2013 FLEXIBLE BENEFITS PLAN

Benefits Enrollment Quick Reference Guide

District School Board of Pasco County

DISTRICT SCHOOL BOARD OF PASCO COUNTY NOTICE OF SOCIAL SECURITY NUMBER DISCLOSURE

Section 119.071(5)(a)2.-4., Florida Statutes requires agencies to notify individuals of the purpose(s) that require the collection of Social Security numbers.

The District School Board of Pasco County collects social security numbers (SSNs) for the following purposes:

Social Security numbers for employees and dependents are required for enrollment in:

- health insurance
- life insurance
- other miscellaneous insurances

The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

DEPENDENT CHILD AGES 19-26

There are no eligibility requirements that must be met for medical coverage.

DEPENDENT CHILD AGES 27-30 (MEDICAL & VISION ONLY)

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.

Dear Employee,

Thank you for serving as a valued employee of the District School Board of Pasco County team. I want you to know that we appreciate the unique contributions of every employee, and recognize that our community is best served when everyone is working together to help all students reach their highest potential.

One of the ways that we strive to show our gratitude for your tireless service is through a comprehensive benefits package. Our District contributes $5,973.24 per employee per year towards each eligible employee benefits package. Our Insurance Committee works diligently to ensure that this package includes the highest quality products and services available. The committee's innovative work on behalf of all District employees has resulted in our District being recognized as a finalist for the *Tampa Bay Employer of the Year Award* by the Tampa Bay Business Journal for 2012.

The Committee's work has also resulted in the development and expansion of the Health and Wellness Centers. Through these centers, eligible employees (and their covered dependents) can receive free, high quality health care services and prescriptions. This initiative has saved our employees and the District a tremendous amount of money. If you have not already done so, I would like to encourage you to visit one of the Health and Wellness Centers.

Our goal is to provide you with many options and services designed to meet the individual needs of you and your family. As you review this guide, I hope you will find the flexibility that you need and deserve to ensure you and your family have a healthy year.

Again, thank you for continuing to share your time and talents with the students of Pasco County. We are fortunate to have you as a part of our team. If you have questions or concerns about your benefits, please do not hesitate to contact the Employee Benefits Department at extension 42253.

Warmest Regards,

Heather Fiorentino
Superintendent

YOUR GROUP HEALTH PLAN OVERVIEW

The District School Board of Pasco County provides ALL ELIGIBLE EMPLOYEES a comprehensive benefit package that includes:

- Fully paid HMO Standard Plan
- Fully paid Group Term Life Insurance $35,000
- Fully paid Prescription Drug Plan
- Fully paid Behavioral Health and Substance Abuse benefits
- Flex Dollars—Board contributes $150 per employee annually ***$250 annually if you enroll in Standard HMO Plan for 2013.**
- Employee Assistance Program (EAP)—counseling, wellness, financial advisement and other specialized programs.

You may purchase medical, dental or vision coverage for your eligible dependents through pretax payroll deductions.

HEALTHCARE PLANS

Choice of Four Medical Plans

BlueCare HMO Standard Plan
BlueCare HMO Premium Plan - Contribution required
BlueOptions Premium PPO
**Employee contributions required*
BlueOptions Standard PPO
**Employee contributions required*

HEALTH OPT OUT PLAN

Employees may waive participation in the health plan and receive $1,200 taxable income.

Health Opt Out Benefits	Benefits Waived
$1,200 Taxable Income	Medical
$35,000 Group Term Life	Prescription Drug Plan
$150 Flex Dollars	Mental Health & Substance Abuse
Employee Assistance Program	Access to Health Wellness Centers

VOLUNTARY BENEFITS PLAN

You may elect additional voluntary benefits that may be paid through TAX-FREE SALARY REDUCTION. You reduce the actual premium cost of the benefit(s) because you pay no FICA or Federal withholding taxes.

REDUCED DEPENDENT PREMIUM 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 plan. 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 currently have no dependent coverage and anticipate the addition of a dependent during the new plan year, you should plan ahead at this time, and choose the same Medical plan, since you can only change your Medical plan during the Open Enrollment period.

HEALTH REIMBURSEMENT ACCOUNT

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

If you don't spend the full $150, Pasco County Schools will place the balance in a Health Reimbursement Account (HRA) for your use.

A Health Reimbursement Account (HRA) is similar to a Medical Flexible Spending Account (FSA), except that you may carry any unspent funds over to the next 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 a Medical FSA.

HOW DO I ENROLL IN MY BENEFITS?

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

1. Contact the Sunbelt Call Center at 1-800-822-8045
   After you have enrolled with the Sunbelt Call Center, you may view your benefit elections and print an election summary by visiting the following website: www.mypascodsbbenefits.com

2. Self-enroll by logging onto the NBA website -
   (Not available during open enrollment - Please see enroller)

Please be sure to print out a benefit election form 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 benefit election form.

To access your benefit record and make changes you must enter an online ID 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:** mmddyyyy (date of birth)

If you require additional assistance to view this record, please call the Sunbelt Call Center or the Employee Benefit Department.

YOUR 2013 EMPLOYEE BENEFITS PROGRAM
VALUABLE PLANS AND PROVIDERS

Benefit	Provider	Type	Tax	Page
Medical	Florida Blue	Core	Pre-tax	4-15
Prescription Drugs	Envision Rx	Core	Pre-tax	16-17
Dental	Delta Dental	Voluntary	Pre-tax	18-20
Vision	Davis Vision	Voluntary	Pre-tax	21-22
Employee Assistance	Pasco County Schools	Core	Provided	23
Mental Health	Horizon Health	Core	Pre-tax	24-25
PASCO Health Center	Care Here	Core	Provided	26
Flex Spending Accts	TASC	Voluntary	Pre-tax	27-28
Basic Life	Minnesota Life	Core	Provided	29
Supplemental Life	Minnesota Life	Voluntary	After-tax	29
Group Term Life	LINA (Cigna Company)	Voluntary	Pre-tax	30
Universal Life	Transamerica	Voluntary	After-tax	30
Disability	Cigna	Voluntary	After-tax	31
Critical Illness	Aflac	Voluntary	Pre-tax	33
Cancer Insurance	Aflac	Voluntary	Pre-tax	34-43
Accident Insurance	Aflac	Voluntary	Pre-tax	44
Whole Life	Aflac	Voluntary	After-tax	45
Hospital Insurance	Aflac	Voluntary	Pre-tax	46
Identity Protection	LifeLock®	Voluntary	After-tax	47
Legal Insurance	ARAG	Voluntary	After-tax	48-49
Pension Plan	Florida Retirement System	Core	Pre-tax	50-51
Retirement Savings	TSA Providers	Voluntary	Pre-tax	52
Reference Material	Pasco County Schools	N/A	N/A	53-60
Rate Chart	Pasco County Schools	N/A	N/A	61

This quick reference guide is designed to help you become familiar with your benefit choices. It does not include all of the plan limitations and exclusions. Please refer to the benefits reference manual available on the employee benefits department website at http://ebarm.pasco.k12.fl.us/ for additional detailed information.

THINK ABOUT YOUR **HEALTH**

IT'S YOUR MOST VALUABLE ASSET. It's more important than your house. Your furniture. Your car. Your possessions. Your money. Your health is the key to your quality of life.

To protect your health means you must do three things: choose a medical insurance program, use available medical information resources, and take control of your own health.

As a lucky employee of Pasco County Schools, you have all three protections available to you right here. That is, you have…

- An excellent medical plan, with several options to best meet your needs.
- Outstanding access to medical information from Florida Blue.
- Other programs designed to help you take control like wellness benefits, Flexible Spending Accounts, and more.

The big idea here is that although there are many resources available to you, you are the only one in charge of your own health.

On April 2, 2012, Blue Cross Blue Shield of Florida changed its name to **Florida Blue**. It's a friendlier name that reflects the personal service and commitment to all Floridians that we've practiced for nearly 70 years. It's shorter and more memorable, representing a familiar, trusted face, enduring values and a uniquely Floridian approach that stands apart from the industry in meeting the needs of consumers today and long into the future.

HERE ARE THE TOP 3 MOST COMMON BENEFIT ISSUES:

Outpatient Hospital Services:

When you receive non-surgical services at an outpatient hospital, a copay of up to $500 per visit will apply under the BlueCare Premium HMO plan and $400 per visit will apply for the BlueCare Standard HMO plan. Non-surgical services include lab work and diagnostic testing. For example, if you obtain a MRI at the hospital, your copay will be $500. If you have lab work performed you will be responsible for the allowable charges for that procedure. If the allowable charges for the lab work are $125, this amount will be your copay.

Pre-operative services:

When receiving pre-operative services at a hospital, these services are subject to the outpatient hospital copay per visit. If the preoperative services are performed on same day as the outpatient surgery, there is no additional charge to you. One option is to go to Quest Diagnostics for your pre-op testing. There is no copay to utilize Quest Diagnostics. Another option would be to use an Independent Diagnostic Testing Facility (IDTF), such as Tower Radiology Center or Rose Radiology for any pre-operative diagnostic testing, i.e., x-rays or EKG's, the copay will be considerably less. All you need is a script from your physician.

Non-Par Labs:

Quest Diagnostics is the only participating Florida Blue lab. If you have a planned procedure, please advise the participating provider to send all lab work analysis or pathology to Quest Diagnostics. Any lab work sent to a non-participating provider WITHOUT prior authorization WILL NOT be covered under your plan.

BLUECARE STANDARD & PREMIUM HMO BENEFITS

What is an HMO?

A Health Maintenance Organization (HMO) is like a club for patients and a network of healthcare professionals. Members receive services from participating doctors, clinics, and hospitals.

An insurance company sets up an HMO, and gets a group of doctors to participate. Everybody agrees on certain costs and charges. That lets the insurance company control expenses, and give you lower prices.

Before you join the HMO, make sure your current doctor is a member of the HMO BlueCare Network.

How does BlueCare HMO work? Let's look at how you would use the HMO in various medical situations.

Choosing a Primary Care Physician

To enroll in the BlueCare HMO, you choose a Primary Care Physician (PCP) from a list of doctors who are in the network. You can find the list of doctors online at www.FloridaBlue.com or by calling customer service at 1-800-507-9820.

Your PCP is your personal physician, who will function as your family doctor, and manage your health care. Note: you must provide the doctor's national provider ID number when you enroll.

Caution. If you see a doctor who is not in the network, you do not have any benefits

Visiting Your Doctor's Office

After enrolling, you will receive an ID card. You can then visit your PCP anytime for your routine medical care. You pay a portion of the real cost (a co-payment) for each office visit, $30 per visit.

Referring Yourself to a Specialist

Very Important. Unlike most HMOs, with BlueCare HMO, you don't need a referral from your PCP to see a Specialist. As long as the doctor is in the HMO network, and accepts your plan, you're good to go.

Changing Your Primary Care Physician

Let's say, after several visits with your PCP, you want to change to a different doctor.

1) Pick a new PCP
2) Call PCP to verify participating status and accepting new patients
3) Call Florida Blue to change PCP

Entering the Hospital

Once your PCP has determined that you need hospital care, he or she notifies the insurance company. Your job is to make sure you are entering an in-network hospital. Your inpatient hospital co-pay is $500 per day up to a maximum of 5 days or $2,500 under the Premium HMO Plan. Deductible and coinsurance applies to hospital stays under the Standard HMO Plan.

Outpatient Hospital Services

Outpatient hospital services that are non-surgical, i.e., diagnostic testing, labs, etc. and surgical services are subject to $500 co-pay or less depending upon the allowable contracted amount for the services under the Premium PPO Plan and $400 copay under the Standard HMO Plan.

Dealing with a Medical Emergency

In a medical emergency, you don't have to worry about getting to your PCP. Of course, the first thing to do is to seek medical attention immediately. Then, contact your PCP and Florida Blue within 48 hours.

Anyone can call, a family member, friend, doctor, or hospital. But ultimately, it is your responsibility to notify Florida Blue.

Receiving Care Away from Home

Under the BlueCare HMO Plans, typically only emergency services are covered out of state.

To meet your healthcare needs when you are traveling, or the needs of family members who are attending school, or working out-of-state, the HMO offers separate benefits for both short trips and long stays. Check with Florida Blue for more information on our "Away from Home" Program.

GENERAL DISCLAIMER

The Florida Blue Medical Plans described in these pages are only a summary of your comprehensive healthcare coverage. This guide is not an Insurance Contract or a Certificate of Coverage. For a complete description of benefits, services, and exclusions, refer to your Master Policy.

HEALTH INSURANCE TERMS YOU SHOULD KNOW

Balance Billing
This is the practice where a provider charges full fees in excess of covered amounts, and bills you for the portion of the bill that your medical plan does not pay. In-network providers do not balance bill for covered services. Non-network providers, however, are not under contract, so they can balance bill.

Coinsurance
A method of medical cost-sharing that requires you to pay a stated percentage of expenses. If have a 60/40 split, the plan pays for 60% of your eligible medical expenses, and you're responsible for the remaining 40%. And this is after you've paid your deductible.

Co-payment
A specified dollar amount that you must pay out-of-pocket for a specified service at the time when you receive the service.

Deductible
A specified dollar amount you must pay before the plan will make any benefit payments. You are responsible for a deductible each plan year.

Out-of-Pocket Maximums
The applicable Calendar Year Deductible, any applicable Copayments and Coinsurance amounts added together under the plan. Once you reach the Out of Pocket Maximum amount listed in the Schedule of Benefits, you will have no additional Out of Pocket responsibility for the remainder of the Calendar Year and covered services rendered during the remainder of that Calendar Year will be paid at 100% of the allowed amount.

BlueCare

Florida Blue

For Pasco Schools
Standard HMO Health Benefit Plan Summary

Benefits for Covered Services	Amount Member Pays
Office Services	
Physician Office Services	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network Office Visit	Not Covered
In-Network e-Office Visit Family Physician / Specialist	$10 Copayment
Out-of-Network e-Office Visit	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$50 Copayment
Out-of-Network	Not Covered
Maternity Initial Visit	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	Not Covered
Allergy Injections (per visit)	
In-Network	$10 Copayment
Out-of-Network	Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)	
In-Network Monthly Out-of-Pocket (OOP) Maximum[1]	**$200**
In-Network Provider	**20% Coinsurance**
Out-of-Network	**Not Covered**
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your medical benefit. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.	
Convenient Care Centers	
In-Network	$30 Copayment
Out-of-Network	Not Covered
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network	Not Covered
Mammograms	
In-Network	$0
Out-of-Network	Not Covered
Colonoscopy (Routine for age 50+ then frequency schedule applies)	
In-Network	$0
Out-of-Network	Not Covered
Emergency Medical Care	
Urgent Care Centers	
In-Network	$60 Copayment
Out-of-Network	Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network and Out-of-Network	$250 Copayment
Ambulance Services	No Maximum
In-Network	$100 Copayment
Out-of-Network (Emergency Services Only)	$100 Copayment
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS) (X-rays, Ultrasounds)	$50 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$50 Copayment
Out-of-Network	Not Covered
Independent Clinical Lab (e.g. Blood Work) (Quest Diagnostics)	
In-Network	$0
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays)	
In-Network (Any Surgical or *Non-Surgical Service, e.g. Labs, X-rays)	$400 Copayment
Out-of Network	Not Covered
Other Provider Services	
Provider Services at Hospital and ER	
In-Network	DED[2] + 10% Coinsurance
Out-of-Network ER	DED + 10% Coinsurance
Out-of-Network Hospital	Not Covered

BlueCare

Florida Blue

For Pasco Schools
Standard HMO Health Benefit Plan Summary

Benefits for Covered Services	Amount Member Pays
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network Specialist	$50 Copayment
Out-of-Network	Not Covered
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	Not Covered
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max)	35 Visits
Locations other than Physician's Office and Hospital	
In-Network	$50 Copayment
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit)	
In-Network	$50 Copayment
Out-of-Network	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics	
In-Network – Motorized Wheelchair	$500 Copayment
In-Network – All Other	$0 Copayment
Out-of-Network	Not Covered
Home Health Care (PBP Max)	20 Visits
In-Network	$0
Out-of-Network	Not Covered
Skilled Nursing Facility (PBP Max)	60 days
In-Network	DED + 10% Coinsurance
Out-of-Network	Not Covered
Hospice	
In-Network	DED + 10% Coinsurance
Out-of-Network	Not Covered
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC)	
In-Network	$200 Copayment
Out-of-Network	Not Covered
Inpatient Hospital Facility & Rehabilitation Services (per admit) (PBP Max)	Rehabilitation Services Limit - 21 days
In-Network	DED + 10% Coinsurance
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit)	
In-Network – Therapy Services	$50 Copayment
In-Network – All other (Any Surgical or *Non-Surgical Service, i.e., labs, x-rays)	$400 Copayment
Out-of-Network	Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network and Out-of-Network	$250 Copayment
Financial Features	
Deductible (DED) (Per Person / Family Aggregate)	
In-Network	$1,500 / $4,500
Out-of-Network	Not Covered
(DED is the amount the member is responsible for before Florida Blue pays)	
Coinsurance	
In-Network	10%
Out-of-Network	Not Covered
(Coinsurance is the percentage the member pays for services)	
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate)	
In-Network	$4,000 / $8,000
Out-of-Network	Not Covered
(Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	
Total Lifetime Maximum Benefit	Unlimited

[1] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

[2] DED = Deductible

*Non-Surgical Services at an out-patient facility - Subject to copayment. Services include but not limited to bloodwork and x-rays.

BlueCare

Florida Blue

For Pasco County Schools
Premium HMO Health Benefit Plan Summary

Benefits for Covered Services	Amount Member Pays
Office Services	
Physician Office Services	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network Office Visit	Not Covered
In-Network e-Office Visit Family Physician / Specialist	$30 Copayment / $50 Copayment
Out-of-Network e-Office Visit	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$30/$50 Copayment
Out-of-Network	Not Covered
Maternity Initial Visit	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	Not Covered
Allergy Injections (per visit)	
In-Network	$20 Copayment
Out-of-Network	Not Covered
Convenient Care Centers	
In-Network	$30 Copayment
Out-of-Network	Not Covered
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network	Not Covered
Mammograms	
In-Network	$0
Out-of-Network	Not Covered
Colonoscopy (Routine for age 50+ then frequency schedule applies) (Note: Diagnosis code needs to be routine.)	
In-Network	$0
Out-of-Network	Not Covered
Emergency Medical Care	
Urgent Care Centers	
In-Network	$50 Copayment
Out-of-Network	Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network and Out-of-Network	$200 Copayment
Ambulance Services	
In-Network and Out-of-Network	$100 Copayment
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS) (X-rays, Ultrasounds)	$0 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$50 Copayment
Out-of-Network	Not Covered

BlueCare Florida Blue

For Pasco County Schools
Premium HMO Health Benefit Plan Summary

Benefits for Covered Services	Amount Member Pays
Independent Clinical Lab (e.g. Blood Work) (Quest Diagnostics)	
In-Network	$0
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit)	
In-Network – All (Any Surgical or Non-Surgical Services, i.e., labs, x-rays)	$500 Copayment
Out-of Network	Not Covered
Other Provider Services	
Provider Services at Hospital and ER	
In-Network	$0
Out-of-Network	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network	$0
Out-of-Network	Not Covered
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	$0
In-Network Specialist	$0
Out-of-Network	Not Covered
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max)	
Locations other than Hospital and Physician's Office	
In-Network	$30
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit)	
In-Network	$50 Copayment
Out-of-Network	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics	
In-Network – Motorized Wheelchair	$500 Copayment
In-Network – All Other	$0 Copayment
Out-of-Network	Not Covered
Home Health Care (PBP Max)	
In-Network	$0
Out-of-Network	Not Covered
Skilled Nursing Facility (PBP Max)	60 days
In-Network	$0
Out-of-Network	Not Covered
Hospice	
In-Network	$0
Out-of-Network	Not Covered
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC)	
In-Network	$400 Copayment
Out-of-Network	Not Covered
Inpatient Hospital Facility & Rehabilitation Services (per admit) (PBP Max)	
In-Network	$500 per day / $2,500 Maximum
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit)	
In-Network – Therapy Services	$50 Copayment
In-Network – All other (Any Surgical or Non-Surgical Service, i.e., labs, x-rays)	$500 Copayment
Out-of-Network	Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network and Out-of-Network	$200 Copayment
Financial Features	
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate)	
In-Network	$3,000 / $9,000
Out-of-Network	Not Covered
(Out-of-Pocket Maximum includes Copayments for Covered Services)	
Total Lifetime Maximum Benefit	Unlimited

BLUEOPTIONS STANDARD & PREMIUM PPO BENEFITS

What is a PPO?

A Preferred Provider Organization (PPO) gives participants the freedom to access services from out-of-network providers.

ROADBLOCK: A Previous Medical Problem

Very Important. The BlueOptions PPO Plans have a pre-existing conditions clause. This means…

You will have to wait 12 months for the plan to cover the cost of treatment for any previous medical condition that existed less than 6 months prior to your date of hire (for new employees or dependents) or prior to your coverage effective date for current employees.

Exception: If you have proof of prior insurance coverage, you will be given credit towards the pre-exclusionary period. If you have 12 months of continuous coverage with no lapse of 63 days, the pre-ex will be waived. You will need to provide a "Certificate of Credible Coverage Letter" from your prior carrier providing the begin and end dates of coverage.

Enrolling in a PPO

As a new BlueOptions PPO member you will receive a new PPO insurance card. The card contains a magnetic strip, which includes all of your benefit information. It can be easily scanned and read in a hospital or doctor's office. It is called "the card for life."

Choosing a Physician

Unlike the HMO, you don't have to choose a Primary Care Physician (PCP), but we recommend that you select a physician to coordinate your overall care. You can see any healthcare professional in the network. You don't need referrals for specialists such as chiropractors or ob-gyn or other medical practitioners. Just make sure they are in the BlueOptions "Network Blue" Provider Network.

Staying in the Network

It's a good idea to stay within the network of healthcare providers. You'll save money in the long run. However, the PPO is all about choice and access.

You can see medical providers outside the established PPO network. However, if you do, your out of pocket expenses will definitely be higher. Is there a big difference? Yes.

For example, under Premium Plan, your individual deductible is $0 in-network, and $500 out of network. Your coinsurance is 20% in network, and 40% out of network. More choice. More cost.

Entering the Hospital

Under the Premium PPO Plan, there is an in-network copay of $600 per admission. Under the Standard PPO Plan, the hospital admission is subject to a deductible and coinsurance for in or out-of-network facilities.

Getting Lab Services

Doctor, where are you sending my lab tests? A powerful question. If your doctor sends lab work to in-network Quest labs, your cost is zero.

If he or she sends your tests to an out-of-network lab, then you'll be subject to an additional $500 (Premium PPO) or $1,000 (Standard PPO) deductible, plus 40% of the cost of the test. That test hurts. So pay attention.

Receiving Care Away from Home

As a BlueOptions member, you are covered under the BlueCard Program when you are traveling outside the state of Florida.

The BlueCard Program gives you access to thousands of participating providers in BCBS organizations around the world. If you receive services from a BlueCard doctor, you will get in-network benefits, and you will not get balance billed. Feel secure with the BlueCard.

Convenient Care Centers

Using convenient care centers such as Minute Clinic, The Little Clinic and Take Care Health Clinics is fast and easy.

* Not all Convenient Care Centers are in-network. Please check the on-line provider directory.

Selecting a BlueOptions PPO

Only you can determine if a PPO option is right for you. That's why we continue to urge you to take the time to "understand the plan."

BlueOptions

Florida Blue

For Pasco County Schools
Premium PPO Health Benefit Plan Summary

Benefits for Covered Services	Amount Member Pays
Office Services	
Physician Office Services	
In-Network Family Physician	$20 Copayment
In-Network Specialist	$35 Copayment
Out-of-Network Office Visit	DED[1] + 40% Coinsurance
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	DED + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$150 Copayment
Out-of-Network	DED + 40% Coinsurance
Maternity Initial Visit	
In-Network Specialist	$35 Copayment
Out-of-Network	DED + 40% Coinsurance
Allergy Injections (per visit)	
In-Network Family Physician	$10 Copayment
In-Network Specialist	$10 Copayment
Out-of-Network	DED + 40% Coinsurance
Preventive Care	
Routine Adult Physical Exam and Immunizations	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Well Woman Exam (e.g. Annual GYN)	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Mammograms (Covered at 100% of Allowed Amount)	
In-Network and Out-of-Network	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies) (Covered at 100% of Allowed Amount)	
In-Network and Out-of-Network	$0
Well Child	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Emergency Medical Care	
Urgent Care Centers	
In-Network	$45 Copayment
Out-of-Network	DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network	$100 Copayment
Out-of-Network	$100 Copayment
Ambulance Services (Ground, air and water travel, combined per day maximum, $5,500)	
In-Network and Out-of-Network	20% Coinsurance
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS)	$50 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$150 Copayment
Out-of-Network	DED + 40% Coinsurance
Independent Clinical Lab (e.g. Blood Work) Quest Diagnostics	
In-Network	$0
Out-of-Network	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (*Surgical and Non-Surgical)	
In-Network	$200 Copayment
Out-of Network	DED + 40% Coinsurance

* Surgical and Non-Surgical Services including but not limited to labs and x-rays.

BlueOptions

For Pasco County Schools
Premium PPO Health Benefit Plan Summary

Florida Blue

Benefits for Covered Services	Amount Member Pays
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	$20 Copayment
In-Network Specialist	$35 Copayment
Out-of-Network	DED + 40% Coinsurance
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies / Spinal Manipulations (26 Visit Maximum)	35 Visits Combined Maximum
In-Network Locations other than Hospital and Physician's Office	$35 Copayment
Out-of-Network Locations other than Hospital	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit)	
In-Network	$45 Copayment
Out-of-Network	DED + 40% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics	
In-Network	20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Home Health Care (PBP[2] Max)	20 Visits
In-Network	20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Skilled Nursing Facility (PBP[2] Max)	60 days
In-Network	20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Hospice	
In-Network	20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC)	
In-Network	$100 Copayment
Out-of-Network	DED + 40% Coinsurance
Inpatient Hospital Facility & Rehabilitation Services (per admit) (PBP[2] Max)	Rehabilitation Services limit - 21 days
In-Network	$600 Copayment
Out-of-Network	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (*Surgical and Non-Surgical)	
In-Network – Therapy Services	$45 Copayment
In-Network – All other Services	$200 Copayment
Out-of-Network	DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network	$100 Copayment
Out-of-Network	$100 Copayment
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate)	
In-Network	$0 / $0
Out-of-Network	$500 / $1,500
(DED is the amount the member is responsible for before Florida Blue pays)	
Coinsurance (*Surgical and Non-Surgical)	
In-Network	20%
Out-of-Network	40%
(Coinsurance is the percentage the member pays for services)	
Out-of-Pocket Maximum (PBP[2]) (Per Person / Family Aggregate)	
In-Network	$2,500 / $5,000
Out-of-Network	$5,000 / $10,000
(Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	
Total Lifetime Maximum Benefit	Unlimited

[1] DED = Deductible
[2] PBP = Per Benefit Period

* Surgical and Non-Surgical Services including but not limited to labs and x-rays.

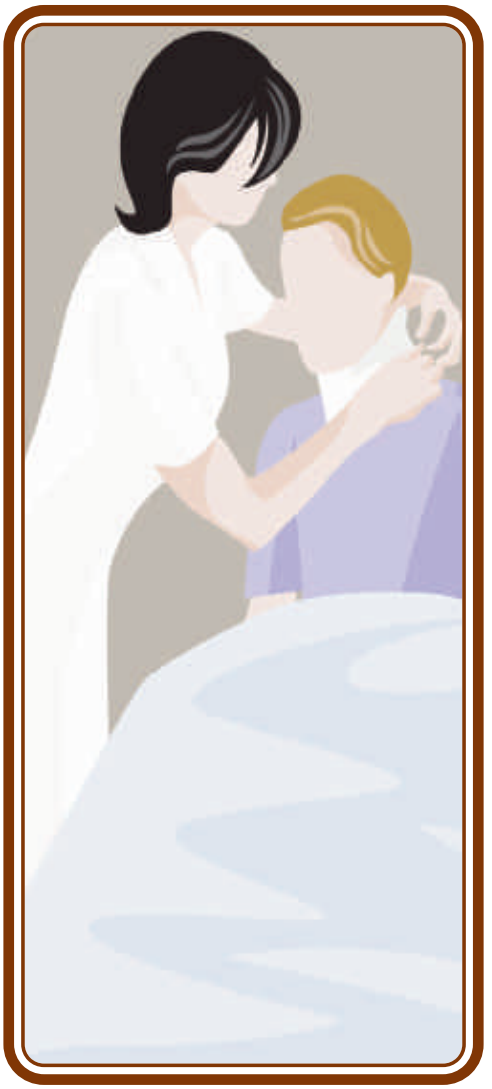
BlueOptions

Florida Blue

For Pasco County Schools
Standard PPO Health Benefit Plan Summary

Benefits for Covered Services	Amount Member Pays
Office Services	
Physician Office Services	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network Office Visit	DED[1] + 40% Coinsurance
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	DED + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$200 Copayment
Out-of-Network	DED + 40% Coinsurance
Maternity Initial Visit	
In-Network Specialist	$50 Copayment
Out-of-Network	DED + 40% Coinsurance
Allergy Injections (per visit)	
In-Network Family Physician	$20 Copayment
In-Network Specialist	$20 Copayment
Out-of-Network	DED + 40% Coinsurance
Preventive Care	
Adult Wellness Benefit Maximum (PBP[2], includes Routine Adult Physical Exam and Immunizations & Well Woman)	
In-Network	No Maximum
Out-of-Network	No Maximum
Routine Adult Physical Exam and Immunizations	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Well Woman Exam (e.g. Annual GYN)	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Mammograms (Covered at 100% of Allowed Amount)	
In-Network and Out-of-Network	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies) (Covered at 100% of Allowed Amount)	
In-Network and Out-of-Network	$0
Well Child (No PBP Max)	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Emergency Medical Care	
Urgent Care Centers	
In-Network	$50 Copayment
Out-of-Network	DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network	$100 Copayment
Out-of-Network	$100 Copayment
Ambulance Services (Ground, air and water travel, combined per day maximum, $5,500)	
In-Network and Out-of-Network	In-Network DED + 20% Coinsurance
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS)	$50 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$200 Copayment
Out-of-Network	DED + 40% Coinsurance
Independent Clinical Lab (e.g. Blood Work) Quest Diagnostics	
In-Network	$0
Out-of-Network	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (*Any surgical or non-surgical services)	
In-Network	$300 Copayment
Out-of Network	DED + 40% Coinsurance

* Surgical and Non-Surgical Services including but not limited to labs and x-rays.



BlueOptions

For Pasco County Schools
Standard PPO Health Benefit Plan Summary

Florida Blue

Benefits for Covered Services	Amount Member Pays
Other Provider Services	
Provider Services at Hospital and ER	
In-Network and Out-of-Network	$50 Copayment
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network and Out-of-Network	$50 Copayment
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	DED + 40% Coinsurance
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies / Spinal Manipulations (26 Visit Maximum)	35 Visits Combined Maximum
In-Network Locations other than Hospital	$30 Copayment
Out-of-Network Locations other than Hospital	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit)	
In-Network	$50 Copayment
Out-of-Network	DED + 40% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics	
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Home Health Care (PBP [2] Max)	20 Visits
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Skilled Nursing Facility (PBP [2] Max)	60 days
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Hospice	
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC)	
In-Network	$200 Copayment
Out-of-Network	DED + 40% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP [2] Max)	Rehabilitation Services limit - 21 days
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) -*Surgical and Non-Surgical	
In-Network – Therapy Services	$50 Copayment
In-Network – All other Services	$300 Copayment
Out-of-Network	DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network	$100 Copayment
Out-of-Network	$100 Copayment
Financial Features	
Deductible (DED) (PBP [2]) (Per Person / Family Aggregate)	
In-Network	$250 / $750
Out-of-Network	$1,000 /$3,000
(DED is the amount the member is responsible for before Florida Blue pays)	
Coinsurance	
In-Network	20%
Out-of-Network	40%
(Coinsurance is the percentage the member pays for services)	
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate)	
In-Network	$3,000 / $6,000
Out-of-Network	$6,000 / $12,000
(Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	
Total Lifetime Maximum Benefit	Unlimited

[1] DED = Deductible

[2] PBP = Per Benefit Period

* Surgical and Non-Surgical Services including but not limited to labs and x-rays.

BLUE365 DISCOUNT PROGRAM*

As part of Florida Blue's ongoing commitment to bringing expanded choices and greater value to your health plan, we are pleased to offer a program of discounted products and value-added services called, "Blue365 Discount Program."

Blue365 Discount Program is available to you automatically as a plan member at no additional premium cost. This program includes these valuable services.

Access these services

To take advantage of any of these services, just access the Florida Blue website at www.floridablue.com.

1. Login as a registered member.
2. Click on "Health & Wellness" tab.
3. Select "Discounts & Rewards".
4. Click on "Discount Programs".
5. On the Authorization Page, read the Agreement and then click on "I agree" button.
6. On the Blue365 Page, select the offerings at the bottom of the page. Click on the">" to scroll through the offerings.
7. To Redeem any offer, you will need to register.

OR

Follow these instructions without logging in:

1. Access www.floridablue.com.
2. At the bottom of page, click on the 6th box from the left labeled, "Member Discounts".
3. On the Authorization Page, read the Agreement and then click on "I agree" button.
4. On the Blue365 Page, select the offerings at the bottom of the page. Click on the ">" to scroll through the offerings.
5. To Redeem any offer, you will need to register.

Note: These vendors are subject to change without prior notice.

Healthy Eating

eDiets - A premier online diet, fitness and healthy living destination providing products/services to those seeking to improve their health and longevity.
Call 1-866-731-3432

Jenny Craig - A leading provider of weight management products and services, offering a holistic approach to healthy weight management.
Call 1-800-597-5366

NutriSystem - A leading provider of weight management products and services, offering a systematic weight loss program based on portion-controlled prepared meals.
Call 1-800-310-6353

Vision

Davis Vision - Providing comprehensive vision care programs and services for nearly 45 years.
Call 1-888-897-9350

Qualsight Lasik - Contracts with providers of laser vision correction services.
Call 1-877-283-2010

Hearing

Beltone - One of the largest manufacturers of hearing instruments, Beltone products are sold in the U.S., Canada, and over 40 countries worldwide.
Call 1-888-896-2365

TruHearing - Offers discounted hearing aids. Hearing tests are performed by a professional using the latest diagnostic equipment.
Call 1-877-396-7190

Eldercare Concierge Services

Seniorlink Care - has a nationwide network of credentialed care managers with professionals located in all 50 states that provide Eldercare Concierge services. Toll Free Number Not Available.

Fitness

Healthways - $25 monthly fee for access to network of 8,000 +gyms nationwide. Low $25 enrollment fee.
Call l-888-242-2060 for more details.

Polar - Selection of multi-price point heart-rate monitor watches that allow members to track the progress of and provides recommendations on personalized exercise regimens. Toll Free Number Not Available.

Reebok - Creates and markets various types of sports and lifestyle products for men, women and children.
Call 1-866-870-1743

Snap Fitness - Provides a convenient alternative to large format clubs at a lower-tiered price point, with no contracts and 24/7 access. Toll Free Number Not Available.

THINK ABOUT YOUR **MEDICATIONS**

IT'S A WHOLE NEW WORLD OUT THERE IN PRESCRIPTION DRUG LAND.

There are dramatic changes going on—changes that affect the way you buy your prescription medications now, and in the future.

What's happening with prescription drugs?
Doctors are writing more prescriptions. Drug companies are introducing new medicines. Prescription prices are skyrocketing.

So it's NOT business as usual.
To control the rising costs of prescription drugs, employers, insurance companies, and pharmacy benefit managers have created new ways for you to buy medicines.

You don't just drop down to the drugstore anymore, see Friendly Fred the Pharmacist, and pick up your pills. It's much more complicated than that now.

Today, there are generic drugs, preferred brand name drugs, and non-preferred brand name drugs. There are formularies, specialty drugs, step care therapies, and much more.

You need to understand the new world of prescription drugs, so you can save money, and get the best care for you and your family.

PRESCRIPTION PLAN

You are automatically enrolled.
If you are enrolled in any of the medical plans – then you are automatically enrolled in the prescription drug plan.

It's a totally separate plan.
Your Prescription Drug Plan offered by Envision Rx is not part of your Florida Blue Plan.

Important. You will receive a separate Identification Card for the prescription drug program. You must show this card, not your Florida Blue card to get your prescriptions.
Depending on your personal and family medical situation, the prescription plan offers two ways to get your prescriptions: (1) from your local drugstore or (2) through the Mail Service Pharmacy. Let's look at each one.

Go Generic! Did you know that the United States Food and Drug Administration (FDA) requires generic drugs to be as safe and effective as their brand-name counterparts? That means you can save money without compromising quality. A generic must contain identical amounts of the same active ingredients—in the same dosage form and strength—as its brand-name counterpart and be shown to work the same way in the body. There are many new generics available for conditions such as high cholesterol, allergies and depression. We suggest you discuss with your doctor whether a generic medication is appropriate for you.

1 IF YOU NEED MEDS OCCASIONALLY

If you only need to fill prescriptions occasionally throughout the year, then you simply go to your local, retail pharmacy.

You can choose from more than 60,000 participating pharmacies nationwide.

Three Categories

So let's look at the three categories of drugs, and see who made the list, and who did not. This is important because it determines your personal costs (co-pays).

Generics are on the list. They contain the same active ingredients as their brand-name equivalents, and offer the same effectiveness and safety. They have the lowest co-pay.

Preferred Brands are on the list. Brand name drugs that are preferred by the plan, and that made the list have a higher co-pay than their generic counterparts.

Non-Preferred Brands are NOT on the list. Why? Because there's usually a generic or preferred brand drug available instead. That's why they have the highest co-pays.

You do have options.

Just because your doctor prescribes a brand-name drug, he or she isn't necessarily opposed to substituting a less-expensive, generic-equivalent drug. Be sure to discuss with your doctor whether a generic would work for you.

Category	You Pay*
Generic	$10.00
Preferred Brand	$25.00
Non-Preferred Brand	$40.00

* Your cost for (up to) a **30-day** supply.

2 IF YOU NEED MEDS CONTINUOUSLY

Many employees take maintenance medications on a regular, continuous basis.

These are drugs for chronic conditions like diabetes, blood pressure, and cholesterol. And because they are for long-term use, they are usually dispensed in 90-day doses.

If you take a daily medication you will be required to refill for a 90-day supply.

You have two ways to save money if you take these medications: the Retail 90 Program or the Mail Service Pharmacy.

The Retail 90 Program

This program is available at selected local pharmacies. For example, here you get a generic 90-day supply for $25.00 or 2.5 co-pays versus a 90-day supply (a month at a time) that would cost you $30.00 or 3 co-pays with the regular plan.

Example 1: A Good Value	
Category	**You Pay***
Generic	$25.00
Preferred Brand	$62.50
Non-Preferred Brand	$100.00

* Your cost for (up to) a **90-day** supply.

The Mail Service Pharmacy

This program takes a little extra planning because you're getting your meds through the mail. But it's worth it because you save even more money than you do with Retail 90.

For example, here you get a 90-day supply for $20.00 or 2 co-pays versus a 90-day supply (a month at a time) that would cost you $30.00 or 3 co-pays with the regular plan. That's one month FREE.

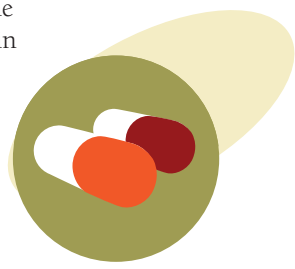
Take advantage of convenient delivery of your covered maintenance medications to your home or other specified address. Be sure to ask your physician for a 90-day prescription in order to take advantage of this benefit.

Example 2: Your Best Value	
Category	**You Pay***
Generic	$20.00
Preferred Brand	$50.00
Non-Preferred Brand	$80.00

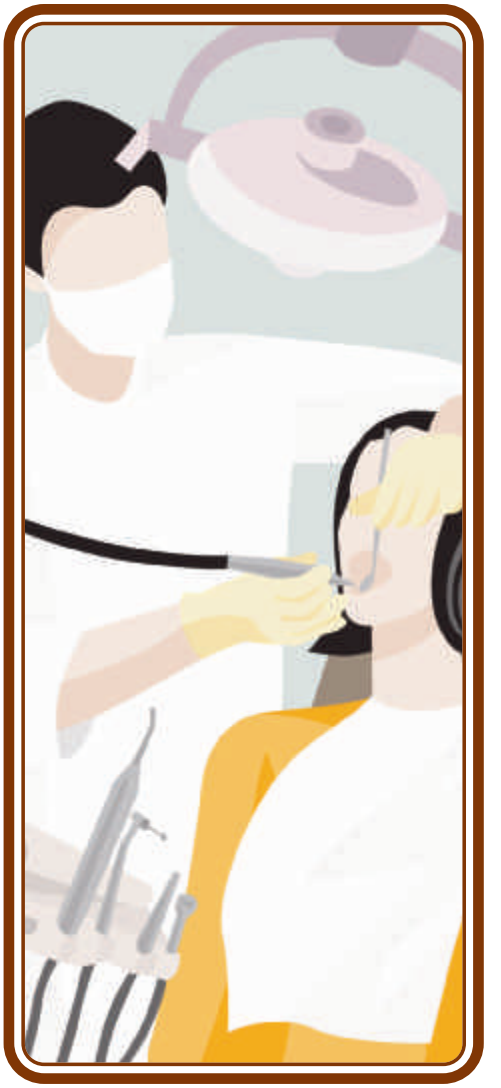
* Your cost for (up to) a **90-day** supply.

Be alert to special situations.

There are special situations that may require prior authorization, step care, or specialty drugs. The pharmacy will notify you if the dispensing of certain medications requires additional information from your doctor.



THINK ABOUT YOUR TEETH



FORGET ABOUT THE TOOTH FAIRY! Dental health is your responsibility. It's your job to make sure that a consistent, focused program of oral hygiene is a lifelong habit for you. And one that's built on a strong partnership between you and your dentist.

What is good dental health?

The American Dental Association recommends five steps for good oral hygiene. You should…

- Brush your teeth at least twice a day with fluoride toothpaste.
- Replace your toothbrush every three or four months. They wear out quickly.
- Floss daily. Why? Because between the teeth is where cavities and other bad things happen. This is a critical piece.
- Eat a balanced diet, and reduce the amount of sugar you consume.
- See your dentist regularly for cleanings and oral exams.

See your dentist for heart health?

It's not as strange as it may sound. Research from the Academy of General Dentistry shows that more than 90% of all diseases in your system produce oral signs and symptoms.

Oral exams can play a key role in screening for diseases such as cancer, diabetes, hypertension, leukemia, osteoporosis, and autoimmune diseases, among other conditions.

And researchers for the New England Journal of Medicine found that treating severe gum disease can improve the function of blood vessel walls, actually improving heart health.

You'll be checked for gum disease

More than 75 percent of Americans over 35 have some form of gum disease. Periodontal (gum) disease is one of the main causes of tooth loss.

But research also links it to heart disease, stroke, respiratory disease, pre-term pregnancies, and diabetes. Serious issues, yes? Your dentist will check you for signs of gum disease.

You'll be examined for oral cancer

30,000 Americans are diagnosed with oral cancer each year—and nearly 8,000 die of the disease durin a twelve-month period.

During your semi-annual oral exam, your dentist will check for oral cancer and other serious conditions. Here's an example that shows it's not just about cavities anymore.

No, I never had wooden teeth. My dentures were actually carved from hippopotamus ivory and gold. But I did have a history of dental problems. Toothaches, abscessed teeth, inflamed gums, and extractions. It gave me a very bad temper. By the time I became President, I had only one natural tooth. So make sure you use your dental benefits.

George Washington, Big Thinker

DELTA DENTAL INSURANCE COMPANY

is a recognized leader in the dental industry, collectively providing coverage to over 60 million people. Quality Assurance is extremely important and participating Delta Dental dentist are monitored to ensure they deliver quality care and that all treatment meets professional standards.

You have the option to choose from the three plan options, Delta Dental High PPO, Delta Dental Low PPO and Delta Care USA (prepaid plan)

DeltaCare USA will require the selection of a primary care dentist (or one will be assigned to you by Delta Dental). This plan offers services based on set copayments, with no annual deductible or maximums for covered services.

Delta Dental PPO Plan allows you to see any dentist although you will most likely experience less out-of-pocket cost by selecting a dentist participating in the PPO Program.

Delta Dental offers both the Delta Dental PPO and Delta Dental Premier Networks. By selecting the Delta Dental PPO network, you will usually achieve greater savings, due to lower negotiated fees. Additionally in this plan you do have the option of using a dentist not participating with Delta Dental; however you will need to file paper claims and usually it will incur higher out of pocket costs.

*Who's Eligible

Primary enrollee, spouse, eligible dependent children to age 26.

CHOICE 1: DELTA DENTAL – HIGH PPO PLAN

How does the Dental PPO plan work?

The Dental PPO plan has a calendar year maximum of $1,500. That's the maximum amount the plan will pay toward the dental care for each person enrolled.

There is a yearly deductible of $75 per person, up to 3 deductibles. So, 3 times $75, or an annual deductible of $225 a year is all you will pay for your whole family.

There is also a coinsurance percentage for each covered procedure. Coinsurance is the percentage the plan pays after deductible (if applicable). The plan also covers ($1,000) on orthodontics for adults and dependent children up to age 26.

There are in and out-of-network benefits

Reimbursement percentage is the same in and out of network. If you see a contracted Delta Dental Dentist, you will reduce your out of pocket cost. Plus, you won't have to do any paperwork. Your Delta Dental dentist will file your claims for you.

With this plan, you can receive care from any licensed dental care professional. But if you see a contracted Delta Dental dentist, you will reduce your out-of-pocket costs.

CHOICE 2: DELTA DENTAL – LOW PPO PLAN

How does the Dental PPO plan work?

The Dental PPO plan has a calendar year maximum of $1,000. That's the maximum amount the plan will pay toward the dental care for each person enrolled.

There is a yearly deductible of $75 per person, up to 3 deductibles. So, 3 times

District School Board of Pasco County — EFFECTIVE DATE: 1/01/2013

Who's Eligible: Primary enrollee, spouse, eligible dependent children to age 26	High PPO Plan		Low PPO Plan		DeltaCare - Prepaid Plan	
Dental Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	
Dental Networks - Payment Basis	PPO	Premier/80th	PPO	PPO	14A	
Plan Year Maximum	$1,500 per covered member		$1,000 per covered member		No Plan Year Max for covered members	
Deductible (Per Member/Per Family) Per Calendar Year	$75/$225	$75/$225	$75/$225	$75/$225	Office Visit $0 copay	
Diagnostic & Preventive Svc (D&P)	100%	100%	100%	60%	D&P $0 - $70 copay	
Deductible Waived for D&P	Yes	Yes	Yes	Yes	N/A	
Basic Service	80%	80%	80%	50%	DeltaCare Schedule A	
Major Services	50%	50%	50%	40%	DeltaCare Schedule A	
Orthodontics - 3 Treatment Levels	50%		Not covered		$1900 Child	$2100 Adult
Lifetime Ortho Max	**$1,000**		Not covered		N/A	
Coverage Eligibility	Child & Adult		Not covered		Child & Adult	
Simple Extractions	Basic	Basic	Basic	Basic		
Complex Oral Surgery	Basic	Basic	Basic	Basic		
Endodontics (Root Canal)	Basic	Basic	Basic	Basic	DeltaCare Schedule A	
Periodontics (Gum Disease)	Basic	Basic	Basic	Basic		
Crowns, Bridges, Inlays, Onlays	Major	Major	Major	Major		
Implants	Major	Major	Not covered		Not covered	

$75, or an annual deductible of $225 a year is all you will pay for your whole family.

There is also a coinsurance percentage for each covered procedure. Coinsurance is the percentage the plan pays after deductible (if applicable).

There are in and out-of-network benefits

With this plan, your reimbursement percentage on the Low PPO plan will be higher in network. So you can save two ways, deepest discount on PPO reduced fees and higher reimbursement on in network services. Plus, you won't have to do any paperwork. Your Delta Dental dentist will file your claims for you.

You can receive care from any licensed dental care professional. But if you see a contracted Delta Dental dentist, you will reduce your out-of-pocket costs.

Both PPO Plans

You don't have to pre-select a dentist

There is no requirement to pre-select a dentist. Note, however, that you will save money by receiving care from a contracted dentist. There's a directory of contracted dentists for your area on the Delta Dental website.

Do you have other dental coverage?

If you do have other dental coverage in addition to the Dental PPO plan, be aware there's a coordination of benefits program in place.

In short, you can't get paid benefits from two dental plans for the same treatment. That means this plan will "coordinate" with your other policies. Bottom line: your combined benefits may pay up to, but no more than, the total covered expense.

Filing a claim

In most instances, your dentist's office staff will ask you to sign an assignment form. That authorization form allows them to file the claim for you, and to get paid directly from the plan. 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 Delta Dental.

Pre-approval for treatments costing $300 or more

Generally, you don't have to get pre-approval for PPO treatments. But we do encourage your to have your dentist submit a preauthorization request for a treatment plan that will cost more than $300.

This will ensure that any of the procedures your dentist suggests are, in fact, covered benefits. It also gives you a chance to find out beforehand what your out-of-pocket expenses will be.

For more information, go to the Employee Benefits Department website and follow the links to Delta Dental.

CHOICE 3: DELTA DENTAL – DELTACARE-PREPAID DMO PLAN

What is DeltaCare DMO?

It's a network-based plan from Delta Dental that emphasizes prevention and cost containment. This plan provides savings ranging from 20% to 60% off regular dental procedures. Here's how it works.

You must select an In-Network General Dentist

There are both private practice dentists and those who are in a group practice. Every dentist has been thoroughly screened prior to acceptance, and is also subject to regular audits. So don't worry, you are protected.

You can also change dentists. Just call 1-800-422-4234 or visit our web site at www.deltadentalins.com to change dentists by the 15th of the month. Your transfer will be effective on the first of the following month.

Qualified, screened, audited dentists

There are both private practice dentists and those who are in a group practice. Every dentist has been thoroughly screened prior to acceptance, and is also

subject to regular audits. So don't worry, you are protected.

You can also change dentists. Just call 1-800-422-4234 or visit our web site at www.deltadentalins.com to change dentists by the 15th of the month. Your transfer will be effective on the first of the following month.

You can get emergency care

All DeltaCare 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. Please refer to your Evidence of Coverage (EOC).

On specialists and second opinions

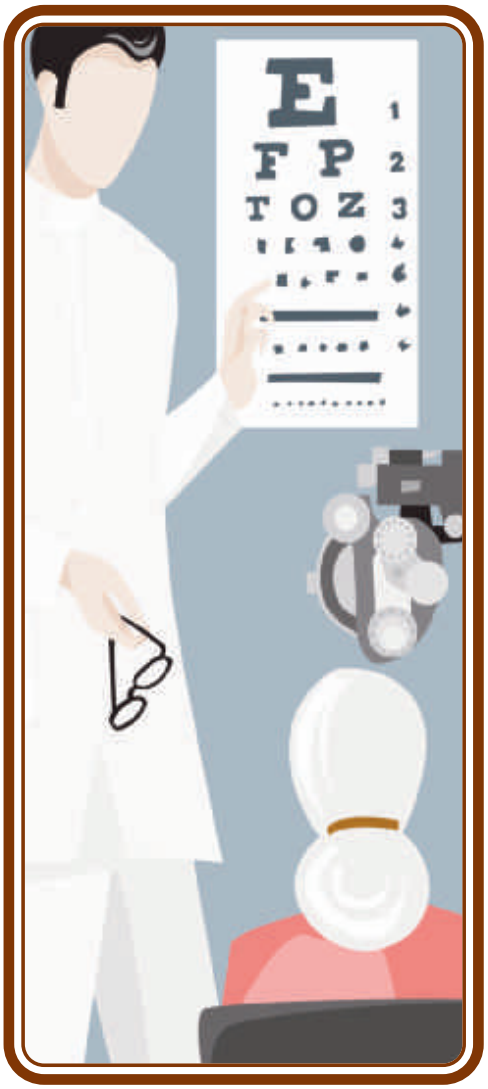
Specialists. The DMO is a "direct referral" plan. This means your general dentist will refer you to a contracted specialist in your area.

Pediatric Dentists. ***For this plan children can see a pediatric dentist through the age of seven.***

Second Opinions. Just let DeltaCare know that you would like another clinical opinion and they will provide the name of a dentist for you to see.

For more information

Go to the Employee Benefits Department website and follow the links to Delta Dental.



THINK ABOUT YOUR **VISION**

WHAT COMES TO MIND? READING GLASSES AND NIGHT DRIVING? THINK HARDER.

Most people think of vision care when they need glasses to read, watch television, or drive at night. But vision care is much more.

Our eyes give doctors a clear and unequaled view into our bodies and into our overall health. That's why optometrists constantly discover health problems during eye exams.

Get an Annual Eye Exam

What do you need for good eye health? An annual eye exam. We're not talking about a minor eye screening. You should have a full-on eye exam by a licensed optometrist.

An eye doctor has a wide range of diagnostic and treatment tools that can uncover serious health problems. Problems like…

- High blood pressure
- High cholesterol
- Glaucoma
- Tumors

In addition to detecting what might be serious health problems, an eye exam can provide a host of other vision benefits to you. Your eye doctor can…

- Measure for prescription lenses to correct nearsightedness, farsightedness, and astigmatism.
- Check for the presence of eye diseases like glaucoma, macular degeneration, cataracts, etc.

YOUR DAVIS VISION COVERAGE

Value-Added Features:

Replacement contacts through Lens 123!® mail-order contact lens replacement service, saving both time and money.

Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

How do I receive services from a provider in the network?

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as Davis Vision plan participant.
- Provide the office with the member's ID number and the date of birth of any covered children needing services.

It's that easy! The provider's office will verify your eligibility for services, and no claim forms or ID cards are required!

Who are the network providers?

They are licensed providers who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please call 1.800.999.5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you, or you may access our Web site at www.davisvision.com and utilize our "Find a Doctor" feature.

For additional information:

Please call Davis Vision at 1.800.999.5431 with questions or visit our Web site: www.davisvision.com. Member Service Representatives are available (EST): Monday through Friday, 8:00 AM to 11:00 PM, Saturday, 9:00 AM to 4:00 PM, and Sunday, 12:00 PM to 4:00 PM. Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling 1.800.523.2847.

For more details about the plan, just log on to the Open Enrollment/Discount Plan section of our Member site at **davisvision.com** or call **1.877.923.2847** and enter Client Code:
2825: Option I (Designer)
2826: Option II (Premier Platinum Plus)
2827: Option III (Premier Platinum Plus/two-pair benefit)

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $52 | Frame up to $45 Spectacle Lenses (per pair) up to: Single Vision $55, Bifocal $75, Trifocal $95, Lenticular $95 Elective Contacts up to $105, Medically Necessary Contacts up to $210

Services	Frequency	Plan Design Options		
		Option I: Designer CC#: 2825	Option II: Premier Platinum Plus CC#:2826	Option III: Premier Platinum Plus (Two-Pair Benefit[1]) CC#: 2827
Eye Examination Includes dilation when professionally indicated	Every 12 months	$10 copayment	$10 copayment	$10 copayment
Frames				
Retail Allowance	Every 24 months	Up to $130 plus 20% discount[2]	Up to $150 plus 20% discount[2]	Up to $150 plus 20% discount[2]
Davis Vision Frame Collection		(in lieu of allowance)		
Fashion		Covered in Full	Covered in Full	Covered in Full
Designer		Covered in Full	Covered in Full	Covered in Full
Premier		$25 copayment	Covered in Full	Covered in Full
Spectacle Lenses Includes single-vision, bifocal, trifocal, lenticular, polycarbonate lenses, and scratch-resistant & UV coating, other lens options available	Every 12 months	$15 copayment	$15 copayment includes all lens options, covered in full	$15 copayment includes all lens options, covered in full
Contact Lenses (in lieu of eyeglasses)				
Retail Allowance	Every 12 months	Up to $130 plus 15% discount[2]	Up to $150 plus 15% discount[2]	Up to $150 plus 15% discount[2]
Davis Vision Collection (in lieu of allowance)		Covered in Full	Covered in Full	Covered in Full
Medically Necessary		Covered in Full	Covered in Full	Covered in Full
Contact Lens Evaluation, Fitting & Follow-Up Care	Every 12 months	$15 copayment	$15 copayment	$15 copayment
Retail Allowance: Standard Type		Covered in Full	Covered in Full	Covered in Full
Retail Allowance: Specialty Type		Up to $60 plus 15% discount	Up to $60 plus 15% discount	Up to $60 plus 15% discount
Davis Vision Collection		Covered in Full	Covered in Full	Covered in Full
Medically Necessary		Covered in Full	Covered in Full	Covered in Full

[1] Members have three options available; two pairs of eyeglasses; one pair of eyeglasses & contact lenses; or two dispenses of contact lenses
[2] Additional discounts not available at Walmart or Sam's Club locations

Spectacle Lenses Benefit	Plan Design		
	Option I: Designer CC#: 2825	Option II: Premier Platinum Plus CC#:2826	Option III: Premier Platinum Plus (Two-Pair Benefit[1]) CC#: 2827
All ranges of prescriptions and sizes	**Included**	**Included**	**Included**
Choice of glass or plastic lenses	**Included**	**Included**	**Included**
Oversize Lenses	**Included**	**Included**	**Included**
Tinting of plastic lenses	**Included**	**Included**	**Included**
Scratch-Resistant Coating	**Included**	**Included**	**Included**
Polycarbonate Lenses	**Included**	**Included**	**Included**
Ultraviolet Coating	**Included**	**Included**	**Included**
Standard Anti-Reflective (AR) Coating	$35	**Included**	**Included**
Premium AR Coating	$48	**Included**	**Included**
Ultra AR Coating	$60	**Included**	**Included**
Standard Progressive Lenses	**Included**	**Included**	**Included**
Premium Progressives (Varilux®, etc.)	$40	**Included**	**Included**
Intermediate-Vision Lenses	$30	**Included**	**Included**
Blended-Segment Lenses	$20	**Included**	**Included**
High-Index Lenses	$55	**Included**	**Included**
Polarized Lenses	$75	**Included**	**Included**
Photochromic Glass Lenses	$20	**Included**	**Included**
Plastic Photosensitive Lenses	$65	**Included**	**Included**
Scratch Protection Plan: Single Vision Lenses | Multifocal	$20 | $40	$20 | $40	$20 | $40

THINK ABOUT YOUR **EMPLOYEE ASSISTANCE PROGRAM**

DO PERSONAL ISSUES MAKE YOU LESS PRODUCTIVE AT WORK? Are you distracted by family or emotional concerns, by marital or financial concerns, or by work-related issues? If so, Pasco County Schools has the resources to help you.

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program is a counseling and referral service for personal issues, wellness initiatives, financial concerns, and other specialized situations.

The purpose of the program is to help create and maintain a healthy, productive work environment for all employees, and to provide the proper support and services for employees who need help.

The EAP Focuses on Important Issues

Here are the kinds of problems and issues the Employee Assistance Program can help resolve.

You Can Get Counseling For…
Marital and Relationship Issues
Family / Child Adjustment Issues
Elder Care Issues
Job-Related Stress
Stress / Burnout
Depression
Anxiety / Panic Attacks
Alcohol / Substance Abuse
Eating Disorders
Tobacco Addiction
Personal Finance Issues
Wellness
Family Mediation

Who are the EAP counselors?

We have fifteen licensed professional counselors available in offices throughout Pasco County.

The offices are located in Hudson/Bayonet Point, New Port Richey, Tarpon Springs, Lutz/Land O' Lakes, Dade City, Zephyrhills, North Tampa, Spring Hill and Wesley Chapel.

You get up to 5 FREE sessions per year

The Employee Assistance Program is designed to help with issues that can be resolved in a relatively short period of time.

That's why the EAP allows you up to 5 sessions per school year. Even better, the School Board provides these valuable counseling sessions at NO COST to you.

If you need additional assistance you may continue with the counselor (most are included in our insurance plan), or accept a referral to another counselor or community resource. Note: there will be additional charges, or deductibles, or co-pays for these additional services/resources.

Services are CONFIDENTIAL

All EAP services are totally confidential. All counseling offices are separate from school properties. There's no record of EAP services in your personnel file.

Only your counselor has information about your sessions, and only you can choose to share the information with others.

Accessing Care through the Employee Assistance Program

To arrange for a referral for treatment through the EAP, contact the EAP office at 813-794-2366.

Services are voluntary

EAP services are voluntary. If you choose to tell others that you have accessed EAP services, it won't be seen as negative during performance evaluations. You cannot be required to use the EAP.

Go to the EAP first

If you are experiencing personal issues that affect your work life or your home life, the EAP is a great first step.

If you need longer-term solutions for more serious behavioral or mental health issues, your EAP counselor will provide a seamless transition through our Mental and Behavioral Health Program.

HORIZON HEALTH: MENTAL AND BEHAVIORAL HEALTH PROGRAM

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. Behavioral health care can be helpful 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 covered family members a full range of behavioral health care services.

Accessing Care Through Your Insurance

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.

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. Our goal is to help you make the most appropriate decisions about your behavioral health care. Most behavioral health care treatment takes place in an outpatient setting, such as a therapist'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 Services

To help employees better manage their personal and family responsibilities, Horizon Health provides all employees and their loved ones with personalized consultation, resource, and referral services. Your WorkLife services are included in your benefit package at no cost to you! There are no premiums, deductibles or co-pays associated with these services.

We help find real solutions for child care, elder care, and care for persons with disabilities, as well as a host of other everyday personal and family issues. Your WorkLife Counselor will gather all of the information needed and do all of the legwork to save you time. Additionally, your Horizon Health benefits include legal and financial consultations. Here are just a few ways you can utilize this benefit:

- Free Simple Will Preparation
- Locating a Pet Groomer
- Community Wellness Resources
- Traffic Ticket Legal Consultation
- Identify Theft Fraud Resolution
- Tax Questions

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	▪ 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
Out of Pocket Maximum	▪ In-network $2,500 individual/$5,000 family ▪ Out-of-Network $5,000 individual/$10,000 family

* Mental health and substance abuse benefit accumulators are combined with medical benefit deductibles and out of pocket maximums.

**Members enrolled in the District's medical plan are automatically enrolled in the Horizon mental health and substance abuse plan.

However, all employees have access to the worklife services program.

CareHere!

PASCO COUNTY SCHOOL BOARD IS PROUD TO ANNOUNCE...

CareHere

Employees, retirees and dependents covered by Pasco County School District's group health plans can receive medical services that includes treatment for primary care , lab work, medication, x-ray and more, all at no out-of-pocket cost at your onsite CareHere Health Center located at Centennial Middle School, Gulf High School and Land O' Lakes High School….FREE Medical Care! No deductibles! No co-pays! No out-of-pocket costs to you. What Are The Benefits To You? No more long stays in a waiting room! No out of pocket expense at the health center…increased convenience and access! More one-on-one time with the doctor! On-site dispensing of generic medications.

What Types of Conditions Can Be Treated At The Health Center?

Colds, Flu, Sore Throats, Flu Shots, High Blood Pressure, High Cholesterol, Diabetes, Annual Physicals, School Physicals for insured dependents over age 10, Lab work, Electrocardiogram (ECG / EKG) and more! X-Ray available at the Centennial and Land O' Lakes locations.

Disease Management and Wellness Services

– assigned Registered Dietician and Exercise Physiologist

Life Style Program Samples

- Diabetes Class
- Smoking Cessation program
- How to Eat Right
- CareHere Weigh (weight loss program)

And many more - watch for Wellness Wednesday flyers in your email.

How Do You Schedule an Appointment?

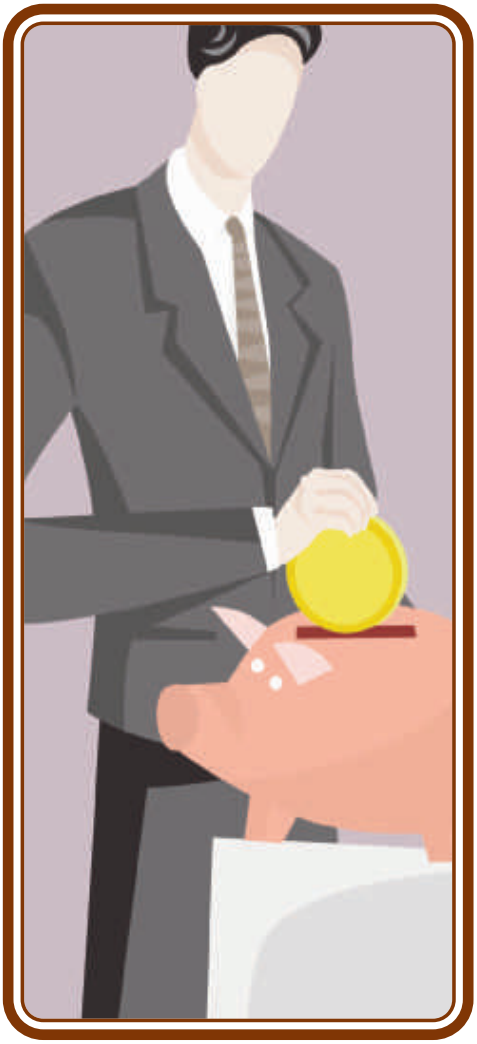
You will find it so simple and convenient to set an appointment at our health centers. Make sure you have registered with CareHere by completing your profile either online or by telephone. You may go online at www.carehere.com. Select member login and select the appointment scheduler to choose the day and time slot for your appointment (or you may call the 24/7 call center at 1.877.423.1330 to set your appointment by phone).

What about Privacy?

You will enjoy complete privacy and confidentiality (HIPAA/Privacy compliant) at your CareHere Health Centers! Your private health information and visit activity will never be shared with anyone at the School District.

Annual Health Risk Assessment!

The CareHere annual Health Risk Assessment (HRA) is an in-depth analysis of 26 key lab panels plus other health measures indicating high cholesterol, diabetes, liver functions, chemistry levels, nutrition, prostate cancer, hypertension and more. From a blood draw and health questionnaire, you will receive a detailed report which explains your results through color-coded graphs to help you better understand your results. Armed with this powerful tool, you will be encouraged to discuss your health risks with the CareHere medical team in detail, prepare a plan of action, and track trends that are essential to healthy living.



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 lose 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 by estimating your out-of-pocket medical expenses and co-payments for the coming year.

MEDICAL CARE REIMBURSEMENT FSA ACCOUNT

NEW Limit this year!

The Medical Care reimbursement account gives you the opportunity to reimburse yourself tax-free for up to **$2,500** 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.

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.

FSA 2013

Due to Heath Care Reform, effective 1/1/2011, over-the-counter (OTC) medicines and drugs, except for insulin, will require a Letter of Medical Necessity or prescription from your physician to be reimbursed from your Health FSA. Health-related supplies purchased over-the-counter continue to be eligible without additional documentation.

Run Out Period Claims

Keep in mind that Pasco County Schools utilizes the FSA Grace Period allowing participants until March 31, 2013 to spend the funds in their 2012 FSA. If you have a remaining balance in your 2012 FSA please utilize your 2012 claim card or submit claims as you currently do until March 31st or until this balance is exhausted. Once the 2012 funds are spent you may begin using your new claim card and/or submitting to FlexSystem.

How Do You File a Claim

Your Flexible Spending Account (FSA) is part of FlexSystem offered by TASC. With FlexSystem you will have several conveniences.

- 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.

In 1862, I created the Office of the Commissioner of Internal Revenue. Then, I pushed a law through Congress establishing the wildly-successful "income tax" to pay for Civil War expenses. That was the start of the IRS. People have been trying to cut their income taxes ever since. But you can with your new-fangled flexible spending accounts.

Abraham Lincoln, Big Thinker

- Online account access 24 hours a day/ 7 days a week
- Toll-free customer service assistance, email and web chat customer service
- 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)
- Opportunity to sign up for text/email notifications of account activity (i.e. claim receipt by TASC, claim payments, etc.)

Questions

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

THINK ABOUT YOUR LIFE

WHAT HAPPENS IF YOU'RE NOT THERE?

What happens to your spouse, children, parents, and loved ones? Will they have the income they need to carry on? People don't like to think about their own mortality. Or about insuring their lives. But they must.

Why think about life insurance?

Life insurance will not make up for your loss, but it will ease the future financial burden on your family and loved ones.

Life insurance is simply protection against the loss of your income and earning power. That's why experts say that life insurance is the foundation of sound financial planning. Life insurance can…

- Replace income for dependents
- Pay final expenses
- Create an inheritance for your heirs
- Pay federal and state death taxes
- Make significant charitable contributions
- Create a source of savings

Fortunately, you don't have to think too hard about where to get life insurance. That's because you have four different life insurance programs available right here at Pasco County Schools. They are…

- Basic Term Life Insurance
- Supplemental Term Life Insurance
- Group Term Life Insurance
- Universal Life Insurance

Life insurance is unique in that it can be an effective tool for both protection (the term life plans) and cash accumulation (the universal life plan). Bottom line: it's all about peace of mind. Let's look at each program individually.

BASIC TERM LIFE INSURANCE

Minnesota Life

Let's start with the basic term life insurance program. Everyone should have a basic term life program. As an employee of Pasco County Schools, you are fortunate because you get…

A FREE $35,000 Term Life Plan

That's right. The District School Board of Pasco County pays the premiums for you for a $35,000 term life plan from Minnesota Life Insurance Company. There is no cost to you.

But wait, there's more. You also get $35,000 of Accidental Death and Dismemberment coverage as well. It's automatically included in your life plan, and costs you nothing.

Not only that, you get the basic term life coverage without having to answer those probing, uncomfortable health questions. Finally, the $35,000 benefit is guaranteed.

SUPPLEMENTAL TERM LIFE INSURANCE

Minnesota Life

In addition to your Basic Term Life and AD&D plan, you can purchase Supplemental Term Life Insurance for yourself, your spouse and your children. Let's look at the coverages that are available to you.

Check out these valuable features

First, as a new employee you may purchase up to 5 times your salary or a maximum of $300,000. Guaranteed - No questions asked.

In addition, you may purchase up to $25,000 for your spouse and $10,000 for your dependent children even if you do not purchase Supplemental Life Insurance for yourself. Guaranteed issue – no questions asked.

Second, during annual enrollment, if you already have this supplemental life plan, you can increase your coverage by $10,000 or $20,000. No questions asked.

Coverage	Amount
For You	You can purchase coverage up to 5 times your annual salary or $300,000 (whichever is less). Must buy in blocks of $10,000.
For Your Spouse	You can purchase coverage up to $300,000 in $5,000 blocks or 100% of your coverage (whichever is less). Minimum coverage is $5,000.
For Your Children	You can purchase coverage for all your dependent children for a single amount per pay. Each child gets $10,000 life coverage.

Third, this supplemental coverage is portable. That means you can take it with you if you retire or leave Pasco County Schools. You have to follow the insurance company rules, but this could be very important to you.

This plan also offers valuable features...

- Accelerated death benefits
- Portability or conversion privilege
- Waiver of premiums
- Retirement continuance
- Travel Insurance

Important: 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.

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.

GROUP TERM LIFE INSURANCE

Cigna/LINA Life

This group term life insurance is another way to supplement the basic life plan the School Board provides for you.

This plan is for employees only. It does not offer dependent coverage. However, your beneficiaries receive tax-free life insurance payments from this plan. You can choose from 3 different coverage amounts. They are…

Coverage	Amount
Level 1	$5,000 of coverage
Level 2	$10,000 of coverage
Level 3	$15,000 of coverage

This coverage coordinates with your Board-provided coverage. That means there's a maximum benefit amount you can have when you add your basic life coverage and coverage from this plan together. And that's $50,000.

This plan also offers valuable features

This group term life insurance plan also offers other valuable features. You can get more information on the website, however, the short version is that it provides…

- Accelerated death benefit
- Extended death benefit
- Conversion privilege
- Retirement continuance
- Waiver of premium
- Identity Theft Protection

The Life Insurance Company of North America (LINA), which is a subsidiary of well-known CIGNA, underwrites this plan.

UNIVERSAL LIFE INSURANCE

Enrollment Available NEW this year!

Transamerica

So far, we've been talking about term life insurance. The no-frills life insurance plan. It has neither cash value nor loan value. It simply pays a pre-set benefit if you die during the policy period. But let's move on now, and discuss universal life.

Accelerated Death Benefit for Long-Term Care Rider

Get your money early if you ever need long-term care and an added benefit to make the money go further.

Wouldn't it be helpful to take an "advance" against your life insurance death benefit if you are ever diagnosed as being

chronically ill and still know there will be life insurance left for your family? That's the purpose of your Accelerated Death

Benefit for Long-Term Care Rider. Chronically ill means a licensed physician says you are unable to perform for 90 days or longer at least two activities of daily living—such as dressing, taking a shower, eating, toileting, and being able to move from one activity to another—or that you suffer severe issues with memory or being able to think.

4% of your life insurance death benefit amount is available each month

The amount of money available to you if you are ever chronically ill will be 4% of your life insurance benefit for up to 25 months, provided you are in a licensed nursing or assisted living facility. If you are receiving home health care or day care instead, it will be 2% for 50 months.

When benefits are paid under this provision, your life insurance death benefit, surrender charges, and your policy's accumulation value will be reduced proportionately. If you have an outstanding policy loan, your monthly loan payments will be subtracted from your benefits every month to continuing paying off your loan balance. Any remaining balance will be paid to your beneficiary in the event of your death. If you have used all of your death benefit, the policy will end.

You don't have to make monthly payments when you're chronically ill

You will not need to make monthly premium payments during the months you are receiving benefits under this provision (those amounts are waived for you). When you file a claim, there will be administrative expenses deducted from your monthly claim payments.

Accelerated death benefit provisions all work together

You may have other accelerated death benefits that allow you to access your life insurance early for critical illness or other purposes. Remember that all of these provisions work together up to a maximum 100% of your life insurance death benefit.

Be aware of how this money is taxed

When you get early life insurance benefits, you may have to pay taxes on all or part of this money, although these payments are intended to be excluded from your gross income for federal tax purposes. We may update the policy language with an amendment from time to time to meet any future tax changes or make needed tax clarifications, and if we do, you'll receive a written notice of any changes. We cannot guarantee how these payments will be treated for income tax purposes. These monthly payments could also impact your eligibility for public assistance programs. Talk with a qualified tax advisor and appropriate social services agencies to help you understand how an early payout could affect you and your family.

This rider may not cover all the costs associated with long term care incurred during the period of coverage.

I was one of the most influential men in history. I created the Roman Empire. My ideas transformed government and society. I invented the concept of life insurance. How? I set up Fratres (burial clubs) to help families who needed money to pay for the funerals of their loved ones. It's all about caring for others, I said. Get your care insurance today.

Julius Caesar, Big Thinker

THINK ABOUT YOUR **ABILITY TO WORK**

WHAT IF AN INJURY OR ILLNESS STOPPED YOU FROM WORKING?

Think about it. What if you became sick or disabled tomorrow, and couldn't work for the next 3 months, 6 months, 12 months, or more? Would you have enough savings to cover your living expenses during that time?

The risk is greater than you think

According to the Health Insurance Association of America, about 30% of Americans, ages 35 to 65, will suffer a disability lasting at least 90 days sometime during their careers.

What's more, in the past 25 years, the number of people suffering disabling injuries or illnesses has increased 400%. A result of our work hard, play hard lifestyle.

Fire insurance is a necessity, right? But only 1 out of 1,200 of you will ever need it. However, 1 out of 8 of you will be sick or hurt, and unable to work. Think about it.

Statistics like this are scary. That's why experts see disability insurance as a critical piece of your overall financial plan.

District School Board of Pasco County Disability Benefits Summary	
Monthly Benefit	Increment of $100 Minimum benefit: $200
Monthly Maximum Benefit	The lesser of the amount applied for; 60% of monthly earnings rounded to the nearest $100 or $7,500
Monthly Benefit Percentage	60%
Minimum Monthly Benefit	$200
Benefit Waiting Period	Option A: 14 days for disability due to injury 14 days for disability due to sickness Option B: 30 days for disability due to injury 30 days for disability due to sickness Option C: 60 days for disability due to injury 60 days for disability due to sickness Option D: 90 days for disability due to injury 90 days for disability due to sickness Option E: 180 days for disability due to injury
ACCUMULATED SICK LEAVE	**Must be exhausted prior to benefits starting.**
Trial Work Days During the Benefit Waiting Period	No limit on trial work days during benefit waiting period provided earnings received do not exceed the earnings test over the entire period.
Definition of Disability	Option 1: 24 Months Own/Any Occupation Option 2: 24 Months Own Occupation
Own Occupation Earnings Test	80 %
Any Occupation Earnings Test	60 %
Definition of Covered Earnings	Standard Wage includes the employee's wage or salary as reported by the employer but excludes overtime, bonuses or commissions.
1st Day Hospitalization **Waiver of Premium**	Not included Included
Maximum Benefit Duration (ADEA)	**Option 1:** ***24 months Own Occupation and any Occupation thereafter for 10 years or up to age 65 whichever comes first.*** Age 62 or younger — 65th birthday or 42nd monthly disability benefit Age 63 — 36th monthly disability benefit Age 64 — 30th monthly disability benefit Age 65 — 24th monthly disability benefit Age 66 — 21st monthly disability benefit Age 67 — 18th monthly disability benefit Age 68 — 15th monthly disability benefit Age 69 or older — 12th monthly disability benefit **Option 2:** 24 months Own Occupation
Pre-Existing Condition Limitation	12months Prior/24 months Insured. Applies to any new participants or any increases in coverage made by current participants. The pre-existing condition does not apply to current enrollee's.
Mental Illness Limitation	12 Month Lifetime Limitation
Substance Abuse Limitation	24 Month Lifetime Limitation
Subjective Symptom Limitation	12 months

NEW Limit this year!

***Please note:** The disability benefit is offset by other income. This does include Social Security and may result in little or no benefit.*

We've got you under our wing.℠

PASCO COUNTY SCHOOLS **AFLAC PRODUCTS GUIDE**

GROUP CRITICAL ILLNESS Includes Cancer

Policy Series CI2100-C-FL

CI G

PLAN FEATURES

GUARANTEED ISSUE **$10,000 EMPLOYEE/$5,000 SPOUSE** Participation Requirement for groups 250 or less is 50 applications; for groups 250+ participation requirement is 20% of eligible employees. **$5,000 EMPLOYEE** Participation Requirement for groups 250 or less is 25 applications; for groups 250+ participation requirement is 10% of eligible employees.

SAME DAY COVERAGE Coverage will be effective the date the employee signs the application pending underwriting approval.

PORTABILITY Employees can keep coverage at same rates and benefits if they leave their job, with certain stipulations.

CANCER OPTION May be sold with or without cancer benefit.

PREMIUM OPTIONS May be sold on tobacco/non-tobacco structure or uni-tobacco structure.

PLAN BENEFITS

FIRST OCCURRENCE BENEFIT After the waiting period, a Lump Sum Benefit is payable upon initial diagnosis of a covered illness. Employee benefit amounts available from $5,000 to $50,000. Spouse coverage is also available in benefit amounts up to $25,000. If you are deemed ineligible due to a previous medical condition you still retain the ability to purchase spouse coverage.

ADDITIONAL OCCURRENCE BENEFIT If an insured collects full benefits for a critical illness under the plan and later has one of the remaining covered illnesses, then we will pay the full benefit amount for each additional illness. Occurrences must be separated by at least 90 days.

When we have paid the benefits due once for each Specified Critical Illness, the Employee's Certificate ends. No additional benefits are payable for a Surgical Procedure performed as a result of a Specified Critical Illness for which we have paid benefits.

COVERED SPECIFIC CRITICAL ILLNESSES:

CANCER	100%
HEART ATTACK (Myocardial Infarction)	100%
STROKE (Apoplexy or Cerebral Vascular Accident)	100%
MAJOR ORGAN TRANSPLANT	100%
RENAL FAILURE (End Stage)	100%
CARCINOMA IN SITU	25%
CORONARY ARTERY BYPASS SURGERY	25%

NOTE: If a benefit is paid for carcinoma in situ, the internal cancer benefit will be reduced by 25%. If a benefit is paid for coronary artery bypass surgery, the heart attack benefit will be reduced by 25%. All covered conditions are subject to the definitions found in your certificate.

25% CHILD COVERAGE AT NO ADDITIONAL COST Each dependent child is covered at 25 percent of the primary insured amount at no additional charge.

$50 HEALTH SCREENING BENEFIT (EMPLOYEE AND SPOUSE) After the Waiting Period, pays a maximum of $50 for any one covered health screening test per calendar year. We will pay this benefit regardless of the results of the test. *Covered health screening tests include (but are not limited to): mammography, colonoscopy, pap smear, breast ultrasound, chest x-ray, PSA (blood test for prostate cancer), stress test on a bicycle or treadmill, and bone marrow testing.*

Personal Cancer Protector Plan

A CANCER EXPENSE INSURANCE POLICY

Level 1

Plan Benefits

- First-Occurrence
- Hospital Confinement
- Radiation and Chemotherapy
- Cancer Screening Wellness
- Surgical/Anesthesia
- NCI Evaluation and Consultation
- Home Health Care
- Plus ... much more

AFLAC Without it, no insurance is complete.

Personal Cancer Coverage

Cancer Insurance Only; Policy Series A-59100

FIRST-OCCURRENCE BENEFIT

AFLAC will pay a $1,500 FIRST-OCCURRENCE BENEFIT to any covered person when diagnosed as having internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in this policy. *Internal cancer* includes melanomas classified as Clark's Level III and higher. When the hospitalization is based on tentative diagnosis, benefits are payable from the date of tentative diagnosis, at the time and date that a positive diagnosis is obtained. In addition to the pathological or clinical diagnosis required by the policy, AFLAC may require additional information from the attending physician and hospital. Any covered person who has had a previously diagnosed cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension or metastatic spread of that same cancer.

HOSPITAL CONFINEMENT BENEFIT

(This includes confinement in a U.S. government hospital.) AFLAC will pay $200 for each day any covered person is hospitalized and charged as an inpatient for the first 30 days for cancer treatment. Benefits increase to **$400** per day beginning with the 31st day of continuous confinement. The wording "for each day any covered person is charged as an inpatient" does not apply to confinements in U.S. government hospitals. **No lifetime maximum.**

For treatment of cancer: Radiation and Chemotherapy, Experimental Treatment, Anti-Nausea, Nursing Services, Surgical/Anesthesia, Skin Cancer Surgery, Prosthesis, and In-Hospital Blood and Plasma Benefits are not payable when a covered person is confined in a U.S. government hospital unless the covered person is actually charged and is legally required to pay for such services.

RADIATION AND CHEMOTHERAPY BENEFIT

AFLAC will pay the charges incurred up to $200 per day when any covered person receives one or more of the following cancer treatments for the purpose of modification or destruction of abnormal tissue: (1) cytotoxic chemical substances and their administration in the treatment of cancer — administration by medical personnel in a doctor's office, clinic or hospital; self-injected medications or medications dispensed by a pump will be limited to the actual cost of the drugs up to **$200** per prescription; oral chemotherapy, regardless of where administered, will be limited to the actual cost of the drugs up to **$200** per prescription (monthly maximum of **$800**); (2) radiation therapy; or (3) the insertion of interstitial or intracavitary application of radium or radioisotopes in sealed or nonsealed sources. (The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal. Benefits will not be paid for each day the radium or radioisotope remains in the body.) This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulation, dosimetry, treatment planning or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Experimental Treatment Benefit is paid and is limited to $200 per day. **No lifetime maximum.**

EXPERIMENTAL TREATMENT BENEFIT

AFLAC will pay the charges incurred up to $200 per day for a covered person who receives experimental cancer treatment for the purpose of modification or destruction of abnormal tissue. The treatments must be consistent with one or more National Cancer Institute-sponsored protocols. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Radiation and Chemotherapy Benefit is paid. **No lifetime maximum.**

ANTI-NAUSEA BENEFIT

AFLAC will pay the charges incurred up to $100 per calendar month when a covered person receives anti-nausea drugs that are prescribed while receiving radiation or chemotherapy treatments. **No lifetime maximum.**

NURSING SERVICES BENEFIT

AFLAC will pay the charges incurred up to $100 per 24-hour day to a covered person while confined to a hospital for full-time private care by RNs, LPNs or LVNs other than those regularly furnished by the hospital. Services must be required and authorized by the attending physician. This benefit is not payable for private nurses related to any covered person. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. **No lifetime maximum.**

AFLAC®

Without it, no insurance is complete.

SURGICAL/ANESTHESIA BENEFIT

AFLAC will pay $95 to $3,000 of the indemnity listed when a surgical operation is performed on a covered person for a diagnosed internal cancer (depending on type of surgery performed). Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid for the most expensive procedure. If any operation for the treatment of cancer is performed other than those listed, AFLAC will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity (surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit). **AFLAC will pay an indemnity benefit equal to 25%** of the amount shown on the Schedule of Operations for the administration of anesthesia during a covered surgical operation. The combined benefits payable in the Surgical/Anesthesia Benefit for any one operation shall not exceed $3,750. **No lifetime maximum** on number of operations. See Schedule of Operations.

SKIN CANCER SURGERY BENEFIT

AFLAC will pay $100 to $600 of the indemnity listed (depending on the procedure performed) for surgery (with or without anesthesia) to any covered person when a surgical operation is performed for a diagnosed skin cancer. **No lifetime maximum** on number of operations.

PROSTHESIS BENEFIT

(1) AFLAC will pay the charges incurred up to $2,500 to any covered person for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. **Lifetime maximum of $2,500 per covered person. (2) AFLAC will pay up to $200** to any covered person for the charges incurred per person for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Examples of these include voice boxes, hair pieces and removable breast prosthetics. **Lifetime maximum of $200 per covered person.**

IN-HOSPITAL BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to but not exceeding $50 times the number of days of covered hospital confinement if a covered person receives blood/plasma, blood processing, blood administration, crossmatching and transfusion during a hospital confinement. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

Refer to policy and riders for complete details, limitations and exclusions.

This brochure is for illustration purposes only.

OUTPATIENT BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to $200 for blood/plasma, processing, blood administration, crossmatching and transfusion for each day a covered person receives blood transfusions for the treatment of cancer as an outpatient in a doctor's office, clinic, hospital or ambulatory surgical center. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

SECOND SURGICAL OPINION BENEFIT

AFLAC will pay the charges incurred up to $200 to any covered person for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician not related to the covered person. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. **No lifetime maximum.**

NATIONAL CANCER INSTITUTE (NCI) EVALUATION/CONSULTATION BENEFIT

AFLAC will pay $500 when a covered person seeks evaluation or consultation at an NCI-sponsored cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. **AFLAC will also pay $250** for the transportation and lodging of the person receiving the evaluation/consultation if the cancer center is more than 100 miles from the covered person's residence. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable once per covered person. NCI-sponsored cancer centers include but are not limited to:

- M.D. Anderson Cancer Center
- Norris Comprehensive Cancer Center at USC
- Mayo Cancer Center
- Johns Hopkins Oncology Center
- Memorial Sloan-Kettering Cancer Center
- St. Jude Children's Research Hospital

This is a partial listing of NCI-designated cancer centers, and AFLAC does not endorse any center over another. Please see insert Form A-59276 for a complete listing of the current facilities and their locations.

This benefit is also payable at the AFLAC Cancer Center at Children's Healthcare of Atlanta.

AMBULANCE BENEFIT

AFLAC will pay you or any covered person the charges incurred for transportation in a licensed ambulance to and from a hospital within 100 miles of the covered person's residence where confined overnight for cancer treatment. This benefit is limited to two trips per confinement. **No lifetime maximum.**

TRANSPORTATION BENEFIT

AFLAC will pay 40 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train or bus fare) for transportation of a covered person for the round-trip distance between the hospital or medical facility and the residence of the covered person if special cancer treatment has been prescribed by the local attending physician. Reimbursement will be made only for the method of transportation actually taken. **Benefits are limited to $1,200 per round trip.** This benefit will be paid only for the covered person for whom the special cancer treatment is prescribed; or if the treatment is for a dependent child and commercial travel is necessary, **AFLAC will pay for up to two adults** to accompany the dependent child. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the residence of the covered person.

LODGING BENEFIT

AFLAC will pay the charges incurred up to $50 per day for lodging for you or any one adult family member when a covered person receives special cancer treatment at a hospital or medical facility. The hospital or medical facility and lodging must be more than 100 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment nor for lodging occurring more than 24 hours following treatment. **This benefit is limited to 60 days per calendar year.**

BONE MARROW TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $10,000 if a covered person receives a bone marrow transplantation for the treatment of cancer during a covered hospital confinement. It does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. If the bone marrow transplant is performed on an outpatient basis, **AFLAC will pay the charges incurred up to $5,000. AFLAC will pay the bone marrow donor the greater of $1,000 or medical costs** to the same extent and limitations as costs associated with the insured person for a covered bone marrow transplant. This benefit is not payable for the same procedure as the Stem Cell Transplantation Benefit. **Lifetime maximum of $10,000 per covered person.**

STEM CELL TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $2,500 if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit is payable once per covered person. This benefit is not payable in conjunction with the payment of the Bone Marrow Transplantation Benefit. **Lifetime maximum of $2,500 per covered person.**

EXTENDED-CARE FACILITY BENEFIT

AFLAC will pay $100 per day if a covered person is hospitalized and receives the Hospital Confinement Benefit and is later confined, within 30 days, to a section of the hospital used as an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit, or to any bed designated as a swing bed, for such continued confinement. Benefits are limited to the same number of days that the covered person receives the Hospital Confinement Benefit. For each day this benefit is payable, benefits under the Hospital Confinement Benefit are not payable. If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a hospital prior to the second such confinement. **Lifetime maximum of 365 days per covered person.**

HOSPICE BENEFIT

AFLAC will pay $100 per day for the first 60 days and **$50** per day for days over 60 for care provided by a hospice organization for any covered person when medical evaluation determines that cancer treatment is no longer appropriate and the covered person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit does not cover nonterminally ill patients or organizations not qualifying as hospices. This benefit is payable once per covered person and is not payable the same day as the Home Health Care Benefit. **Lifetime maximum for each covered person is $12,000.**

HOME HEALTH CARE BENEFIT

AFLAC will pay the charges incurred up to $50 per visit for home health care or health supportive services when provided on a covered person's behalf within seven days of release from the hospital for the treatment of cancer. The number of visits shall not exceed 10 per hospitalization. This benefit will not be payable unless the attending physician prescribes such services to be performed in the home of the insured person and certifies that if these services were not available, the insured person would have to be hospitalized to receive the necessary care, treatment and services. Home health care and health supportive services must be performed by or under the supervision of a person who is licensed, certified or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility. This benefit is not payable the same day the Hospice Benefit is payable. **This benefit is limited to 30 visits per calendar year for each covered person.**

AFLAC's Cancer Screening Wellness Benefit is a preventative benefit.

CANCER SCREENING WELLNESS BENEFIT:

AFLAC will pay $40 per calendar year for each covered person when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear (lab and procedure), biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon cancer), CA 125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), thermography or colonoscopy. These tests must be performed to determine if cancer exists in a covered person. This benefit is limited to one payment per calendar year per covered person. **No lifetime maximum.**

WAIVER OF PREMIUM BENEFIT

If you, due to having internal cancer, are completely unable to do all of the usual and customary duties of your occupation [*or, if you are not employed*: are completely unable to perform two or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, AFLAC will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, AFLAC will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties or activities, and may each month thereafter require a physician's statement that total inability continues. AFLAC may ask for and use an independent consultant to determine whether you can perform an ADL without assistance.

NEWBORN TRANSPORTATION BENEFIT

Under a family policy, if cancer in a newborn child requires the newborn to receive treatment to protect his/her health and safety, we will pay transportation charges as follows: Actual transportation costs to and from the nearest available facility appropriately staffed and equipped to treat the condition of the newborn. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage for such transportation costs shall not exceed the usual and customary charges up to $1,000.

CONTINUATION OF COVERAGE BENEFIT

AFLAC will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions: (1) Your policy was in force for at least six months. (2) We receive premiums for at least six consecutive months. (3) Your premiums were paid through payroll deduction. (4) You or your employer notifies us in writing within 30 days of the date your premium payments ceased due to your leaving employment. (5) You re-establish premium payments through your new employer's payroll deduction process or direct payment to AFLAC. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we have received premiums for at least six consecutive months. *Payroll deduction* means your premium is remitted to AFLAC for you by your employer through a payroll deduction process.

GUARANTEED-RENEWABLE

This policy is guaranteed-renewable for life subject to AFLAC's right to change applicable table of premium rates for all policies of this class.

EFFECTIVE DATE

The effective date of the policy will be the date shown in the Policy Schedule, not the date the application is signed. This policy is available through age 70 on payroll deduction and through age 64 on direct billing. Payroll rate may be retained after one month's premium payment on payroll deduction.

FAMILY COVERAGE

Family coverage includes the insured; the insured's spouse; and dependent, unmarried children to age 25. Newborn children are automatically insured as any other family member. *One-parent family* includes the insured and dependent, unmarried children to age 25.

IMPORTANT NOTICE

When you receive your policy and application, please examine them thoroughly. If you are not satisfied, you may return the policy and application within 30 days for a full refund.

LIMITATIONS AND EXCLUSIONS

AFLAC pays only for treatment of cancer including direct extension, metastatic spread or recurrence. Benefits are not provided for premalignant conditions; conditions with malignant potential; complications of any other disease, sickness or incapacity. Pathological proof of diagnosis must be submitted. Clinical diagnosis will be accepted when a pathological diagnosis cannot be made, provided medical evidence sustains the diagnosis and the covered person receives cancer treatment. This policy contains a 30-day waiting period. This means that no benefits are payable for any covered person who has cancer diagnosed before coverage has been in force 30 days from the effective date shown in the Policy Schedule. If a covered person has cancer diagnosed during the waiting period, benefits for treatment of that cancer will apply only to treatment occurring after two years from the effective date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. The First-Occurrence Benefit is not payable for: (1) any internal cancer diagnosed or treated before the effective date of this policy and subsequent recurrence, extension or metastatic spread of such internal cancer that is diagnosed or treated after the effective date of this policy (2) cancer diagnosed during this policy's 30-day waiting period (3) the diagnosis of skin cancer or melanomas classified as Clark's Levels I and II. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension or metastatic spread of that same cancer. No benefits are payable for immunoglobulins or colony-stimulating factors.

Personal Cancer Protector Plan

A CANCER EXPENSE INSURANCE POLICY

Levels 2 & 3

Plan Benefits

- First-Occurrence
- Hospital Confinement
- Radiation and Chemotherapy
- Cancer Screening Wellness
- Surgical/Anesthesia
- NCI Evaluation and Consultation
- Home Health Care
- Plus ... much more

AFLAC Without it, no insurance is complete.

Personal Cancer Coverage

Cancer Insurance Only; Policy Series A-59000

☐ **$2,000 FIRST-OCCURRENCE BENEFIT** *(Policy Series A-59200)*

☐ **$5,000 FIRST-OCCURRENCE BENEFIT** *(Policy Series A-59300)*

AFLAC will pay the FIRST-OCCURRENCE BENEFIT selected above to any covered person when diagnosed as having internal cancer. This benefit is payable only once for each covered person and will be paid in addition to any other benefit in this policy. *Internal cancer* includes melanomas classified as Clark's Level III and higher. When the hospitalization is based on tentative diagnosis, benefits are payable from the date of tentative diagnosis, at the time and date that a positive diagnosis is obtained. In addition to the pathological or clinical diagnosis required by the policy, AFLAC may require additional information from the attending physician and hospital. Any covered person who has had a previously diagnosed cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension or metastatic spread of that same cancer.

The benefits listed below are payable for either the A-59200 Policy Series or the A-59300 Policy Series.

HOSPITAL CONFINEMENT BENEFIT

(This includes confinement in a U.S. government hospital.) AFLAC will pay $300 for each day any covered person is hospitalized and charged as an inpatient for the first 30 days for cancer treatment. Benefits increase to **$600** per day beginning with the 31st day of continuous confinement. The wording "for each day any covered person is charged as an inpatient" does not apply to confinements in U.S. government hospitals. **No lifetime maximum.**

For treatment of cancer: Radiation and Chemotherapy, Experimental Treatment, Anti-Nausea, Nursing Services, Surgical/Anesthesia, Skin Cancer Surgery, Prosthesis, and In-Hospital Blood and Plasma Benefits are not payable when a covered person is confined in a U.S. government hospital unless the covered person is actually charged and is legally required to pay for such services.

RADIATION AND CHEMOTHERAPY BENEFIT

AFLAC will pay the charges incurred up to $300 per day when any covered person receives one or more of the following cancer treatments for the purpose of modification or destruction of abnormal tissue: (1) cytotoxic chemical substances and their administration in the treatment of cancer — administration by medical personnel in a doctor's office, clinic or hospital; self-injected medications or medications dispensed by a pump will be limited to the actual cost of the drugs up to **$300** per prescription; oral chemotherapy, regardless of where administered, will be limited to the actual cost of the drugs up to **$300** per prescription (monthly maximum of **$1,200**); (2) radiation therapy; or (3) the insertion of interstitial or intracavitary application of radium or radioisotopes in sealed or nonsealed sources. (The Surgical/Anesthesia Benefit provides additional amounts payable for insertion and removal. Benefits will not be paid for each day the radium or radioisotope remains in the body.) This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, therapeutic devices, simulation, dosimetry, treatment planning or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Experimental Treatment Benefit is paid and is limited to $300 per day. **No lifetime maximum.**

EXPERIMENTAL TREATMENT BENEFIT

AFLAC will pay the charges incurred up to $300 per day for a covered person who receives experimental cancer treatment for the purpose of modification or destruction of abnormal tissue. The treatments must be consistent with one or more National Cancer Institute-sponsored protocols. This benefit does not pay for laboratory tests, diagnostic X-rays, immunoglobulins, immunotherapy, colony-stimulating factors, and therapeutic devices or other procedures related to these therapy treatments. This benefit is not payable on the same day that the Radiation and Chemotherapy Benefit is paid. **No lifetime maximum.**

ANTI-NAUSEA BENEFIT

AFLAC will pay the charges incurred up to $100 per calendar month when a covered person receives anti-nausea drugs that are prescribed while receiving radiation or chemotherapy treatments. **No lifetime maximum.**

NURSING SERVICES BENEFIT

AFLAC will pay the charges incurred up to $100 per 24-hour day to a covered person while confined to a hospital for full-time private care by RNs, LPNs or LVNs other than those regularly furnished by the hospital. Services must be required and authorized by the attending physician. This benefit is not payable for private nurses related to any covered person. This benefit is payable for only the number of days the Hospital Confinement Benefit is payable. **No lifetime maximum.**

AFLAC®

Without it, no insurance is complete.

SURGICAL/ANESTHESIA BENEFIT

AFLAC will pay $100 to $5,000 of the indemnity listed when a surgical operation is performed on a covered person for a diagnosed internal cancer (depending on type of surgery performed). Two or more surgical procedures performed through the same incision will be considered one operation, and benefits will be paid for the most expensive procedure. If any operation for the treatment of cancer is performed other than those listed, AFLAC will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity (surgery for skin cancer will be payable under the Skin Cancer Surgery Benefit). **AFLAC will pay an indemnity benefit equal to 25%** of the amount shown on the Schedule of Operations for the administration of anesthesia during a covered surgical operation. The combined benefits payable in the Surgical/Anesthesia Benefit for any one operation shall not exceed $6,250. **No lifetime maximum** on number of operations. See Schedule of Operations.

SKIN CANCER SURGERY BENEFIT

AFLAC will pay $100 to $600 of the indemnity listed (depending on the procedure performed) for surgery (with or without anesthesia) to any covered person when a surgical operation is performed for a diagnosed skin cancer. **No lifetime maximum** on number of operations.

PROSTHESIS BENEFIT

(1) AFLAC will pay the charges incurred up to $3,000 to any covered person for surgically implanted prosthetic devices that are prescribed as a direct result of surgery for cancer treatment. **Lifetime maximum of $3,000 per covered person. (2) AFLAC will pay up to $200** to any covered person for the charges incurred per person for nonsurgically implanted prosthetic devices that are prescribed as a direct result of cancer treatment. Examples of these include voice boxes, hair pieces and removable breast prosthetics. **Lifetime maximum of $200 per covered person.**

IN-HOSPITAL BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to but not exceeding $100 times the number of days of covered hospital confinement if a covered person receives blood/plasma, blood processing, blood administration, crossmatching and transfusion fees during a hospital confinement. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

Refer to policy and riders for complete details, limitations and exclusions.

This brochure is for illustration purposes only.

OUTPATIENT BLOOD AND PLASMA BENEFIT

AFLAC will pay the charges incurred up to $250 for blood/plasma, processing, blood administration, crossmatching and transfusion fees for each day a covered person receives blood transfusions for the treatment of cancer as an outpatient in a doctor's office, clinic, hospital or ambulatory surgical center. This benefit does not pay for immunoglobulins, immunotherapy or colony-stimulating factors. **No lifetime maximum.**

SECOND SURGICAL OPINION BENEFIT

AFLAC will pay the charges incurred up to $250 to any covered person for a second surgical opinion concerning cancer surgery for a diagnosed cancer by a licensed physician not related to the covered person. This benefit is not payable the same day the NCI Evaluation/Consultation Benefit is payable. **No lifetime maximum.**

NATIONAL CANCER INSTITUTE (NCI) EVALUATION/CONSULTATION BENEFIT

AFLAC will pay $500 when a covered person seeks evaluation or consultation at an NCI-sponsored cancer center as a result of receiving a prior diagnosis of internal cancer. The purpose of the evaluation/consultation must be to determine the appropriate course of cancer treatment. **AFLAC will also pay $250** for the transportation and lodging of the person receiving the evaluation/consultation if the cancer center is more than 100 miles from the covered person's residence. This benefit is not payable the same day the Second Surgical Opinion Benefit is payable. This benefit is payable once per covered person. NCI-sponsored cancer centers include but are not limited to:

- M.D. Anderson Cancer Center
- Norris Comprehensive Cancer Center at USC
- Mayo Cancer Center
- Johns Hopkins Oncology Center
- Memorial Sloan-Kettering Cancer Center
- St. Jude Children's Research Hospital

This is a partial listing of NCI-designated cancer centers, and AFLAC does not endorse any center over another. Please see insert Form A-59276 for a complete listing of the current facilities and their locations.

This benefit is also payable at the AFLAC Cancer Center at Children's Healthcare of Atlanta.

AMBULANCE BENEFIT

AFLAC will pay you or any covered person the charges incurred for transportation in a licensed ambulance to and from a hospital within 100 miles of the covered person's residence where confined overnight for cancer treatment. This benefit is limited to two trips per confinement. **No lifetime maximum.**

TRANSPORTATION BENEFIT

AFLAC will pay 50 cents per mile for noncommercial travel or the costs incurred for commercial travel (coach class plane, train or bus fare) for transportation of a covered person for the round-trip distance between the hospital or medical facility and the residence of the covered person if special cancer treatment has been prescribed by the local attending physician. Reimbursement will be made only for the method of transportation actually taken. **Benefits are limited to $1,500 per round trip.** This benefit will be paid only for the covered person for whom the special cancer treatment is prescribed; or if the treatment is for a dependent child and commercial travel is necessary, **AFLAC will pay for up to two adults** to accompany the dependent child. This benefit is not payable for transportation to any hospital located within a 100-mile radius of the residence of the covered person.

LODGING BENEFIT

AFLAC will pay the charges incurred up to $60 per day for lodging for you or any one adult family member when a covered person receives special cancer treatment at a hospital or medical facility. The hospital or medical facility and lodging must be more than 100 miles from the covered person's residence. This benefit is not payable for lodging occurring more than 24 hours prior to treatment nor for lodging occurring more than 24 hours following treatment. **This benefit is limited to 60 days per calendar year.**

BONE MARROW TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $10,000 if a covered person receives a bone marrow transplantation for the treatment of cancer during a covered hospital confinement. It does not include the harvesting of peripheral blood cells or stem cells and subsequent reinfusion. If the bone marrow transplant is performed on an outpatient basis, **AFLAC will pay the charges incurred up to $5,000. AFLAC will pay the bone marrow donor the greater of $1,000 or medical costs** to the same extent and limitations as costs associated with the insured person for a covered bone marrow transplant. This benefit is not payable for the same procedure as the Stem Cell Transplantation Benefit. **Lifetime maximum of $10,000 per covered person.**

STEM CELL TRANSPLANTATION BENEFIT

AFLAC will pay the charges incurred up to $2,500 if a covered person receives a peripheral stem cell transplantation for the treatment of cancer. This benefit is payable once per covered person. This benefit is not payable in conjunction with the payment of the Bone Marrow Transplantation Benefit. **Lifetime maximum of $2,500 per covered person.**

EXTENDED-CARE FACILITY BENEFIT

AFLAC will pay $100 per day if a covered person is hospitalized and receives the Hospital Confinement Benefit and is later confined, within 30 days, to a section of the hospital used as an extended-care facility, a skilled nursing facility, a rehabilitation unit or facility, a transitional care unit, or to any bed designated as a swing bed, for such continued confinement. Benefits are limited to the same number of days that the covered person receives the Hospital Confinement Benefit. For each day this benefit is payable, benefits under the Hospital Confinement Benefit are not payable. If more than 30 days separates a stay in an extended-care facility, benefits are not payable for the second confinement unless the covered person was again confined to a hospital prior to the second such confinement. **Lifetime maximum of 365 days per covered person.**

HOSPICE BENEFIT

AFLAC will pay $100 per day for the first 60 days and **$50** per day for days over 60 for care provided by a hospice organization for any covered person when medical evaluation determines that cancer treatment is no longer appropriate and the covered person's medical prognosis is one in which there is a life expectancy of six months or less as the direct result of cancer. This benefit does not cover nonterminally ill patients or organizations not qualifying as hospices. This benefit is payable once per covered person and is not payable the same day as the Home Health Care Benefit. **Lifetime maximum for each covered person is $12,000.**

HOME HEALTH CARE BENEFIT

AFLAC will pay the charges incurred up to $50 per visit for home health care or health supportive services when provided on a covered person's behalf within seven days of release from the hospital for the treatment of cancer. The number of visits shall not exceed 10 per hospitalization. This benefit will not be payable unless the attending physician prescribes such services to be performed in the home of the insured person and certifies that if these services were not available, the insured person would have to be hospitalized to receive the necessary care, treatment and services. Home health care and health supportive services must be performed by or under the supervision of a person who is licensed, certified or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a health care facility. This benefit is not payable the same day the Hospice Benefit is payable. **This benefit is limited to 30 visits per calendar year for each covered person.**

AFLAC's Cancer Screening Wellness Benefit is a preventative benefit.

CANCER SCREENING WELLNESS BENEFIT: **AFLAC will pay $75** per calendar year for each covered person when a charge is incurred for one of the following: mammogram, breast ultrasound, Pap smear (lab and procedure), biopsy, flexible sigmoidoscopy, hemocult stool specimen, chest X-ray, CEA (blood test for colon cancer), CA 125 (blood test for ovarian cancer), PSA (blood test for prostate cancer), thermography or colonoscopy. These tests must be performed to determine if cancer exists in a covered person. This benefit is limited to one payment per calendar year per covered person. **No lifetime maximum.**

NEWBORN TRANSPORTATION BENEFIT

Under a family policy, if cancer in a newborn child requires the newborn to receive treatment to protect his/her health and safety, we will pay transportation charges as follows: Actual transportation costs to and from the nearest available facility appropriately staffed and equipped to treat the condition of the newborn. The transportation must be certified by the attending physician as necessary to protect the health and safety of the newborn child. The coverage for such transportation costs shall not exceed the usual and customary charges up to $1,000.

WAIVER OF PREMIUM BENEFIT

If you, due to having internal cancer, are completely unable to do all of the usual and customary duties of your occupation [*or, if you are not employed*: are completely unable to perform two or more of the activities of daily living (ADLs) without the assistance of another person] for a period of 90 continuous days, AFLAC will waive, from month to month, any premiums falling due during your continued inability. For premiums to be waived, AFLAC will require an employer's statement (if applicable) and a physician's statement of your inability to perform said duties or activities, and may each month thereafter require a physician's statement that total inability continues. AFLAC may ask for and use an independent consultant to determine whether you can perform an ADL without assistance. AFLAC will also waive from month to month any premiums falling due while you are receiving hospice benefits under the Hospice Benefit.

CONTINUATION OF COVERAGE BENEFIT

AFLAC will waive all monthly premiums due for the policy and riders for up to two months if you meet all of the following conditions: (1) Your policy was in force for at least six months. (2) We receive premiums for at least six consecutive months. (3) Your premiums were paid through payroll deduction. (4) You or your employer notifies us in writing within 30 days of the date your premium payments ceased due to your leaving employment. (5) You re-establish premium payments through your new employer's payroll deduction process or direct payment to AFLAC. You will again become eligible to receive this benefit after you re-establish your premium payments through payroll deduction for a period of at least six months and we have received premiums for at least six consecutive months. *Payroll deduction* means your premium is remitted to AFLAC for you by your employer through a payroll deduction process.

GUARANTEED-RENEWABLE

This policy is guaranteed-renewable for life subject to AFLAC's right to change applicable table of premium rates for all policies of this class.

EFFECTIVE DATE

The effective date of the policy will be the date shown in the Policy Schedule, not the date the application is signed. This policy is available through age 70 on payroll deduction and through age 64 on direct billing. Payroll rate may be retained after one month's premium payment on payroll deduction.

FAMILY COVERAGE

Family coverage includes the insured; the insured's spouse; and dependent, unmarried children to age 25. Newborn children are automatically insured as any other family member. *One-parent family* includes the insured and dependent, unmarried children to age 25.

IMPORTANT NOTICE

When you receive your policy and application, please examine them thoroughly. If you are not satisfied, you may return the policy and application within 30 days for a full refund.

LIMITATIONS AND EXCLUSIONS

AFLAC pays only for treatment of cancer including direct extension, metastatic spread or recurrence. Benefits are not provided for premalignant conditions; conditions with malignant potential; complications of any other disease, sickness or incapacity. Pathological proof of diagnosis must be submitted. Clinical diagnosis will be accepted when a pathological diagnosis cannot be made, provided medical evidence sustains the diagnosis and the covered person receives cancer treatment. This policy contains a 30-day waiting period. This means that no benefits are payable for any covered person who has cancer diagnosed before coverage has been in force 30 days from the effective date shown in the Policy Schedule. If a covered person has cancer diagnosed during the waiting period, benefits for treatment of that cancer will apply only to treatment occurring after two years from the effective date of the policy or, at your option, you may elect to void the policy from its beginning and receive a full refund of premium. The First-Occurrence Benefit is not payable for: (1) any internal cancer diagnosed or treated before the effective date of this policy and subsequent recurrence, extension or metastatic spread of such internal cancer that is diagnosed or treated after the effective date of this policy (2) cancer diagnosed during this policy's 30-day waiting period (3) the diagnosis of skin cancer or melanomas classified as Clark's Levels I and II. Any covered person who has had a previous diagnosis of cancer will not be eligible for a First-Occurrence Benefit under this policy for a recurrence, extension or metastatic spread of that same cancer. No benefits are payable for immunoglobulins or colony-stimulating factors.

GROUP ACCIDENT INSURANCE

Policy Series CAI7700FL

ACG

PLAN FEATURES

24-Hour or Non-occupational Coverage.

No limit on the number of claims.

Supplements and pays regardless of any other insurance programs.

Benefits available for spouse and/or dependent children.

Benefits for both inpatient and outpatient treatment of covered accidents.

Guaranteed Issue – No underwriting required to qualify for coverage.

Immediate effective date – Coverage will be effective the day the employee signs the application.

PLAN BENEFITS (employee benefits shown, please see dependent rider schedule for a complete list of spouse and child benefits.)

ACCIDENTAL-DEATH AND -DISMEMBERMENT

Accidental Common Carrier Death (Plane, Train, Boat or Ship)	$100,000
Accidental Death	$75,000
Double Dismemberment	$37,500
Single Dismemberment	$18,750
Loss of One or More Fingers or Toes	$1,250
Partial Amputation of Fingers or Toes (Including at least one joint)	$100

HOSPITAL BENEFITS

Paralysis	up to $10,000
Hospital Admission	$1,000
Hospital Intensive Care (per day)	$500
Hospital Confinement (per day)	$300
Medical Fees	$300

SPECIFIC INJURIES

Burns	$100–$10,000
Lacerations	$25–$400
Ruptured Disc	$100–$400
Tendons/Ligaments	$400–$600
Torn Knee Cartilage	$100–$400
Eye Injuries	$50–$250
Coma	$10,000
Concussion	$200
Emergency Dental Work	$85–$250

ADDITIONAL BENEFITS

Internal Injuries (requiring surgery)	$1,000
Air Ambulance	$750
Prosthesis	$500
Ambulance	$450
Transportation	$150–$300
Exploratory Surgery	$250
Blood/Plasma	$250
Appliances	$200
Family Lodging Benefit	$200
Wellness Benefit	$60
Physical Therapy	$75
Accident Follow-up Treatment	$50

MAJOR INJURIES

Fractures* (open reduction)	
Hip/Thigh	$9,000
Vertebrae	$8,100
Pelvis	$7,200
Skull (depressed)	$6,750
Leg	$5,400
Forearm/Hand	$4,500
Foot/Ankle/Knee Cap	$4,500
Shoulder Blade/Collar Bone	$3,600
Lower Jaw (mandible)	$3,600
Skull (simple)	$3,150
Upper Arm/Upper Jaw	$3,150
Facial Bones (except teeth)	$2,700
Vertebral Processes	$1,800
Coccyx/Rib/Finger/Toe	$720
Dislocations* (open reduction)	
Hip	$6,750
Knee (not kneecap)	$4,875
Shoulder	$3,750
Foot/Ankle	$3,000
Hand	$2,625
Lower Jaw	$2,250
Wrist	$1,875
Elbow	$1,500
Finger/Toe	$600

*Closed reduction pays a benefit 33% less than open reduction.

GROUP WHOLE LIFE INSURANCE

Policy Series WL9800-MP

WL G

PLAN FEATURES

FLEXIBILITY TO MEET YOUR NEEDS
Employee–Coverage amount: up to $100,000.
Spouse–Coverage amount: up to $50,000 (not to exceed employee's coverage).
Children (ages 15 days-24 years)–$10,000 child term rider covers all your dependent children for only $1.38 per week.

BUILDS CASH VALUE In addition to having valuable life insurance protection, you can accumulate savings at a guaranteed rate of return (competitive interest rates) and pay no taxes on any of the money until you use it. You have access to your cash value and have the ability to make loans or withdrawals.

NO MEDICAL EXAMS Required Employees and their families may apply for benefit amounts by answering only a few medical questions.

GUARANTEED ISSUE $10,000 employee/$5,000 spouse based on 20% participation and 50 applications • $5,000 employee based on 10% participation and 25 applications.

IMMEDIATE EFFECTIVE DATE Guaranteed Issue coverage will be effective the date the employee signs the application.

PERMANENT INSURANCE PROTECTION Once your insurance application has been approved and payroll deductions have started, the coverage is yours to keep by continuing to pay premiums. Your premium will never increase.

PORTABILITY Take your coverage with you if you leave the company.

PLAN BENEFITS

WAIVER OF PREMIUM RIDER (Employee only • Issue ages 18-55)
Waives entire premium amount for employee coverage after the insured has been totally disabled for 4 months and continues throughout the duration of the disability. Any recurrence of a prior disability will be covered, provided the prior disability continued for at least 6 consecutive months, if it begins within 30 days of the recovery, and is due to the same or related causes. The waiver of premium is also available for loss of sight or loss of limbs even though the employee may be able to engage in an occupation. The rider terminates on the employee's certificate anniversary coinciding with or next following his 60th birthday.

ACCIDENTAL DEATH BENEFIT RIDER (Employee and Spouse only • Issue ages 18-60)
The benefit provides an additional benefit equal to the face amount if the insured dies in an accident. The maximum coverage available under this rider is $100,000.

ACCELERATED BENEFIT RIDER
This offers one-half of the death benefit to be paid prior to death, when the insured is diagnosed with a terminal illness. This is a life insurance rider, which pays, Accelerated Death Benefits at your option under conditions specified in this rider. This rider is not intended to provide health, nursing, home or long term care insurance. Benefit payments may affect your eligibility to receive Medicaid and other government benefits or entitlements. Insureds and/or spouses are eligible for this benefit. Receipt of Accelerated Benefits may be taxable. The Insured should consult with his personal tax advisor.

CAI9880

GROUP HOSPITAL INDEMNITY

Policy Series CA8500-MP

HIG

PLAN BENEFITS

	PLAN 1	PLAN 2	PLAN 3	PLAN 4
HOSPITAL CONFINEMENT per day (up to 180 days per confinement) This benefit is paid when an insured is confined to a hospital as a resident bed patient because of a Covered Sickness or as the result of injuries received in a Covered Accident (within six months of the Covered Accident).	$150	$200	$250	$300
HOSPITAL ADMISSION per admission This benefit is paid when an insured is admitted to a hospital and confined as a resident bed patient because of injuries received in a Covered Accident (within six months of the Covered Accident, or a Covered Sickness). Emergency room treatment, outpatient treatment and observation units are not considered hospital admissions. We will pay this benefit once per period of confinement.	$250	$300	$500	$500
HOSPITAL INTENSIVE CARE per day This benefit is paid if an Insured is confined in a hospital intensive care unit because of a Covered Sickness or due to an injury received from a Covered Accident (within six months of the Covered Accident).	$150	$200	$250	$300
SURGICAL BENEFIT up to the amount shown If an insured has surgery performed by a physician due to an injury received in a Covered Accident or because of a Covered Sickness, we will pay the appropriate surgical benefit amount shown in the Schedule of Operations. The surgical benefit paid will never exceed the maximum surgical benefit designated in the plan. The surgery can be performed in a Hospital (on an inpatient or outpatient basis), in an Ambulatory Surgical Center, or in a Physician's office.	$1,500	$2,000	$2,500	$3,000
ANESTHESIA BENEFIT up to the amount shown When an insured receives benefits for a surgical procedure covered under the Surgical Benefit, we will pay the appropriate benefit amount shown in the Schedule of Operations for anesthesia administered by a physician. However, the anesthesia benefit paid will not exceed 25 percent of the amount paid under Surgical Benefit.	$375	$500	$625	$750
HOSPITAL EMERGENCY ROOM/PHYSICIAN BENEFIT (medical fees) If an insured is injured in a Covered Accident or has treatment as the result of a Covered Sickness, he will receive the following (total combined benefit maximum per visit is up to $100, depending on plan chosen): Physician (per visit) – $50 Laboratory fees (per visit) – $25 X-ray (per visit) – $50 Injections/medications (per visit) – $25 Family calendar year maximum – $250 (per insured) • $1,000 (per family)	$50	$50	$50	$50
WELL BABY CARE per visit We will pay the well baby care benefit amount associated with each benefit plan option when an insured baby receives well baby care (four visits per calendar year per insured baby). For this plan, a baby is a dependent child 12 months of age or younger.	$25	$25	$25	$25
OUT-OF-HOSPITAL PRESCRIPTION DRUG BENEFIT per prescription We will pay the out-of-hospital prescription drug benefit associated with each benefit plan option for each prescription filled for an insured (limit five covered prescriptions per insured per calendar year).	$10	$10	$20	$20

NEW Benefit!

THINK ABOUT HOW TO SAVE YOUR IDENTITY

Millions of people will have their identity stolen this year. **DON'T BE ONE OF THEM.**

Protect everything you've worked for — add LifeLock® Identity Theft Protection to your benefits package during this year's annual enrollment. Identity theft is one of the fastest growing crimes in the nation.[1] When criminals steal your identity, they can ruin your good name by:

- Opening new lines of credit
- Draining your savings and retirement accounts
- Running up utility or healthcare bills
- Obtaining jobs and filing fraudulent tax returns
- Giving your name to police when arrested

Fortunately, your employer has elected to make LifeLock® Identity Theft Protection a part of your benefits package and available at a special rate. LifeLock® service works to safeguard your identity, 24 hours a day, seven days a week. Using advanced detection technology, LifeLock's always-on service helps protect you from identity theft before it happens.

The enrollment process is simple. Your employer has all the information LifeLock® needs to start protecting your identity.

WHY ADD LIFELOCK?

Real Proactive Identity Theft Protection.
LifeLock can detect and help shut down fraud as it occurs — sometimes up to 60 days sooner than credit monitoring.

Comprehensive Safeguards.
LifeLock helps stop identity thieves by protecting you online, helping protect against mail rerouting by identity thieves, helping to cancel and replace stolen credit cards, and much more.

Advanced Protection.
LifeLock offers additional services, including public records monitoring, Peer-to-Peer file sharing protection and credit monitoring to provide protection that's customized for your lifestyle.

24/7/365 Member Service.
Identity thieves don't keep bankers' hours, so neither does LifeLock. Should you become a victim of identity theft, or just have a question, LifeLock's live and domestic identity theft protection experts are ready to help.

$1 Million Total Service Guarantee.
If you become a victim of identity theft while you are a LifeLock member because of some failure or defect in LifeLock's service, LifeLock will spend up to $1 million to hire experts, lawyers, investigators, consultants and whoever else it takes to help your recovery. Restrictions apply. See terms and conditions at www.LifeLock.com for details. Due to New York State law restrictions, the LifeLock $1 Million Total Service Guarantee cannot be offered to residents of New York.

You are four times more likely to have your identity stolen than to have your home burglarized.[2]

An identity is stolen every 4 seconds.[3]

Start protecting your identity today, add LifeLock® Identity Theft Protection during annual enrollment.

LEGAL INSURANCE PLAN

When should I get an attorney?

In almost every area of legal conflict —divorces, bankruptcies, consumer disputes and so on—things will go better for you if you get professional legal advice early on.

Why buy legal insurance?

Normally when an attorney gets involved in a case, fees start immediately. And as everyone knows, attorney fees can put a major dent in your bank account.

That's why Pasco County Schools offers a legal insurance plan. There are three main reasons why this legal plan is a good idea for you.

- First, you get easy access to an attorney.
- Second, you get significant cost savings on attorney's fees.
- Third, you get preventive services that can help with issues before they reach crisis proportions.

In short, the goal of the plan is to provide a clear path for preventing and resolving legal matters. And that enables people to protect their families' finances and futures.

Your legal insurance plan

With this legal insurance plan, you can select a Network Attorney, or an out-of-network attorney. As usual, however, going out-of-network will cost you more.

The network consists of thousands of attorneys nationally, with more than 1,000 in Florida alone.

Now, if you want to use an out-of-network attorney, there's a maximum amount the plan will pay for each legal service. You'll be reimbursed up to that amount. Check the web site for the full details.

Finally, with this legal plan, there are no waiting periods, and no deductibles. Plus, you can get legal representation anywhere in the United States.

Your legal insurance benefits

Your legal insurance plan covers a wide range of legal services. See the following plan options to determine which one is right for you.

ULTIMATEADVISOR® A COMPREHENSIVE LEGAL PLAN

UltimateAdvisor Protects You and Your Family

We want to help you take control of any legal matters that may cause stress, hardships or financial challenges. And you have the opportunity to do that by enrolling in UltimateAdvisor from ARAG®. This benefit offers trusted and affordable legal resources, services and representation to help you plan for, protect against and resolve legal issues.

How the Plan Helps You

A dispute with a contractor. A sudden illness. The need for estate planning. We understand that situations like these can happen to anyone, and UltimateAdvisor can help you address legal or financial events – both planned and unplanned – at any time in your life.

UltimateAdvisor helps you *save time* looking for the right attorney and *avoid paying high-cost attorney fees*, which average $294 an hour.* Whether you want to plan for the future, research your legal matter, need advice or resolve your legal issue, ARAG is with you every step of the way, at a price you can afford.

ARAG's Online Resources are Your Starting Point for Legal Relief

Your path to legal protection starts with easy-to-use online resources via the ARAG® Legal Center™ (ARAGLegalCenter.com, Access Code 17843pcs) to help you handle legal issues on your own. There you can learn more about your legal issues and take your first steps towards protection. Online resources include:

- The Education Center contains Guidebooks, hundreds of articles, newsletters and more to help you understand everyday legal issues.
- DIY Docs™ offer the convenience and control of creating your own state-specific, legally-valid documents online.

- Online Financial Tools help you map out a solid financial strategy with a personalized financial plan, articles, calculators and more.

Get Advice and Direction from a Trusted Professional

Get assistance from experienced professionals and an award-winning Customer Care Center, with specialists who will help you navigate your legal issues. Plus, you'll benefit from the following services:

- Legal Hotline offers you unlimited legal advice from Network Attorneys who can help you better understand most general legal issues and how to address them. Plus, they can help you review or prepare documents, including a Standard Will.

- Identity Theft Services provided by Certified Identity Theft Case Managers guide you through the steps of prevention – and are there to assist you in recovery if your identity is stolen.

- Financial Wellness Hotline includes guidance and education on a wide range of financial topics – cash and debt management, budgeting, retirement planning, federal tax information and more – from a Financial Counselor.

Resolve Your Legal Issues with an Experienced Attorney by Your Side

When a life event turns into a legal issue, we'll be there for you, with a comprehensive array of legal services – many of which are 100% paid-in-full when you work with a Network Attorney. They can review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation, and represent you in court.

You can rely on the services and experience of our Network Attorneys for legal help and protection on a wide range of covered services, including:

Civil Damage Claims (Defense)

- Civil Damage
- Pet-Related Matters

Consumer Protection Issues

- Auto Repair
- Buying a New or Used Vehicle
- Consumer Fraud
- Consumer Protection for Goods or Services
- Home Improvement/Contractor Issues

Criminal Matters

- Habeas Corpus
- Juvenile Matters
- Misdemeanor Matters

Debt-Related Matters

- Debt Collection Matters

Family Law

- Adoption
- Alimony (up to 8 hours)
- Child Custody (up to 8 hours)
- Child Support (up to 8 hours)
- Divorce/Annulment/Separation (up to 15 hours)
- Incapacity
- Name Change
- Parental Responsibilities
- Pre-marital Agreements

Government Benefits

- Medicare/Medicaid Disputes
- Social Security Disputes
- Veterans Benefits Disputes

Landlord/Tenant Matters

- Contracts/Lease Agreements
- Eviction
- Security Deposits
- Tenant Disputes with a Landlord

Preventative Legal Services

- General In-Office Services (up to 4 hours per year)

Real Estate Matters

- Building Codes/Zoning Variances
- Foreclosure
- Home Improvement/Contractor Issues
- Neighbor Disputes/Easements

Small Claims Court

- Small Claims Court Issues

Tax Issues

- Federal IRS Tax Audit
- Federal IRS Tax Collection

Traffic Matters

- Drivers License Suspension, Revocation and Restoration

Wills and Estate Planning

- Codicil
- Complex Will
- Durable/Financial Power of Attorney
- Health Care Power of Attorney
- Living Will
- Standard Will

For any legal matters not covered and not excluded, you can still receive at least 25% off normal Network Attorney rates (including Immigration Assistance).

For additional details regarding your plan's specifically-covered services, visit ARAGLegalCenter.com and enter Access Code 17843pcs.

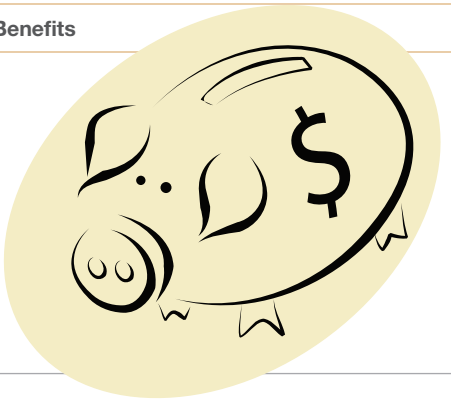
TAKE CONTROL – ENROLL TODAY!

Enrolling in UltimateAdvisor is quick, easy and affordable. In fact, you can get quality comprehensive legal coverage for as low as $16.75 per month.

Visit ARAGLegalCenter.com and enter Access Code 17843pcs to learn more about what the plan offers, research legal topics and MORE! Or call 800-247-4184 to speak with an ARAG Customer Care Specialist.

You can use the Attorney Finder on the website. To access it:

1. Visit www.ARAGLegalCenter.com and enter access code 17843pcs
2. Click on the "choose your plan" tab
3. Click on the attorney finder in the "find a network attorney" section on the left side of the page (in gray box)



THINK ABOUT YOUR **FUTURE**

IT'S NOT YOUR PARENTS' RETIREMENT. You will live longer. You will have a more active lifestyle. Your retirement will cost more. You will need more income than they did.

So where will the money come from? Typically, employees get retirement income from one or more of these sources:

- Social Security
- An Employer Pension Plan
- A Personal Retirement Savings Plan

You are very fortunate. As an employee of Pasco County Schools, you have all three sources available to you right here.

SOURCE 1: YOU GET SOCIAL SECURITY

Social Security is a safety net that was designed to provide a financial foundation for retirees and their families.

You contribute 7.65% of your pay to the program (6.2% to Social Security and 1.45% to Medicare). Pasco County Schools also contributes an equal amount for you.

SOURCE 2: YOU GET A PENSION PLAN

You can choose from one of two available retirement plans. You pick the one that best fits you: the FRS Pension Plan or the FRS Investment Plan.

Applicable to All FRS Members

Employee Contributions

The bill requires all FRS Investment Plan and Pension Plan members (except those in DROP) to make 3% employee contributions on a pretax basis. This change will require both you and your employer to pay the retirement contributions needed to fund your retirement benefits. Your employer will deduct this amount from your gross salary each paycheck.

Applicable to ALL FRS Pension Plan Members

DROP Interest Rate Reduced. The bill changes the Deferred Retirement Option Program (DROP) annual interest rate from 6.5% to 1.3% per year for any member whose DROP participation date is effective on or after July 1, 2011.

Cost of Living Adjustment (COLA) Reduced. There will be no Pension Plan COLA on FRS service earned on or after July 1, 2011. A reduced COLA will be calculated if a member's retirement or DROP participation date is effective on or after August 1, 2011. The reduced COLA will be calculated by taking the total years of service earned prior to July 1, 2011 and dividing it by the total years of service at retirement, then multiplying it by 3%.

For example, a member who retires effective July 1, 2012 with 30 years of service (29 years earned before July 1, 2011) will receive a 2.9% COLA each July: 29 ÷ 30 = .9667 x 3% = 2.9%.

How to Decide on a Plan

What are the important differences between the two retirement plans? Let's look at plan type, vesting, and benefits.

Plan Type. The Pension Plan is a traditional plan for longer-service employees. The Investment Plan is for employees who change jobs more frequently (say every 5 years).

Enrolled before July 1, 2011.

Vesting. In the Pension Plan, you qualify for benefits after 6 years of service. Under the Investment Plan, you qualify in 1 year.

Applicable to New FRS Pension Plan Members

The following changes are applicable only to new Pension Plan members enrolling in the FRS for the first time on or after July 1, 2011.

Vesting. The bill changes the Pension Plan's vesting requirement (your right to a benefit) from 6 years to 8 years. If you use your 2nd Election and transfer from the Pension Plan to the Investment Plan, the present value of your Pension Plan benefit will vest after you complete 8 years of service. The Investment Plan's 1-year vesting requirement has not changed.

Average Final Compensation (AFC). The bill changes the Pension Plan's AFC calculation (used in calculating retirement benefits) from the average of the 5 highest fiscal years of salary to the 8 highest fiscal years of salary.

Normal Retirement Date. The bill changes the Pension Plan's normal retirement date to – Age 65 with 8 years of service or 33 years of service regardless of age.

Warning: You have 5 months from your hire date to decide which retirement plan is best for you. If you don't decide by the deadline, you get the Pension Plan.

Contact FRS

Pension Plan (888) 738-2252

Investment (866) 446-9377

Benefits. The Pension Plan pays a guaranteed monthly lifetime benefit based on your years of service and salary. With the Investment Plan. Your retirement benefit is based on your account balance at retirement.

You Can Switch Plans. Once.

During your working career as an FRS member, you can switch your plan from the Pension Plan to the Investment Plan or vice versa. But you can only do it once.

This is called your Second Election. Once you do it, your decision is final. You can never change again. So get some unbiased financial advice before you make a move.

You May Get Credit for Other Service.

If you're enrolled in the Pension Plan now, and you have been a public service employee (in-state or out-of-state), you may be able to buy up to 5 years of FRS service credit. You may also be able to buy up to 4 years of military service. It's a good way to increase your retirement income.

Now, of course, to buy service credits, you have to follow the rules. The rules dictate job type, position, location, retirement coverage and so on. So it's best to check with the powers at the Florida Division of Retirement.

When You are Close to Retirement

When you are getting close to retirement, call the Florida Division of Retirement. There are several programs that impact your retirement and your pension. One example is…

- The Deferred Retirement Option Plan (DROP) that allows you to retire under the pension plan, and accumulate retirement benefits without stopping work for up to 5 years.

Thinking of Returning to Work After Retirement

After retiring under the Florida Retirement System or concluding DROP participation, you may work for any private employer or for any public employer that does not participate in the FRS without affecting your FRS retirement benefits. However, you are subject to certain limitations with respect to your employment with any FRS employer during the first twelve months of retirement.

If you are a retired member of the FRS Pension Plan, you should **always** contact the Bureau of Retirement Calculations at (888) 738-2252 before returning to employment in any capacity with any FRS employer in your first year of retirement. Investment Plan members should contact the FRS Financial Guidance Line at (866) 446-9377 before returning to employment.

SOURCE 3: YOUR RETIREMENT SAVINGS PLAN

Here's a startling statement. If you want to live well in retirement, you can no longer rely on your Social Security and pension benefits alone! You must save more.

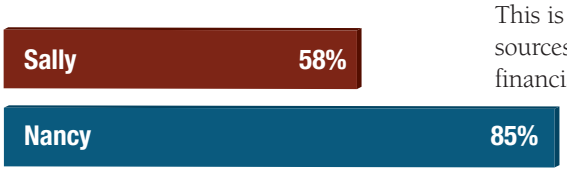
Fortunately, you have many excellent retirement savings plan options available here. However, you must take action. You must get into one or more of these plans. You must save as much as you can, as early as you can.

There are several retirement plan vendors that have been approved by the Board. You can feel comfortable with any one of them.

The Rewards of a Personal Savings Plan

The main reward is a more secure, more comfortable retirement that allows you to live your dreams. But there are many more rewards of a personal plan. For example:

- Participation in plans is voluntary
- Most flexible savings plans available
- Hundreds of investment options
- Options to fit your investing personality
- Change contributions and investments
- Lower taxable income, pay less taxes
- The amazing power of compounding
- Tax-deferred growth of nest egg



You don't have to be a genius like me to see the financial benefits of a personal retirement savings plan. And only 30% of you have signed up for a plan!! Get smart. Get into it. Take it from me. The math adds up.

Albert Einstein, Big Thinker

Your Retirement Projections

Your retirement picture is all about replacing your pre-retirement income. How much of your working level of income do you need to have to live comfortably?

Let's take a look at an estimate of how much of your pre-retirement income your Social Security and pension benefits will replace? Here's what some 2006 retirees discovered.

Scenario 1.

Sally retired at age 62 with 20 years of service. She was a Pension Plan participant, with no additional savings.

Her final salary in 2006 was $58,000. She wants to collect Social Security immediately.

Plans replace 58% of her income.

Scenario 2.

Nancy is in the same situation (retiring at 62, with 20 years, same salary, pension plan, and Social Security) except that she has saved $200,000 in her Retirement Savings Plan.

Plans replace 85% of her income

Clearly, Nancy will live more comfortably in retirement, will have a more flexible lifestyle, and will be better able to accomplish her goals for the future.

This is a brief summary of your available sources of retirement income. Consult your financial advisor about your future plans.

VOLUNTARY RETIREMENT SAVINGS PROGRAM

As an employee of the District School Board of Pasco County (District), you have a unique opportunity to invest a portion of your income for retirement. Depending on the plan you choose, you do not have to pay income tax on the amount you contribute or any earnings, until you retire or withdraw funds. You can start with as little as $200 annually and increase your contributions up to the maximum amount allowed by the Internal Revenue Service (IRS). The investment options include a wide selection of mutual funds, fixed accounts, and variable annuities managed by authorized investment companies.

All regularly scheduled employees, with the exception of school board members, may elect to contribute to a personal retirement savings account through salary reduction. Upon employment, you are immediately eligible to participate.

What is the Voluntary Retirement Savings Program?

The Voluntary Retirement Savings Program is the District's tax-sheltered annuity (TSA) program that allows eligible employees to save toward retirement through payroll deductions by contributing to either a 403(b), Roth 403(b) or 457(b) plan. Contributions are made solely by the employee through payroll deductions on either a pre-tax or post-tax basis.

1. A **403(b)** plan is a tax-advantaged retirement savings plan for employees of public schools, tax-exempt organizations and ministers. You contribute into a 403(b) plan before you pay income tax on your current salary and contributions grow tax-deferred until you withdraw the money out of the plan.

2. A **Roth 403(b)** plan is a tax-advantaged retirement savings plan for employees of public schools and tax-exempt organizations. You contribute into a Roth 403(b) plan after you pay income tax on your current salary. As long as your withdrawals meet qualified distribution rules, you are not required to pay federal income tax.

3. A **457(b)** plan is a type of tax-advantaged deferred compensation retirement plan that is available for governmental and certain non-governmental employers. You defer portions of your current salary into the 457(b) plan on a pre-tax basis. For the most part, the plan operates similarly to a 403(b) plan. The key difference is that, unlike the 403(b) plan, there is no 10% penalty for withdrawal before age 59 ½. Withdrawals are subject to ordinary income taxation.

You decide the amount of money you want to set aside for retirement through a salary reduction agreement. You must choose from the list of investment companies authorized by the District. Each company provides a selection of investment options for you to invest your contributions.

You may request additional information concerning the specific provisions of each plan. It is important to select an account and company best suited to your specific needs and goals.

Once you have selected a company, you must meet with a representative and complete a salary reduction agreement (SRA). Both the company's authorized representative and you must sign the SRA. The representative is responsible for forwarding the signed agreement to the Employee Benefits Department for processing. Please read the agreement carefully before signing. Be sure to retain a copy of the agreement for your records.

The Employee Benefits Department must receive your SRA form 8 to 10 days prior to the payroll for which you wish the change to be effective.

Authorized Investment Companies

Board policy and District administrative requirements allow companies that meet certain standards and qualifications to provide voluntary retirement saving plans to employees. A list of authorized investment companies is available on Employee Benefits and Risk Management's website at www.pasco.k12.fl.us/benefits/tsa.

Plan Administration

IRS rules governing the Board's voluntary retirement savings program requires that the District be accountable for transactions occurring within the District's 403(b) and 457(b) plan. These rules require the District to certify that all transactions from your account meet the IRS guidelines governing the District's plan. TSA Consulting Group (TSACG) is the District's third party administrator for the voluntary retirement savings program. TSACG will review all requests for distribution or transfer of assets on behalf of the District, determine whether your request meets IRS guidelines and approve or deny your request.

Plan Distribution Transactions

Distribution transactions may include any of the following:

1. Exchanges
2. Hardship Distributions
3. Loans
4. Rollovers
5. Transfers of Assets
6. Withdrawal of Funds (Distribution)

Employees/Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. Submit all completed forms to TSACG, the plan administrator, for processing.

As the 403(b) and 457(b) Plan Administrator for the District, TSACG has developed an online system, known as the ART System, for you to use when requesting loans, rollovers, distributions, and contract exchanges from your account. The ART System will expedite the time required to process your requests.

For additional information about TSACG's role in the District's plan, visit TSA Consulting Group's website at www.tsacg.com or call (888) 777-5827.

ABOUT WORKERS' COMPENSATION WORK-RELATED ACCIDENTS

If you are involved in a work-related accident, you have the responsibility to report all work-related accidents or illnesses to your supervisor or the designated person at your work location within 24 hours when possible, or as soon as you have knowledge. The District School Board of Pasco County (District) has teamed up with Johns Eastern Company (JECO) to provide you quality medical services if you are involved in a work-related accident that results in the need for medical treatment. The State of Florida has approved this arrangement to provide you with quality medical care for your work-related injury within an authorized network of medical providers.

What are your rights and responsibilities?

1. Immediately report all work-related accidents to your supervisor.

2. If your work-related accident results in the need for medical treatment, and is not an emergency, you must immediately report the injury to your supervisor before seeking medical treatment.

   If your accident is serious and requires immediate medical treatment, go to the nearest hospital for treatment or call 911. After treatment, have a representative from the facility call Johns Eastern Company at 1-800-749-3044.

3. Contact the designated person at your work site to complete a notice of injury report and obtain authorization for medical services.

4. Obtain all medical services from a provider within the District's authorized workers' compensation provider network. If your treating physician approves treatment by another physician, you must obtain authorization from Johns Eastern Company at 1-800-749-3044 before your first date of treatment.

5. Keep all scheduled appointments and be on time for all medical treatments and evaluations. You are encouraged to schedule appointments before or after your normal work schedule.

6. If you choose to cancel or do not keep your scheduled appointment(s), you may be considered in non-compliance which may affect your eligibility for workers' compensation benefits. Contact the nurse case manager or adjuster assigned to your case before canceling or rescheduling an approved appointment.

7. Return to work as soon as your treating physician releases you.

8. Cooperate and respond to all requests from Johns Eastern Company regarding your work-related injury.

Medical Treatment After Normal Business Hours

If you are involved in a work-related accident that occurs after normal business hours and require immediate medical treatment, go to the nearest urgent care facility, hospital emergency room or call 911.

Whenever possible, you should attempt to access one of the District-approved urgent care facilities or hospitals first. However, if the injury is life threatening, go to the nearest hospital emergency room for treatment. A list of approved facilities is available at www.pasco.k12.fl.us/benefits/comp.

Examples of when you should use an urgent care facility or hospital emergency room as initial treatment for a work-related injury or illness:

1. The injury or illness is life threatening.

2. You are involved in an accident at the end of the day and the injury is serious enough that you cannot wait until the next business day to seek medical treatment.

3. The work-related injury or illness occurs after normal business hours or when all District administrative offices are closed.

After receiving treatment at a hospital emergency room, you must follow up with an authorized workers' compensation network provider before returning to work. Within 24 hours of emergency treatment, call Johns Eastern Company at 1-800-749-3044 to coordinate all follow-up medical treatment.

Fraud Statement

Workers' compensation fraud occurs when any person knowingly, and with intent to injure, defraud, or deceive, any employer or employee, insurance company, or self-insured program, files false or misleading information. Workers' compensation fraud is a third degree felony that can result in fines, civil liability, and jail time.

Workers' Compensation Contacts
District School Board of Pasco County Phone: (813) 794-2520 or 2345 Fax: (813) 794-2173
Johns Eastern Company Phone: (800) 749-3044 Fax: (813) 402-7922

Procedures to report injuries to Johns Eastern Company is separate from your regular group health insurance. Notify your supervisor of your work-related injury within 24 hours when possible, or as soon as you have knowledge.

CHANGING YOUR COVERAGE

Under some circumstances, the IRS may permit you to make mid-plan year election changes to your benefits, or vary a salary reduction amount, depending on the qualifying event and requested change.

To Make a Change: Within 30 days of an event that is consistent with one of the events on this page, you must complete and submit a Change in Status/Election Form to the Employee Benefits Department. Contact the Employee Benefits Department to obtain this form. Documentation supporting your election change request is required. Upon the approval and completion of processing your election change request changes to your benefits will be made effective on the first day of the month following receipt of all properly completed paperwork and documentation, unless otherwise provided by law. If your election change request is denied, you will have 30 days; from the date you receive the denial, to file an appeal with the Employee Benefits Department.

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.

QUALIFICATIONS FOR CHANGE IN STATUS

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.

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 State Children's Health Insurance Program (SCHIP) (Florida Kidcare) coverage may trigger a permitted election change.

Health Insurance Portability & 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

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 *
- 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.

* *New* **Dependent child under the age of 26:** There are no eligibility requirements that must be met.

* **Dependent child ages 27-30:** 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 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 currently have no dependent coverage and anticipate the addition of a dependent during the new plan year, you should plan ahead at this time, and choose the same Medical plans, since you can only change your Medical 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.

ABOUT YOUR RIGHT TO CONTINUE MEDICAL COVERAGE

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 1-800-720-4460.

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

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 post-marked, 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 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.

ABOUT MEDICARE PART D AND YOUR PRESCRIPTION DRUG PLAN

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

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

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

(2) Wakely Consulting Group 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 standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current District School Board of Pasco County coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through District School Board of Pasco County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

DSBPC PRIVACY NOTICE ABOUT THE USE OF YOUR PERSONAL MEDICAL INFORMATION

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 disclose 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, Employee Benefits Department, 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

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 request 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.

*Dependent Premiums for Florida Blue Options PPO Plans include single coverage buy up amounts.

MINNESOTA LIFE GROUP TERM LIFE INSURANCE

Age	Employee Only Per $10,000 Per Pay	Spouse Only Per $5,000 Per Pay	Child(ren) Only Per Pay
18 – 24	$0.29	$0.15	$0.79
25 – 29	$0.25	$0.12	
30 – 34	$0.29	$0.15	
35 – 39	$0.44	$0.22	
40 – 44	$0.69	$0.35	
45 – 49	$1.14	$0.57	
50 – 54	$1.73	$0.86	
55 – 59	$2.57	$1.28	
60 – 64	$3.66	$1.83	
65 – 69	$6.08	$3.04	
70 – 74	$10.88	$5.44	
75 & over	$22.20	$11.10	

LINA TERM LIFE INSURANCE

Employee Only Coverage	20 Pays	24 Pays
$5,000	$0.96	$0.80
$10,000	$1.92	$1.60
$15,000	$2.88	$2.40

LEGAL SERVICES

PRE-PAIDLEGAL SERVICES	
24 Ded	$8.38
20 Ded	$10.05

OPT-OUT TAXABLE INCOME PER PAY

24 Ded	20 Ded
$50.00	$60.00

DEPENDENT MEDICAL PLANS

FLORIDA BLUE HMO STANDARD PLANS

	1 DEPENDENT		FAMILY (2 or More Dep's)		2 EE's of the Board (Spouse COVERING Child(ren)	
	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded
BCBS	$125.00	$150.00	$250.00	$300.00	$39.00	$46.80
Mental Health	$ 1.72	$ 2.06	$ 1.79	$ 2.15	$ .27	$ .32
Prescription	$53.62	$64.34	$85.00	$102.00	$35.00	$42.00
TOTAL	$180.33	$216.40	$336.79	$404.15	$74.27	$89.12

FLORIDA BLUE HMO PREMIUM PLANS

	SINGLE COVERAGE		1 DEPENDENT		FAMILY (2 or More Dep's)		2 EE's of the Board (Spouse COVERING Child(ren)	
	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded
BCBS			$225.98	$271.18	$380.92	$457.10	$159.92	$191.90
Mental Health			$ 1.72	$ 2.06	$ 1.79	$ 2.15	$ .27	$ .32
Prescription			$53.62	$64.34	$85.00	$102.00	$35.00	$42.00
Buy Up for Employee Coverage	$10.00	$12.00	$10.00	$12.00	$10.00	$12.00	$10.00	$12.00
TOTAL	$10.00	$12.00	$291.31	$349.57	$477.71	$573.25	$205.19	$246.22

FLORIDA BLUE OPTIONS PREMIUM PLANS

	SINGLE COVERAGE		1 DEPENDENT		FAMILY (2 or More Dep's)		2 EE's of the Board (Spouse COVERING Child(ren)	
	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded
BCBS			$239.41	$287.29	$393.30	$471.96	$139.80	$167.76
Mental Health			$ 1.72	$ 2.06	$ 1.79	$ 2.15	$ .27	$ .32
Prescription			$53.62	$64.34	$85.00	$102.00	$35.00	$42.00
Buy Up for Employee Coverage	$42.50	$51.00	$42.50	$51.00	$42.50	$51.00	$42.50	$51.00
TOTAL	$42.50	$51.00	$337.24	$404.68	$522.59	$627.11	$217.57	$261.08

FLORIDA BLUE OPTIONS STANDARD PLANS

	SINGLE COVERAGE		1 DEPENDENT		FAMILY (2 or More Dep's)		2 EE's of the Board (Spouse COVERING Child(ren)	
	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded
BCBS			$225.11	$270.13	$376.16	$451.39	$140.16	$168.19
Mental Health			$ 1.72	$ 2.06	$ 1.79	$ 2.15	$ .27	$ .32
Prescription			$53.62	$64.34	$85.00	$102.00	$35.00	$42.00
Buy Up for Employee Coverage	$25.00	$30.00	$25.00	$30.00	$25.00	$30.00	$25.00	$30.00
TOTAL	$25.00	$30.00	$305.44	$366.53	$487.95	$585.54	$200.43	$240.51

DENTAL PLANS

DELTA DENTAL	High PPO Plan		Low PPO Plan		DHMO 14A	
	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded
Employee Only	$19.69	$23.62	$13.16	$15.79	$9.55	$11.46
Employee + one Dependent	$49.08	$58.90	$31.91	$38.29	$16.72	$20.06
EE+ 2 or more Dependents	$67.18	$80.62	$44.54	$53.49	$26.28	$31.54

VISION PLAN

DAVIS VISION	Option I Designer CC#2825		Option II Premier Platinum Plus CC#2826		Option III Premier Platinum Plus (Two-Pair Benefit) CC#2827	
	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded
Employee Only	$3.82	$4.58	$5.34	$6.40	$8.36	$10.03
Employee + Family	$10.92	$13.10	$15.25	$18.29	$23.90	$28.68

IDENTITY PROTECTION PLANS

LIFELOCK PLANS	LifeLock Identity Theft Protection		LifeLock Command Center		LifeLock Ultimate	
	24 Ded	20 Ded	24 Ded	20 Ded	24 Ded	20 Ded
Employee Only	$4.25	$5.10	$6.38	$7.65	$10.63	$12.75
Employee + Spouse	$8.50	$10.20	$12.75	$15.30	$21.25	$25.50
EE + Children	$7.44	$8.93	$10.10	$12.11	$15.41	$18.48
EE + Family	$11.69	$14.03	$16.47	$19.76	$26.03	$31.24

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.