Pasco County Schools

Your 2021 Retiree Benefit Reference Guide

Kurt S. Browning, Superintendent

What's inside

Plan Provider Contact Information

Medical		
Florida Blue	(800) 507-9820	www.floridablue.com
Pharmacy		
Florida Blue	(800) 507-9820	www.floridablue.com
Elect Rx	(844) 353-2879	www.electrx.com
Behavioral Health (BEH)*		
New Directions Behavioral Health Information	(866) 287-9569	www.ndbh.com
Employee Assistance Program	(800) 624-5544	www.ndbh.com
Employee Health & Wellness		
MyHealth Onsite	(888) 644-1448	www.myhealthonsite.com
Voluntary Benefits		
Allstate	(800) 822-8045	www.allstatebenefits.com/mybenefits/
ARAG Legal	(800) 247-4184	www.araglegalcenter.com
Minnesota Life	(866) 293-6047	https://web1.lifebenefits.com/sites/lbwem/home
Unum Disability	(800) 635-5597	www.lifebalance.net
Dental Benefits		
Delta Dental- DHMO	(800) 422- 4234	www.deltadentalins.com
Delta Dental- PPO	(800) 521- 2651	www.deltadentalins.com
Vision Benefits		
Davis Vision	(800) 999- 5431	www.davisvision.com
Flexible Spending Accounts		
Health Equity (formerly WageWorks)	(877) 924-3967	www.wageworks.com
FRS		
Florida Retirement System	Pension (844) 377-1888 Investment (866) 446-9377	www.myfrs.com
Employee Benefits, Assistance & Risk Management, HREQ		
Benefits Administration	mybenefits@pasco.k12.fl.us	(813) 794- 2253
Leave Administration	my leaves@pasco.k12.fl.us	(813) 794- 2981
Retirement Services - DSBPC	retirementsvcs@pasco.k12.fl.us	(813) 794- 2394
Risk Management	riskmanagement@pasco.k12.fl.us	(813) 794- 2520
Wellness Programs & Incentives	wellness@pasco.k12.fl.us	(813) 794-2276

* Retirees without Behavioral Health Coverage should call 911 or the Crisis Stabilization Unit at (727) 849-9988
Additional plan provider information is available online at http://www.pasco.k12.fl.us/ebarm/planproviders

What's New with Retiree Benefits

New Wellness Center!

The District opened a new Wellness Center. The Center is located on the Long Leaf Elementary campus. The address is 3381 Town Avenue, New Port Richey.

Medical Buy-up increases

For the 2021 plan year the medical buy-ups will be increasing. The new rate charts are included in this guide.

Retiree Enrollment Appointments

This year open enrollment meetings for retirees, who need assistance with open enrollment will be scheduled utilizing Microsoft Bookings at http://www.pasco.k12.fl.us/ebarm/page/retirement/ (Click the "Book Now" button).

Minnesota Life Insurance Premium Increase

Effective January 1, 2021, premiums for Minnesota Life insurance will increase by 25%. During open enrollment you have the option to continue your current coverage at the new rate, decrease coverage to a lower tier, or cancel coverage. If you elect to cancel coverage, you cannot re-enroll at a future date. Refer to rate chart on the last page of this guide for 2021 premiums.

Dependent Verification

All retirees who elect to enroll their dependents in the District group health plan (medical, dental, vision) must provide documentation of dependent eligibility. The documentation may include a birth certificate, marriage certificate, or other legal documentation and must be submitted by the end of Open Enrollment. Dependent verification documents may be sent to Jessica Jardine's attention via:

1. Emailed to retirementsvcs@pasco.k12.fl.us or
2. Faxed to (813)794-2173 or
3. Mailed to:
   Pasco County Schools
   Attention: EBARM - DV
   7227 Land O' Lakes Blvd
   Land O' Lakes, FL 34638 or
4. Hand delivered to the District Office Complex

If Employee Benefits does not receive the dependent verification documentation your dependent coverage will end December 31, 2020.

Frequently Asked Questions

I never received or I have lost my card. How do I get a new one?

- If you create an account on the carrier's website (FL Blue, Delta, Davis) you are able to request a new card and print out a copy of your card.

I can't sign-in to my Employee Self-Serve.

- If you have forgotten your Munis ID or password you will need to send a help ticket to munishelp@pasco.k12.fl.us to receive that information.

What is an NPI?

- An NPI is a National Provider Number that is associate with your primary care doctor. Each member or dependent needs to have a primary care doctor or Florida Blue will auto assign you one.
- Carehere doctors are NOT primary care providers.

How do I find my NPI?

Visit
https://providersearch.floridablue.com/providersearch/pub/index.htm

- To choose a provider for an HMO Plan go to this link https://providersearch.floridablue.com/providersearch/pub/index.htm and choose Blue Care (HMO) and fill in your personal criteria.
- Call your Primary Care office and ask the office staff.
- Google your Primary Care doctor with NPI.

Will I be receiving a new card every year?

No, you will only receive a new card if you are changing plans. For example, switching from the HMO to the PPO plan.

How do I access My Health Onsite for the first time?

Retirees who are covered by the District and have a unique valid email address will receive an email invitation from "no-reply@eclinicalmail.com" with instructions the week their benefits become effective.

To access your New Patient Portal, simply follow the instructions in the email sent which includes your User Name and Temporary Password. If you have not received the email invitation, please call 1-888-644-1448 to update your email address.

How do I contact My Health Onsite?

888-644-1448; www.MyHealthOnSite.com

When do the incentive payments post for Pascofit participants?

Pascofit incentive rewards post quarterly, based on the date the VHP follow-up is completed. Please visit www.PascoGoHealthy.net and click on "Health and Wellness Incentive Program" in the top menu bar for the full payment schedule.

(https://connectplus.pasco.k12.fl.us/do/gohealthy/index.php/incentive-fit-options/#incentivepayments)

When you have other health coverage

Who pays first?
Coordination of benefits with Medicare

If you have Medicare and other health coverage, each type of coverage is called a "payer." When there's more than one payer, "coordination of benefits" rules decide who pays first. The "primary payer" pays what it owes on your bills first, and then you or your health care provider sends the rest to the "secondary payer" to pay. In some rare cases, there may also be a "third payer."

Whether Pasco pays first depends on a number of things, including the situations listed in the chart on the next page. However, this chart doesn't cover every situation. Be sure to tell your doctor and other providers if you have health coverage in addition to Pasco or Medicare. This will help them send your bills to the correct payer to avoid delays.

Where to go with questions

If you have questions about who pays first, or if your coverage changes, please contact Patty Nguyen, the Florida Blue On-Site Representative at (813)794-2492, (727)774-2492, or (352)524-2492.

How Medicare works with other coverage

Use the chart below to find your type(s) of coverage and situation to see which payer pays first. You can also get this information by visiting Medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance/which-insurance-pays-first.

If you	Situation	Pays First	Pays Second
Are 65 or older, are covered by a group health plan because you or your spouse is still working, and entitled to Medicare	The employer has 20 or more employees	Group health plan	Medicare
Have an employer group health plan through your former employer after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work, or from a family member (like spouse, parent, domestic partner, son, daughter, or grandchild) who is working, and entitled to Medicare	The employer has 110 or more employees	Large Group health plan	Medicare
	The employer has less than 100 employees	Medicare	Group health plan
*Have End-Stage Renal Disease (ESRD) (permanent kidney failure requiring dialysis or a kidney transplant) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group health plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group health plan
Have ESRD and COBRA coverage	First 30 months of eligibility or entitlement to Medicare based on having ESRD	COBRA	Medicare
	After 30 months	Medicare	COBRA
Age 65 or over OR under 65 and disabled and covered by 1) COBRA coverage or 2) retiree group health plan coverage (other than by ESRD)	Entitled to Medicare	Medicare	COBRA or retiree group health plan coverage (whichever one you have)
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation for services or items related to workers' compensation claim	Usually doesn't apply. However, Medicare may make a conditional payment (a payment that must be repaid to Medicare when a settlement, judgement, award, or other payment is made)

** If you originally got Medicare due to your age or a disability other than ESRD, and Medicare was your primary payer, it still pays first when you become eligible because of ESRD.*

Open Enrollment

October 1, 2020 - October 31, 2020

Benefit Effective Dates

January 1, 2021 - December 31, 2021

Retiree Benefits Enrollment Appointments

This year open enrollment meetings for retirees, who need assistance with open enrollment will be scheduled utilizing Microsoft Bookings at : http://www.pasco.k12.fl.us/ebarm/page/retirement/ (Click the "Book Now" button to schedule an appointment).

District Office Complex
7227 Land O' Lakes Blvd
Land O' Lakes, FL 34638

This year will be a passive enrollment. What does that mean to you? If you want to continue your 2020 benefits into 2021 there is no need to take any action during Open Enrollment.

Benefit Enrollment Process

All employees that wish to make any changes to their current benefits must enroll using Munis Employee Self Service.

The following steps are required to enroll:

1. Go to Pasco County Schools homepage
2. Next select “Employee Self Service”
3. Enter your Munis “User Name” and “Password”
4. Click on “Employee Self Service”
5. Click on “Benefits”
6. Click on “Open Enrollment”
7. Elect, change, or decline for each benefit
8. **Submit** 2021 election choices
9. Print Confirmation Statement

*If you cannot remember your Munis log-in ID and password, you must send an email to munishelp@pasco.k12.fl.us requesting this information prior to enrolling.

Dependent Eligibility

Federal Law: The Affordable Care Act makes coverage available to adult children up to age 26. No dependent eligibility requirements can be applied from newborn to age 26.

State of Florida Law (Florida Statute 627.6562):
Requires that extended coverage for adult children over age 26 be offered through the end of the calendar year in which they reach age 30. Extended coverage applies to medical and vision only.

A covered dependent child may continue coverage beyond the age of 26, provided he or she is:

- Unmarried and does not have a dependent;
- A Florida resident or a full-time or part-time student;
- Not enrolled in any other health coverage policy or plan;
- Not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.

Eligible Dependents Include

Your Spouse - The person to whom you are legally married.

Your Child - Through the end of the calendar year in which he/she turns age 26, your biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.

Your Child with a Disability - Your covered child who is permanently mentally or physically disabled. This child may continue health insurance coverage after reaching age 26 if you provide adequate documentation validating disability upon request and the child remains continuously covered in a State Group Insurance health plan. The child must be unmarried, dependent on you for care and for financial support, and can have no dependents of his/her own.

Your Step-Child - Through the end of the calendar year in which he/she turns age 26, the child of your spouse for as long as you remain legally married to the child's parent.

Your Foster Child - Through the end of the calendar year in which he/she turns age 26, a child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible to their age of maturity.

Legal Guardianship - Through the end of the calendar year in which he/she turns age 26, a child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible until his or her age of maturity.

Your Grandchild - A newborn dependent of your covered child. Coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered.

Your over-age Dependent - Your child after the end of the calendar year in which they turned age 26 through the end of the calendar year in which they reach 30 if they are unmarried, have no dependents of their own, are dependent on you for financial support, live in Florida or attend school in another state, and have no other health insurance.

Notifying Employee Benefits of Change in Dependent Status

Retirees who cover their spouse or dependent children under the Board's group health plan are required to notify Employee Benefits within 30 days, of their change in marital status or change in dependent status of a covered dependent. Failure to notify Employee Benefits may result in the retiree receiving a benefit under the group health plan that he/she is not entitled to receive. Should this occur you will be required to repay the Board any premiums due or benefits received that you were not entitled to receive.

Tax Implications for over age dependents

Employees are allowed to cover dependent(s) over age 26-30 under the District's group health plan; however, the Internal Revenue Service requires the District to include the value of the coverage provided for your dependents over age 26 in your adjusted gross income before issuing your W-2 form.

The value of premiums for adult children over age 26 will be deducted post-tax on a per payroll basis. If you cover dependent(s) in both age groups as stated above, you will see two separate payroll deductions on your paycheck reflecting the pre-tax and post-tax value of dependent premiums.

Tax Status of Dependent Premiums		
Dependent Age	Birth - Age 26*	Over Age 26- 30
Taxable Status	Pre-tax	Post-tax

**Through the end of the year in which they turn 26. Post tax benefits will begin January 1st of the next calendar year.*

Dependent Verification

All retirees who elect to enroll their dependents in the District group health plan (medical, dental, vision) must provide documentation of dependent eligibility. The documentation may include a birth certificate, marriage certificate, or other legal documentation and must be submitted by the end of Open Enrollment. If Retirement Services does not receive the dependent verification documentation your dependent coverage will end December 31, 2020.

Documentation Requirements	
Dependent Type:	**Required Documentation:**
Spouse	Copy of the government issued marriage certificate or • Most recent tax return transcript for IRS
Children up to age 26	• Copy of the child's government issued birth certificate or adoption certificate naming the employee or spouse as the child's parent. • Copy of the court order naming employee or spouse as legal guardian. • Copy of the records showing the employee or spouse as the dependent's foster parent.
Child or covered dependent	Copy of the newborn's birth certificate naming the covered dependent as the parent
Unmarried child age 26 up to age 30	The same documentation for children under age 26 and • Copy of the affidavit of adult child and • Documentation of student status or • Bill or statement in the child's name dated within the past 60 days showing Florida residency.
Disabled children age 26 or older	The same documentation for children under age 26 and • Most recent tax return transcript for IRS

Submitting Dependent Verification Documentation

The documentation may include a birth certificate, marriage certificate, or other legal documentation and must be submitted by the end of Open Enrollment. Dependent verification documents may be sent to Jessica Jardine's attention via:

1. Emailed to retirementsvcs@pasco.k12.fl.us or
2. Faxed to (813)794-2173 or
3. Mailed to:
   Pasco County Schools
   Attention: EBARM - DV
   7227 Land O' Lakes Blvd
   Land O' Lakes, FL 34638 or
4. Hand delivered to the District Office Complex

Working Spouse Exclusion

Working Spouse Exclusion

If your spouse is employed and has access to medical coverage through his/her employer, they are not eligible for coverage under Pasco County Schools' group medical plan.

If your spouse does not work, works only part-time, is not eligible for coverage or has lost coverage as an active employee but has been offered cobra, the spousal exclusion does not apply. If your spouse is covered by Medicare, the exclusion does not apply.

If your spouse experiences a qualifying life event (loss of job or loss of coverage, etc.) during the year, he or she can be added to your medical plan within 30 days of the qualifying event. For additional information, call Employee Benefits at extension 4-2376 or (813) 794-2376; (727) 774-2376; or (352) 524-2376.

If you designate your spouse as a dependent to be enrolled in Pasco County Schools' group medical plan, a waiver form will be sent to you requesting verification of their ineligibility for coverage under their employer's medical plan. If you do not complete and return the waiver form, your inaction will deem your spouse ineligible for coverage. If deemed ineligible for coverage, your spouse will be removed from Pasco County Schools' group medical plan.

The "Working Spouse Waiver" does not affect your option to enroll your spouse in voluntary benefits such as dental, vision or other applicable voluntary benefits.

Policy Exemption:

- If you and your spouse are both employed by Pasco County Schools, you are not subject to this policy.
- If you are enrolling in family coverage (employee plus spouse and children), you are not subject to this policy.

Pasco County Schools reserves the right to verify the validity of information provided.

Spousal Waiver

District School Board of Pasco County

WORKING SPOUSE WAIVER FORM

Date: _____ Employee ID: _____

Employee: _____ Spouse Name: _____

You MUST complete this form if you are enrolling your spouse in Pasco County Schools' medical plan.

If your spouse is eligible for medical coverage under another employer's plan, your spouse is NOT eligible for the waiver and cannot enroll in Pasco County Schools' group medical plan. If you do not complete and return the waiver form, your inaction will deem your spouse ineligible for coverage. If deemed ineligible for coverage, your spouse will be removed from Pasco County Schools' group medical plan.

The "Working Spouse Waiver" does not affect your option to enroll your spouse in voluntary benefits such as dental, vision or other applicable voluntary benefits.

Instructions to complete form:
Please complete and return this form to request a waiver of the "working spouse" medical coverage policy to the Employee Benefits Office.

Section I – Employee Certification

Is your spouse employed? ☐ Yes* ☐ No If no, please check the appropriate box:

☐ Self-Employed ☐ Not Employed ☐ Retired

**If you answered yes, your spouse must take this form to his or her employer for completion of Section II.*

Section II – Working Spouse Employer Certification *(Must be completed by Spouse Employer)*

Spouse Employer: _____

1. Does your company/organization offer medical insurance to the above-named spouse?

   ☐ Yes ☐ No ☐ Spouse not eligible

_____

Printed Name Title Telephone Number

_____

Employer Representative Signature Date

Additional Information for Consideration:

_____

Employee Acknowledgement and Signature

I certify that the information provided here is correct and if this information changes at any time, I will notify Employee Benefits within thirty (30) days. I also understand the information on this form is subject to verification.

_____

Employee Signature **Date**

Please return form to: Employee Benefits FAX: 813.794.2173 Email: retirementsvcs@pasco.k12.fl.us

Medical Insurance
Provider: Florida Blue

What plans are available?
Pasco County Schools offers three medical plans for you to choose from:
- HMO Basic • HMO Premium • PPO Standard

Glossary of Terms
What is Coinsurance? Coinsurance is the cost sharing between you and the plan that will occur after the deductible has been met. For 2020, the in-network medical coinsurance amounts are 20% your responsibility and 80% plan responsibility.

What is an out-of-pocket maximum? The out-of-pocket maximum is the most that you will have to pay in a year for deductible and coinsurance for covered medical and pharmacy benefits. It operates like a safety net, to protect you from high costs.

What are reasonable and customary amounts? Reasonable and customary (R&C) amounts are the fees the insurance carrier considers appropriate for a medical expense based on the typical rates charged by other providers for a comparable service within the provider's zip code. If you go to an **out-of-network** provider who charges more than the allowable amounts established by the insurance carrier, the provider may bill you for the remaining balance.

At Pasco County Schools, we are fortunate to have an onsite Florida Blue representative available to assist you with any claims or coverage issues that you may experience. If you have questions, please contact Patty Nguyen, the Florida Blue On-site Representative at (813)794-2492, (727)774-2492, or (352)524-2492.

Understanding HMO Plans

HMO plan participation requires the members to obtain services within an authorized network of providers. If you enroll in one of the HMO plans, you will need to choose a Primary Care Physician (PCP) in the BlueCare HMO Network. Your PCP will help you manage all aspects of your health care.

Even though you will be required to select a PCP when you enroll, you do not need a referral from your (PCP) to consult with a specialist. However, you must verify that the specialist is a participating provider in the BlueCare HMO Network. This information should be confirmed when you schedule an appointment. You may locate a provider in your network by visiting www.floridablue.com and on the link, "Find a Doctor." Then select "BlueCare (HMO)" as your plan.

Like all HMOs, there is no coverage for services received from "out-of-network" or non-participating providers, except for qualified emergencies. Similarly, you do not have coverage out of state or out of the service area unless it is an emergency. For non-emergency and routine services to be covered, your PCP would need to request approval from Florida Blue prior to the services being rendered.

If you are comfortable with the requirements for HMO participation, then how will you choose between enrollment in the HMO Basic or HMO Premium plan?

Annual Out-of-Pocket Maximum			
Basic HMO		Premium HMO	
Individual	Family	Individual	Family
$5,500	$11,000	$3,000	$9,000

What are the Differences Between the HMO Basic and HMO Premium Plan?

The Basic HMO plan premiums are lower, but has higher out-of pocket costs associated with deductibles, coinsurance and copays.

The Premium HMO Plan requires you to contribute additional "buy-up" costs of $75.00 per month but in most cases, has lower out-of pocket-costs at the time of service. When evaluating your participation in an HMO plan, consider the following circumstances:

- Is your current physician in the BlueCare HMO network?
- Do you have a chronic condition where you need to see a doctor every month or have gone to the emergency room?
- Do you require services at an outpatient hospital on a frequent basis? For example, infusion treatment.
- Do you require provider administered medications, i.e., cortisone shots, chemotherapy in a physician's office?

The HMO Basic plan is free for retiree only to retirees with Board-paid medical coverage. However, while you do not have a monthly buy-up cost for your plan participation, in most cases you will pay more at the time of service. The HMO basic plan has a large out-of-pocket annual maximum of $5,500 per individual and $11,000 per family aggregate.

HMO Basic

Coverage Selected	Monthly	
Retiree Only	$ 592.76	
Retiree Plus Child(ren)	$ 962.14	
Retiree Plus Spouse	$ 1,153.66	
Retiree Plus Spouse and Child(ren)	$ 1,523.67	
Married Retirees/ Employees of Board Plus Child(ren)	$ 906.35	

HMO Premium

Coverage Selected	Monthly	
Retiree Only	$ 672.26	
Retiree Plus Child(ren)	$ 1,211.12	
Retiree Plus Spouse	$ 1,474.94	
Retiree Plus Spouse and Child(ren)	$2,010.57	
Married Retirees/ Employees of Board Plus Child(ren)	$ 1,147.91	

The HMO Basic plan has a deductible you have to meet before Florida Blue will pay any part of the claim. A $2,000 Individual Deductible would apply for major services such as: inpatient or outpatient hospital services, doctors' fees associated with a hospital visit or admission, ambulance, surgical and non-surgical services. It is important to note that lab work, diagnostic imaging tests performed in a hospital will be subject to a deductible. You will receive one bill for the facility charges (hospital equipment/supplies) and one or more bills from the physicians, i.e., Surgeon, Radiologist, Anesthesiologist, Pathologist, etc.

With the Premium HMO plan, you know what to expect to pay upfront. This plan does not have deductibles just co-payments by service/procedure. Refer to the benefit summary to see the copays associated with that service. There is also a lower out-of-pocket individual maximum of $3,000 and 9,000 per family associated with this benefit. If your doctors accept the BlueCare HMO plan and you regularly have a need to see a provider, you should consider enrollment in this plan.

BlueCare HMO Basic

BlueCare
HMO Basic Plan

Florida Blue HMO

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue HMO pays)	$2,000 per person $6,000 per family	Not covered
In-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	$100	Not covered
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	Not covered
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Medical and Prescription Drugs Copayments)	$5,500 per person $11,000 per family	Not covered
Office Services		
Physician Office Services		
Primary Care Physician	$35 Copay	Not covered
Specialist	$65 Copay	Not covered
Convenient Care	$35 Copay	Not covered
e-Office Visit	$10 Copay	Not covered
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$35 Copay	Not covered
Specialist	$65 Copay	Not covered
Allergy Injections (per visit)		
Primary Care Physician	$10 Copay	Not covered
Specialist	$10 Copay	Not covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$300 Copay	Not covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum[3]		
Preferred	$200	
Non-Preferred	Combined with Preferred OOP Maximum	
Provider		
Preferred	20%	Not covered
Non-Preferred	20%	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 the *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	Not covered
Mammograms (Routine & Diagnostic)	$0	Not covered
Colonoscopy (Routine for age 50+; no age criteria for high risk)	$0	Not covered

[1] DED = Deductible
[2] PBP = Per Benefit Period
[3] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

BlueCare HMO Basic

BlueCare
HMO Basic Plan

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Emergency Medical Care		
Urgent Care Centers	$50 Copay	Not covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$300 Copay	$300 Copay
Ambulance Services	20% after Deductible	20% after In-Network Deductible
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	 $50 Copay $300 Copay	 Not covered Not covered
Independent Clinical Lab (e.g., Blood Work) Quest Diagnostics is preferred lab	$0	Not covered
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	20% after Deductible	Not covered
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$250 Copay	Not covered
Outpatient Hospital Facility Services (per visit) Therapy Services All other Services	 $65 Copay 20% after Deductible	 Not covered Not covered
Inpatient Hospital Facility and Rehabilitation Services (per admit)	$100 PAD, then 20% after Deductible	Not covered
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)	$100 PAD, then 20% after Deductible	Not covered
Outpatient Hospitalization Facility Service (per visit)	20% after Deductible	Not covered
Emergency Room Facility Services (per visit)	$300 Copay	$300 Copay
Provider Services at Hospital Primary Care Physician / Specialist	 $0	 Not covered
Provider Services at ER Primary Care Physician / Specialist	 $0	 $0
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	 $35 Copay	 Not covered
Outpatient Office Visit Primary Care Physician / Specialist	 $35 Copay	 Not covered
Other Provider Services		
Provider Services at Hospital	20% after Deductible	Not covered
Provider Services at ER	20% after Deductible	20% after In-Network Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	$65 Copay	Not covered
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	 $35 Copay $65 Copay	 Not covered Not covered
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	 $65 Copay $65 Copay	 Not covered Not covered

BlueCare HMO Basic

BlueCare
HMO Basic Plan

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services (continued)		
Durable Medical Equipment, Prosthetics and Orthotics Motorized Wheelchair All Other (Services coordinated by CareCentrix, call 1-877-561-9910.)	 $500 Copay $0	 Not covered Not covered
Home Health Care (Services coordinated by CareCentrix, call 1-877-561-9910.)	$0	Not covered
Skilled Nursing Facility	20% after Deductible	Not covered
Hospice	20% after Deductible	Not covered

Preauthorization for select services: Members don't need a referral to see a participating specialist, however authorizations are required for certain services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment. Ensure members know that **before an appointment** they should visit floridablue.com/Authorization or call the toll-free number on their member ID card to see if a prior authorization is required.

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

BlueCare Rx Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue HMO, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

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

This summary is only a partial description of the many benefits and services covered by Florida Blue HMO, an 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 Florida Blue HMO BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueCare HMO Premium

BlueCare
HMO Premium Plan

Florida Blue HMO

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Financial Features		
Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue HMO pays)	$0 per person $0 per family	Not covered
Coinsurance (Coinsurance is the percentage the member pays for services)	0% of the allowed amount	Not covered
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Medical & Prescription Drugs Copayments)	$3,000 per person $9,000 per family	Not covered
Office Services		
Physician Office Services		
Primary Care Physician (PCP)	$30 Copay	Not covered
Specialist	$50 Copay	Not covered
Convenient Care	$30 Copay	Not covered
e-Office Visit (PCP/Specialist)	$30/$50 Copay	Not covered
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$30 Copay	Not covered
Specialist	$50 Copay	Not covered
Allergy Injections (per visit)		
Primary Care Physician	$20 Copay	Not covered
Specialist	$20 Copay	Not covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$50 Copay	Not covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)		
In-Network Monthly Out-of-Pocket (OOP) Maximum[3]		
Preferred	$0	
Non-Preferred	$0	
Provider		
Preferred	0%	Not covered
Non-Preferred	0%	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 the *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	Not covered
Mammograms (Routine & Diagnostic)	$0	Not covered
Colonoscopy (Routine for age 50+; no age criteria for high risk)	$0	Not covered
Emergency Medical Care		
Urgent Care Centers	$50 Copay	Not covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$300 Copay	$300 Copay

[1] DED = Deductible
[2] PBP = Per Benefit Period
[3] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

BlueCare HMO Premium

BlueCare
HMO Premium Plan

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Emergency Medical Care (continued)		
Ambulance Services	$100 Copay	$100 Copay
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	 $0 Copay $50 Copay	 Not covered Not covered
Independent Clinical Lab (e.g., Blood Work) Quest Diagnostics is preferred lab	$0	Not covered
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	$500 Copay	Not covered
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$400 Copay	Not covered
Outpatient Hospital Facility Services (per visit) Therapy Services All other Services (Surgical or Non-Surgical services)	 $50 Copay $500 Copay	 Not covered Not covered
Inpatient Hospital Facility and Rehabilitation Services (per admit)	$500 Copay per day ($2,500 max)	Not covered
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit) ($2,500 max)	$500 Copay per day	Not covered
Outpatient Hospitalization Facility Service (per visit)	$35 Copay	Not covered
Emergency Room Facility Services (per visit)	$200 Copay	$200 Copay
Provider Services at Hospital Primary Care Physician / Specialist	 $0 Copay	 Not covered
Provider Services at ER Primary Care Physician / Specialist	 $0 Copay	 $0 Copay
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	 $35 Copay	 Not covered
Outpatient Office Visit Primary Care Physician / Specialist	 $35 Copay	 Not covered
Other Provider Services		
Provider Services at Hospital	$0	Not covered
Provider Services at ER	$0	$0
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	$0	Not covered
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	 $0 Copay $0 Copay	 Not covered Not covered
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	 $30 Copay $50 Copay	 Not covered Not covered
Durable Medical Equipment, Prosthetics and Orthotics Motorized Wheelchair All Other (Services coordinated by CareCentrix ,call 1-877-561-9910)	 $500 Copay $0 Copay	 Not covered Not covered
Home Health Care (Services coordinated by CareCentrix, call 1-877-561-9910)	$0	Not covered

BlueCare HMO Premium

BlueCare
HMO Premium Plan

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Other Special Services (continued)		
Skilled Nursing Facility	$0	Not covered
Hospice	$0	Not covered

Preauthorization for select services: Members don't need a referral to see a participating specialist, however authorizations are required for certain services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment. Ensure members know that **before an appointment** they should visit floridablue.com/Authorization or call the toll-free number on their member ID card to see if a prior authorization is required.

Benefit Maximums	
Home Health Care	Unlimited Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Additional Benefits and Features

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- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

BlueCare Rx Prescription Drug Program

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

This summary is only a partial description of the many benefits and services covered by Florida Blue HMO, an 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 Florida Blue HMO BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

Understanding the PPO Standard Plan

If your doctor does not participate in the BlueCare HMO network or you have family members who participate and live out-of-state, you might want to consider enrollment in the PPO standard plan.

A PPO is a group of providers (doctors, hospitals, and other medical facilities) who have agreed to provide services at discounted rates. A significant difference between an HMO and a PPO is that a PPO allows you to use providers who are not in the network.

When you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use an out-of-network provider, you are subject to a deductible and coinsurance, as well as any charges that are higher than what is considered reasonable and customary (R&C) by Florida Blue, and you could pay substantially more out-of-pocket.

Accessing out-of-network services may also subject you to plan limitations that might be avoided when you receive care from in-network providers.

Always remember to verify a provider's participation status prior to receiving health care services. Access www.floridablue.com and click on the "Find a Doctor" link. Select "BlueOptions" for your plan. Out of state providers, skip "Select a Plan". Scroll down to the bottom of the page and under "Other Provider Searches", click on "Doctors & Hospitals Nationally".

As a PPO participant, you must be proactive and check on the status of all providers that will be involved in your care/treatment. For example, if you are having surgery, verify with the surgeon if he or she will be using an assistant surgeon. If so, make sure he/she is participating in the BlueOptions network. Also, make sure the anesthesiologist, pathologist or radiologist is participating. This could save you significant out-of-pocket expenses. If any of these providers are out-of-network, then a $3,000 deductible and 40% coinsurance would apply. You would be responsible for the difference of what the provider bills and what Florida Blue allows, in addition to the out-of -network deductible and coinsurance. This is called out-of-network provider balance billing and it can be expensive.

An additional advantage of enrolling in a PPO plan is that you can receive treatment outside of the state of Florida, as long as the provider is a participant of the Independent Blue Cross and/or Blue Shield organization in that state. This is referred to as the "BlueCard PPO Program". Covered services will pay at the in-network benefit rate. For example, your Florida specialist recommends a specialist in New York. That specialist participates with Empire Blue Cross Blue Shield of New York. Just make your appointment with the New York specialist and pay your specialist copay of $50 per visit.

If you travel nationwide or have residence in another state, you have the peace of mind that you have coverage for "routine" as well as "emergency" visits.

PPO Standard

Coverage Selected	Monthly	
Retiree Only	$ 758.76	
Retiree Plus Child(ren)	$ 1,327.76	
Retiree Plus Spouse	$ 1,637.00	
Retiree Plus Spouse and Child(ren)	$ 2,221.79	
Married Retiree/ Employees of Board Plus Child(ren)	$1,257.27	

BlueOptions PPO Standard

BlueOptions
PPO Standard Plan

Florida Blue

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue pays)	$1,000 per person $3,000 per family	$3,000 per person $9,000 per family
Coinsurance (Coinsurance is the percentage the member pays for services)	20%	40% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Medical and Prescription Drugs Copayments)	$3,000 per person $9,000 per family	$6,000 per person $12,000 per family
Office Services		
Physician Office Services Primary Care Physician Specialist Convenient Care e-Office Visit	 $30 Copay $50 Copay $30 Copay $10 Copay	 40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	 $30 Copay $50 Copay	 40% after Deductible 40% after Deductible
Allergy Injections (per visit) Primary Care Physician Specialist	 $20 Copay $20 Copay	 40% after Deductible 40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$200 Copay	40% after Deductible
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum[3] Provider	 $0 0%	 40% after Deductible
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 the *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	40%
Mammograms (Routine and Diagnostic)	$0	$0
Colonoscopy (Routine for age 50+; no age criteria if high risk)	$0	$0
Emergency Medical Care		
Urgent Care Centers	$50 Copay	$50 Copay after Deductible
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$300 Copay	$300 Copay[4]
Ambulance Services	20% after Deductible	20% after Deductible

[1] DED = Deductible
[2] PBP = Per Benefit Period
[3] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.
[4] If admitted as an Inpatient from the Emergency Room member pays Out-of-Network DED and In-Network Emergency Room Copay.

Note: Out-of-Network services may be subject to balance billing.

BlueOptions PPO Standard

BlueOptions
PPO Standard Plan

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	 $50 Copay $200 Copay	 40% after Deductible 40% after Deductible
Independent Clinical Lab (e.g., Blood Work) Quest Diagnostics is preferred lab	$0	40% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	$300 Copay	40% after Deductible
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$200 Copay	40% after Deductible
Outpatient Hospital Facility Services (per visit) Therapy Services All other Services	 $50 Copay $300 Copay	 40% after Deductible 40% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit)	20% after Deductible	40% after Deductible[4]
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)	20% after Deductible	40%[4]
Outpatient Hospitalization Facility Service (per visit)	$35 Copay	40%
Emergency Room Facility Services (per visit)	$100 Copay	$100 Copay
Provider Services at Hospital and ER Primary Care Physician / Specialist	 $0	 $0
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	 $35 Copay	 40%
Outpatient Office Visit Primary Care Physician / Specialist	 $35 Copay	 40%
Other Provider Services		
Provider Services at Hospital and ER	$50 Copay	$50 Copay
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	$50 Copay	$50 Copay
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	 $30 Copay $50 Copay	 40% after Deductible 40% after Deductible
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	 $30 Copay $50 Copay	 40% after Deductible 40% after Deductible
Durable Medical Equipment, Prosthetics and Orthotics (Services coordinated By CareCentrix, call 1-877-561-9910)	20% after Deductible	40% after Deductible
Home Health Care (Services coordinated by CareCentrix, call 1-877-561-9910)	20% after Deductible	40% after Deductible

BlueOptions PPO Standard

BlueOptions
PPO Standard Plan

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services (continued)		
Skilled Nursing Facility	20% after Deductible	40% after Deductible
Hospice	20% after Deductible	40% after Deductible

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services **you need to get an approval** from Florida Blue before your service or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

BlueScript Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them. Important Note: Your health plan may include prescription drug coverage that only provides coverage at Exclusive Pharmacies except for emergency situations.

Access to Our Strong Networks

NetworkBlue℠ is the Preferred Provider Network designated as "In-Network" for BlueOptions. While In-Network providers remain the best value, members are still **protected from balance billing** if they go Out-of-Network to someone who is part of our Traditional Provider Network. You may also receive **out-of-state coverage through the BlueCard®** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

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

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

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 and more.

To take advantage of the Blue365 offerings, please follow these instructions:
1. Access the website: **www.blue365deals.com/bcbsfl**
2. On the Blue365 page, click on **Browse All Deals** or you may narrow your search by category, i.e. Fitness, Nutrition, Hearing and Vision, etc.
3. To redeem any offers, you will need to register by clicking on "Join."

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

Nutrition

InsideTracker:
Save 25% on a Science-based, Personalized Nutrition and Lifestyle Plan - $36.75 or $89.25 (regularly $49 or $119)

Profile by Sanford:
Save $100 on a Nutrition, Activity and Lifestyle Coaching Plan

Sun Basket:
$40 off first two weeks of Meal delivery ($20 each week) plus 5% off future orders

Fitness

Fitness Your Way By Tivity Health, Inc.™:
$29 monthly fee for access to network of 10,000+ gyms nationwide. Enrollment fee of $29.

Rugged Maniac:
20% off Obstacle Race Registration

4id:
Save 55% Off Plus Free Shipping on 4id's LED Lights for Safety and Fun

Vision

LASIK PLUS:
Receive $800 or more off LASIK at LASIKPlus centers nationwide.

EyeMed:
$50 Eye exams and 35% off frames when paired with prescription lenses at any one of Eyemed®'s 45,000 participating providers nationwide

ContactsDirect® :
Discounts on annual supply of Contact Lenses plus free express air shipping (a $19.99 value)

Hearing

HearUSA:
Free Hearing screenings and savings between 30% and 73% off on Hearing Aids, plus unlimited service office visits for one year

Beltone:
Free Hearing screening and Hearing aids starting at $995

TruHearing:
Save 30% to 60% on Hearing aids

Away From Home Care (AFHC) Program

Away From Home Care (AFHC) is a valued-added, voluntary program providing managed care coverage to group HMO members temporarily residing within another BlueCross BlueShield Plan's HMO operational area. Members eligible and enrolled in this program have access to routine and emergency care while out of the service area or outside the state of Florida.

To qualify for AFHC, the member must be in the Host service area for more than 90 consecutive days. The subscriber or policy holder should start the AFHC process as early as possible. The process consists of contacting the Customer Service telephone number on the identification card and requesting AFHC. The AFHC Coordinator will review the request to determine if coverage is available using the member's out-of-area address (P.O. Boxes are not acceptable). If coverage is available, an application will be created and sent to the subscriber. The subscriber must sign and return the application before Florida Blue can send any information to the other BlueCross BlueShield Plan. In addition to the application, a release of personal information form must also be completed and returned.

Those members for whom subscribers should consider AFHC are:

- Students (away at school in another state)
- Families apart (dependents in other states)
- Long term travel to another state

Florida Counties included in the service area for the AFHC Program: Calhoun, Gadsden, Jefferson, Liberty, Leon and Wakulla. (Note: Students attending school in Tallahassee (Leon County), i.e., FSU, Tallahassee Community College or FAMU.)
The AFHC Program may not be available in all states or counties within the states.
The AFHC coordinator will verify participation.

Pharmacy Benefit
Provider: Prime Therapeutics, Florida Blue's Pharmacy Benefit Manager

Pharmacy Choices:

Your choice of pharmacies will depend on which pharmacies are in your health plan's network, what kind of medication you need and the quantity. Your pharmacy options may include:

1. **Retail Pharmacy for up to a 30-day supply**
   Fill prescriptions for non-specialty generic and Brand Name drugs at your local participating retail pharmacy, including national chains, such as Walgreen's, Publix Pharmacy or Walmart.

2. **Retail Extended Pharmacy for up to a 90-day supply**
   For long-term medications, certain retail pharmacies are designated as an "extended" pharmacy and can provide up to a 90-day supply of medication. Other retail pharmacies may only dispense 30 days of medication.

3. **Mail-order for up to a 90-day supply**
   Ordering your drugs through AllianceRx Walgreens Prime Home Delivery is a smart way to save time and money. You pay less for ordering a 90-day supply by mail, rather than going to a retail pharmacy, one month at a time.

4. **Specialty Pharmacies**
   Fill Specialty medications through AllianceRx Walgreens Prime Specialty Pharmacy (1-877-627-6337) or CareMark Specialty Pharmacy (1-866-278-5108).

The Drug Categories are:

- **Generics:**
  These contain the same active ingredients as their brand name equivalents, and offer the same effectiveness and safety. They have the lowest copay.

- **Preferred Brands:**
  These are brand name drugs that are preferred by the plan and have a higher co-pay than their generic counterparts.

- **Non-Preferred Brands:**
  These are higher cost because there is usually a generic or a preferred brand drug available instead.

- **Specialty Drugs:**
  These are prescription medications that require special handling, administration or monitoring. These medications are used to treat chronic diseases or genetic disorders such as Multiple Sclerosis, Rheumatoid Arthritis, Hepatitis C, and Hemophilia.

Prior Authorization Programs (Responsible Steps and Responsible Quantity):

- **Encourages the appropriate, safe and cost-effective use of medication.**
  If you are currently taking or are prescribed a medication that is included in the Prior Authorization Program, your physician will need to submit a request form in order for your prescription to be considered for coverage. If you do not request and/or receive prior approval, the medication will not be covered. A current listing of drugs requiring prior authorization are indicated in the prior authorization column following the product name in the Medication Guide which can be found online at www.floridablue.com.

Pharmacy Benefit

Member Prescription Cost Share (Same Copay Structure)

UP TO 30 DAY SUPPLY AT RETAIL	
Category	**You Pay**
Generic	$10.00
Preferred Brand	$35.00
Non-Preferred Brand	$60.00

UP TO 90 DAY EXTENDED RETAIL	
Category	**You Pay**
Generic	$25.00
Preferred Brand	$87.50
Non-Preferred Brand	$150.00

UP TO 90 DAY SUPPLY MAIL ORDER	
Category	**You Pay**
Generic	$20.00
Preferred Brand	$70.00
Non-Preferred Brand	$120.00

Member Prescription Cost Share for Specialty Drugs *(up to 30 day supply)*

Specialty Generic	Specialty Preferred	Specialty Non-Preferred
$25	$50	$100

Elect Rx
Personal Importation Program

Pasco County Schools is offering a great option for you to save money on certain brand name prescription drugs through Elect Rx Personal Importation Program. This program is known as Personal Importation or PI. You can order your brand name drugs from Canada, New Zealand, Australia, and England using the same brick and mortar pharmacies that people in these countries use for their medications. Plan members will have a $0 co-pay (Free!) on these medications for their first fill. All subsequent refills through this program will only have a $10 co-pay. Here's how you can begin using the program.

1. Members can enroll by calling 1-844-ElectRx or 1-844-353-2879. A Customer Service Representative will complete the enrollment process and order for you. You will be asked several questions related to your medical condition including any known allergies and a list of the prescription drugs you are currently taking. **You should have those prescription drugs with you when you make the call.**
2. Have your Physician prepare a prescription for a **90-day supply with 3 refills** and FAX it to the Elect Rx Toll Free Number at 1-844-333-0700. Again, you will have no co-pay on the first 90-day fill and only $10 on all subsequent refills. You will receive an automated reminder notification of a pending renewal/refill on or around day 60 of the last 90-day supply shipped. Shipping takes 10-15 business days from the date of completed requirements (Faxed Rx from Physician and initial call to customer service from the member/employee). Tip: **Have a 30-day supply on hand to allow for plenty of delivery time.** Pharmacists are available via email at **pharmacist@electrx.com** to answer any and all questions regarding your prescriptions.
3. If you use the Internet the process is even simpler. The dedicated link for Pasco County Schools' employee – members to activate an account online is:

https://my.globalrxmanage.com/customers/pasco-county-schools/sign-up

Elect Rx Customer Service:
1-844-ElectRX or 1-844-353-2879
(Monday-Friday 9AM-9PM; Saturday-Sunday 9AM-4PM)

Elect Rx Physician Fax:
1-844-333-0700

Customer Service Email:
inquiries@electrx.com

Please view the Elect Rx familiarization and instruction video at:
https://vimeo.com/105646309


Apidra Vial
Apidra Solostar
Basaglar KwikPen
FIASP Vial
Fiasp Flex Touch Pen
Humalog Vial
Humalog Kwikpen
Humalog Cartridge
Humalog Jr Kwikpen
Humulin Vial
Humulin Kwikpen
Lantus Vial
Lantus SoloStar
Levemir Flextouch
Novolin Vial
Novolog 30/70
Novolog Flex Pen
Novolog/Novorapid
Saxenda
Toujeo Solostar
Tresiba
Trulicity
Victoza
And more...
TrueNorth MEDS
Only Available through Pasco County Schools
True North Meds specializes in safe Canadian Made Insulin from the same manufacturers you know and trust. Let us help you save on your insulin needs.
No Co-pay + High Quality + Canadian Made Insulins
Talk to our licensed pharmacists today to have your insulin mailed directly to you...
and No Co-pay!
Phone: 1-844-681-8783
Fax: 1-844-682-8783
Email:
meds@truenorthmeds.com
www.truenorthmeds.com
PASCO COUNTY SCHOOLS
A WORLD-CLASS EDUCATION
TrueNorth MEDS
powered by
Elect Rx
Rx
True North Meds is a Licensed Canadian Pharmacy in Winnipeg, Manitoba. License # 34861.

Behavioral Health Benefits

New Directions Behavioral Health

NDBH is Florida Blue's partner for behavioral health capabilities and programs. NDBH manages behavioral health servcies for BlueCare HMO and BlueOptions PPO members receiving services in Florida. New Directions provides a centralized solution that coordinates all of the patient's behavioral health care needs (i.e., authorization and manages utilization management).

Once you locate a participating behavioral health specialist (counselor, psychologist, psychiatrist), just confirm he/she is contracted with your health plan network (BlueCare HMO or BlueOptions PPO). Then provide your Florida Blue Member ID card and pay $35 copay per office visit. The provider will submit the claims directly to Florida Blue.

Behavioral Health Benefits by Plan			
MH=Mental Health SA=Substance Abuse DED=Deductible PAD=Per Admission Deductible Coins.= Coinsurance	**BlueCare HMO Premium**	**BlueCare HMO Basic**	**Blue Options PPO Standard**
MH/SA Emergency Room Services *In & Out-of-Network*	$300 Copay	$300 Copay	$300 Copy
MH/SA Inpatient Hospital Facility Services *In-Network* *Out-of-Network*	$500/day $2,500 Max. Not Covered	$100 PAD + $2,000 DED + 20% Coins. Not Covered	$1,000 DED + 20% Coins. 40% Coins.
MH/SA Inpatient Residential Treatment Facility *In-Network* *Out-of-Network*	$500/day $2,500 Max. Not Covered	$100 PAD + $2,000 DED + 20% Coins. Not Covered	$1,000 DED + 20% Coins. 40% Coins.
MH/SA Outpatient (Physician's Office) Family Physician & Specialist *In-Network* *Out-of-Network*	$35 Copay Not Covered	$35 Copay Not Covered	$35 Copay 40% Coins.
MH/SA Outpatient Hospital Facility Services *In-Network* *Out-of-Network*	$35 Copay Not Covered	$2,000 DED + 20% Not Covered	$35 Copay 40% Coins.
MH/SA Provider Services at Locations other than office, hospital & ER; Family Physician & Specialist *In-Network* *Out-of-Network*	$35 Copay Not Covered	$35 Copay Not Covered	$35 Copay 40% Coins.
Out of Pocket Maximum (Individual/ Family Aggregate) *In-Network combine with medical*	$3,000/$9,000	$5,500/$11,000	$3,000/$9,000

- *Access behavior health services/ providers: 1-866-287-9569*
- *Benefit information or questions: 1-800-507-9820 or contact Patty Nguyen, Florida Blue's on-site representative at District 813-794-2492*

To access participating providers, follow the instructions below:

1. **www.ndbh.com**
2. Click on For Individuals & Families Link.
3. Choose Your Program-"Managed Behavioral Health"
4. Just click on Search for Providers link.
5. On the Provider Search Page, Select the following Network/Plan: For **BlueCare HMO Basic/Premium members select, "BCBS FL Health Maintenance Organization (HOI)". For BlueOptions Standard PPO members, select, "BCBS FL Network Blue (NWB)" OR**
6. Use your Member ID Number (Enter the entire alphanumeric ID number.)
7. Enter 5-digit Zip Code
8. Click on "Search"
9. Click on "I understand."
10. Your search results should appear.

NOTE: You may perform an Advanced Search. Just click on the plus sign (+) and input your search criteria.

Employee Assistance Program

NEW DIRECTIONS

The Employee Assistance Program (EAP) is a benefit program intended to ensure a healthy work environment for all staff. Through a partnership between the Pasco County Schools and New Directions (our behavioral health care provider), our employees will have access to enhanced services. These services include counseling and referral for personal or work-related issues, health coaching, legal and financial consultation, and a wealth of on-line resources.

Why does Pasco County Schools need an EAP?

- Benefits individuals needing help
- Improves the health and effectiveness of the organization
- Reduces rising medical insurance costs
- Reduces sick leave utilization
- Increases employee effectiveness and productivity

Who can access services through EAP?

All School Board employees and retirees are eligible for EAP services. Employees may be full or part time, active or on leave. Services are also available for all insurable dependents of our employees.

How many free counseling services are provided?

Up to five (5) counseling sessions are available per issue, at no cost, for each employee, retiree, and insurable dependent of an employee. If more specialized, intensive services are needed, the employee (or dependent, retiree) will be connected with the appropriate professional as available through the behavioral health insurance plan or other resources

Where are counseling services provided?

Counseling services are available in private offices in Land O' Lakes, Lutz, Dade City, New Port Richey, Port Richey, Spring Hill, Tampa, Tarpon Springs, Trinity, Wesley Chapel, and Zephyrhills. All locations are totally separate from any school or district campuses.

When are services provided?

All of the EAP providers are individual professionals who schedule appointments according to their office hours. Most providers offer some appointments during the after school hours and/or on weekends.

What credentials do the counselors have?

All counselors are licensed through the Florida Department of Health. Program counselors include licensed psychologists, marriage and family therapists, mental health counselors, or clinical social workers. Some of the providers are also substance abuse professionals or certified addictions professionals.

What additional services are available through the EAP?

In addition to counseling services, the EAP offers

- Legal and Financial Consultation (face to face or telephonic)
- Health Coaching
- Elder Care Consultation
- Healthcare-related information, self-assessment, and educational guides
- Access to telephonic or on-line information and resources for varied Work/Life issues.
- Web-based family resource services
- Online Health Risk Assessments
- Interactive EAP website.

What types of issues can be addressed by the counseling and referral services?

- Marital and relationship issues
- Family/Child adjustment issues
- Job-related stress
- Stress/Burnout
- Depression
- Anxiety/Panic Attacks
- Alcohol/Substance Abuse
- Eating Disorders
- Tobacco Addiction
- Legal Issues
- Financial consultation

If you feel that you or your family needs assistance with these or any other issues, please call for help:
New Directions EAP services at 1-800-624-5544 / Direct referral to the District School Board's local counselor/ Clinical Coordinator or for further information:
Cental Pasco - (813) 794-2366 East Pasco- (352) 524-2366 West Pasco- (727) 774-2366

Why should I Utilize the Onsite Health and Wellness Centers?

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 HWC
- Increased convenience and access
- More one-on-one time with the doctor
- Onsite dispensing of generic medications
- Wellness Services

What can be treated at the HWC?
- Colds, flu, sore throats
- High blood pressure
- High cholesterol
- Diabetes
- Annual physicals
- Electrocardiogram (ECG/EKG)
- Lab work
- X-ray
- And much more!

Additional Services
- Immunizations
- Diabetic supplies
- Health risk assessments
- Annual Wellness Visits
- Imaging Studies
- Pulmonary Function Testing (PFT)/ Spirometry
- Sleep studies

Available Vaccines
- Recombivax (Hep B) series
- Hepatitis A
- Hepatitis A/B combo
- Mantoux PPD (TB test)
- TDap (Tetanus, Diptheria, Pertussis)
- Shingles vaccine
- MMR (Measles, Mumps, Rubella)
- Pneuomovax (Pneumonia) vaccine

Who is Eligible for Service?
All employees, retirees, spouses and dependents 8 years and older (see provider schedule for details) covered under the District's group medical plan are eligible to use the Health and Wellness Centers.

No Show Policy
Unfortunately, the number of employees/dependents who fail to show up for appointments without canceling remains significantly higher than other districts offering this same benefit. The demand on the available appointment slots has been overwhelming and "no shows" greatly diminish the capacity for others to secure an available time slot.

If you are unable to keep your appointment, please provide at least one-hour notice by calling My Health Onsite's Help Desk at (888) 644-1448 to cancel your appointment.

Employees/dependents who continue to "no show" for scheduled appointments will be subject to monetary fines and/or restrictions on usage of the Health and Wellness Centers.

Late Arrivals
Please arrive at least 5 minutes before your scheduled appointment. In consideration of others, if you arrive after your scheduled appointment time, you may be rescheduled for another time and/or day if the Health and Wellness Center is unable to work you in among the other scheduled appointments.

We Value Your Privacy
You will enjoy complete privacy and confidentiality (HIPAA/Privacy compliant) at your onsite Health and Wellness Centers! Your private health information and visit activity will never be shared with anyone at the school district.

Flu Vaccines

The Health and Wellness Centers (HWC) offer the flu vaccine annually to all insured employees, retirees, spouses and dependents 10 years and older covered under the district's group medical plan, as well as non-insured employees, at no cost to you.

The best time to receive the flu vaccine is October through May

Coverage from the flu vaccine typically lasts 16 weeks. Therefore, suggests patients receive the vaccine during the fall (beginning October/November) to provide maximum coverage throughout flu season. Talk with your HWC provider to learn more about the vaccine or call the HWC Help Desk for more information. Please visit **www.PascoGoHealthy.net** for the most up-to-date schedule and contact information.

Wellness Programs

Health and Wellness Center (HWC) patients have access to all new wellness programming through My Health Onsite. Patients will work one-on-one (telephonically, electronically, or face-to-face) with a member of My Health Onsite's wellness team, which includes an onsite Nurse, Registered Dietitian, Nurse Educator, and Health Coach.

My Health Onsite's Wellness Programs Put Patients in Control of Their Goals!

Each wellness program is tailored to the specific needs and interests of the patient. Once enrolled by their provider, the patient will work one-on-one with their health coach to come up with **S**pecific, **M**easureable, **A**ttainable, **R**elevant, and **T**imely **(S.M.A.R.T.)** goals. Coaching sessions last approximately 40 minutes each. The time to complete each program will vary, with the exception of the Tobacco Cessation program (6 weeks) and the Group Weight Loss program (12 weeks).

How Do I Get Started?

Patients interested in starting a new wellness program may enroll through their My Health Onsite (MHO) Provider. If you have yet to be established with an MHO provider, a great way to become established is by completing an annual Vital Health Profile (VHP). During the VHP Physical, your provider can refer you into the wellness program based on your test results and interests.

Locations & Service Hours

(Verify current schedule online or call)

Monday – Friday Schedule

Lab Services Only
(All Centers)
(HRA, blood draws, drug tests, etc.)

Monday:	6a – 10:45a
Tuesday:	6a – 10:45a
Thursday:	6a – 10:45a
Friday:	6a – 10:45a

Medical Services
(Land O' Lakes, Centennial & Hudson & Odessa)

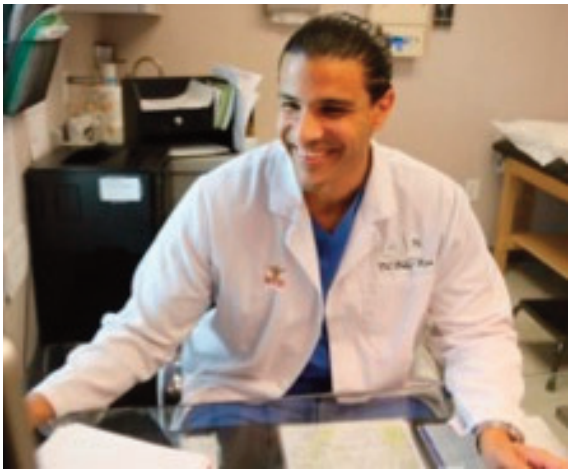
Monday:	8a – 12p; 1p – 5p
Tuesday:	7a – 7p
Wednesday:	7a – 7p
Thursday:	7a – 7p
Friday:	8a – 12p; 1p – 5p

Medical Services
(Gulf)

Monday:	7a – 12p; 1p – 7p
Tuesday:	7a – 12p; 1p – 4p
Wednesday:	7a – 12p; 1p – 7p
Thursday:	8a – 12p; 1p – 5p
Friday:	8a – 12p; 1p – 5p

Medical Services
(Wesley Chapel)

Monday:	8a – 12p; 1p – 5p
Tuesday:	7a – 12p; 1p – 4p
Wednesday:	10a – 2p; 3p – 7p
Thursday:	8a – 12p; 1p – 5p
Friday:	8a – 12p; 1p – 5p



New Wellness Center!

Long Leaf HWC
3881 Town Avenue
New Port Richey, FL
34655

Saturday Schedule (8a.m. - 1p.m.)

Land O' Lakes HWC
20360 Gator Lane, Bldg. 14
Land O' Lakes, FL 34638
Saturday Hours
Every Saturday

Wesley Chapel HWC
30833 Wells Road
Wesley Chapel, FL 33545
Saturday Hours
2nd & 4th Saturday

Centennial HWC
38503 Centennial Road
Dade City, FL 33525
Saturday Hours
1st & 3rd Saturday

Gulf HWC
5117 Madison Street
New Port Richey, FL 34652
Saturday Hours
2nd & 4th Saturday

Hudson HWC
14730 Cobra Way
Hudson, FL 34669
Saturday Hours
1st & 3rd Saturday

Sunday Closed

Pasco Go Healthy Website

(Pasco County Schools' Wellness Portal)

The goals of the District's wellness program are to both decrease the risk of disease and to enhance the quality of life of our employees and retirees. Healthy, happy, and motivated employees are an essential part of creating a community, which works together so all our students will reach their highest potential.

The Pasco Go Healthy wellness portal **(www.PascoGoHealthy.net)** hosts all of the latest information on current and upcoming health and wellness initiatives. Popular topics include:

- The Health and Wellness Incentive (HWI) Program Details and Payment Schedule
- My Health Onsite Health and Wellness Center Information
- Tobacco Cessation Resources

The Pasco Go Healthy wellness portal also includes important information about yearly wellness events such as the:

- Pasco Go Healthy Walking Challenge
- Great American Smokeout
- National Employee Health and Fitness Day

Pasco Go Healthy has something for everyone! While some of the programs and services detailed on the Pasco Go Healthy wellness portal are open to benefit-eligible employees only, there are many other resources and initiatives outlined on the site that are available to ALL employees. Be sure to read the program descriptions to determine which programs are right for you.

Please check out the Pasco Go Healthy wellness portal at **www.PascoGoHealthy.net** to get all the latest information on the District's health and wellness initiatives, resources, as well as yearly wellness events.

Tobacco Cessation Resources

Tobacco use can lead to life-threatening conditions including cancer, heart disease, and stroke. The programs below are offered at no cost to employees and provide participants with an unlimited number of quit attempts per year:

Available to all employees:

- Tobacco Free Florida offers resources for all school district employees. In addition to online and toll-free counseling, Tobacco Free Florida offers free face-to-face classes through the Florida Area Health Education Centers (AHEC). AHEC hosts 2 onsite classes; one 2-hour session or a six week group session. AHEC also provides participants with one month free Nicotine Replacement Therapy (gum, lozenges, and patches) for those who enroll in one of the two programs. Registration is required. Please contact AHEC at 813-929-1000 for more information or to sign up.

Available to covered retirees:

- The onsite Health and Wellness Centers (HWC) provide a six -week onsite Tobacco Cessation course, monitored closely by our HWC Provlders. Chantix medication is also available, for $0 copay, to participants who are working through the onsite or online HWC Tobacco Cessation program and who have been approved by our providers for medication. To sign up for this program, please visit your HWC provider.

Dental Benefits
Provider: Delta Dental

Voluntary dental plans are available to all retirees currently enrolled and their eligible dependents.

What Dental Plans are available?
Pasco Schools offer three dental plans for you to choose from:

- DHMO (Delta Care USA)
- PPO Low Plan
- PPO High Plan

What about the networks?
You will have access to a large network of Delta Dental general dentists and specialty dentists. With enrollment in the PPO High or Low plans, you have the freedom to choose to see an in-network or out-of-network provider.

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 it usually results in higher out-of-pocket cost to the member.

If you choose to participate in the DHMO Plan you will have to select a participating dentist from the DeltaCare USA network. In order to be covered for services under the DHMO plan, you must have services provided at your selected DHMO dental office. You can access the network directories of participating dentists by visiting deltadentalins.com.

Is there an age limitation for children to see a pediatric dentist?
If you are enrolled in the DHMO plan, your primary dental office must refer your child (under 8 years of age) to a pediatric dentist.
If you are enrolled in the PPO plan- there are no age limits that are applicable.

If you are traveling and experience a dental emergency, please contact Delta Dental customer service and a representative will assist you with treatment options.

What is a diagnostic & preventive maximum waiver (D&P waiver)?
Your PPO plans includes a D&P Maximum Waiver benefit, allowing you to obtain diagnostic and preventive dental services without those costs applying towards the plan year maximum. This benefit promotes good oral health and may reduce the need for more expensive, restorative dental services that can result from undetected oral or related health problems.

Which plans offer an orthodontic benefit?
The DHMO and the PPO High plans offer orthodontic coverage.

Who's eligible?
Primary enrolled employee, spouse, eligible dependent children to age 26. **Coverage will end at the end of the month in which a dependent child reaches age 26** (unless that dependent child is disabled.)

What is a pre-authorization?
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.

Dental Benefits

What if I need to see a specialist?

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

What if I would like a second opinion?

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 regarding your dental benefit?

Go to the Employee Benefits Department website and follow the links to Delta Dental. To locate an in-network provider please visit www.deltadentalins.com.

Do any of the dental plans have a pre-exisiting condition clause?

No. There are no pre-exisiting condition clauses associated with any of the dental plans.

Dental Benefits

Who's Eligible: Primary enrollee, spouse, eligible dependent children to age 26	High PPO Plan		Low PPO Plan		DeltaCare USA DHMO	
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 Co-Pay	
Diagnostic & Preventive SVC (D&P)	100%	100%	100%	60%	D&P $0-$70 Co-Pay	
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 (applies to DHMO only)	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	DeltaCare Schedule A	
Complex Oral Surgery	Basic	Basic	Basic	Basic	DeltaCare Schedule A	
Endodontics (Root Canal)	Basic	Basic	Basic	Basic	DeltaCare Schedule A	
Periodontics (Gum Disease)	Basic	Basic	Basic	Basic	DeltaCare Schedule A	
Crowns, Bridges, Inlays, Onlays	Major	Major	Major	Major	DeltaCare Schedule A	
Implants	Major	Major	Not Covered		Not Covered	

Dental Rates (Monthly)

Delta Detal	DHMO 14A		PPO High Plan		PPO Low Plan	
	Monthly		**Monthly**		**Monthly**	
Retiree Employee Emp	$19.50		$44.08		$29.44	
Retiree + 1 Dependent	$34.12		$109.92		$71.46	
Retiree+ 2 or more Dependents	$53.64		$150.46		$99.76	

Vision Benefits

Provider: Davis Vision

Vision coverage is available all currently enrolled retirees and their dependents. The vision plan covers routine eye examinations, corrective lenses, frames and contact lenses.

What are the benefits?

Option 1 & 2 (one-pair benefit) plan frequencies:

- Exam every 12 months
- Lenses every 12 months
- Frames every 24 months

Option 3 (two pair benefit) plan frequencies:

- Exam every 12 months
- Lenses every 12 months
- Two frames every 24 months

***Note:** If you enroll in the vision program your initial enrollment period drives eligibility for your frames. Therefore, if you enroll for the first time, in 2020 then you must obtain your frames in 2020. If you do not get them in 2020, you will be unable to order them in 2021, even if you continue your participation in the vision benefit.

Are there any restrictions or limitations?

If you see a Davis Vision participating provider, you will receive full benefits. If you use a non-participating provider, your benefits will be reduced.

Could I incur additional costs?

Yes, depending upon the plan option that you choose. If you choose option 2 or 3, you will see in the comparison chart that extra features such as tint or polarized lenses will be covered without any additional charges. Please refer to the coverage chart for more detail regarding covered benefits and co-payment costs.

What is the 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

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 website: www.davisvision.com.

Member Service Representatives are available (EST): Monday through Friday 8:00am- 11:00pm, Saturday 9:00am- 4:00pm, Sunday 12:00pm- 4:00pm. Participants who use a TTY (Teletypewritter) 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 your Client Code:
2825: Option 1 (Designer)
2826: Option 2 (Premier Platinum Plus)
2827: Option 3 (Premier Platinum Plus/ Two-pair Benefit)

DavisVision™

Vision benefits for Pasco County School employees

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 most lens options, Covered in full	$15 copayment includes most 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
Visually required		Covered in full	Covered in full	Covered in full
Contact lens evaluation, Fitting & follow-up care		$15 copayment	$15 copayment	$15 copayment
Retail allowance: standard type	Every 12 months	Covered in full	Covered in full	Covered in full
Retail allowance: specialty type		Up to $60 plus 15% discount[2]	Up to $60 plus 15% discount[2]	Up to $60 plus 15% discount[2]
Davis Vision collection		Covered in full	Covered in full	Covered in full
Visually required		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

Out-of-network reimbursement rate

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, Visually required contacts up to $210

Contact your benefits department today to enroll.

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)

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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
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
Ultimate AR coating	$85	$85	$85
Standard progressive lenses	Included	Included	Included
Premium progressive lenses	$40	Included	Included
Ultra progressive lenses	$90	$50	$50
Ultimate progressive lenses	$175	$175	$175
Intermediate-vision lenses	$30	Included	Included
Blended-segment lenses	$20	Included	Included
High-index lenses 1.67	$55	Included	Included
High-index lenses 1.74	$120	$120	$120
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

Value-added features:

Replacement contacts through DavisVisionContacts.com mail-order contact lens replacement service ensures easy, convenient purchasing online and quick shipping direct to your door. Davis Vision provides you and your eligible dependents with the opportunity to receive discounted laser vision correction, often referred to as LASIK. For more information, visit www.davisvision.com.

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

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

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

Who are the network providers?

They are licensed providers who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please call 1 (800) 999-5431 to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you, or you may access our Web site at **www.davisvision.com** and utilize our "Find a Doctor" feature.

DV-MKG18-0293v001 PDF 10/2018

Want 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.

Vision Benefits

Vision Plans (Monthly)

Davis Vision Rates 2020		
Option 1: Designer	**Monthly**	
Retiree Only	$13.10	
Retiree + One	$23.56	
Family	$36.64	
Option 2: Premier Platinum Plus	**Monthly**	
Retiree Only	$21.26	
Retiree +One	$38.26	
Family	$59.52	
Option 3: Premier Platinum Plus 2 Pair	**Monthly**	
Retiree Only	$35.84	
Retiree + One	$64.52	
Family	$100.36	

Basic Term Life Insurance
Provider: Minnesota Life

Basic term life insurance
As a retiree, you are eligible to keep your current coverage from Minnesota Life. Age reductions automatically apply at age 65 and age 70.

How do I designate a beneficiary?
Beneficiary information must be provided to Minnesota Life Insurance Company. Minnesota Life provides a secure website, www.lifebenefits.com for electing, storing, and updating life insurance beneficiary designation. You may view or update your designations at any time on the Life Benefits website using your user id and password provided by Minnesota Life Insurance Company. For additional information, contact Minnesota Life at 1-866-293-6047.

Proof of Coverage
A combination of your annual benefits confirmation statement and the certificate of coverage is your proof that you have an active Minnesota Life benefit. A copy of the certificate of coverage is available online at www.pasco.k12.fl.us/ebarm under the "claims forms" section on the navigation menu.

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 anytime. Coverage amounts and premiums will reduce at age 65 and further reduce at age 70.

Travel Assistance
Services include a full range of medical, travel, legal and emergency transportation services when you travel more than 100 miles from home or internationally. Medical professional locater services, assistance replacing lost or stolen luggage, medication, or other critical items, medical or security evacuation.

Legal Services
You have access to an online library of legal forms, comprehensive web and mobile resources. Also available is a free 30-minute consultation with a participating attorney.

Legacy Planning
Access to a variety of information and resources to work through end-of-life issues: End-of-life planning, final arrangements, Express Assignment™ for expedited funeral home assignments.

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 is 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 Expenses 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 WageWorks at 1-877-924-3967.

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

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 is 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 Expenses 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 WageWorks at 1-877-924-3967.

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.

Marketplace Language

Are there other coverage options besides Continuation Coverage?

Yes. Instead of enrolling in continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than continuation coverage.

You should compare your other coverage options with continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under because the new coverage may impose a new deductible.

When you lose job-based health coverage, it is important that you choose carefully between continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

You may be able to get coverage through the Health Insurance Marketplace that costs less than continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit **www.HealthCare.gov.**

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days, your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for continuation coverage, can I switch to coverage in the Marketplace? What if I choose Marketplace coverage and want to switch back to continuation coverage?

If you sign up for continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also send your continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." However, be careful though - if you terminate your continuation coverage early without another qualifying event, you will have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you have exhausted your continuation coverage and the coverage expires, you will be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of continuation coverage, you cannot switch to continuation coverage under any circumstances.

Marketplace Language

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect continuation coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within 30 days of losing your continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- **Provider Networks:** If you are currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

- **Drug Formularies:** If you are currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- **Service Areas**: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- **Other Cost-Sharing**: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Medicare Part D

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. 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.

Important Notice from Pasco County Schools about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it . This notice has information about your current prescription drug coverage with Pasco County Schools and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered and 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:

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 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.

Pasco County Schools has determined that the prescription drug coverage offered by Pasco County Schools is on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current credible prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period 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 Pasco County Schools coverage will be affected.

If you decide to KEEP your Pasco County Schools prescription drug coverage and enroll in a Medicare prescription drug plan, your Pasco County Schools coverage generally will be your primary coverage. You may be required to pay a Medicare Part D premium in addition to your Pasco County Schools medical plan contributions.

If you decide to join a Medicare Drug plan and drop your current Pasco County Schools prescription drug coverage by dropping your medical plan, 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 Pasco County Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medical drug plan later.

If you go 63 continuous days or longer without credible 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 credible coverage, your premium may consistently be at least 19% higher than the Medicare has beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the Benefits Office at 813-794-2253 for further information.
NOTE: You will recieve this notice each year. You will recieve it before the next period so you can join a Medicare drug plan, and if this coverage through Pasco County Schools changes you also may request a copy of this notice at anytime.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is avialable in the "Medicare & You" handbook. You'll recieve 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 Pasco County School District 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 are 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 Pasco County Schools May Use or Disclose Your Health Information

Pasco County Schools 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 Pasco County Schools receives related to claims or treatment is as "summary health data" and does not identify individual employees or family members. However, Pasco County Schools 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 Pasco County Schools 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 Pasco County Schools is permitted to use and disclose information will fall within one of the categories.

1. Workers Compensation—Pasco County Schools 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, Pasco County Schools 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—Pasco County Schools 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, Pasco County Schools 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, Pasco County Schools 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, Pasco County Schools may use and disclose your health information when required by a court order. Pasco County Schools 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, Pasco County Schools 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 the 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 Pasco County Schools does not receive any PHI except as may be necessary for enrollment or disenrollment in a plan. Regarding any other health information Pasco County Schools may have access to, such as information related to a disability claim, Pasco County Schools 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 Pasco County Schools should need to use or disclose your health information for any purposes other than as described in this Notice of Privacy Practices, Pasco County Schools will do so only with your authorization 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, Pasco County Schools will no longer be able to use or disclose health information about you for the reasons covered by your written authorization, though Pasco County Schools will be unable to take back any disclosures that have already made with your permission. Pasco County Schools 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

Pasco County Schools 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. Pasco County Schools 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 Pasco County Schools has handled your health information can be directed to: Employee Benefits & Risk Management,
7227 Land O' Lakes Blvd.
Land O' Lakes, Florida 34638
or via e-mail at EbarmPDH@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 de pending 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.

NOTICE REGARDING WELLNESS PROGRAM

The “Pasco Go Healthy” Health and Wellness Incentive (HWI) Program is a voluntary wellness program available to employees and retirees covered under the District’s group medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the HWI program you will be asked to complete a voluntary biometric questionnaire that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a vital health profile (VHP), which 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. A complete list of the included panels can be found at the link below: https://connectplus.pasco.k12.fl.us/do/gohealthy/wp-content/uploads/2019/02/MHO-VHP-PCS2.pdf

You are not required to complete the biometric questionnaire or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the HWI program will receive an incentive valued up to $150 by completing the biometric questionnaire, vhp blood draw and follow-up visit at the My Health Onsite Health and Wellness Centers. Although you are not required to complete the VHP or participate in the biometric screening, only employees who do so will receive the incentive of $150. Employees who complete the Vital Health Profile may choose to participate in either the Youfit, Peerfit, Pascofit, or Yfit Buy-up options.

Employees who participate in the Pascofit option may earn additional incentives of up to $100 by completing up to 2 approved wellness programs. If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Lisa Giblin at lgiblin@crowneinc.com.

The information from your VHP and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as diabetes management, diabetes prevention, hypertension management, cholesterol management, etc. You also are encouraged to share your results or concerns with your outside provider.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Pasco County Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, My Health Onsite and the Health and Wellness Incentive (HWI) Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Patricia Howard at ebarmpdh@pasco.k12.fl.us or 813-794-2253.

Sunbelt Worksite Marketing, Inc.
PO Box 1287
Auburndale, FL 33823-1287
Customer Service 1.800.822.8045
Information contained herein does not constitute an insurance certificate or policy.
Certificates will be provided to participants following the start of the plan year, if applicable.

2021 RETIREE PREMIUM RATE CHART

Plan Year: January 1, 2021 – December 31, 2021

Dependent Verification Requirement

Retirees covering a spouse or dependent child under the district's group health plan **MUST verify their dependent's eligibility for coverage by November 6, 2020.** Dependents of retirees who fail to comply with the dependent verification guidelines coverage will be removed from the district's group health plan effective December 31, 2020.

Additional information about the dependent verification requirements is available online:
http://www.pasco.k12.fl.us/ebarm/page/dependent-verification

	Group Health Plan			BlueMedicare	
Coverage Level	**Basic HMO**	**Premium HMO**	**PPO Standard**	**Blue Medicare**	**Blue Medicare Plus**
Retiree Buy-up	0.00	79.50	166.00	-	-
Retiree Only	592.76	672.26	758.76		
Retiree + Children	962.14	1,211.12	1,327.76	-	-
Retiree + Spouse	1,153.66	1,474.94	1,637.00		
Retiree + Spouse and Children	1,523.67	2,010.57	2,221.79		
Married Retiree/Employee of Board + Children	906.35	1,147.91	1,257.27		

Two married retirees/employees of the Board plus children: Both spouses must be eligible for benefits and must enroll in the same medical plan.

Retiree Eligible for Board-paid Medical Premiums

The Board pays an amount equal to contributions made for an active employee less the retiree portion. Retirees eligible for Board-paid health premiums are required to pay the monthly buy-up plus an amount equal to his or her FRS health insurance subsidy.

	Delta Dental			Davis Vision		
Coverage Level	**DHMO**	**Low PPO**	**High PPO**	**Designer**	**Platinum**	**Platinum II**
Retiree Only	19.50	29.44	44.08	13.10	21.26	35.84
Retiree + 1 Dependent	34.12	71.46	109.92	23.56	38.26	64.52
Retiree + Family	53.64	99.76	150.46	36.64	59.52	100.36

	Minnesota Life		
Under Age 65	**$35,000**	**$20,000**	**$10,000**
With Board-paid Health	60.06	32.11	13.48
Without Board-paid Health	65.21	37.26	18.63
Age 65 – 69	**$17,500**	**$10,000**	**$5,000**
	32.60	18.63	9.32
Age 70 and Over	**$12,250**	**$7,000**	**$3,500**
	22.83	13.05	6.53

Legal w/Identity Theft	
Retiree + Family	**Monthly**
Ultimate Advisor	18.26
Ultimate Advisor Plus	22.58