DISTRICT SCHOOL BOARD OF PASCO COUNTY

Kurt S. Browning, Superintendent of Schools

retiree benefits

2014 Retiree Guide

Open Enrollment:
Begins on October 21, 2013
Ends on November 15, 2013

DISTRICT SCHOOL BOARD OF PASCO COUNTY

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HOW TO ENROLL IN YOUR BENEFITS:

This year the District School Board of Pasco County will be offering you the opportunity to use the "self-serve" enrollment option at www.MyPascoDSBBenefits.com to enroll in your benefits. You will need a username and password to access the site and those will be mailed to youin your open enrollment materials. If you have not received your user name and login or have lost them, please call 1-800-390-1224 to request them.

Thank you,

Retiree & COBRA Benefits Administrator
CBIZ National Benefit Alliance
175 South West Temple, Suite 650
Salt Lake City, UT 84101
Toll Free: 800-390-1224*208
Fax: 800-511-2124

YOUR GROUP HEALTH PLAN OVERVIEW

IMPORTANT INFORMATION

Effective January 1, 2014, the only medical plan that does not require a retiree contribution is the BlueCare HMO Basic plan. Therefore, even if you are eligible for Board-paid benefits, but elect to participate in a PPO plan or the HMO Premium Plan you will be required to pay a buy-up amount. Please see the rate sheet for costs per plan.

Open enrollment begins October 21, 2013 and ends November 15, 2013.

Late forms will not be accepted. If you wish to make changes to your current benefits, CBIZ must receive your enrollment form postmarked no later than Monday, November 15, 2013.

OPEN ENROLLMENT ASSISTANCE

The summaries of benefits located in this booklet will provide you with information regarding your benefits and answer questions that you may have.

BlueMedicare – Group Medicare Plan

Retirees and spouses of retirees will have the option to enroll in a Group Medicare Plan offered through the District.

The Blue Medicare PPO Plan is a Nationwide Plan. It is available to Retirees of The Pasco County School Board residing in/or out of the State of Florida.

HEALTHCARE PLANS

Choice of Medical Plans

- BlueCare HMO Basic
- BlueCare HMO Premium
- BlueOptions Standard PPO

Group Medicare Plan (Nationwide Network)

- BlueMedicare PPO

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 retirees and dependents are required for enrollment in:

- health insurance
- life insurance
- other miscellaneous insurances

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

DEPENDENT RATES FOR TWO MARRIED RETIREES/ EMPLOYEES OF THE SCHOOL BOARD

There are many married couples that are employed by the District School Board of Pasco County. As retirees and active 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 the retiree and the employee, a married couple, are covered under the same Medical and/or Dental plans. If you and your spouse elect coverage under different health plans, the spouse who carries the dependents will be charged the full "one dependent" or full "family" rate, as applicable.

- If you and your spouse 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 and/or Dental plans, since you can only change your Medical and/or Dental plans during the Open Enrollment period.

DEPENDENT CHILD AGES 19-26

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

DEPENDENT CHILD AGES 27-30 (MEDICAL AND 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 meets the following criteria:

- 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.
- Coverage is only available under the medical plans for dependents between the ages of 27-30. Dental, legal or vision coverage is not available.

OUT OF AREA COVERAGE

If you live outside of the state of Florida or in the Florida Panhandle area, a PPO medical plan must be selected.

The HMO is an available option only if dependent(s) have a temporary change of address (such as a college).

CHANGES TO COVERAGE

The benefit plans you enroll in during the open enrollment period will be effective January 1, 2014 through December 31, 2014. You cannot change your medical or dental plans during the calendar year, except that participants who permanently relocate out of state may change from the FloridaBlue HMO Basic/Premium to the BCBS BlueOptions Standard plans. You may also add or drop dependents during the calendar year. Contact CBIZ for assistance.

Any changes to your Retiree benefits will require your written authorization. Premium changes required because of such written authorization will be initiated as soon as possible after CBIZ receives your written request.

BENEFIT ADMINISTRATION

QUESTIONS & ANSWERS

CBIZ BENEFITS will be handling billing for all Medical, Dental, Vision, Life, Legal and Life Lock Insurance premiums.

Below you will find some commonly asked questions regarding retiree billing. If you have any further questions please feel free to contact CBIZ BENEFITS at any time.

Where will I be sending my payments and who should checks be made payable to?

A. All payments should be made payable to The District School Board of Pasco County and mailed to:
CBIZ Benefits & Insurance Services Inc
DBA PASCO
3179 MOMENTUM PLACE
CHICAGO, IL 60689-5331

Q. What payment options are available?

A. Option 1:
Florida Retirement System (FRS)
If you are already signed up with FRS, you do not need to do anything, your deduction will continue.
Option 2: Check/Money Order
Option 3: ACH

If you are not signed up for automatic monthly deductions from the Florida Retirement System, simply fill out an Insurance Payroll Deduction Authorization Form and forward to CBIZ BENEFITS for processing.

Q. Who should I contact if I have a question regarding my retiree benefits?

A. PASCO Retiree Administrator at:
Phone: 1-800-390-1224 ext. 208
Fax: 1-800-511-2124
Web: www.MyPascoDSBBenefits.com

Q. What type of information should I communicate to CBIZ BENEFITS going forward?

A. Please notify CBIZ BENEFITS if you have any change in status or a qualifying event. A qualifying event would include a marriage, adoption, birth, divorce, or death of a spouse.

Please notify CBIZ BENEFITS within 30 days of any such event. ***Also, any change in address should be communicated.***

RETIREE HEALTH OPT OUT PLAN

Retirees eligible for Board-paid coverage, who are covered under a different major medical plan, may waive participation in the health plan and receive $1,200 taxable income.

Health Opt Out Benefits

- $1,200 Taxable Income
- Employee Assistance Program

Benefits Waived

- Medical
- Prescription
- Mental Health & Substance Abuse

The Retiree Health Opt-Out Plan is available only to those retirees who, at retirement, were eligible for District-paid group health insurance in accordance with either Article X, Section F-1 of the Instructional Master Contract, Article XI, Section F-1 of the SRP Master Contract, or School Board GBBC, and who are enrolled in a comparable major medical health insurance plan through another carrier.

Eligibility is contingent upon the retiree meeting the following conditions at retirement:

1. 30 years of service under the Florida Retirement System (FRS)

   or

   at least 25 years of service under the FRS and is at least age 50 at retirement.

2. At least 20 years of service in the District School Board of Pasco County.

When a retiree enrolls in the Health Opt-Out Plan, the Board will pay the retiree the current value available to active employees, $1,200 for the 2014 plan year. This amount is subject to federal income tax. An annual payment for the number of months the retiree participates in the Health Opt-Out Plan will be issued in a lump sum in December of the plan year or upon termination of eligibility, whichever occurs first. A participant in the Retiree Health Opt-Out Plan will not be required to contribute to the Pasco School Board his/her FRS Health Insurance Subsidy.

A participant in the Retiree Health Opt-Out Plan may re-enroll in the District-paid group health insurance plan only if he/she is no longer covered by another major medical health insurance plan.

A retiree wishing to re-enroll must submit the following documentation to CBIZ within thirty (30) calendar days following the date of cancellation/termination of coverage.

- a written request to re-enroll,
- completed Retiree Benefit/Enrollment Change forms, and
- a letter from the previous major medical carrier or employer stating the date of cancellation/termination of coverage. The letter must be on letterhead from the major medical carrier or employer, include the cancellation/termination date of coverage, and signature of the benefit administrator of the major medical carrier or employer.

The effective date of coverage of the District-paid group health insurance coverage will be the first day of the month following the submission of the written request, enrollment form, and related documents. The District does not guarantee continuous health coverage.

A retiree who fails to re-enroll in the District-paid group health insurance plan in accordance with the timelines stated in the above paragraph will remain in the Retiree Health Opt-Out Plan until Medicare eligible or until January 1 following the next regularly scheduled District Open Enrollment period, whichever comes first.

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ADDRESS CHANGES

PLEASE KEEP US INFORMED

PLEASE VERIFY AND KEEP YOUR ADDRESS ON FILE WITH CBIZ UP-TO-DATE. IF YOU EXPERIENCE A CHANGE OF ADDRESS DURING THE PLAN YEAR, CALL US TO UPDATE YOUR INFORMATION.

(800) 390-1224

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://www.pasco.k12.fl.us/benefits/retiree for additional detailed information.

Customer Service Information

Company	Department	Hours	Phone / Web Address
CBIZ *Contracted administrator for all premium payments and benefit processing*	Customer Service	Mon – Fri 8:30 am – 5:00 pm	1-800-390-1224 - ext.208 www.mypascodsbbenefits.com
Florida Retirement System (FRS) *Issues FRS benefit payments and contribution refunds*	Retired Payroll	Mon-Fri 8:00 am – 5:00 pm	888-377-7687 850-488-4742 http://frs.myflorida.com
Employee Benefits Department	Customer Service	Mon-Fri 8:00 am – 4:30 pm	813-794-2253 727-774-2253 352-524-2253 ebarm.pasco.k12.fl.us
Florida Blue *HMO/ BlueOptions* *Florida Blue Member Website*	Customer Service	Mon-Thur 8:00 am – 6:00 pm Friday 9:00 am – 6:00 pm	1-800-507-9820 www.floridablue.com
Envision Rx *Prescription Drug Plan*	Customer Service	24 hours a day 7 days a week	1-800-361-4542 www.envisionrx.com
New Directions *Mental Health & Substance Abuse*	Customer Service	24 hours a day 7 days a week	TBD login: TBD password: TBD
Employee Assistance Program *Employee Counseling*	Appointments	8:00 am – 4:30 pm	813-794-2366 727-774-2366 352-524-2366 ebarm.pasco.k12.fl.us/pages/eap.html
Minnesota Life *Basic Core Life*	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-866-293-6047 www.lifebenefits.com
Delta Dental *Dental Plans – Delta Dental PPO* *Dental Plans – DeltaCare USA*	Customer Service	Mon – Fri 8:00 am – 6:00 pm	1-800-521-2651 1-800-422-4234 www.deltadentalins.com
Davis Vision *Vision Plan*	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-800-999-5431 www.davisvision.com
ARAG Legal *Legal Services*	Customer Service	Mon – Fri 8:00 am – 8:00 pm	1-800-247-4184 www.ARAGLegalCenter.com
LifeLock **TransAmerica**	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-800-322-0426
Life Insurance Company of North America (LINA) *Group Term Life Insurance*	Customer Service	Mon – Fri 8:00 am – 5:00 pm	1-800-822-8045 www.cigna.com

2014 Medical Rates

2014 Medical Rates: Includes Envision Prescription Coverage, Employee Assistance Program, and Mental Health/Substance Abuse		Retiree	Retiree +1 Dependent	Retiree + Family	**Children Only
Retiree Qualifies for Board-Paid Insurance					
BlueCare HMO PREMIUM	Subsidy applies to this:	$551.49	$1,156.31	$1,557.07	$ 417.92
PLUS: HMO Buy Up	Retiree MUST pay this:	$ 40.00	$ 40.00	$ 40.00	$ 40.00
Final Monthly PREMIUM		$591.49	$1,196.31	$1,597.07	$ 457.92
BlueCare HMO BASIC (NEW 2014)	Subsidy applies to this:	$551.49	$ 931.34	$1,259.47	$ 160.32
BlueOptions PPO STANDARD	Subsidy applies to this:	$551.49	$1,154.44	$1,546.83	$ 377.68
PLUS: PPO Buy Up	Retiree MUST pay this:	$ 70.00	$ 70.00	$ 70.00	$ 70.00
Final Monthly PREMIUM		$621.49	$1,224.44	$1,616.83	$ 447.68
FloridaBlue (BlueMedicare PPO)	Retirees/Spouses Age 65+	$366.05	$ 732.10	N/A	N/A
Retiree DOES NOT Qualify for Board-Paid Insurance					
BlueCare HMO PREMIUM		$591.49	$1,196.31	$1,597.07	N/A
BlueCare HMO BASIC (NEW 2014)		$551.49	$ 931.34	$1,259.47	N/A
BlueOptions PPO STANDARD		$621.49	$1,224.44	$1,616.83	N/A
BlueMedicare Group PPO		$366.05	$ 732.10	N/A	N/A

** ALL Retirees are required to pay the Blue Options Monthly Buy Up*

***The Children Only Rate is the rate for a dependent or dependents of (1): 2 Retirees of the District School Board who both have their medical/dental premiums fully funded by the Board or; (2): 1 active employee and 1 retiree of the District School Board of Pasco County who both have their medical/dental premium fully funded by the Board.*
ALL COVERED FAMILY MEMBERS MUST BE ENROLLED IN THE SAME PLAN TO QUALIFY FOR THE CHILDREN ONLY RATES.

GROUP TERM LIFE INSURANCE	
$ 5,000	$ 1.60
$10,000	$ 3.20
$15,000	$ 4.80

ARAG ULTIMATE ADVISOR	
	$16.75

DAVIS VISION	Option I Designer	Option II Premier	Option III Premier Platinum Plus
Retiree Only	$8.40	$11.74	$18.39
Retiree + 1 Dependent	$15.13	$21.13	$33.11
Retiree + Family	$23.53	$32.86	$51.50

DENTAL PLANS	Delta Dental High PPO Plan	Delta Dental Low PPO PLan	Delta Care - Prepaid Plan DHMO
Retiree Only	$40.39	$26.99	$19.49
Retiree + one Dependent	$100.71	$65.47	$34.12
Retiree + 2 or more Dependents	$137.86	$91.40	$53.63

Basic Core Life Insurance – Minnesota Life Insurance Company

After enrollment, the amount of life insurance selected by an eligible retiree cannot be increased, but can be reduced to a lower coverage tier within your age group at any time. Coverage amounts and premiums will reduce at age 65 to 50% of the "Under age 65" amounts and further reduce at age 70 to 70% of the "Age 65 through 69" amounts.

	Under Age 65		Age 65 through 69		Age 70 and Over	
	Coverage	FRS Deduction	Coverage	FRS Deduction	Coverage	FRS Deduction
Tier 1	$10,000	2.00	$ 5,000	1.00	$ 3,500	0.70
Tier 2	$20,000	9.50	$10,000	4.75	$ 7,000	3.33
Tier 3	$35,000	31.85	$17,500	15.93	$12,250	11.15

IDENTITY PROTECTION PLANS

LIFELOCK PLANS	LifeLock Identity Theft Protection	LifeLock Command Center	LifeLock Ultimate
	Monthly	Monthly	Monthly
Employee Only	$ 8.50	$12.76	$21.26
Employee + Spouse	$17.00	$25.50	$42.50
EE + Children	$14.88	$17.86	$30.82
EE + Family	$23.38	$32.94	$52.06

MEDICAL **BENEFITS**

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.

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, such as lab work and diagnostic testing at an outpatient hospital, services will be subject to a deductible and coinsurance under the BlueCare HMO Basic plan. Under the BlueCare Premium HMO plan you can pay up to $500 copay per visit for these services. To reduce your out of pocket expenses, use Quest Diagnostics for lab work and an Independent Diagnostic Testing Facility (IDTF) for diagnostic testing.

Pre-operative services:
Pre-operative services at a hospital are subject to the outpatient hospital copay/deductible/coinsurance per visit as well, unless the pre-operative services were performed on same day as the outpatient surgery. If you have an option to go to Quest Diagnostics for your pre-op lab work, then it will be no copay. In addition, if you 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 participating Florida Blue lab. If you have a planned procedure, please advise the participating provider to send any 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 HMO BASIC & PREMIUM BENEFITS

What is an HMO?
A Health Maintenance Organization (HMO) is an organized system of healthcare that assures the delivery of comprehensive range of health services to members who enroll voluntarily and pay a fixed, prepaid fee. Members receive services from participating doctors, clinics, and hospitals.

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.

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 medical care. You pay a portion of the real cost (a co-payment) for each office visit, $35/$30 per visit.

Referring Yourself to a Specialist
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.

Outpatient Hospital Services

Outpatient hospital services that are non-surgical, i.e., diagnostic testing, labs, etc. and surgical services are subject to deductible and coinsurance on HMO Basic Plan or $500 co-pay on the HMO Premium 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.

BlueCare
HMO Basic Plan

Florida Blue HMO

Summary of Benefits for Covered Services	*Amount Member Pays*
Office Services	
Physician Office Services	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$65 Copayment
Out-of-Network Office Visit	Not Covered
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	
In-Network	$300 Copayment
Out-of-Network	Not Covered
Maternity Initial Visit	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$65 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	$35 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

BlueCare
HMO Basic Plan

Florida Blue HMO

Summary of Benefits for Covered Services	*Amount Member Pays*
Colonoscopy (Diagnostic/ Routine for age 50+ then frequency schedule applies. High Risk, no age criteria) In-Network Out-of-Network	 $0 Not Covered
Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	 $70 Copayment Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network and Out-of-Network	 $300 Copayment
Ambulance Services In-Network Out-of-Network (Emergency Services Only)	 DED[2] + 20% Coinsurance DED + 20% Coinsurance
Outpatient Diagnostic Services	
Independent Diagnostic Testing Center Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine) Out-of-Network	 $50 Copayment $300 Copayment Not Covered
Independent Clinical Lab (e.g. Blood Work) In-Network Out-of-Network	 $0 Not Covered
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network Out-of Network	 DED + 20% Coinsurance Not Covered
Other Provider Services	
Provider Services at Hospital and ER In-Network Out-of-Network ER Out-of-Network Hospital	 DED + 20% Coinsurance DED + 20% Coinsurance Not Covered
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network Specialist Out-of-Network	 $65 Copayment Not Covered
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 $35 Copayment $65 Copayment Not Covered
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max) Outpatient Rehab Therapy Center In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network Out-of-Network	35 Visits $65 Copayment Not Covered $65 Copayment Not Covered

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

[1] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.
Florida Blue HMO is the trade name of Health Options, Inc., an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. Both companies are Independent Licensees of the Blue Cross and Blue Shield Association.

BlueCare
HMO Basic Plan

Florida Blue HMO

Summary of Benefits for Covered Services	*Amount Member Pays*
Other Special Services (Continued)	
Durable Medical Equipment, Prosthetics and Orthotics In-Network – Motorized Wheelchair In-Network – All Other Out-of-Network	 $500 Copayment $0 Not Covered
Home Health Care (PBP Max) In-Network Out-of-Network	20 Visits $0 Not Covered
Skilled Nursing Facility (PBP Max) In-Network Out-of-Network	60 days DED + 20% Coinsurance Not Covered
Hospice In-Network Out-of-Network	 DED + 20% Coinsurance Not Covered
Hospital / Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $250 Copayment Not Covered
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network Out-of-Network	Rehabilitation Services limit - 21 days PAD + DED + 20% Coinsurance Not Covered
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network – Therapy Services In-Network – All other Services Out-of-Network	 $65 Copayment DED + 20% Coinsurance Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network and Out-of-Network	 $300 Copayment
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before Florida Blue HMO pays)	 $2,000 / $6,000 Not Covered
In-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	 $100
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 20% Not Covered
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	 $5,500 / $11,000 Not Covered
Total Lifetime Maximum Benefit	No Maximum

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

BlueCare

Florida Blue

HMO Premium Plan

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 (Diagnostic/Routine for age 50+ then frequency schedule applies, High Risk, no age criteria)	
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

HMO Premium Plan

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

BlueCare

Florida Blue

HMO Premium Plan

Benefits for Covered Services	Amount Member Pays
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC)	
In-Network	$400 Copayment
Out-of-Network	Not Covered
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

Additional Benefits and Features

An Array of Value-Added Programs and Services*

- Access to valuable health information and resources, including care decision support, our online provider directory at www.bcbsfl.com and other interactive
- web-based support tools.
- Expert advice on call. We encourage you to call our care consultants team at 1-888-476-2227 to find out how much they can help you SAVE. Whether comparing the cost of your medications between local pharmacies or researching the quality and cost of treatment options before you make a decision, we can help you shop for the best value for you and your family.
- MyBlueService is your online gateway to everything about your health benefit plan as well as all of our self-service tools, now including an enhanced WebMD website especially for our members only.
- Online access to participating physician offices for e-office visits, consultations, appointment scheduling or cancellation, prescription refills and much more.**
- BlueCare members receive a Member Health Statement that summarizes your health care activity for the preceding month.
- Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.
- Referrals to participating providers are not required, however authorizations are required for certain medical services like hospitalization, rehabilitation services, home care, select DME, and certain office based services such as CT scans, MRIs/MRAs, cardiac nuclear medicine studies, and select injectables, etc. Additional information related to access to providers can be found in the Provider Directory. This summary is only a partial description of the many benefits and services covered by Health Options, the HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Blue Cross and Blue Shield of Florida's BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueOptions
PPO Standard Plan

Florida Blue

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

BlueOptions
PPO Standard Plan

Florida Blue

Benefits for Covered Services	Amount Member Pays
Colonoscopy (Diagnosyic/Routine for age 50+ then frequency schedule applies, High Risk, no age criteria)	
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
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

BlueOptions
PPO Standard Plan

Florida Blue

Benefits for Covered Services	Amount Member Pays
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

2014 BlueMedicare Group PPO* Health Benefits

Benefits	BlueMedicare Group PPO* Plan 1
Deductible	$0 In-Network / $1,000 Out-of-Network
Out-of Pocket Max	$1,000 In-Network / $3,000 Out-of-Network. In-Network out-of-pocket max accumulates toward Out-of-Network out-of-pocket max.
Physician Office	
Primary Care (per visit)	In-Network $10 copay Out-of-Network CYD & 20%
Specialist Care (per visit)	In-Network $30 copay Out-of-Network CYD & 20%
e-visit	In-Network $5 copay Out-of-Network CYD & 20%
Convenient Care Center	In-Network $30 copay Out-of-Network CYD & 20%
Podiatry Services (per visit) (Routine foot care up to 6 visits per year)	In-Network $30 copay Out-of-Network CYD & 20%
Chiropractic Services (per visit) For each Medicare covered visit (manual manipulation of the spine to correct subluxation)	In-Network $20 copay Out-of-Network CYD & 20%
Outpatient Mental Health Care (per visit) For individual or group therapy	In-Network $35 copay Out-of-Network CYD & 20%
Outpatient Substance Abuse Care (per visit)	In-Network $35 copay Out-of-Network CYD & 20%
Part B drugs (including Chemotherapy)	In-Network 20% coinsurance Office visit or facility copay may apply Out-of-Network CYD & 20% coinsurance Office visit or facility charges may apply
Allergy Injections	In-Network $5 copay Out-of-Network CYD & 20%
Other Services	
Outpatient Surgery	In-Network • $150 copay for each outpatient hospital facility visit • $100 copay for each visit to an ambulatory surgical center Out-of-Network CYD & 20% In-Network / Out-of-Network • $0 copay for Physician Services

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO* Plan 1
Diagnostic Tests, X-Rays Office IDTF Lab Services Independent Clinical Lab Outpatient Hospital Advanced Imaging (MRI, MRA, Cat Scan, Pet Scan & Nuclear Med): Office IDTF Outpatient Hospital	In-Network • PCP $10 copay • Specialist $30 copay Office visit copay may apply Out-of-Network CYD & 20% In-Network $50 copay Out-of-Network CYD & 20% In-Network $0 copay In-Network $15 copay Office visit or facility copay may apply Out-of-Network CYD & 20% In-Network $150 copay Out-of-Network CYD & 20% In-Network $125 copay Out-of-Network CYD & 20% In-Network $150 copay Out-of-Network CYD & 20%
Outpatient Hospital Services (per visit): • Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac and Pulmonary Rehab • Radiation • Dialysis • Lab only • All other Diagnostic Tests, X-Rays Advanced Imaging, etc.	In-Network / Out-of-Network $30 / CYD & 20% $50 / CYD & 20% 20% / 20% $15 / CYD & 20% $150 / CYD & 20%
Urgently Needed Care (This is not emergency care, and in most cases is out of the service area.)	In-Network / Out-of-Network $30 copay
Emergency Services	In-Network / Out-of-Network $50 copay Worldwide coverage
Dental - Medicare approved (No Preventive)	In-Network $30 copay Out-of-Network CYD & 20%
Home Health	In-Network / Out-of-Network $0 copay

Benefits	BlueMedicare Group PPO* Plan 1
Ambulance	In-Network / Out-of-Network $150 copay for Medicare-covered ambulance services
Outpatient Medical Services and Supplies	
Durable Medical Equipment/Diabetic Supplies • Diabetic Supplies (glucose meters, test strips and Lancets) – needles, syringes and insulin for self-injection is covered under your Part D benefit • Equipment: Electric customized wheelchairs, electric scooters • All other Medicare-covered durable medical equipment	In-Network $0 copay Out-of-Network CYD & 20% In-Network 20% coinsurance Out-of-Network CYD & 20% In-Network $0 copay Out-of-Network CYD & 20%
Prosthetic Devices	In-Network $0 copay for Medicare-covered items Out-of-Network CYD & 20%
Outpatient Rehabilitation - Office or Free Standing Facility Services: • Occupational Therapy • Physical Therapy • Speech and Language Therapy • Cardiac and Pulmonary Rehab • Dialysis	In-Network $30 copay for each visit Out-of-Network CYD & 20% In-Network/Out-of-Network 20% coinsurance
Outpatient Rehabilitation – Outpatient Hospital Services: • Occupational Therapy • Physical Therapy • Speech and Language Therapy • Cardiac and Pulmonary Rehab	In-Network $30 copay for each visit Out-of-Network CYD & 20%
Inpatient Care	
Inpatient Hospital Care (includes Substance Abuse)	In-Network • $150 copay each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • After the 7th day, the plan pays 100% of covered expenses per stay. Out-of-Network CYD & 20%
Inpatient Mental Health Care (may also include Substance Abuse)	In-Network • $200 copay each day for day(s) 1-7 for a Medicare-covered stay in a network psychiatric hospital • For day(s) 8-90, $0 copay for Medicare-covered stay in a network psychiatric hospital

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO* Plan 1
	190-day lifetime limit in a psychiatric hospital Out-of-Network CYD & 20%
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In-Network • $0 copay each day for days 1-20 per benefit period • $75 copay each day for days 21-100 per benefit period There is a limit of 100 days for each benefit period 3-day prior hospital stay is not required Out-of-Network CYD & 20%
Hospice	Member must receive care from a Medicare-certified hospice
Preventive Services	
Annual Screening Mammograms (for women with Medicare age 40 and older)	In-Network: • $0 copay for Medicare-covered Screening Mammogram Out-of-Network CYD & 20%
Pap Smears and Pelvic Exams (for women with Medicare)	In-Network: • $0 copay per Pap smear • $0 copay per pelvic exam Out-of-Network CYD & 20%
Bone Mass Measurement (for people with Medicare who are at risk)	In-Network: • $0 copay for each Medicare-covered Bone Mass Measurement Out-of-Network CYD & 20%
Colorectal Screening Exams (for people with Medicare age 50 and older)	In-Network: • $0 copay for Medicare-covered Colorectal screening exam Out-of-Network CYD & 20%
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	In-Network: • $0 copay for Medicare-covered Prostate Cancer Screening exam Out-of-Network CYD & 20%
Vaccines – Medicare covered	In-Network / Out-of-Network • $0 copay for Influenza vaccine • $0 copay for Pneumococcal vaccine • $0 copay for Hepatitis B vaccine
Health & Wellness Benefit	
Fitness	Free membership through SilverSneakers

BlueMedicare Group PPO out-of-pocket maximum includes all covered health services member cost share rendered in/out of network on a calendar year basis. Supplemental services and Part D costs are not applied to out-of-pocket maximum.

Medicare Part B - the premium provided under this plan excludes the Medicare Part B premium payments. (Members must continue to pay the Medicare Part B premium unless paid by Medicaid or another third party.)

Florida Blue is a PPO Plan with a Medicare contract. .

Florida Blue
In the pursuit of health®

2014 BlueMedicare Group Rx*

Benefits	BlueMedicare Group Rx* Option 1
Deductible	$0
Retail	**31-day Supply**
Tier 1 - Preferred Generics	$10
Tier 2 - Non-Preferred Generics	$10
Tier 3 - Preferred Brand	$40
Tier 4 - Non-Preferred Brand	$70
Tier 5 - Specialty Drugs	25%
Mail Order	**30-day Supply with PRIME Mail Order**
Tier 1 - Preferred Generics	$0
Tier 2 - Non-Preferred Generics	$0
Tier 3 - Preferred Brand	$80
Tier 4 - Non-Preferred Brand	$140
Tier 5 - Specialty Drugs	25%
Formulary Type	Added coverage for selected CMS excluded drugs. Generic & multi-source brand prescription drugs will be covered for the following categories: • Cough • Cold
Gap	**31-day Supply**
Tier 1 - Preferred Generics	$10
Tier 2 - Non-Preferred Generics	$10
Tier 3 - Preferred Brand	$40
Tier 4 - Non-Preferred Brand	$70
Tier 5 - Specialty Drugs	25%
Catastrophic	Greater of $2.55 or 5% / Greater of $6.35 or 5%

* Florida Blue is an Rx (PDP) Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

* Prescription drug copays do not accumulate towards the health plan calendar year out-of-pocket maximum.

* Part D Creditable Coverage – The enrolling member may incur late enrollment penalties as defined and set by CMS in accordance with Part D guidelines if prior creditable coverage cannot be proven.

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

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

Healthy Eating

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

Lasik Plus - 15% discount on laser vision correction surgery.
Call 1-866-713-2044

Qualsight Lasik - Contracts with providers of laser vision correction services.
Call 1-877-358-9327

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.

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.

PHARMACY BENEFIT

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.

- Generics 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 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 higher cost. Because there's usually a generic or preferred brand drug available instead.

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.

30 Day Supply

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

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

The Retail 90 Program

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 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.

The Mail Service Pharmacy

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.

The Mail Service Pharmacy

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.

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.

DENTAL BENEFITS

DELTA DENTAL INSURANCE COMPANY

- Delta Dental High PPO
- Delta Dental Low PPO
- 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.

We do encourage you 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.

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.

District School Board of Pasco County — EFFECTIVE DATE: 1/01/2014

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/MPA	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	

VISION BENEFIT

DAVIS VISION COVERAGE

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!

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

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

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

EMPLOYEE **ASSISTANCE PROGRAM**

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) 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 environment for all retirees. And to provide the proper support and services for retirees 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 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.

Services are voluntary

EAP services are voluntary. You cannot be required to use the EAP program.

Go to the EAP first

If you are experiencing personal issues that affect your 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 to the services in our Mental and Behavioral Health Program.

Central PASCO - 813.794.2366
East PASCO - 352.524.2366
West PASCO - 727.774.2366

BEHAVIORAL HEALTH BENEFITS

Behavioral Health Benefit Options at a Glance	
	▪ Immediate access to behavioral health and convenience service benefits ▪ Contact to access premier benefit coverage options
Outpatient Mental Health	▪ $35 co-pay when approved (In-Network) ▪ 40% coinsurance without approval after deductible met (Out-of-Network) ▪ Member can be balance billed if member chooses to see a non-participating provider Pays a maximum of $35 per visit to the non-participating provider.
Outpatient Substance Abuse	▪ $35 co-pay when approved (In-Network) ▪ 40% coinsurance without approval after deductible met (Out-of-Network) ▪ Member can be balance billed if member chooses to see a non-participating provider Pays a maximum of $35 per visit to the non-participating provider.
Intensive Outpatient	▪ $35 co-pay when approved (In-Network) ▪ 40% coinsurance without approval after deductible met (Out-of-Network) ▪ Member can be balance billed if member chooses to see a non-participating provider 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 mental health and substance abuse plan.

CareHere!®

PASCO COUNTY SCHOOL BOARD IS PROUD TO ANNOUNCE...

NOTE:
You may only register tp use the Health Centers if you are enrolled in one of the Board's Medical Plans.

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).* Wellness Access Code is: PCFSD7

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.

TERM LIFE INSURANCE

MINNESOTA LIFE

As a retiree, you are able to keep your current coverage from Cigna/LINA and Minnesota Life. On the two following pages are rates if you choose to continue or decrease your coverage.

Reminder: If you elect to cancel, you cannot reinstate coverage at a future date.

Basic Core Life Insurance – Minnesota Life Insurance Company

After enrollment, the amount of life insurance selected by an eligible retiree cannot be increased, but can be reduced to a lower coverage tier within your age group at any time. Coverage amounts and premiums will reduce at age 65 to 50% of the "Under age 65" amounts and further reduce at age 70 to 70% of the "Age 65 through 69" amounts.

	Under Age 65		Age 65 through 69		Age 70 and Over	
	Coverage	FRS Deduction	Coverage	FRS Deduction	Coverage	FRS Deduction
Tier 1	$10,000	2.00	$ 5,000	1.00	$ 3,500	0.70
Tier 2	$20,000	9.50	$10,000	4.75	$ 7,000	3.33
Tier 3	$35,000	31.85	$17,500	15.93	$12,250	11.15

BENEFICIARY DESIGNATION

Beneficiary information must be provided to Minnesota Life. Minnesota Life provides a secured website, www.lifebenefits.com, for electing, storing, and updating life insurance beneficiary designations. You may view or update your designations at any time on the life benefits website using your user id and password. Paper forms are available upon request. For additional information, contact Minnesota Life at 1-866-293-6047.

CIGNA/LINA LIFE INSURANCE

Life Insurance is one of the best ways to provide for those who depend on you because your beneficiary receives a tax-free life insurance payment from this plan. You can continue, change or cancel, but not increase, your Term Group Life Insurance.

Accelerated Death Benefit

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

Extended Death Benefit

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

Coverage Level at Ages 65 and 70

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

Plan Provider

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

CIGNA

MINNESOTA LIFE

Chart 1
Your monthly rates

Coverage	Retiree before 1/1/03
$ 1,000	$ .32
$ 3,000	$ .96
$ 4,000	$1.28
$ 6,000	$1.92
$ 8,000	$2.56
$ 9,000	$2.88
$10,000	$3.20
$11,000	$3.52
$13,000	$4.16
$14,000	$4.48
$15,000	$4.80
$16,000	$5.12
$18,000	$5.76
$19,000	$6.08
$20,000	$6.40
$23,000	$7.36
$24,000	$7.68
$25,000	$8.00
$26,000	$8.32
$28,000	$8.96
$30,000	$9.60
$34,000	$10.88
$38,000	$12.16

Chart 2
Your monthly rates

Coverage	Retiree after 1/1/03
$5,000	$1.60
$10,000	$3.20
$15,000	$4.80

IDENTITY THEFT PROTECTION

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.

ULTIMATEADVISOR® A COMPREHENSIVE LEGAL PLAN

The 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

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.

LEGAL BENEFITS

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.

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)

Consumer Protection Issues

Criminal Matters

Debt-Related 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

Landlord/Tenant Matters

Preventative Legal Services

Real Estate Matters

Small Claims Court

Tax Issues

Traffic Matters

Wills and Estate Planning

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.

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)

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: 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.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Patty Nguyen, On-site Florida Blue Repesentative at (813) 794-2492, (727) 774-2492 or (352) 524-2492.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name District School Board of Pasco County		4. Employer Identification Number (EIN) 59-6000792
5. Employer address 7227 Land O' Lakes Blvd		6. Employer phone number (813) 794-2253
7. City Land O' Lakes	8. State FL	9. ZIP code 34638
10. Who can we contact about employee health coverage at this job? Office for Human Resources and Educator Quality, Employee Benefits Section		
11. Phone number (if different from above) (813) 794-2253	12. Email address cganci@pasco.k12.fl.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees.
  - ☑ Some employees. Eligible employees are:

    As describe in Instructional (Article X, Section B) and School Related Personnel (Article XI, Section B) Master Contracts. Copies of the master contracts are available online at http://www.pasco.k12.fl.us/er/contracts.

- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    As described on page 2 of the benefits enrollment guide. A copy of the benefits enrollment guide is available online at www.pasco.k12.fl.us/benefits.

  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

**Employees may request an employee specific notice by contacting the Employee Benefits Section at (813) 794-2253.

Contract Administrator

CBIZ National Benefit Alliance
175 South West Temple, Suite 650
Salt Lake City, UT 84101