible met (Out-of-Network) ▪ Member can be balance billed if member chooses to see a non-participating provider. Horizon pays a maximum of $35 per visit to the non-participating provider
Outpatient Substance Abuse	▪ $35 co-pay when approved by Horizon (In-Network) ▪ 40% coinsurance without approval by Horizon after deductible met (Out-of-Network) ▪ Member can be balance billed if member chooses to see a non-participating provider. Horizon pays a maximum of $35 per visit to the non-participating provider
Intensive Outpatient	▪ $35 co-pay when approved by Horizon (In-Network) ▪ 40% coinsurance without approval by Horizon after deductible met (Out-of-Network) ▪ Member can be balance billed if member chooses to see a non-participating provider. Horizon pays a maximum of $35 per visit to the non-participating provider
Inpatient Mental Health	▪ $600 co-pay per admission (In-Network) ▪ No deductible applied for in-network services ▪ 40% coinsurance for out-of-network services after deductible met (Out-of-Network) ▪ Balance billing may apply if member chooses services from a non-participating provider
Inpatient Substance Abuse	▪ $600 co-pay per admission (In-Network) ▪ No deductible applied for in-network services ▪ 40% coinsurance for out-of-network services after deductible met (Out-of-Network) ▪ Balance billing may apply if member chooses services from a non-participating provider
Partial Hospitalization	▪ $200 co-pay per admission (In-Network) ▪ No deductible applied for in-network services ▪ 40% coinsurance for out-of-network services after deductible met (Out-of-Network) ▪ Balance billing may apply if member chooses services from a non-participating provider
Residential Treatment	▪ 60 days per year maximum ▪ 20% coinsurance paid by member for in-network services (In-Network) ▪ 40% coinsurance for out-of-network services after deductible met (Out-of-Network) ▪ Balance billing may apply if member chooses services from a non-participating provider
Deductible	▪ Applies only to out-of-network services ▪ $500 deductible per individual per year ▪ $1,500 deductible per family per year
Lifetime Maximum	▪ Combined lifetime maximum of $5,000,000

Autism Benefit Information

Autism Benefit

The District School Board of Pasco County provides coverage for the screening, diagnosis, intervention and treatment of autism spectrum disorders in certain children. Autism Spectrum Disorder means any of the following as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM-IV): Autistic Disorder, Asperger's Syndrome, Pervasive Developmental Disorder Not Otherwise Specified.

Applied Behavior Analysis (ABA) is considered the recommended treatment for Autism Spectrum Disorders. To be eligible for ABA services, the treatment must be prescribed by the insured's treating medical physician in accordance with a treatment plan; AND the individual must be diagnosed as having Autism Spectrum Disorder at 8 years of age or younger. The benefits and coverage shall be provided to any eligible person younger than 18 years of age or to any eligible person who is 18 years of age or older who is in high school.

To access ABA services, contact Horizon Health at 866-882-9791. Services are covered as follows:

20% coinsurance paid by member for in-network services

40% coinsurance paid by member for out-of-network services after deductible is met; Balance billing may apply if member selects services from a non-participating provider.

To access and determine eligibility for the special autism benefit, call Horizon Health at 866-882-9791.

Dental Insurance HMO Q & A

Do I need to select a general dentist when I enroll?
Yes. The SafeGuard general dentist you select at enrollment will provide your routine dental care… and with SafeGuard's individual selection feature, you and your enrolled dependents can each select different network dentists.

Who are the dentists in your network?
SafeGuard contracts with both private practice dentists and those who are in a clinic environment. Every dentist in our network has been thoroughly screened prior to acceptance and we report regularly to the State of Florida with regard to the quality of care within our network. SafeGuard is also subject to regular audits both in our offices and in the dental practices. You are protected when you enroll in a SafeGuard plan.

A list of providers in your area can be found on the SafeGuard website at www.safeguard.net.

Can I change dentists?
Yes. Call us or use SafeGuard's interactive web site to change dentists. Your transfer will be effective the first of the following month.

What if I need emergency care?
All SafeGuard general dental offices provide emergency access 24 hours a day, 7 days a week. If you cannot reach your selected general dentist, you may receive emergency care from any licensed dental care professional. (The definition of what is considered "emergency care" can be found in your Evidence of Coverage booklet (located on the Pasco Employee Benefits Department website*). Or you may go to SafeGuard's Member website (www.safeguard.net) for Florida-specific emergency information.

*http://ebarm.Pasco.k12.fl.us.

I noticed some dental offices in your directory appear to be closed to new members. What if one of them is my current dentist?
That's why we list all network dentists, not just the offices that are open to new membership. If you are currently a patient in one of those offices, you will not have to change dentists since you are not really considered a "new" patient.

What if I need to see a specialist?
This is a "direct referral" plan which means your SafeGuard general dentist will refer you to a contracted specialist in your area.

Do these plans cover second opinions?
Absolutely. Just let us know that you would like another clinical opinion and we will provide the name of a dentist for you to see.

How long can my dependent child see a pediatric dentist?
Children can receive treatment from a pediatric dentist until they reach 8 years of age. Once they reach 8, they would need to see a general dentist.

SafeGuard®

*A MetLife Company

Dental Insurance DHMO

Dental HMO Plan Highlights – SGC1027

For full plan information, please see the Schedule of Benefits, Exclusions & Limitations and Evidence of Coverage.

CDT Code	Procedure/Treatment	Co-Pay
Diagnostic Treatment		
D0150	Comprehensive oral evaluation	$0
D0180	Comprehensive periodontal evaluation	$0
D0210	Intraoral x-rays – complete series	$0
D0431	Adjunctive pre-diagnostic test *(cancer screening)*	$0
Preventive Services		
D1110	Cleaning *(prophylaxis)* - adult	$0
1111	Additional cleaning *(maximum two per year)* – adult	$35
D1203	Topical application of fluoride	$0
D1351	Sealant – per tooth	$0
Restorative Treatment		
D2150	Amalgam *(silver)* filling – 2 surfaces, primary or permanent tooth	$0
D2331	Resin-based composite – 2 surfaces, anterior	$0
D2392	Resin-based composite – 2 surfaces, posterior	$45
Crowns, Veneers	**additional charges may apply depending on metal type and use of porcelain*	
D2751	Porcelain fused to predominantly base metal*	$185
D2962	Labial veneer *(porcelain laminate)* - laboratory	$350
D2970	Temporary crown *(fractured tooth)*	$0
Endodontics		
D3310	Root canal – anterior *(excluding final restoration)*	$80
D3346	Retreatment of previous root canal therapy – anterior	$135
D3410	Apicoectomy/periadicular surgery - anterior	$95
Periodontics		
D4210	Gingivectomy or gingivoplasty–4 or more contiguous teeth, per quad	$90
D4341	Periodontal scaling & root planning-4 or more contiguous teeth, per quad	$40
D4910	Periodontal maintenance	$30
Dentures, Bridges	**additional charges may apply depending on metal type and use of porcelain*	
D5110	Complete upper denture	$210
D5850	Tissue conditioning, upper	$10
D6241	Pontic *(tooth replacement portion of bridge)* – porcelain fused to predominantly base metal*	$185
Oral Surgery		
D7140	Extraction, erupted tooth & exposed root	$0
D7220	Removal of impacted tooth – soft tissue	$45
D7288	Brush biopsy	$50
Orthodontics (Braces)		
D8070	Comprehensive orthodontic treatment – child, adolescent, adult	$1695
D8090		
D8680	Retention *(removal of appliances, placement of retainers)*	$250
Adjunctive General Services		
D9220	Deep sedation/general anesthesia – 1st 30 minutes	$150
D9242	Intravenous conscious sedation – 1st 30 minutes	$150
D9972	External bleaching – per arch	$125

Dental Insurance PPO

How does this plan work?

This plan has a calendar year maximum of $1500, which is the maximum amount MetLife will pay toward the dental care for each person enrolled on this plan. There is a yearly deductible of $75 per person up to 3 - $225 a year deductible is all you will pay per family. There is a "coinsurance percentage" for each type of procedure covered which is the percentage MetLife pays, after deductible, if applicable.

Your Summary of Benefits provides more information – you can find it on the Pasco Employee Benefits Department website.

Do I select a dentist when I enroll?

There is no requirement to "pre-select" a dentist. You will save money by receiving care from a MetLife contracted dentist and a directory for your area is available on the MetLife website – a link is available on the Pasco Employee Benefits Department website. You can search by name, city, county or zip code – use the "Visitor" access prior to enrolling.

What if I have other dental coverage in addition to the MetLife plan?

We will coordinate our benefits with those you may be entitled to from other policies. Your combined benefits may pay up to, but no more, than the total covered expense.

What's the difference between in and out-of-network benefits?

With this plan, you can receive care from any licensed dental care professional…but if you see a contracted MetLife dentist, you will reduce your out-of-pocket costs. These network dentists have agreed to reduce their treatment fees up to 30% for MetLife enrollees. In addition, your reimbursement percentage will be higher in-network…you will save two ways! And, you won't have to do any paperwork – your MetLife dentist will file your claims for you.

How do I file a claim?

In most instances, your dentist's office staff will ask you to sign an "assignment" form that allows them to file the claim for you and pay them directly. Both you and your dentist will receive an Explanation of Benefits that details how the claim was paid.

If your out-of-network dentist prefers that you pay first and file your own claim, complete a standard claim form and submit it to: MetLife.

Do I need to get approval on some costs before treatment starts?

Approval of benefits is not required but we do encourage you to have your dentist submit a preauthorization request for a treatment plan of more than $300. This will ensure that any of the procedures suggested are, in fact, covered benefits. It also gives you a chance to find out beforehand what the out-of-pocket expenses will be.

More questions?
Call MetLife at 800.942.0854 –
8am to 9pm weekdays.

MetLife®

Dental Insurance DHMO & PPO Plan Comparison

Depending upon your eligibility status, you have a choice of two dental plans – one is an HMO and a PPO. Both plans will provide you with excellent benefits and access to a network of highly-qualified dental care professionals. The following chart is a summary to show you how the two types of plans compare.

Plan Features

	SGC1027 Dental HMO	MetLife Dental PPO	
		In-Network	Out-of-Network
Access to care	Benefits provided through a network of dental care professionals. Employee and dependents must choose a SafeGuard contracted dentist at enrollment.	You may receive treatment from any licensed dentist or receive potential savings by receiving care from a MetLife contracted dentist.	
Calendar Year Deductible	None	$75 per person $225 per family	$75 per person $225 per family
Calendar Year Maximum	None	$1,500	$1,500
Co-payments and Co-Insurance*	Co-payments are set by procedure and all covered procedures are listed on the Schedule of Benefits	Preventive: Plan pays 100% General: Plan pays 50% Major: Plan pays 60%	Preventive: Plan pays 80% General: Plan pays 80% Major: Plan pays 50%
Non-Surgical TMJ	Not Covered	50% up to $1000 Calandar Year Maximum	50% up to $1000 Calandar Year Maximum
Adult/Child Orthodontic Services	Co-payments by type of service - $1695 for comprehensive treatment	$1,000 Lifetime Maximum	$1,000 Lifetime Maximum
Waiting Period	None	**MetLife PPO** – No waiting period **MetLife Voluntary Plan*-** 12 Month waiting period on Major Services & Non-surgical TMJ	

This is a summary only; for more information regarding the plans, you will find full benefit information at the Pasco Employee Benefits Department website.

The MetLife Voluntary plan is the "Opt Out Only Plan".

Vision Insurance

VSP Coverage As of January 1, 2009

Your Coverage from a VSP Doctor

Exam covered in full after copay.....every 12 months

Prescription Glasses Lenses covered in full after copay.....every 12 months

- Single vision, lined bifocal, and lined trifocal lenses.
- Polycarbonate lenses for dependent children.

Frame.....every 24 months

- Frame of your choice covered up to $ 120.00
- Plus, 20% off any out-of-pocket costs.

~OR~

Contact Lens Care.....every 12 months

When you choose contacts instead of glasses, your $120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts. If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained.

Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or www.vsp.com.
See provider list at www.vsp.com or call 800-877-7195

Advantages of Coverage

Without coverage, an exam and prescription glasses can cost $300 or more. With VSP coverage, you'll save. Plus, with pre-tax payroll deductions, you'll be budgeting for your eye care while reducing your taxable income.

Your Co pays

Exam.....$10
Prescription Glasses.....$15
Contacts.....No co pay applies

Extra Discounts and Savings

Laser Vision Correction Discounts
Please learn more on www.vsp.com or call 800-877-7195

Prescription Glasses

- Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives
- 20% off additional prescription glasses and sunglasses* Contacts*
- 15% off cost of contact lens exam (fitting and evaluation)
- Available from the same VSP doctor who provided your eye exam within the last 12 months

Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, co pays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement. If you decide to see a provider not in the VSP network, call us first at 8 00-877-7195.

Out-of-Network Reimbursement Amounts:
Exam.....Up to $52.00

Lenses:
Single Vision.....Up to $55.00
Lined Bifocal.....Up to $75.00
Lined Trifocal.....Up to $95.00
Frame.....Up to $45.00
Contacts.....Up to $105.00

Basic and Supplemental Term Life

MINNESOTA LIFE

- Basic Life premiums for $35,000 are paid for by the District School Board of Pasco County.
- Basic Accidental Death & Dismemberment (AD&D) matches your Basic Life coverage amount, and is automatically included with your Basic Life coverage.
- All amounts of Basic Life are guaranteed with no health questions.

SUPPLEMENTAL LIFE

- In addition to Basic Life and AD&D, you may purchase Supplemental Term Life insurance in $10,000 increments up to the lesser of five times your annual salary or $300,000.
- Employees who are new hires and within the first 31 days of eligibility can get any amount of coverage guaranteed. Evidence of Insurability (EOI) is not required.
- During annual enrollment, employees currently participating in the Supplemental Life program are eligible to increase supplemental coverage by $10,000 or $20,0000 on a guaranteed issue basis. Evidence of good health or an Evidence of Insurability (EOI) for is not required. You may increase your coverage by more than $20,000 up to the lesser of 5 times salary or $300,000 but EOI will need to be provided (note: employees who have previously been declined for coverage increases are not eligible for the guaranteed coverage increase).

SPOUSE LIFE

- You may insure your spouse for up to $150,000 in $5,000 increments or 50 percent of your Supplemental coverage amount, whichever is less. Minimum coverage is $5,000.
- Employees who are new hires and within the first 31 days of eligibility may insure their spouse for up to $25,000 of coverage on a guaranteed basis. EOI is not required.
- During annual enrollment, EOI is required for any election or increase.

CHILD LIFE

- You may insure your eligible children for $10,000 in coverage.
- Eligible child is defined as a child from live birth to 19 years or up to age 26 if a full-time student at an accredited post-secondary school.
- Employees who are new hires and within the first 31 days of eligibility may insure their eligible children for $10,000 of coverage on a guaranteed basis. EOI is not required.
- During annual enrollment, EOI is required for any election or increase.

ELIGIBILTY

- All full-time non-management and management employees in active employment in the U.S. and with the District School Board of Pasco County and are in a benefits earning position working a minimum of 20 hours per week.
- Individuals may only be covered once under the group policy. Employees cannot also be insured as a spouse, or child. A child can only be insured by one parent. An individual cannot be insured as both an ex-employee and an employee.

FEATURES OF COVERAGE

Accelerated Benefit

Up to 100 percent of the policy's face amount or a maximum of $1,000,000 can be paid as an accelerated benefit if the insured person becomes terminally ill.

Portability

Portability is the ability to continue your Life and AD&D coverage after your eligibility under your group insurance coverage ends. If you retire or your eligibility with the District School Board of Pasco County ends you may take your coverage with you and continue to pay group rates, but your rates may change.

- Basic Core: you may port your coverage only if you do not have a medical condition which will have a material effect on life expectancy. If you are not in good health you may convert your coverage to an individual life policy, but your rates may change.
- Supplement: You may elect to port coverage without evidence of good health. No EOI is required

MINNESOTA LIFE

NEW

All employees must provide beneficiary information to Minnesota Life for their supplemental and/or basic core life benefits provided by the District. Minnesota Life provides a secure website, www.lifebenefits.com, for electing, storing and updating your life insurance beneficiary designations. You may view or update your beneficiary designations at any time on the Life Benefits website using your user ID and password. For additional information contact Minnesota Life at 1-866-293-6047.

WAIVER OF PREMIUM

Premiums are waived if you become disabled prior to age 60. Continues to earlier of retirement, age 65 or recovery.

BENEFICIARY FINANCIAL COUNSELING

Beneficiaries may take advantage of independent financial counseling services from PriceWaterhouseCoopers.

PREMIUM PAYMENTS

Premiums will be withheld from your paycheck on an after-tax basis. Premiums will be deducted from 20 paychecks per year.

REDUCTIONS (SUPPLEMENTAL LIFE)

- Age 70 – reduces to 65 percent of original coverage amount
- Age 75 – reduces to 50 percent of original coverage amount

WHEN DOES MY COVERAGE BEGIN?

Your period of coverage is from January 1, 2010 through December 31, 2010.

Group Term Life Insurance

WHEN BENEFITS TERMINATE
Coverage (Basic Core Life and Supplemental Life) that is not ported terminates at retirement or loss of eligibility.

WHEN CAN YOU MAKE CHANGES TO YOUR COVERAGE?
Changes are limited to your annual open enrollment period or with a qualifying change in status event.

NOTE: Your rate will increase as you age and move into the next age group. Yearly rates are based on your age as of January 1. Rates are not guaranteed and may change.

A copy of your Minnesota Life Certificate of Insurance is available on the Employee Benefits Department website for review and printing. If you do not have access to a computer, contact the Benefits Coordinator at your work location or the Employee Benefits Department for assistance.

LIFE INSURANCE COMPANY OF NORTH AMERICA (LINA)
Life insurance is one of the best ways to provide for those who depend on you because your beneficiary receives a tax-free life insurance payment from this plan. This insurance supplements your School Board-provided life insurance. You can choose from the levels of life insurance below:

$5,000 $10,000 $15,000

MAXIMUM BENEFIT AMOUNT
You can have up to $50,000 combined between your School Board-provided group term life insurance and this life insurance. You can have this coverage without having to provide evidence of insurability.

ACCELERATED DEATH BENEFIT
If you are diagnosed by two unaffiliated physicians with a terminal illness with a life expectancy of 12 months or less, you can receive 50 percent of your life insurance benefit or $50,000, whichever is less, in a lump sum. This benefit is payable only once in your lifetime and will reduce your life insurance death benefit.

EXTENDED DEATH BENEFIT
If you become totally disabled, the extended death benefit ensures that if you die after being totally disabled for 12 months, Life Insurance Company of North America (LINA) will pay the life insurance benefit you elected, provided you remain totally disabled during the 12 month period.

WHEN YOU LEAVE EMPLOYMENT
You can convert this plan to an individual policy within the 31-day period after you leave the School Board by contacting Life Insurance Company of North America at 1-800-441-1832. Evidence of insurability is not required if you apply within the 31-day period.

AFTER YOU RETIRE
You can continue this benefit if you contact Sunbelt Worksite Marketing Customer Service at 1-800-822-8045 within the 60-day period preceding your retirement.

WAIVER OF PREMIUM
If you are totally disabled prior to age 60 and can't work for at least nine months, you won't need to pay premiums for your coverage while you are disabled, provided LINA approves you for this benefit. You must continue to pay premiums until the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until age 65 or the date you retire, whichever occurs first and will be subject to proof of continuing disability each year.

COVERAGE LEVEL AT AGES 65 AND 70
Your Account A and Account B term life insurance coverage decreases to 65 percent of the insured amount on the policy anniversary coinciding with or next following your 65th birthday, and is further reduced by 15 percent of the amount for which you were insured on the policy anniversary coinciding with or next following your 70th birthday.

INSURANCE PREMIUMS AND THE IRS
Please refer to the Beyond Your Benefits section of this booklet for more details.

PLAN PROVIDER
Life Insurance Company of North America (LINA), a CIGNA company, underwrites this plan. A.M. Best Company, which compares and rates the financial s trength and performance of insurance companies, rates LINA "A-" Excellent.

THINK ABOUT HOW TO **REDUCE YOUR TAXES**

WANT TO CUT YOUR INCOME TAX BILL? Yes? Then, take advantage of a valuable benefit that allows you to pay for medical expenses, AND reduce your income taxes, AND increase your spendable income. It's cool, and legal!

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) is a separate benefit plan that allows you to direct a part of your pay, TAX-FREE, into a special account.

You can use this account throughout the year to reimburse yourself for eligible out-of-pocket healthcare and dependent care expenses.

How the FSA tax advantage works

Each pay period, a portion of your annual election amount is automatically deducted from your pay before Federal and Social Security (FICA) taxes are calculated.

This means your FSA deposits are not taxable income, and therefore are not included as taxable income on your W-2. Since your annual income is reduced, so are your annual taxes.

You get the exclusive FSA debit card

The FlexSystem Claim Card can be used at any MasterCard accepting merchant with a medical merchant code. The card can be used at facilities such as; doctor's offices, hospitals, pharmacies and medical laboratories.

When you use the claim card, things happen automatically. The provider gets paid; your account balance is adjusted and no online claim filing or claims forms are required.

If the provider does not accept MasterCard just use another form of payment and submit a Request for Reimbursement (RFR) on www.tasconline.com or manually submit an RFR with receipt to TASC via fax or mail.

The minimum annual amount for an FSA is $240

Now there are some rules (of course) that go along with your FlexSystem Claim Card.

- The IRS requires that you keep all receipts for FlexSystem Claim Card transactions.
- Remember that if a purchase you make with your claim card cannot be automatically substantiated you may still need to provide documentation to back it up.

You've got to use it or lose it

Let's understand the use-it-or-lose it rule. You get tax savings when you spend monies from your FSA for unreimbursed medical, and child care expenses however if you don't spend those elected funds by plan year end you'll loose it. That's the rule. Any money taken pre-tax must be used to pay for eligible medical and dependent care, or it will be forfeited back to Pasco County School.

How do you make sure to elect only what you can spend?

Make a conservative election. Do your homework; use the worksheets available in the reference manual on the Employee Benefits Department website to determine an amount you know you'll be able to spend and elect no more than that amount.

MEDICAL CARE REIMBURSEMENT FSA ACCOUNT

The Medical Care reimbursement account gives you the opportunity to reimburse yourself tax-free for up to $5,000 or 20% of your income (whichever is less) each year for eligible healthcare expenses not covered, or not fully paid, by health care plans.

What is an eligible healthcare expense?

Eligible healthcare expenses include; deductibles, co-payments, dental services, eyeglasses, contact lenses and solutions, over the counter medications and much more.

Flexible Spending Accounts Eligibility Requirements

An interesting fact about your Medical FSA

The full amount of your annual Medical FSA election (at open enrollment) is available to you on the 1st day of the plan year. That's because the funds available for medical reimbursement is based on your annual election amount, not on your contributions to date.

DEPENDENT CARE REIMBURSEMENT FSA ACCOUNT

A Dependent Care reimbursement account gives you the opportunity to pay for the first $5,000 of employment-related dependent care expenses tax-free.

Tax Filing Status	Maximum Contribution
Single or Married Filing Jointly	$5,000
Married Filing Separately	$2,500

Your eligible dependents are children under age 13, and adults incapable of self-care that you claim as dependents.

A FlexSystem Claim Card will not automatically be issued to you if you elect the Dependent Care FSA alone, if you would like to utilize one you may call customer care and request that one be issued.

What are eligible dependent care expenses?

- Expenses for services provided in your home as long as someone you also claim as a dependent, or your other children under age 19 are NOT providing these services.
- Expenses for daycare services outside your home at a facility compliant with state and local laws.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Just like in past years, you will get $150 from the Board to buy voluntary benefits, and/or reduce the cost of your dependent premiums.

A Health Reimbursement Account (HRA) is similar to a Medical FSA except that you may carry any unspent funds over to the next plan year. This is good.

Only Board dollars can go into the HRA, if you need access to additional pre-tax funds for medical expense reimbursement you will need to contribute to the Medical FSA.

NEW FSA FEATURES FOR 2010!

NEW CLAIM CARD EFFECTIVE JUNE 1, 2009 **If you are currently participating in the Flexible Spending Plan, you must make a new election for the upcoming plan year to continue participating.**

Effective January 1, 2010, we will be upgrading the Flexible Spending Plan (FSA), which will require a new FlexSystem Claim Card to be issued to existing participants.

Run Out Period Claims

For expenses incurred between January 1, 2009 and December 31, 2009 (your current plan year) you will continue to submit claims as you currently do, until this balance is exhausted. For expenses incurred between January 1, 2010 and December 31, 2010, you will submit those claims to FlexSystem.

Keep in mind that Pasco County Schools utilizes the FSA Grace Period allowing participants until March 15, 2010 to spend the funds in their 2009 FSA. If you have a remaining balance in your 2009 FSA please utilize your 2009 claim card or submit claims as you currently do until March 31st or until this balance is exhausted. Once the 2009 funds are spent you may begin using your new claim card and/or submitting to FlexSystem.

How Do You File a Claim

At the start of your new plan, January 1, 2010, your Flexible Spending Account (FSA) will be a part of FlexSystem offered by Cornerstone/TASC. With FlexSystem you will continue to have all of the conveniences you have come to expect, and more, including:

- Fast and efficient claim reimbursements
- Multiple claim submission options including via claim card (also referred to as debit card), online, by fax or regular mail.
- Online account access 24 hours a day/ 7 days a week
- Toll-free customer service assistance, email and web chat customer service
- *NEW:* Interactive Voice Response System availability 24 hours a day/7 days a week to check account activity, account balance and more
- Direct deposit availability (if you are currently signed up for direct deposit your account information will continue to be utilized. If you are new or want to update your existing direct deposit information, you can add/change direct deposit information via your online account)
- *NEW:* Opportunity to sign up for text/email notifications of account activity (i.e. claim receipt by Cornerstone/TASC, claim payments, etc.)

Questions

Should you have any immediate questions, please contact our Customer Care Center at 800-422-4661.

Flexible Spending Accounts

Getting Answers to Your Questions About Your Flexible Spending Account

Getting answers to many of your questions about the flexible spending plan is easy. Cornerstone customer care offers you a variety of resources to make inquiries, including information from the Cornerstone website or the toll-free customer care center.

Cornerstone Website

Cornerstone's website provides comprehensive details on your Flexible Spending Account(s).

Account Information

To login to the Cornerstone online system, simply go to www.teamcornerstone.com/pasco and click on the login in button. Cornerstone will assign a user name and login to you, which can be changed after your initial visit to the online system.

After you have successfully logged in, you will have the following menu available to you:

Home

The home page provides the basic information about the plan as well as navigation to other areas of the site.

File Claims

In the file claims tab, you will have the option to file health care and dependent care claims. Simply click on the file claim button next to the account that you would like to file a claim for, select the plan year, complete the online claim form and click calculate total. Verify the amount and then click submit. You will receive a confirmation indicating that we you have successfully submitted a claim to your claims basket. You can enter additional claims or submit your claims basket to Cornerstone. Once you have submitted, the system will generate a confirmation page with claim numbers for future reference.

My Account

In the My Account tab, you will have access to the current plan year and prior plan year account balances. The balance information includes your annual election amount, your submitted claims, your paid claims, pending claims, denied claims, your plan year balance, as well as your available balance.

In addition, you will also be able to view profile information about you and your dependents, furthermore, you will have the ability to add a dependent to the system.

You will be able to view your claim history which will include the claim number, claim status, receipt status, date of service, recipiet of service, claim amount, amount paid, pending or denied.

Finally, you will be able to view the payment history of each check or direct deposit or debit card swipe that you made with detailed transaction information.

Plans

Under the Plans tab, you will be able to view a summary of the flexible spending account plans that you are enrolled in as well as frequently asked questions.

Forms

Under the Forms tab, you will see all of the forms that are available for printing, including claim forms, direct deposit forms, change forms and online instructions.

Cornerstone Customer Care

The Cornerstone customer care center can be contacted toll free at 1-800-422-4661. You will get a live representative from our customer care team between 8:00am and 5:00pm Eastern Standard Time, Monday through Friday.

Our friendly staff will be able to assist you with all questions regarding your flexible spending plan.

Dependent Care Flexible Spending Account

DEPENDENT CARE REIMBUREMENT ACCOUNT

A FSA Dependent Care Reimbursement Account gives you the opportunity to pay for the first $5,000 of employment-related child care expenses tax-free. The rules for eligibility are the same as those for Child Care Credit outlined in IRS Publication 503. This includes children under 13 as well as adults incapable of self-care that are claimed as dependents.

ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE

- Payments made for services provided in your home as long as services are not provided by someone you also claim as a dependent, or your other children under age 19.
- Payments made for child care services outside your home.
- If a child care center (caring for six or more children) is used, it must be in compliance with state and local law.

MAXIMUM CONTRIBUTION TO DEPENDENT CARE REIMBURSEMENT ACCOUNT IS

- $5,000 if married filing jointly.
- $2,500 if married filing separately.
- The lower of your earned income or your spouse's earned income. If your spouse is a full time student or disabled, special rules apply.

Medical Flexible Spending Account

UNDER THE PLAN, YOU WILL BE REIMBURSED ONLY FOR MEDICAL EXPENSES. THEY INCLUDE, FOR EXAMPLE, EXPENSES YOU HAVE INCURRED FOR:

1. Medicine, drugs, birth control pills and vaccines.
2. Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
3. Medical examination, X ray and laboratory service, and insulin treatment and whirlpool baths the doctor prescribed.
4. Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.
5. Hospital care (including meals and lodging), clinic cost and lab fees.
6. Medical treatment at a center for Substance abuse.
7. Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
8. Ambulance service and other travel costs to get medical care. If you used your own car, you can claim what you spent for gas and oil to go to and from the place you received the care; or you can claim 15 cents a mile. Add parking and tolls to the amount you claim under either method.

YOU CANNOT OBTAIN REIMBURSMENT FOR:

1. The basic cost of Medicare insurance (Medicare A).
2. Life insurance or income protection policies.
3. Accident or health insurance for you or members of your family.
4. The hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self employment tax.
5. Nursing care for a healthy baby.
6. Illegal operations or drugs.
7. Travel your doctor told you to take for a rest or change.
8. Cosmetic Surgery.
9. Long-term care expenses

QUALIFING MEDICAL EXPENSES INCLUDE ONLY THOSE EXPENSES INCURRED FOR:

1. Yourself
2. Your spouse
3. All dependents you list on your federal tax return

IRS Publication 502, Medical and Dental Expenses, has a checklist of most of the medical expenses that can be deducted and are therefore reimbursed under this Plan. Some other medical expenses are also reimbursable. However, regardless of any statements in Publication 502 to the contrary, expenses under this Plan are treated as being “incurred” when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care. Also, no reimbursement will be allowed for any privately held insurance policies or long-term care expense.

Medical Flexible Spending Account OTC Items

SAMPLE OF ACCEPTABLE OVER-THE COUNTER ITEMS*

ANTISEPTICS
Antiseptic wash or ointment
For cut, scrapes or burns
Benzocaine swabs
Boric acid powder
First aid wipes
Hydrogen peroxide
Iodine tincture
Rubbing alcohol
Sublime sulfur powder

ASTHMA MEDICATION
Bronchodilator tablets
Expectorant tablets
Bronchial asthma inhalers

COLD FLU & ALLERGY MEDICATION
Allergy medications
Cold relief syrup
Cold relief tablets
Cough drops
Cough syrup
Flu relief tablets or liquid
Medicated chest rub
Nasal decongestant inhaler
Nasal decongestant spray or drops
Nasal strips to improve congestion
Sinus & Allergy homeopathic

DIABETES
Diabetic lancets
Diabetic test strips
Glucose meters

EAR/EYE CARE
Ear drops
Ear water-drying aid
Ear wax removal drops
Eye drops
Contact lens solution

HEALTH AIDS
Band-Aids, gauze and tape
Sleeping aids
Thermometers
Anti-fungal treatments
Denture adhesives
Diuretics and water pills
Hemorrhoid relief
Incontinence supplies
Lice control
Medicated bandages
Motion sickness tablets

PAIN RELIEF
Arthritis pain reliever
Bunion and blister treatments
Orajel
Pain relievers, aspirin and Non-aspirin
Throat pain medications

PERSONAL TEST KITS
Cholesterol test
Colorectal cancer screening tests
Home drug test
Ovulation indicators
Pregnancy test

SKIN CARE
Acne medications
Anti-itch lotion
Bunion and blister treatments
Cold sore and fever blister medications
Corn and callus removal medications
Diaper rash ointment
Eczema cream
Medicated bath products
Wart removal medications

STOMACH CARE
Acid reducers
Antacid gum
Antacid liquid
Anti-diarrhea medications
Gas prevention food enzyme dietary supplement
Gas relief drops, tablets or chewable
Ipecac syrup
Laxatives

NOT ACCEPTABLE*
Aromatherapy
Baby bottle and cups
Baby oil
Breast enhancement system
Cosmetics
Cotton Swabs
Dental floss
Deodorants
Diabetic replacement foods
Facial care
Feminine care
Fragrances
Hair re-growth
Low “carb” and calorie food
Oral Care
(mouth wash / plaque rinse)
Shampoo and conditioner
Spa salts
Sun tanning products
Teeth whitening treatment or products
Toothbrushes
Toothpaste
Petroleum jelly

DUAL USE – REQUIRES DOCTOR LETTER*
Foot spa
Gloves and masks
Herbs
Multivitamins
Special supplements
Vitamins
Leg or arm brace
Minerals
Massagers

**Plan restrictions may apply check with plan administrator.*
Please note: This is a “sample” listing and all items are subject to review by Plan Administrator.

Medical Expense Reimbursement Worksheet

Reminder: Plan Year is January 1, 2009 to December 31, 2009

This worksheet will help you estimate your annual medical costs, which may not be reimbursed by a health plan. This list is not intended to be comprehensive, but it contains some of the more common medical expenses. Please review the attached list for additional qualifying medical care expenses.

List all costs that are not reimbursed by other coverage incurred by you, your spouse or qualified dependents:

QUALIFYING EXPENSE	ESTIMATED ANNUAL EXPENSE
Medical doctors' fees	$ _____
Annual physical examinations	$ _____
Dental examinations	$ _____
Eye examinations	$ _____
Eyeglasses	$ _____
Contact lenses	$ _____
Drugs	$ _____
X rays	$ _____
Lab fees	$ _____
Hospital services	$ _____
Chiropractors	$ _____
Hearing aids	$ _____
Surgery	$ _____
Ambulance service	$ _____
False teeth	$ _____
Psychiatrists	$ _____
Psychologists	$ _____
Orthodontists (child only)	$ _____
Over the counter Medicine	$ _____
_____	$ _____
_____	$ _____
_____	$ _____

TOTAL ESIMATED ANNUAL EXPENSE $ _____ **(A)**

NUMBER OF PAY PERIODS $ _____ **(B)**

AMOUNT OF REDUCTION PER PAY PERIOD (A/B) $ _____

Disability Insurance

Unum's Educator Select Disability Insurance

- Guarantee Issue at this Annual Enrollment for 2009 benefits
- 10 plan options available:
  - 14, 30, 60, 90 and 180 day elimination periods
  - To age 65 and 2 year benefit durations
- $100 incremental benefit amounts up to 66.7% of monthly income
- 1st day Hospital on 14 and 30 day elimination period plans
- Dependent Care Benefit: $350 per dependent to a $1000/monthly maximum
- Additional 10% of benefit when voluntarily participating in a Return to Work Program
- Work-Life Balance EAP program
- 3/12 Pre-existing Conditions limitation

VOLUNTARY SHORT TERM DISBILITY

MetLife Insurance Company has developed this document to provide information about the optional coverage you may select through your employer. Written in non-technical language, this is not intended as a complete description of the coverage. If you have additional questions, please refer to the Voluntary Short Term Disability brochure included in your packet or check with your human resources representative.

ELIGIBILITY

To become insured, you must be:

- An active employee of District School Board of Pasco County, excluding, temporary or seasonal employees and full-time members of the armed forces
- Actively at work at least 20 hours each week

EMPLOYEE COVERAGE EFFECTIVE DATE

Please contact your human resources representative for more information regarding the following requirements that must be satisfied for your insurance to become effective. You must satisfy:

- Eligibility requirements
- An eligibility waiting period
- An evidence of insurability requirement for employees who enroll more than 31 days after eligibility.
- An active work requirement. This means that 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.

GROUP INSURANCE CERTIFICATE

If you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage. The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by MetLife Insurance Company.

Hospital Indemnity

Issue ages
Employee and Spouse 18-64
Dependent children up to age 21
(and 25 if they are full time students)

Benefits are paid directly to the employee in addition to any other medical plans and regardless of any other benefits

Three Levels of coverage available
Basic, Enhanced and Premier

Age Banded
Rates 18-35, 36-49, 50-59, 60-64

4 Tiers Plans:
- Individual Employee
- EE+ Children
- EE+ Spouse
- Family

12 Month Pre-x applies (unless takeover)
Pregnancy is considered a pre-ex if occurs within the first 10 months of the policy.

Coverage ends at the age of 65

Portable
The employee may take this coverage with them if they terminate employment with the school board

Allstate
Workplace Division

Universal Life

There's no better time to consider the benefits of Universal Life Insurance.
As a School Board employee, you have the opportunity to purchase Universal Life Insurance from Transamerica Life Insurance Company.

This valuable Universal Life Insurance is designed to:
- Last until age 95, with level premiums
- Can provide protection beyond retirement
- Is portable if you terminate employment with PASCO County
- Builds cash value at a competitive interest rate (currently 5.25%)
- You can borrow from the policy's cash value to supplement your income or for retirement needs

Employee	**Guaranteed Issue** **Up to $100,000** **Conditional Issue** **Up to $200,000** *(Subject to a five times salary maximum)* **Simplified Issue** **Up to $300,000**
Spouse	**Conditional Guaranteed Issue Up to $25,000** *(Spouse limitation of 50% of employee's coverage)*
Children	**Conditional Guaranteed Issue Up to $25,000** *(Option: $10,000 child(ren)'s term rider)*

Act now to ensure your financial future. *Make plans to meet with an enrollment counselor to discuss the benefits of this program for you and your family.*

- Life insurance you can take with you whenever you leave the school system
- Long-term protection and cash values that can increase during your lifetime

Who is eligible?
- Full-time or regular part-time employees working an average of 20 hours per week;
- Employees between the ages of 18 and 70;
- Employees who are actively working at the time of application and on the date of the first payroll deduction.

Can I apply for coverage for my dependents?
Yes. Your spouse and children also qualify for coverage. If you have any questions, please speak with your enrollment representative.

What does the plan offer?
The plan offers the peace of mind that your family will be taken care of if something happens to you. Plus, it also offers valuable cash value accumulation, protection in the event of your layoff, and an accelerated death benefit.

TRANSAMERICA
LIFE INSURANCE COMPANY

Accident Plan

You can recover from an accident and help keep your finances intact. While you can count on health insurance to cover medical expenses, it doesn't usually cover indirect costs that can arise with a serious, or even a not-so-serious, injury. You may end up paying out of your own pocket for things like transportation, over-the-counter medicine, day care or sitters and extra help around the house. With accident insurance, the benefits you receive can help take care of these extra expenses and anything else that comes up. Group Accident Plan Insurance provides extra money to help make ends meet and manage medical costs and keep your savings intact. The Group Accident Plan Policy consists of a variety of benefits that can help cover you and your family from accident and medical expenses and hospital expenses due to accidents. Group Voluntary Accident Coverage pays the following benefits for covered on and off the job accidental injuries that result within 90 days (180 days for Accidental Death or Dismemberment) from the date of the accident. A physician must diagnose covered losses. The policy pays you a benefit up to a specified amount for:

	LOW	HIGH
Accidental Death	$20,000 for primary insured	$40,000 for primary insured
	$10,000 for spouse	$20,000 for spouse
	$5,000 for child	$10,000 for child
Common Carrier Accidental Death	$100,000 for Primary insured	$200,000 for Primary insured
Dismemberment	Up to $20,000 maximum amount for primary insured	Up to $40,000 maximum amount for primary insured
Dislocation or Fracture	Up to $2,000 maximum amount for primary insured	Up to $4,000 maximum amount for primary insured
Initial Hospitalization Confinement	One-time benefit of $500 when the covered person is admitted	One-time benefit of $1,000 when the covered person is admitted
Hospital Confinement	$100 per day, Maximum of 90 days per injury.	$200 per day, Maximum of 90 days per injury.
Intensive Care	$200, per day of confinement. The maximum 90 Days	$400, per day of confinement. The maximum 90 Days
Ambulance	$100 Regular Ambulance, $300 Air Ambulance	$200 Regular Ambulance, $600 Air Ambulance
Medical Expenses	Medical fees up to $250 for each covered person.	Medical fees up to $500 for each covered person.
Outpatient Physicians Treatment Benefit	Pays $25 for each visit by a covered person to a doctor, outside of a hospital, for any reason maximum of two times in a calendar year per covered person, not to exceed 4 times per year for family coverage.	Pays $50 for each visit by a covered person to a doctor, outside of a hospital, for any reason maximum of two times in a calendar year per covered person, not to exceed 4 times per year for family coverage.

Critical Illness

Allstate Group Voluntary Critical Illness.

IS AVAILABLE:
- WITH CANCER OR WITHOUT CANCER.
- Includes Re-occurrence benefit and $50 Wellness Benefit

BROCHURES SHOW:
- LOW $10,000
- MEDIUM $20,000
  (GI LIMITS ARE UP TO $20,000 FOR EE THIS YEAR)
- HIGH $30,000

Category Number	Illness	Percentage of the Basic Benefit Amount	Maximum Total Percentage of Basic Benefit Amount for Category
1	Heart Attack	100%	100%
1	Stroke	100%	
1	Heart Transplant	100%	
1	Coronary Artery By-Pass Surgery	25%	
2	Major Organ Transplant (excluding heart transplant)	100%	100%
2	End Stage Renal Failure	100%	
2	Paralysis (not as a result of stroke)	100%	
2	Alzheimer's Disease	25%	

OPTIONAL CANCER COVERAGE

3 Cancer (Invasive) 100% 100%

- Eligibility: Coverage is available for employee age 18 and over if actively at work (70+ OK)
- Spouse/Children up to age 26 may get up to 50% of the employee coverage
- Pre-Existing Clause - 12 month look back - 12 months not covered for pre-existing condition.
- Portable - the employee may take the coverage with them if they leave the school board

Allstate
Workplace Division

Cancer Insurance

Allstate CP10 Individual Cancer & Specified Disease With Optional Intensive Care Rider

- Policy may be issued to employee (Issue Age 18-64) as long they are a full time employee
- Dependent children are covered until married or age 21 (or 25 FT Student)
- BENEFITS PAYABLE IN 30 DIFFERENT AREAS FOR CANCER and 20 Other Specified Dread Diseases
- Benefits for Specified Diseases (listed in the employee brochure)
- 3 Tier Program: Basic, Enhanced and Premier Rates are either : Individual or Family
- 12 Month Pre-Existing Condition Clause – looks back 12 months before effective date

Plan	Initial Diagnosis	Daily Hospital	Radiation/Chemo & Blood/Plasma	New/Experimental Treatment	Wellness	Optional ICU
Basic	NA	$100	$5,000 / 12 Months	$5,000 / 12 Months	$50	$600
Enhanced	$4,000	$300	$15,000 / 12 Months	$10,000 / 12 Months	$100	$600
Premier	$5,000	$400	$20,000 / 12 Months	$10,000 / 12 Months	$100	$600

ICU RIDER –
Monthly premiums for all three plans……
Additional $5.99 Individual or $11.99 Family

- $600 Day (or benefit reduced to $300 Day at age 70)
- ICU Benefits starting Day 1 to 45 for ICU confinement and payable injury as well as sickness.

PORTABLE –
employee may take coverage with them if they terminate employment

Allstate
Workplace Division

Legal Services

When a legal problem comes up, it's better to consult an attorney sooner rather than later. The legal benefit is designed to allow you to get legal advice before your problems become costly or complicated. You may select a Network Attorney or a Non-Network Attorney.

- The Network coverage consists of thousands of attorneys nationally, with more than 1,000 in Florida. Call ARAG® at 1-800-247-4184 to receive a list of Network Attorneys for West Central Florida, or visit http://members.ARAGgroup.com/pasco.

- You also may use an attorney who is not an ARAG® Network Attorney. In that case, you will be reimbursed up to the scheduled maximums shown on the chart.

Plan Features

This plan includes coverage for attorney fees for legal matters where the action is filed and the attorney is first retained after the effective date of the member; coverage in full for most covered matters pending when you leave employment or the plan terminates; no waiting periods or deductibles; coverage anywhere in the United States.

What's not covered?

Legal services with regard to any matter arising out of any business interest, business transaction, business pursuit, profession, partnership or corporation (Any activity which produces or is contemplated to produce revenue shall be considered business.)

- Class Actions, interventions, counter claims and amicus curiae filings
- Preparing, completing or filing of federal, state or local tax returns
- Matters relating to patents or copyrights
- Appeal proceedings
- Any action, proceeding or dispute between an insured and his employer, an insured and his fellow employees, an insured and the policyholder, an insured and ARAG® Insurance Company or its agents, an insured and his union or labor management trust fund or an insured and any other party when such coverage is prohibited by law
- Any action brought in Small Claims Court
- Duplication of services previously claimed and in relation to the same matter
- Filing fees, court costs, reporters' fees and other miscellaneous costs in any proceeding
- Any legal proceeding in which the insured is entitled to legal representation or reimbursement for the costs thereof, from any source other than this policy, whether or not the insured perfects or exercises this right
- Services to anyone except the named insured in any type of proceeding in which the interest of any other insured is opposed to the interest of the named insured
- Matters for which a contingency fee is customarily charged, and probate, Workers' Compensation and similar matters for which a fee is normally allowed, except that the insured may obtain legal advice under the General Office Service Coverage, to the extent available, with respect to such a matter if the insured is not subsequently represented in such matter

Plan Provider

ARAG® Insurance Company underwrites this plan. A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates ARAG Insurance Company, A, "Excellent."

Important: This information is for illustrative purposes only and is not a contract. This information is intended to provide a general review of the plan described. Please remember that only the insurance policy can give actual terms, coverages, amounts, conditions and exclusions.

Visit ARAG® Group's Web site at: http://members.ARAGgroup.com/pasco to view a list of Network Attorneys and the plan benefits.

Legal Services Provider Directory

For your convenience, more attorney information and an online Network Attorney Finder can be found on the Plan Member section of our Web site at http://members.araggroup.com/pasco.

Attorneys are listed by city. To locate an attorney in your area, look up the city in which you are located. To assist you in selecting the proper attorney for your situation, areas of law in which an attorney wishes to practice are indicated by code letters under their name. Please select the code letter applicable to your situation from the list below. Then choose any attorney who has that letter by their name.

A Non-Business Bankruptcy
B Business
C Adoption Proceedings
D Insanity/Incapacity/Infirmity
E Juvenile Court Proceedings
F Defense of Criminal Charges
G Traffic & Driving Privilege Protection
H Expungement
I Habeas Corpus Court Proc.
J Administrative Agency Matters
J1 Agency Proceedings General
J2 IRS Proceedings: Audits/Collections
J3 State/Local Tax Proceedings
J4 Immigration Proceedings
K Real Estate Transactions
L Civil Dispute Proceedings
M Consumer Protection
N Name Change
O Specific Document Preparation
P Tax
Q Contingency Fee Cases
R Dissolution, Divorce, Annulment
S Post Decree Domestic Relations
T Trusts – Revocable & Irrevocable
U Protection of Inheritance Rights
V Guardianship/Conservatorship
W Wills and Testamentary Trusts

Please refer to your policy for coverages. Some of the above areas are covered under the advice portion of your policy only.

We have made every effort to ensure the accuracy of this directory; however, there may occasionally be attorneys who have changed office locations, or been added or deleted fro the program after printing. Prior to making an appointment, please call the attorneys' office to confirm their continued participation and address information. Notification of any errors or inaccuracies should be sent to: Provider Services, ARAG® Group, 480 Capital Square, 400 Locust Street, Des Moines,

BAYONET POINT
Dale Bernstein
727-862-4411
A,Q,W

BROOKSVILLE
James Dysart
352-799-0099
C,E,F,H,N,R,S,V

Paul Nessler
352-596-4242
K,L,T,U,W

CLEARWATER
Douglas Hilkert
727-507-9559
K,T,U,W

Gary Lyons
727-461-1111
K,L,N,O,Q,T,U,W

DADE CITY
Dennis Alfonso
McClain And Alfonso
352-567-5636
J,J1,J2,J3,K,N,R,S,T,U,V,W
Foreign language - Spanish

Daniel Dwyer
Greenfelder, Mander, Etal
352-567-0411
C,K,L,N,S,T,U,V,W

Nancy McCain Alfonso
McClain And Alfonso
352-567-5636
A,C,K,L,M,N,R,S,T,U,V,W
Foreign language - Spanish

HOLIDAY
Ramy Fares
727-938-9099
A,C,F,H,J,J1,J2,J3,L,M,N,Q,R,S,T,U,V,W
Foreign language – French, Arabic

HUDSON
Douglas Amidon
727-862-5906
A,C,D,F,G,J1,J3,J4,K,N,O,R,S,T,U,V,W

Eloise Taylor
727-863-0644
C,K,N,O,R,S,T,U,W

LAKELAND
Matthew Kaylor
863-668-7223
E,F,G,H,Q

Thomas Rutherford
941-858-9528
K,L,N,O,T,U,V,W

Gregory Sanoba
863-683-5353
K,L,T,W

Michael Willison
863-668-8715
C,D,M,N,T,U,V,W

LAND O LAKES
Edward Albrecht
813-995-0064
A,L,R,S,W

Diane Kuenzel
Kuenzel And Lutes, P.A.
813-996-7710
K,L,N,O,R,T,U,V,W

NEW PORT RICHEY
Douglas Amidon
727-834-9500
A,C,D,F,G,J1,J3,J4,K,N,O,R,S,T,U,V,W

Jeffrey Bacca
727-815-8888
A,K,L,M,N,Q,R,S,T,U,W
Foreign language - Greek

Frank Bianco
Bianco And Mansfield
727-843-0097
G,H,Q

Ernest Cole
727-842-2237
C,K,L,N,O,T,U,W

Gary Davis
Davis And Marlowe, P.A.
727-376-3330
K,T,U,W

Gregory Gay
727-849-1122
B,D,T,U,W

Audrey Gay Ehrhardt
727-849-1122
C,D,K,L,N,O,Q,R,T,U,V,W

Frank Grey
727-376-3330
C,D,K,L,N,O,Q,R,T,U,V, W

Frank Klein
727-849-2303
R,S

Declan Mansfield
Bianco And Mansfield
727-843-0097
E,F,G,H,Q

Davis And Marlowe, P.A.
727-376-3330
C,L,M,N,R,S,T,U,V,W

Jay Moreland
727-847-2083
A,C,K,T,U,W

Bruce Przepis
727-841-9594
C, E, F, H

David Ristoff
727-842-9758
E, F, H, K, L, T, U, W

Kimberly Shurtleff
727-815-3693
K,N,T,W

Sallie Skipper
727-847-0913
T, W

Henry Stephenson
727-844-5802
A,K,L,N,O,Q,R,T,U,W

Arnelle Strand
727-848-1777
C,N,R,S,T,U,V,W

Stephen Whalen
727-842-9758
J1,L,R,T,W

Stephen Williams
727-842-9758
A,D,K,L,N,O,Q,T,U,W

OCALA
Charlotte Hunter
352-622-7300
I

James Richard
352-369-1300
T,U,W

PALM HARBOR
Beth Wilson
727-785-7676
K,N,T,U,W

PLANT CITY
Theodore Taylor
813-752-5633
A,C,D,E,F,G,H,K,N,O,Q,R,S,U,V,W
Foreign language - Spanish

PORT RICHEY
James Boyko
727-841-6878
A,C,D,E,F,G,H,I,K,L,O,Q,R,S,T,U,V,W

SPRING HILL
Dale Bernstein
352-688-5297
A,Q,W

Louis Brunoforte
352-686-6200
A,K,Q,T,U

David Day
The Day Law Office, P.A.
352-684-6545
L,Q,W

Sandra Day
The Day Law Office, P.A.
352-684-6545
A,L

Gregory Gay
352-597-3888
B,D,T,V,W

James Jones
352-597-3230
A,C,L,N,R,S,T,U,V,W

TAMPA
Suzette Alfonso
813-258-5400
C,N,O,Q,U,W
Foreign language - Spanish

Darlene Barror
813-877-6970
E,F,G,I,L,Q,R,S,W
Foreign language - Spanish

James Barrow
813-282-7257
A,K,N,P,Q,R,T,U,W
Foreign language - French

George Brezina
813-870-0500
L,Q,T,U,W
Foreign language - Spanish

Donna Buchholz
813-902-9100
C,E,L,N,R,S,W
Jeffrey Collins
813-246-4377
E,F,G,H,M

John Dixon
813-968-2404
A,F,G,H,K,L,N,O,Q,R,S,U,W

Gretchen Elizabeth
813-221-1174
A,B,C,E,H,J,J1,J2,J3,K,L,M,N,R,S,T,U,V,W
Foreign language - Spanish

Edward Friscia
813-286-0315
A,E,F,H,K,L,M,N,R,S,T,U,V,W
Foreign language - Spanish

Elliot Goldstein
813-810-1500
B,C,J,J1,J2,J3,,L,M,N,R,S,T,U,V,W

Perry Gruman
813-870-1614
A,E,F,G,H,K,L,N,O,R,S,T,U,V,W
Foreign language - Spanish

Victoria Holmberg
813-281-0103
C,E,F,G,H,N

F. Lorraine Jahn
813-225-1818
A,L,O,T,W

Scott Jeeves
813-254-3533
Q

Joseph Kalish
813-962-8685
C,K,L,M,N,T,U,V,W

C. J. Keel
813-282-3858
C,K,N,O,Q,T,U,V,W

James La Russa
813-251-1411
F,K,N,Q,R,S,T,U,V,W

Lawrence Lempert
813-935-2162
A,D,G,I,K,L,N,O,R,S,U,V,W

Starlene McGory
813-932-3477
D,F,G,H,N,O,Q,W

Ashley McCorvey Myers
813-839-7440
A,F,N,R,S,W

Byron Nenos
813-264-7929
A,C,Q,T,U,W
Foreign language - Greek

Sheila Norman
813-251-6666
A,J2,L,N,R,S

Carl Ohall
Alfonso And Ohall, P.A.
813-258-5400
B,Q,T,U,W

Laurie Ohall
813-250-6252
R,T,V,W

Gerald Perez
813-832-1888
A,E,F,G,H,Q

Thomas Rutherford
863-256-4030
K,L,N,O,T,U,V,W

Neil Schecht
813-353-9500
K,W

L. David Shear
813-222-6610
K,T,U,W

Timothy Sierra
813-258-3455
A,Q

William Thornton
813-969-2300
L,N,Q,R,S,T,U,V,W

David Thorpe
813-933-5051
A,K,L,O,T,U,W

Keith Warshofsky
813-636-8886
E,F,G,H,T,U,W

Joanne Wilburne
800-298-1112
A,K,T, W
Foreign language – Spanish

WESLEY CHAPEL
Jacob Reiber
813-973-0883
D,H,K,L,N,O,T,U,V,W
Foreign language – German, Yiddish

ZEPHYRHILLLS
Nancy McClain Alfonso
McClain And Alfonso
813-782-8700
A,C,K,L,M,N,R,S,T,U,V,W
Foreign language - Spanish

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Medical Expense FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. "Qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse and dependent children of the covered employee.

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be obtained from your employer.

How long will continuation coverage last?

For Group Health Plans (Except Medical Expense FSAs):
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

For Medical Expense FSAs:

If you fund your Medical Expense FSA entirely, you may continue your Medical Expense FSA (on a post-tax basis) only for the remainder of the plan year, in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Medical Expense FSA for the year. For example, if you elected a Medical Expense FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical Expense FSA for the remainder of the plan year or until such time that you receive the maximum Medical Expense FSA benefit of $1,000.

If your employer funds all or any portion of your Medical Expense FSA, you may be eligible to continue your Medical Expense FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Medical Expense FSAs. If you have questions about your employer-funded Medical Expense FSA, you should call Cornerstone at 1-800-422-4661.

How can you extend the length of continuation coverage?

For Group Health Plans (Except Medical Expense FSAs):
If you elect continuation coverage, an extension of the \maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your employer of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify your employer of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All qualified beneficiaries who have elected continuation coverage and qualify will be entitled to the 11-month disability extension. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify your employer of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage, resulting in a maximum amount of continuation coverage of 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify your employer within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.
You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other

group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. This amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). For Medical Expense FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact your employer to confirm the correct amount of your first payment. Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?

If you are retiring, you may have the right to elect alternative retiree group health coverage instead of the COBRA continuation coverage described in this Notice. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You should also note that if you enroll in the alternative group health coverage, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends. You must contact your employer if you wish to elect alternative coverage.

If your group health plan offers conversion privileges, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy might not be identical to those provided under the Plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum COBRA continuation coverage available to you. You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer. You can get a copy of your summary plan description from the District School Board of Pasco County.

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa.

General Notice of Creditable Coverage

Important Notice from the District School Board of Pasco County 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 the District School Board of Pasco County and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. Reden & Anders, Ltd. has determined that the prescription drug coverage offered by the District School Board of Pasco County is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your District School Board of Pasco County prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your current group health coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan and continue your current group health coverage, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

If you drop your current group health plan, which includes prescription drug coverage, and enroll in Medicare prescription drug coverage, you may enroll back in the District School Board of Pasco County's benefit plan during the open enrollment period under the District School Board of Pasco County's group health benefit plan.

You should also know that if you drop or lose your coverage with the District School Board of Pasco County and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact our office for further information or call Patricia Howard at (813) 794-2345. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the District School Board of Pasco County changes. You also may request a copy.

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 prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you may call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare, which offers prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount. You may request a personalized notice of creditable coverage by contacting Employee Benefits at the telephone number below.

Notice of Privacy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The District School Board of Pasco County has numerous legal and ethical obligations to protect the privacy of information it receives about students and employees. All student records, including health information, are protected by the Family Educational Rights and Privacy Act of 1974 (FERPA) as well as various Florida Statutes. Information covered by FERPA is excluded from coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The purpose of this notice is to provide you with information about requirements under HIPAA.

The employee group health plans (administered by insurance carriers) are covered by HIPAA, and must comply with the privacy requirements as of April 14, 2003. The group dental plan and medical reimbursement accounts must comply with HIPAA privacy requirements by April 14, 2004. However, each of the insurance companies administering these plans is required on their own to comply by April 14, 2003, and is responsible for distributing their own Notice of Privacy Practices to you, the plan participants.

The terms "information" or "health information" in this notice include any personal information that is created or received by us that relate to your physical or mental health or condition, the provision of health care to you or the payment of such health care.

How DSBPC May Use or Disclose Your Health Information

The District School Board of Pasco County does not receive Protected Health Information (PHI) from any current group health plan or insurance carrier. Other than information necessary for enrollment or disenrollment in the benefit plans, the only information DSBPC receives related to claims or treatment is as "summary health data" and does not identify individual employees or family members.

However, DSBPC may receive individual health information about you in our role as employer, for purposes such as Workers' Compensation, sick leave bank, Family & Medical Leave under FMLA or eligibility for disability plans. This information is not covered by HIPAA; however, it is our practice to protect the confidentiality of this information, to maintain or disclose only the minimum necessary, and to disclose only to those with a direct need to know. The following categories describe the ways that DSBPC may use and disclose your health information. For each category of uses and disclosures, there is an explanation and examples. Not every use or disclosure in a category will be listed. However, all the ways DSBPC is permitted to use and disclose information will fall within one of the categories.

1. **Workers Compensation**– DSBPC may use or disclose health information about you to assure that you receive benefits to which you are due under Workers' Compensation if you have a work-related injury or illness. For example, DSBPC may receive information about your treatment from your physician, and disclose it to our workers compensation insurance carrier so that your medical bills are paid.
2. **Sick Leave Bank/Disability Plans**– DSBPC may request and use health information about you to determine eligibility for plan benefits, determine plan responsibility for benefits and to coordinate benefits. For example, DSBPC may require a doctor's statement from you to verify that you are eligible to receive pay for time off due to sickness.
3. **Family & Medical Leave Requests**– If you request a leave for medical reasons under FMLA, DSBPC will request a Certification from your physician, and will use the information on that certification to determine your eligibility for leave.
4. **Reasonable Accommodation Request under ADA**– If you have a disability that is covered under the Americans with Disability Act (ADA) and you request a reasonable accommodation in order to perform the essential functions of your job, we will request and use medical information provided by you to determine how we may be able to provide the accommodation.
5. **Judicial and Administrative Process or Law Enforcement**– As required by law, DSBPC may use and disclose your health information when required by a court order. DSBPC may dis close your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
6. **Public Health**– As required by law, DSBPC may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to he Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

Physical and Administrative Protection of Your Health Information

As stated above, it is our practice that responsibility for protection of your health information related to group health plans is delegated to the insurance carrier for each plan, and the DSBPC does not receive any PHI except as may be necessary for enrollment or disenrollment in a plan. Regarding any other health information DSBPC may have access to, such as information related to a disability claim, DSBPC requests only the minimum amount of information necessary for the purpose, and keeps that information in a file separate from your personnel file. Only those with a specific need to know are allowed access to the information. If DSBPC should need to use or disclose your health information for any purposes other than as describe in this Notice of Privacy Practices, DSBPC will do so only with your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, DSBPC will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though DSBPC will be unable to take back any disclosures that have already made with your permission.

DSBPC has established procedures for the destruction of obsolete records that are intended to prevent any accidental or unauthorized disclosure of confidential information. These procedures include the shredding of paper records and the physical destruction of computer media and hard drives that have contained confidential information prior to any sale or re-assignment of the machine.

Changes to this Notice of Privacy Practices

DSBPC reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. DSBPC will promptly revise our Notice and distribute it to you whenever material changes are made to the Notice.

Complaints

Complaints about this Notice of Privacy Practices or how the District School Board of Pasco County has handled your health information can be directed to: Mary Tillman, Director of Employee Benefits, 7227 Land O' Lakes Blvd., Land O' Lakes, Florida 34638 or via e-mail at mtillman@pasco.k12.fl.us. Effective Date of this Notice: April 14, 2003

Florida Retirement System

NEW EMPLOYEES

As a new employee hired in a pension-eligible position, you are automatically a member of the Florida Retirement System (FRS). You have the choice between two very different retirement plans: the FRS Pension Plan and the FRS Investment Plan. Your deadline to enroll is 4:00 pm on the last business day of the 5th month from your month of hire. If you do not make an enrollment choice by the deadline, your enrollment will default to the FRS Pension Plan.

THE FRS PENSION PLAN

The FRS Pension Plan is a defined benefit plan designed for the more traditional longer service employee. You qualify for a benefit after 6 years of service with an FRS employer. The Pension Plan pays a guaranteed monthly lifetime benefit based on:

- Age and/or years of service at retirement
- The average of the five highest fiscal years of earnings
- Service credit

When you retire, you know what your monthly benefit will be. Deferred Retirement Option Plan (DROP) is available if you qualify.

THE FRS INVESTMENT PLAN

The FRS Investment Plan is a defined contribution plan designed for a mobile workforce. You qualify for a benefit after 1 year of service. The District makes monthly contributions into a portable individual account that you control. You decide how much risk to take by allocating your account balance among professionally managed investment funds. Your benefit is based on the value of your account at retirement. You are not eligible to participate in DROP.

Both the FRS Pension and Investment Plan are non-contributory plans. This means that the District School Board of Pasco County pays the monthly contributions to your retirement plan.

KEY POINTS TO REMEMBER

- Employees who do not enroll by their FRS deadline will default to the FRS Pension Plan
- If you have made a retirement plan choice since June 2002, you will not receive a new retirement choice kit
- Verify and keep your address on file with the District's Human Resource Department up-to-date

SECOND ELECTION

At any time after you have made your initial FRS retirement plan selection you can change your mind and switch plans.

After making your initial FRS retirement plan selection, you have a one-time opportunity to change plans during your FRS working career. This plan change, called your "2nd Election," is not for everyone, but it could be right for you.

Before using your 2nd Election, get unbiased help from the FRS. Review your plan options carefully. Once you make a 2nd Election, that decision is final. You may never again change your FRS Retirement Plan. You must be actively employed by an FRS employer to use your 2nd election.

FRS offers FREE help to assist you in making your decision. Call the toll free My FRS Financial Guidance Line at 1-866-446-9377 or visit the FRS web site at www.MyFRS.com.

Florida Retirement System

IN-STATE/OUT-OF-STATE SERVICE CREDIT

Employees enrolled in the FRS Pension Plan are eligible to purchase up to 5 additional years of FRS service credit for certain in-state or out-of-state service. All service purchased will be credited as Regular Class service under the FRS Pension Plan.

In order for service to be creditable, service must have been covered by a retirement plan and performed as a public employee in another state, as a public employee in Florida, or as an employee in a charter school, charter technical career center, or in a nonpublic school or college in Florida that is accredited by the Southern Association of Colleges and Schools. Service with the federal government or military may qualify as out-of-state service. Service must have occurred before an employee became a member of the FRS Pension Plan.

Contact the State of Florida Division of Retirement at 1-866-44-MyFRS or visit the web site at www.myfrs.com for additional information.

THE DEFFERED RETIREMENT OPTION PLAN (DROP)

The DROP program allows you to retire under the FRS Pension Plan and begin accumulating retirement benefits without terminating employment for up to 5 years from the date you first reach normal retirement age.

While enrolled in DROP you will simultaneously earn a salary and a retirement income. Your monthly retirement benefits accumulate in the FRS Trust Fund, earning tax-deferred interest. When you terminate employment, you will receive your accumulated DROP benefits and begin receiving monthly benefits the month following termination.

To participate in DROP, you must be an active member of the FRS Pension Plan, The Teachers' Retirement System (TRS), or the State and County Officers and Employees' Retirement System (SCOERS). You must be an active member of one of these plans who is vested and eligible for normal retirement based on your years of service or age.

Normal Retirement: Age 62 or 30 years of service

This information represents a brief summary of your options under the Florida Retirement System. You may obtain detailed information from the State of Florida Division of Retirement or the District's Employee Benefits Department.

Florida Division of Retirement

1-866-446-9377
www.myflorida.com/frs
www.myfrs.com

Employee Benefits Department

813-794-2277
http://ebarm.pasco.k12.fl.us

WHAT SHOULD I DO WHEN I AM PLANNING TO RETIRE?

During the 90 days prior to your anticipated retirement date, contact your District employee benefits office and schedule an appointment to discuss retirement and continuation of group health/life plans and flexible benefits.

WHEN I RETIRE, TO WHOM DO I SEND PAYMENTS?

Retirees continuing their eligible group health and/or term life insurance should elect to pay their full premium payments through monthly deductions from their Florida Retirement System (FRS) check. Deductions for health and/or term life insurance must be paid from your FRS retirement check – provided the retirement benefit would support the deduction.

If your retirement benefit will not support your deductions, you will receive payment coupons to provide direct payment to Cornerstone Administrative Services.

Payment arrangements for benefits other than health or term life insurance can be made directly to Cornerstone Administrative Services if FRS payroll deduction is not desired. If a retiree selects payroll deductions through the FRS for optional benefits, Cornerstone requires a completed and signed FRS payroll deduction authorization form.

Cornerstone Administration Services

Customer Service
Monday – Friday, 8:00am-5:00pm ET
1-800-422-4661

Until FRS deductions begin, payment by personal check or money order is required. Full premium payment(s) for health, life or optional insurance(s) must be paid by the due date specified.

TERMS AND CONDITIONS

Deferred Compensation (457 Plan)

Participating in the Flexible Benefits Plan may affect an employee's maximum annual contribution to the 457 plan. That is, Flexible Benefits Plan contributions reduce includible compensation* from which the maximum deferrable amount is computed. Employees should contact the Deferred Compensation vendor or the Tax Deferred Annuity (TDA) provider about the specific effect of the Flexible Benefits Plan.

* *Includible compensation is the gross income shown on your W-2 form.*

Taxable Benefits and the IRS

Disability Income Protection – Disability benefits may be taxed when an employee becomes disabled depending on how the premiums were paid during the year of the disabling event. For example, if you purchased disability coverage with pre-tax premiums and/or nontaxable employer credits, any disability payments received under the plan will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any disability payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis and a disability entitles you to receive payments, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax advisor for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld. Hospital Indemnity Insurance, Personal Cancer Expense Insurance, and Hospital Intensive Care Insurance – If the premiums for these plans are paid with pre-tax dollars and/or nontaxable employer credits, you will be required by the IRS to pay FICA, Medicare, and federal income taxes on your benefit payments that exceed the actual medical expenses you incur. If you have questions, consult your personal tax advisor.

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums tax-free on your first $50,000 of life insurance. You must pay tax on premiums for coverage exceeding $50,000.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided, not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s) and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies and procedures from time to time adopted.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.
However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call Sunbelt Customer Service at 1-800-822-8045 for an approximation.

Sunbelt Worksite Marketing Privacy Notice

This notice applies to products administered by Sunbelt Worksite Marketing. Sunbelt takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of Sunbelt. This notice explains how Sunbelt handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. Sunbelt's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. Sunbelt collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally vary depending on the products or services you re quest and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
  - Responses from you and others such as information relating to your employment and insurance coverage.
  - Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
  - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of Sunbelt's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided by contacting Sunbelt at (800) 822-8045

TERMS AND CONDITIONS

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words “you” and “customer” are used to mean any individual who obtains or has obtained an insurance, financial product or service from Sunbelt that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

PLEASE READ: This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder, and the insurer:

1. Sunbelt has been authorized by your employer to provide administrative services for your employer’s insurance plans offered herein. In some instances, Sunbelt may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. Sunbelt is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

Written Certification

When enrolling in either or both FSAs, written notice of agreement with the following will be required:

- I will only use my FSA to pay for IRS-qualified expenses eligible under my employer’s plan, and only for my IRS-eligible dependents and me
- I will exhaust all other sources of reimbursement, including those provided under my employer’s plan(s) before seeking reimbursement from my FSA
- I will not seek reimbursement through any additional source and
- I will collect and maintain sufficient documentation to vali date the foregoing.

Changing Your Coverage

Am I permitted to make mid-plan year election changes?

Under some circumstances, your employer's plan(s) and the IRS may permit you to make a mid-plan year election change to your FSA election, or vary a salary reduction amount, depending on the qualifying event and requested change.

How do I make a change?

You can change your Flexible Spending Account (FSA) election(s), or vary the salary reduction amounts you have selected during the plan year, only under limited circumstances as provided by your employer's plan(s) and established IRS guidelines. Partial lists of permitted and not permitted qualifying events under your employer's plan(s) appear on the following page. Election changes must be consistent with the event. Your employer will in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To Make a Change: Within 30 days of an event that is consistent with one of the events on the following page, you must complete and submit a Change in Status/ Election Form to your employer. Contact your employer to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate). Generally, mid-plan year, pre-tax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by your employer, unless otherwise provided by law. If your FSA election change request is denied, you will have 30 days; from the date you receive the denial, to file an appeal with your employer. For more information, refer to the "Appeal Process" section.

What is my Period of Coverage?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change. A mid-plan year election change will result in split periods of coverage, creating more than one period of coverage within a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change. However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance providers and IRS regulations governing the plan.

What are the IRS Special Consistency Rules governing Changes in Status?

1. **Loss of Dependent Eligibility**– If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to: your divorce, or annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances.
2. **Gain of Coverage Eligibility Under Another Employer's Plan**– If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage, or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses**– You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC § 129.
4. **Group-term Life Insurance, Dismemberment or Disability Coverage** For any valid CIS event, you may elect either to increase or decrease these types of coverage.

Changing Your Coverage

CHANGES IN STATUS (CIS):

Marital Status
A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).

Change in Number of Tax Dependents
A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.

Change in Status of Employment Affecting Coverage Eligibility
Change in employment status of the employee, or a spouse or dependent of the employee that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.

Gain or Loss of Dependents' Eligibility Status
An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.

Change in Residence*
A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.

Some other Permitted Changes:

Coverage and Cost Changes*
Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.

CHIPRA
Effective April 1, 2009, CHIPRA provides employees and their dependents with a special enrollment right in the group health plan coverage without having to wait for an open enrollment period if either of the following conditions are met: 1) The employee or dependent loses eligibility under CHIP or Medicaid for individuals who otherwise meet the elgibility requirements of group health plan; 2) The employee or dependent becomes eligible for premium assistance from the state under its CHIP or Medicaid program, if otherwise eligible for a group health plan. Enrollment must be requested within 60 days after the loss of eligibility under Medicaid or CHIP or after the date the employee or dependent is determined to be eligible for premium assistance.

Open Enrollment Under Other Employer's Plan*
You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: the other employer's plan has a different period of coverage (usually a plan year) or The other employer's plan permits mid-plan year election changes under this event.

Judgment/Decree/Order†
If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.

Medicare/Medicaid†
Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.

Family and Medical Leave Act (FMLA) Leave of Absence
Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

**Does not apply to a Medical Expense FSA plan*
† Does not apply to a Dependent Care FSA plan

Workers Compensation

If you are injured on the job, you have the responsibility to promptly report all job-related accidents or illness to your work location supervisor within 24 hours when possible, or as soon as you have knowledge, in the case of any disease.

Medical care under Workers' Compensation is to cover work-related injuries and illnesses arising out of, and in the course or scope of, employment and is different from your personal health care coverage.

The District School Board of Pasco County is self-insured for Workers' Compensation with coverage administered through Gallagher Bassett Services. Along with Gallagher Bassett Services, a managed care arrangement (MCA) with GENEX Services has been established and approved by the State of Florida to provide you with your required medical care, should you need it.

If you have a work related illness or injury which requires medical attention, you will need to obtain treatment from a physician within the Workers' Compensation Provider Network. For your convenience, a list of providers is posted at your work site. In the event of a serious or life threatening emergency, treatment may be received from any emergency facility. A Medical Care Coordinator, who acts as your primary care physician, authorizes any needed specialty care and follows your course of treatment through recovery. Unauthorized absences from work and treatment received outside the Workers' Compensation managed care arrangement may not be covered.

If you have any questions regarding Workers' Compensation, please contact the Risk Management Department at ext. 42520, or 352-524-2520 (East), 813-794-2520 (Central), or 727-774-2520 (West).

Who is your Case Manager?

The GENEX Nurse Case manager is your first point of contact to receive medical care in a non-emergency work related accident. This is a nurse who has been trained in Worker's Compensation medical care. She or he can assist you in several ways and answer medical related questions. The Nurse Case Manager, in coordination with your workers' compensation adjuster, authorizes all treatment including therapy, tests, referrals to specialists, hospital stays, and surgeries. Contact her/him during normal business hours, 8:30 a.m. – 5:00 p.m., Monday – Friday, unless there is an urgent need. A nurse will be available at 1-800-477-3502, seven days a week, 24 hours per day for emergencies.

Note: Any and all treatment given without prior authorization may be denied, and you could be responsible for the payment.

Contact the nurse if:

1. You need medical care for your work related injury.
2. You would like to request a different doctor.
3. You would like to discuss a problem or issue with your medical treatment.

Who is your Primary Care Provider?

This is the physician who will provide you with your initial medical care and evaluation and will, in most instances, also coordinate any care you receive from other providers and specialists. A primary care physician may be a family practitioner, a general practitioner, an internist physician, a chiropractor, a podiatrist, an optometrist, or a dentist. This "medical care coordination" by your Primary Care Provider (PCP) helps to ensure that all medical care you receive is in your best interest and is focused toward returning you to work as soon as you are medically able. Your Nurse Case manager will also work with the Primary Care Provider to assist you with your medical questions and your return to work.

Who is your Medical Care Coordinator?

Medical Care Coordinator (MCC) means a Primary Care Physician (PCP) within a provider network who is responsible for managing the medical care of an injured employee including determining other health care providers and health care facilities to which the injured employee will be referred for evaluation or treatment. A medical care coordinator shall be a physician licensed under chapter 458 or an osteopath licensed under chapter 459.

How do I change Physicians?

Once you have been seen by an authorized Medical Care Coordinator (MCC) for treatment of an injury, you will be allowed to make only one change to a different MCC during the course of the treatment for that injury. You will not be asked to justify this request, but we will ask for information, which may allow us to better understand the nature of the request. During the course of your treatment, your MCC may decide to refer you to a specialist within the network. Once your treatment has begun with the specialist, you may request one change to a different provider in the same specialty. A description of the network providers is available. To change physicians, you MUST call or write your assigned Nurse Case manager. He or she will then provide alternative names of providers within the network.

Note: Additional changes may be accomplished only through the grievance procedure.

Retirement Savings Plan

The most common reason employees give for not investing or planning for their future is that they do not have any available money. What they fail to realize is that the financial planning process may actually identify ways to free up funds to meet defined goals and objectives. A great way to start this process is to contact one of the District's approved supplemental retirement companies to schedule an appointment with a representative.

Board policy and District administrative requirements allow companies that meet certain standards and qualifications to provide voluntary retirement saving plans to employees. The companies listed below currently qualify under the guidelines established by the District School Board of Pasco County.

This list does not reflect any opinion as to the financial strength or quality of products or service for any company.

Current Authorized Investment Companies:

AIG Retirement (IBC)	(813) 269-3362 or (888) 467-3726	www.aigretirement.com
American Century (IBC)	800-345-3533	www.americancentury.com
Ameriprise Financial	(813) 994-1190 or (888) 994-1190	www.insurance.ameriprise.com
AXA Equitable (IBC)	(813) 282-9088 or (800) 628-6673	www.axa-equitable.com
Fidelity Investments	(800) 868-1023 (*Plan # 54083)*	www.mysavingsatwork.com
Horace Mann	(813) 788-5889 or (800) 999-1030	www.planmember.com
ING Financial	(813) 281-3792 or (888) 914-2386	www.ing-usa.com
Legend Group	(727) 578-2828 or (800) 749-4421	www.legendgroup.com
Lincoln Investment Planning	(813) 948-8500 or (800) 771-7732	www.lincolninvestment.com
MetLife Resources	(813) 956-3057, (800) 752-6120; (800) 763-2838	www.metlife.com
PlanMember Services (IBC)	(800) 874-6910	http://planmember.com/planmember403b
Suncoast Schools Federal CU	(813) 246-5211 or (800) 999-5887	www.suncoastfcu.org
Waddell & Reed	(727) 785-3195 or (800) 881-3195	www.waddell.com

Customer Service Only:

Great American Financial (GALIC) ..... (800) 854-3649
Hartford/Edward Jones ..... (800) 528-9009
Life of the Southwest (LSW) ..... (800) 579-2878
Symetra Financial ..... (877) 796-3872
TIAA-Cref ..... (877) 267-4510
Vista Management Company ..... (800) 342-8017