Pasco County Schools

Your 2018 Core Benefits Reference Guide

Kurt S. Browning, Superintendent

What's inside

Medical
Pharmacy
Behavioral Health Benefits
Employee Assistance Program
Health and Wellness Centers
Elect RX
Working Spouse Waiver

Plan Provider Contact Information

Medical	
CareHere Health & Wellness Centers	(877) 423-1330
Florida Blue	(800) 507-9820
Prescriptions	
Florida Blue	(800) 507-9820
Elect RX	(844) 353-2879
Voluntary Benefits Administrator	
ARAG Legal	(800) 247-4184
Minnesota Life	(866) 293-6047
Sunbelt (Allstate & Cigna/Lina)	(800) 822-8045
Unum Disability	(800) 635-5597
Cigna/Lina Claims	(800) 238-2125
Allstate	(800) 822-8045
Behavioral Health (BEH)*	
New Directions Behavioral Health Information	(866) 287-9596
Information & Questions	(800) 507- 9820
Employee Assistance Program	(800) 624-5544
Dental Benefits	
Delta Dental- DHMO	(800) 422- 4234
Delta Dental- PPO	(800) 521- 2651
Vision Benefits	
Davis Vision	(800) 999- 5431
Flexible Spending Accounts	
WageWorks	(877) 924-3967
Retirement Benefits	
Florida Retirement System	Pension (844) 377-1888 Investment (866) 446-9377

Employee Benefits & 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- 2275
Wellness Programs & Incentives	wellness@pasco.k12.fl.us	(813) 794-2276
Risk Managment		(813) 794- 2520

* Employees 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 You Need to Know

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.

What is the access code to register for the first time on CareHere?

- The code is PCFSD7

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.

Where can I find my Allstate policy Number?

To locate your Allstate policy number

- Call Sunbelt at 800-822-8045
- Register online at allstatebenefits.com/mybenefits

Open Enrollment

October 1, 2017 - October 31, 2017

Benefit Effective Dates
January 1, 2018 - December 31, 2018

Annual Employee Benefits and Wellness Fair
Saturday, September 30, 2017
9:00 am - 2:00 pm
Sunlake High School
3023 Sunlake Blvd, Land O' Lakes, FL 34638

Both active employees and retirees are invited to attend. Enrollers will be available to assist attendees with their coverage elections for 2018.

If you will be retiring from Pasco Schools in 2018, please be sure to enroll in those benefit plans that you would like to take with you into retirement (i.e, dental, vision, legal). You will only be offered the opportunity to continue those benefits that you are presently enrolled in at the time that you retire.

This year we will be doing a negative enrollment. What does that mean to you? Unless you want to add a new benefit, change an existing one, add dependent coverage or have an FSA that you want to keep you will not have to do anything during Open Enrollment. Once you have checked your current benefits and are not interested in making any changes you will be asked not to go into the benefit section of your Employee Self-Serve during the month of October.

Benefit Enrollment Process

All employees must enroll in benefits using Munis Employee Self Service.

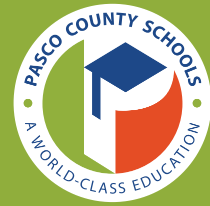
The following are steps required to enroll:

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 every benefit
8. Submit 2018 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.

BENEFITS

of being a **Pasco County Schools** employee



Pasco County Schools provides all eligible employees the following benefits:

Option 1 — GROUP HEALTH PLAN

- HMO Basic Medical *(includes pharmacy)*
- Basic Core Life
- Employee Assistance Program**
- Health and Wellness Centers *(free primary medical care)*
- Wellness Incentive (Earn up to $250)

OR

Option 2 — HEALTH OPT OUT PLAN

- Taxable Income
  - $100 monthly *(prorated per paycheck)*
  - Up to $1,200 annually
- Basic Core Life
- Employee Assistance Program

PLUS

VOLUNTARY BENEFITS

Available to all eligible employees

Additional Benefit Choices:

- Dental
- Vision
- Disability
- Term Life
- Flexible Spending Account
- Legal w/Identity Theft Protection
- Cancer
- Accident Protection

RETIREMENT SERVICES

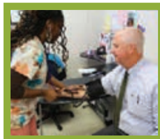
Available to all eligible employees

- State of Florida Retirement System:•
  - Pension Plan *(Define Benefit)*
  - Investment Plan *(Defined Contribution)*
- Voluntary Retirement Savings Program**
  - Pre & Post- tax 403(b) (similar to 401(k))
  - 457(b)
- Financial Wellness Tools**

HEALTH AND WELLNESS CENTER

On-site Health & Wellness Centers (HWC).

Employees and their dependents covered under the medical plan can receive FREE medical services at the on-site Health and Wellness Centers (HWC).



Free Medical Care!

- No deductibles
- No co-pays
- No out-of-pocket costs

What are the Benefits to You?

- Generic medications at no cost
- No more long stays in waiting room
- Increased convenience and access

Employees may elect to cover their dependent spouses or children under the group medical and voluntary benefits plan.

Additional information available online www.pascoschools.org

***Available to all employees including non-benefit eligibility employees.*

Introduction to Benefits

As a benefit eligible employee of Pasco County Schools you have numerous choices of pre-tax and post-tax benefits. These choices allow you to customize your benefit elections to meet the needs of your family.

Fully Board-Paid Option

Benefit eligible employees are eligible for a free benefit option which includes:

- Basic HMO medical plan
- Pharmacy
- Behavioral Health
- Health & Wellness Centers (*with medical participation)
- 35,000 Life Insurance
- Employee Assistance Program
- Elect Rx

Benefit Waiting Period

If you are a new employee enrolling in benefits, there is a 30-day waiting period before your coverage begins. The waiting period for benefits is the first of the month following 30 days of employment, for example, an employee hired on August 17, 2017 becomes benefit eligible on October 1, 2017. Employees will receive an email from the Employee Benefits department notifying you to enroll in your benefit elections. You will make your elections on-line using the Munis Employee Self- Service system.

Health Opt Out

Employee's who carry other medical coverage may "opt-out" of medical coverage.

Pasco County Schools offer employees who opt out of the Board's health insurance plans a $100 per month maximum, $1,200 a year.

To receive the Opt-Out Income for 2018, employees must elect to "opt-out" during the enrollment period. If you were an "opt-out" last year and want to remain an "opt-out" you will not need to do anything during the Open Enrollment period. The election to Opt-Out requires you to waive participation in the Board's medical plan. You must be enrolled in other medical coverage to be eligible to Opt-Out of the Board's medical plans. Upon completion of your Opt-Out election you will receive an e-mail from the Benefits Department notifying you that you are an Opt-Out
for 2018.

Opt-Out Taxable Income

24 Ded	20 Ded
$50.00	$60.00

Choice # 1

- HMO Basic Medical
- Behavioral Health
- Pharmacy
- Basic Core Life
- Employee Assistance Program
- Health & Wellness Centers

Choice # 2

- Health Opt Out (Taxable Income)
- $50 per pay 24-deductions
- $60 per pay 20-deductions
- Basic Core Life
- Employee Assistance Program

Benefit Options

Employees may elect to cover their dependent spouse or children under the group health plan. Additional benefit choices include:

- Dental
- Vision
- Disability
- Flexible Spending Account
- Hospital
- Term Life
- Legal
- Cancer
- Accident Protection
- Additional information in the Voluntary Benefits guide

Wellness Incentive!
Earn up to $250

Employees and their dependents covered under the medical plan can receive FREE medical services at the on-site Health & Wellness Centers (HWC).

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
- On-site dispensing of generic medications

Available Health Coaches

- Registered Nurse
- Registered Dietician
- Exercise Physiologist
- Licensed Mental Health Counselor

What Services are provided at the HWC?

- Treatment for Colds, Flu, Sore Throats, High Blood Pressure, High Cholesterol, Diabetes and more!
- Annual Physicals and Wellness Visits
- School Physicals
- Lab Work
- X-Rays
- Electrocardiogram (ECG/ EKG)
- Immunizations
- Additional information in the Wellness guide

Additional information about the Pasco County Schools' group health plan is available on line at www.pasco.k12.fl.us/ebarm

Two Married Employees of the Board plus Children

When two employees of the Board are legally married to each other and both are eligible for benefits, they are eligible for the two married employees of the board plus children rate.

1. Both spouses are employees of Pasco County Schools and...
2. Both spouses are eligible for Board-paid medical premiums and...
3. Both spouses are enrolled in the same medical plan.

If your marital status changes mid-year and you meet the above criteria, you must contact Employee Benefits to enroll in the two married employees of the board plus children rate. All mid-year plan changes are effective the first of the month following receipt of documentation and complete enrollment.

Two married employees of the Board who anticipate the birth of a child during the upcoming plan year, must enroll in the same medical plan in order to qualify for the two married employees of the board plus children rate. If you and your spouse are not enrolled in the same medical plan, you are not eligible for the two married employees of the board plus children rate and must wait until next open enrollment to enroll in the same medical plan in order to qualify for the two married employees of the board plus children rate.

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 Dependant - 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.

Tax Implications for overage dependents

Employees are allowed to cover dependent(s) age 27 – 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 age 27 – 30 in your adjusted gross income before issuing your W-2 form.

Tax Status of Dependent Premiums		
Dependent Age	Birth - Age 26	Age 27- 30
Taxable Status	Pre-tax	Post-tax

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.

Notifying Employee Benefits of Change in Dependent Status

Employees 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 employee 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.

New: Working Spouse Exclusion

NEW: Working Spouse Exclusion

If your spouse is employed and has access to medical coverage through his/her employer, they are no longer 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: mybenefits@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 2018, 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

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 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 HMO BlueCare 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 is available at “no cost” for employee only coverage, 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 $35-$42 per payroll deduction (depending on your pay type 20/24) 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.
- Do you require provider administered medications, i.e., cortisone shots, chemotherapy in a physician’s office?

The HMO Basic plan is free for employee only coverage. However, while you do not have a per-pay-deduction 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 - Per Pay Deduction

Coverage Selected	24 - Deduct	20-Deduct
Employee Only	$ -	$ -
Employee Plus Child(ren)	$ 170.98	$ 205.18
Employee Plus Spouse	$ 259.63	$ 311.56
Employee Plus Spouse and Child(ren)	$ 430.91	$ 517.09
2 Married Employees of Board Plus Child(ren)	$ 145.16	$ 174.19

HMO Premium - Per Pay Deduction

Coverage Selected	24 - Deduct	20-Deduct
Employee Only	$ 35.00	$ 42.00
Employee Plus Child(ren)	$ 281.13	$ 337.46
Employee Plus Spouse	$ 401.08	$ 481.30
Employee Plus Spouse and Child(ren)	$ 644.59	$ 773.51
2 Married Employees of Board Plus Child(ren)	$ 252.39	$ 302.87

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

Benefits for Covered Services	*Amount Member Pays*
Office Services	
Physician Office Services	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$65 Copayment
Out-of-Network Office Visit	Not Covered
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET Scan, CT Scan, Nuclear Medicine)	
In-Network	$300 Copayment
Out-of-Network	Not Covered
Maternity Initial Visit	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$65 Copayment
Out-of-Network	Not Covered
Allergy Injections (per visit)	
In-Network	$10 Copayment
Out-of-Network	Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)	
In-Network Monthly Out-of-Pocket (OOP) Maximum[1]	$200
In-Network Provider	20% Coinsurance
Out-of-Network	Not Covered
[1] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.	
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**	
Convenient Care Centers (I.E., Participating Take Care Health Services inside Walgreens Pharmacy)	
In-Network	$35 Copayment
Out-of-Network	Not Covered
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network	Not Covered
Mammograms (Routine/Diagnostic)	
In-Network	$0
Out-of-Network	Not Covered
Colonoscopy (Routine/Diagnostic) (Routine age 50+ then frequency schedule applies; High Risk, no age criteria)	
In-Network	$0
Out-of-Network	Not Covered
Emergency Medical Care	
Urgent Care Centers	
In-Network	$70 Copayment
Out-of-Network	Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network and Out-of-Network	$300 Copayment

BlueCare HMO Basic

BlueCare
HMO Basic Plan

Benefits for Covered Services	*Amount Member Pays*
Emergency Medical Care (Continued)	
Ambulance Services (Ground, air and water travel, combined per day maximum) In-Network Out-of-Network (Emergency Services Only)	 DED[2] + 20% Coinsurance DED + 20% Coinsurance
Independent Diagnostic Testing Center Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET Scan, CT Scan, Nuclear Medicine) Out-of-Network	 $50 Copayment $300 Copayment Not Covered
Independent Clinical Lab (e.g. Blood Work) Quest Diagnostics is preferred participating Lab. In-Network Out-of-Network	 $0 Not Covered
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network Out-of Network	 DED + 20% Coinsurance Not Covered
Other Provider Services	
Provider Services at Hospital and ER In-Network Out-of-Network ER Out-of-Network Hospital	 DED + 20% Coinsurance DED + 20% Coinsurance Not Covered
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network Specialist Out-of-Network	 $65 Copayment Not Covered
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 $35 Copayment $65 Copayment Not Covered
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max) Outpatient Rehab Therapy Center In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network Out-of-Network	35 Visits $65 Copayment Not Covered $65 Copayment Not Covered
Durable Medical Equipment, Prosthetics and Orthotics (Coordinate through CareCentrix. Call 1-877-561-9910) In-Network – Motorized Wheelchair In-Network – All Other Out-of-Network	 $500 Copayment $0 Not Covered
Home Health Care (Coordinate through CareCentrix. Call 1-877-561-9910) (PBP Max) In-Network Out-of-Network	20 Visits $0 Not Covered

BlueCare HMO Basic

BlueCare
HMO Basic Plan

Benefits for Covered Services	*Amount Member Pays*
Other Special Services (Continued)	
Skilled Nursing Facility (PBP Max) In-Network Out-of-Network	60 days DED + 20% Coinsurance Not Covered
Hospice In-Network Out-of-Network	 DED + 20% Coinsurance Not Covered
Hospital / Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $250 Copayment Not Covered
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network Out-of-Network	Rehabilitation Services limit - 30 days PAD + DED + 20% Coinsurance Not Covered
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network – Therapy Services In-Network – All other Services Out-of-Network	 $65 Copayment DED + 20% Coinsurance Not Covered
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before Florida Blue HMO pays)	 $2,000 / $6,000 Not Covered
In-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	$100
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 20% Not Covered

Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance and Medical and Prescription Drug Copayments)	 $5,500 / $11,000 Not Covered
Total Lifetime Maximum Benefit	No Maximum

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

Florida Blue HMO is the trade name of Health Options, Inc., an HMO Subsidiary of Blue Cross and Blue Shield of Florida, Inc. Both Companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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

Referrals to participating providers are not required, however authorizations are required for certain medical services like hospitalization, rehabilitation services, home care, select DME, and certain office based services such as CT scans, MRIs/MRAs, cardiac nuclear medicine studies, and select injectables, etc. Additional information related to access to providers can be found in the Provider Directory. This summary is only a partial description of the many benefits and services covered by 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.

HMO Basic - Per Pay Deduction

Coverage Selected	24 - Deduct	20-Deduct
Employee Only	$ -	$ -
Employee Plus Child(ren)	$ 170.98	$ 205.18
Employee Plus Spouse	$ 259.63	$ 311.56
Employee Plus Spouse and Child(ren)	$ 430.91	$ 517.09
2 Married Employees of Board Plus Child(ren)	$ 145.16	$ 174.19

BlueCare HMO Premium

BlueCare
HMO Premium Plan
Benefits for Covered Services

HMO
Amount Member Pays

Office Services	
Physician Office Services In-Network Family Physician In-Network Specialist Out-of-Network Office Visit In-Network e-Office Visit Family Physician / Specialist Out-of-Network e-Office Visit	 $30 Copayment $50 Copayment Not Covered $30 Copayment / $50 Copayment Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET Scan, CT Scan, Nuclear Medicine) In-Network Out-of-Network	 $50 Copayment Not Covered
Maternity Initial Visit In-Network Family Physician In-Network Specialist Out-of-Network	 $30 Copayment $50 Copayment Not Covered
Allergy Injections (per visit) In-Network Out-of-Network	 $20 Copayment Not Covered
Convenient Care Centers (I.E., Participating Take Care Health Services inside the Walgreens Pharmacy) In-Network Out-of-Network	 $30 Copayment Not Covered
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations In-Network Out-of-Network	 $0 Not Covered
Mammograms (Routine/Diagnostic) In-Network Out-of-Network	 $0 Not Covered
Colonoscopy (Routine/Diagnostic) (Routine Age 50+, then frequency schedule applies; High Risk, no age criteria) In-Network Out-of-Network	 $0 Not Covered
Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	 $50 Copayment Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network and Out-of-Network	 $200 Copayment
Ambulance Services In-Network and Out-of-Network	 $100 Copayment
Outpatient Diagnostic Services	
Independent Diagnostic Testing Center Services (per visit) (such as certain ultrasounds, x-rays, bone density scans) In-Network Diagnostic Services (except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET Scan, CT Scan, Nuclear Medicine) Out-of-Network	 $0 Copayment $50 Copayment Not Covered
Independent Clinical Lab (e.g. Blood Work) (Quest Diagnostics is preferred participating lab) In-Network Out-of-Network	 $0 Not Covered

BlueCare HMO Premium

BlueCare
HMO Premium Plan
Benefits for Covered Services

HMO
Amount Member Pays

Benefits for Covered Services	HMO Amount Member Pays
Outpatient Diagnostic Services (Continued)	
Outpatient Hospital Facility Services (per visit) In-Network - All (Any Surgical or *Non-Surgical Service) Out-of-Network *Non-Surgical services include but not limited to blood work and x-rays	 $500 Not Covered
Other Provider Services	
Provider Services at Hospital and ER In-Network Out-of-Network	 $0 Not Covered
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network Specialist Out-of-Network	 $0 Not Covered
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 $0 $0 Not Covered
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Locations other than Hospital In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network Out-of-Network	62 Visits per Lifetime Maximum $30 Not Covered $50 Copayment Not Covered
Durable Medical Equipment, Prosthetics and Orthotics (Coordinate through CareCentrix. Call 1-877-561-9910) In-Network – Motorized Wheelchair In-Network – All Other Out-of-Network	 $500 Copayment $0 Copayment Not Covered
Home Health Care (Coordinate through CareCentrix. Call 1-877-561-9910) In-Network Out-of-Network	 $0 Not Covered
Skilled Nursing Facility (PBP[1] Max) In-Network Out-of-Network	60 days $0 Not Covered
Hospice In-Network Out-of-Network	 $0 Not Covered
Hospital / Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $400 Copayment Not Covered
Inpatient Hospital Facility and Rehabilitation Services (per admit) In-Network Out-of-Network	Rehabilitation Services Limit - 30 days $500 per day / $2,500 Maximum Not Covered
Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services In-Network – All other (Any Surgical or *Non-Surgical Service) Out-of-Network *Non-Surgical Services include but not limited to blood work and x-rays	 $50 Copayment $500 Copayment Not Covered

BlueCare HMO Premium

BlueCare
HMO Premium Plan
Benefits for Covered Services

HMO
Amount Member Pays

Financial Features	
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes Medical and Pharmacy Copayments for Covered Services)	$3,000 / $9,000 Not Covered
Total Lifetime Maximum Benefit	Unlimited

[1]PBP-Per Benefit Period

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HMO Premium - Per Pay Deduction

Coverage Selected	**24 - Deduct**	**20-Deduct**
Employee Only	$ 35.00	$ 42.00
Employee Plus Child(ren)	$ 281.13	$ 337.46
Employee Plus Spouse	$ 401.08	$ 481.30
Employee Plus Spouse and Child(ren)	$ 644.59	$ 773.51
2 Married Employees of Board Plus Child(ren)	$ 252.39	$ 302.87

Additional Benefits and Features

An array of Value-Added Programs and Services* • Access to valuable health information and resources, including care decision support, our online provider directory at www.FloridaBlue.com and other interactive web-based support tools.

- Expert advice on call. We encourage you to call our care consultants team at 1-888-476-2227 to find out how much they can help you SAVE. Whether comparing the cost of your medications between local pharmacies or researching the quality and cost of treatment options before you make a decision, we can help you shop for the best value for you and your family.
- The member portal is your online gateway to everything about your health benefit plan as well as all of our self-service tools, now including an enhanced WebMD website especially for our members only.
- Online access to participating physician offices for e-office visits, consultations, appointment scheduling or cancellation, prescription refills and much more.**
- BlueCare members receive a Member Health Statement that summarizes your health care activity for the preceding month.
- Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.
- Referrals to participating providers are not required, however authorizations are required for certain medical services like hospitalization, rehabilitation services, home care, select DME,and certain office based services such as CT scans, MRIs/MRAs, cardiac nuclear medicine studies, and select injectables, etc. Additional information related to access to providers can be found in the Provider Directory. This summary is only a partial description of the many benefits and services covered by 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.

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

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

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 would apply 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 Licensee in the Blue Cross and/or Blue Shield network in that state. This is referred to as the "BlueCard 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 - Per Pay Deduction

Coverage Selected	24 - Deduct	20-Deduct
Employee Only	$ 75.00	$ 90.00
Employee Plus Child(ren)	$ 334.16	$ 400.99
Employee Plus Spouse	$ 474.75	$ 569.70
Employee Plus Spouse and Child(ren)	$ 740.61	$ 883.71
2 Married Employees of Board Plus Child(ren)	$ 302.11	$ 362.53

Blue Options PPO Standard

BlueOptions
PPO Standard Plan

Benefits for Covered Services	Amount Member Pays
Office Services	
Physician Office Services	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network Office Visit	DED[1] + 40% Coinsurance
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	DED + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$200 Copayment
Out-of-Network	DED + 40% Coinsurance
Maternity Initial Visit	
In-Network Specialist	$50 Copayment
Out-of-Network	DED + 40% Coinsurance
Allergy Injections (per visit)	
In-Network Family Physician	$20 Copayment
In-Network Specialist	$20 Copayment
Out-of-Network	DED + 40% Coinsurance
Preventive Care	
Adult Wellness Office Services (Includes Routine Adult Physical Exam, Well Woman Exam, and Immunizations)	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Mammograms (Routine or Diagnostic)	
In-Network	$0
Out-of-Network	$0
Colonoscopy (Routine/Diagnostic) (Routine Age 50+, then frequency schedule applies; High Risk, no age criteria)	
In-Network	$0
Out-of-Network	$0
Well Child	
In-Network Family Physician	$0 Copayment
In-Network Specialist	$0 Copayment
Out-of-Network	40% Coinsurance
Emergency/Convenient/Urgent Medical Care	
Urgent Care Centers (UCC)	
In-Network	$50 Copayment
Out-of-Network	DED + $50 Copayment
Convenient Care Centers (CCC) (Participating Take Care Health Services inside Walgreens Pharmacy)	
In-Network	$30 Copayment
Out-of-Network	DED + 40%
Emergency Room Facility Services (per visit) (copayment waived if admitted) (Also, Refer to Other Provider Services)	
In-Network	$100 Copayment
Out-of-Network	$100 Copayment
Ambulance Services (Ground, air and water travel, combined per day Maximum, $5,500)	
In-Network and Out-of-Network	In-Network DED + 20% Coinsurance

Blue Options PPO Standard

BlueOptions

PPO Standard Plan

Benefits for Covered Services	Amount Member Pays
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit-including provider services)	
In-Network Diagnostic Services (i.e., x-rays, ultrasounds, except AIS)	$50 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET Scan, CT Scan, Nuclear Medicine)	$200 Copayment
Out-of-Network	DED + 40% Coinsurance
Independent Clinical Lab (i.e., Blood Work) Quest Diagnostics is preferred participating lab	
In-Network	$0
Out-of-Network	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (Surgical or Non-Surgical Services)	
In-Network	$300 Copayment
Out-of- Network	DED + 40% Coinsurance
Other Provider Services	
Provider Services at Hospital and ER	
In-Network and Out-of-Network	$50 Copayment
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network and Out-of-Network	$50 Copayment
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	DED + 40% Coinsurance
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies	35 Visits Calendar Year Combined Maximum
Spinal Manipulations (26 visit per Calendar Year Maximum)	
In-Network Locations other than Hospital	$30 Copayment
Out-of-Network Locations other than Hospital	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit)	
In-Network	$50 Copayment
Out-of-Network	DED + 40% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics (Services coordinated by CareCentrix, call 1-877-561-9910)	
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Home Health Care (PBP² Max) (Coordinated through CareCentrix. Call 1-877-561-9910)	20 Visits PBP Maximum
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Skilled Nursing Facility (PBP Max)	60 days PBP Maximum
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Hospice	
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance

Blue Options PPO Standard

BlueOptions

PPO Standard Plan

Benefits for Covered Services	Amount Member Pays
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $200 Copayment DED + 40% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network Out-of-Network	Rehabilitation Services limit - 30 days DED + 20% Coinsurance DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (Surgical or Non-Surgical Services) In-Network – Therapy Services In-Network – All other Services Out-of-Network	 $50 Copayment $300 Copayment DED + 40% Coinsurance
Financial Features	
Deductible (DED) (Per Benefit Period) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before Florida Blue pays)	 $1,000 / $3,000 $3,000 / $9,000
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 20% 40%
Out-of-Pocket Maximum (Per Calendar Year) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance, Medical and Prescription Drug Copayments)	 $3,000 / $9,000 $6,000 / $12,000
Total Lifetime Maximum Benefit	No Lifetime Maximum

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

PPO Standard - Per Pay Deduction

Coverage Selected	24 - Deduct	20-Deduct
Employee Only	$ 75.00	$ 90.00
Employee Plus Child(ren)	$ 334.16	$ 400.99
Employee Plus Spouse	$ 474.75	$ 569.70
Employee Plus Spouse and Child(ren)	$ 740.61	$ 883.71
2 Married Employees of Board Plus Child(ren)	$ 302.11	$ 362.53

Additional Benefits and Features

An Array of Value-Added Programs and Services*

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***www.floridablue.com*** and other interactive web-based support tools.
- **Member Portal** is your online gateway to everything about your health benefit plan as well as all of our self-service tools, now including an enhanced **WebMD** website especially for our members only.
- **Expert advice on call.** For more personal assistance, you can call our care consultants at 1-888-476-2227 for cost-effective, quality care options. Plus, health coaches are available 24/7 on your schedule.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.**
- BlueOptions members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Access to Our Strong Networks

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

Blue Options PPO Standard

BlueOptions

PPO Standard Plan

Benefits for Covered Services | Amount Member Pays

Physician Discount

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

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

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

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 **See All Deals** or you may narrow your search by category.
3. To redeem any offers, you will need to register.

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

Healthy Eating

Jenny Craig- Skip the fads and gimmicky diets and experience real results with Jenny Craig. Choose from either:

- Free 3 month program and $50 in Food Savings
- Save 50% off Jenny Craig Premium programs

NutriSystem® - 40% Discount on NutriSystem Consecutive 4-week Auto-Delivery Program Orders. Free Shipping within the Continental U.S.

Retrofit - 15% off Private Weight Loss Coaching Programs.

Fitness

Tivity Health® Fitness Your Way - $25 monthly fee for access to network of 9,500+ gyms nationwide. Low $25 enrollment fee.

Heart Rate Monitors USA - Save on select FitBit®, MIO®, and Polar© Heart Rate Monitors, Activity Trackers and more.

Sketchers Direct - 30% off Select Men's and Women's Sketchers styles year-round.

PETPLAN

10% discount on Pet Insurance.
Call 1-800-231-7963

Vision

Davis Vision - 10% to 40% off Vision Products

Lasik Plus - Receive $800 or more off LASIK at LasikPlus centers nationwide.

Qualsight Lasik - Discount on Lasik Eye Surgery.

Hearing

Beltone - Free hearing screenings and set discounted prices on hearing aids.

TruHearing - Save 30% to 60% on hearing aids.

HOPE Paige Medical

30% discount on medical emergency bracelets.

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 PrimeMail® mail 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 CareMark Specialty Pharmacy (1-866-278-5108) or Prime Specialty Pharmacy (1-877-627-6337).

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

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

Personal Prescription Mail Order Program

Customer Service: 1-844-353-2879 Physician Fax: 1-844-333-0700 Email: inquiries@electrx.com

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Pasco County Schools & Elect Rx Announce a New Partnership
To Save You Significant $$$$ on Your Brand Drugs!

Elect Rx is a leading US based group of pharmacy benefit strategists dedicated to driving down the ever-rising cost of prescription drugs for self-insured employer-sponsors, their employees, & retirees.

The Elect Rx Personal Importation Program is designed specifically to offer the true lowest net cost on ***brand*** name prescription drugs for Pasco County Schools, Employees, & Retirees of the district. Medical coverage in the District's group health plan in required to participate in the Elect Rx plan.

The Elect Rx prescription plan is in addition to the District's pharmacy coverage through Florida Blue. Participation is completely voluntary and is for people with chronic health issues such as high cholesterol and high blood pressure.

Through this partnership, plan members will benefit from:

- $0 copay on the ***first order*** of medication
- $10 copay for each 90-day supply of refills

This benefit puts money immediately back where it belongs….In your pocket!

The Elect Rx Personal Importation Program is easy to use:

Check to see if your medication is on the Elect Rx formulary

Then you can choose between 3 easy ways to ***activate your account***:

1. Activate your account by calling the toll free number below to speak with a customer service representative (Hours are 9am-9pm EST Monday-Friday; 9am-4pm Saturday & Sunday)
2. Activate your account online in 5 minutes at: https://my.globalrxmanage.com/customers/pasco-county-schools/sign-up
3. Activate your account at the District's Health and Wellness Centers

Elect Rx Customer Service: 1-844-Elect Rx (1-844-353-2879)
Elect Rx Physician Fax: 1-844-333-0700
Customer Service Email: inquiries@electrx.com
Questions regarding medication: pharmacist@electrx.com

Once your account is activated:

a) Your doctor can fax the **90-day prescription**, with three refills, to the toll-free physician fax number 1-844-333-0700

OR

b) The District's Health and Wellness Centers can fax your prescription to Elect Rx.

OR

c) You can take a picture of your prescription with your smartphone and upload it to your established account.

You will have 24/7 access to your own personal portal using your Account ID and password at: https://my.globalrxmanage.com/customers/login
Medications are delivered directly to your home. You will receive an automated reminder notification of a pending renewal/refill on or around day 60 of the last 90-day supply shipped. Orders are processed in 3-5 days and shipping takes 10-15 business days. There are no shipping costs for the medications and a medical FSA ***cannot*** be used for the $10 copays.

You will be contacted by telephone to make your $10 co-pay using a credit card. Security is very important so credit card numbers are never stored in the Elect Rx system.

FAQ's

1. **Are these brand drugs the same as the ones purchased in the US?**
   They are essentially identical and manufactured in advanced countries like Canada. You may not know that most of the brand drugs sold in the US are actually re-imported back into the US from these same facilities by many US drug companies that invented them.
2. **Are all brand drugs available through Elect Rx?**
   No. Medications that need to be injected or need to be kept cold for long periods cannot be dispensed. However, most other brand drugs are available. The District's drug list (formulary) is updated both electronically and in hard copy on a regular basis. You can see the formulary when you sign into your Elect Rx account.
3. **Why would you want to use the Elect Rx PI Program?**
   You will have a $0 copay on your first 90-day fill. You will pay only $10 on all future 90-day refills. The medications are delivered right to your home. Cost will no longer be a barrier for you to continue to take the medications your doctor feels you need every day.
4. **Where are the medications coming from?**
   Prescriptions are sent from brick and mortar pharmacies located in Canada, England, Australia, and New Zealand. These are the same medications that pharmacists are dispensing in US pharmacies every day.
5. **Why are the medications so much less expensive?**
   Both drug advertising and rebates to pharmaceutical companies are illegal in countries outside of the U

Behavioral Health Benefits

New Directions Behavioral Health

(NDBH) is Florida Blue's partner for behavioral health capabilities and programs. NDBH manages behavioral health services for BlueCare HMO and BlueOptions PPO members receiving services in Florida. New Directions provides a centralized solution that coordinates all of a patient's behavioral health care needs (i.e. authorization and manages all 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 for HMO Basic/Premium members or BlueOptions for PPO Standard members.) Then provide your Florida Blue Member ID card and pay $35 copay per visit. The provider will submit the claims directly to Florida Blue for processing.

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*	$200 Copay	$300 Copay	$100 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. $3,000 + 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. $3,000 + 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, access New Directions website:

1. www.ndbh.com
2. Click on link "For Individuals and Families"
3. Choose Your Program "Managed Behavioral Health" (You do not need to enter your user name or password)
4. Click on link "Search for Providers"
5. Click on "Search by Network Plan"
   - BlueCare HMO select "BCBS FL Health Maintenance Organization (HOI)"
   - BlueOptions PPO select "BCBS FL Network Blue (NWB)"
6. Input data for your search criteria or use your Member ID data
   - Use your Member ID number (Use the entire number. i.e. PJZH********)
7. Enter 5-digit Zip code
8. Click on "Search"
9. Click on "I Understand"
10. Your search results should appear

NEW DIRECTIONS

Employee Assistance Program

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 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 not 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, Hudson, 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 / 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?

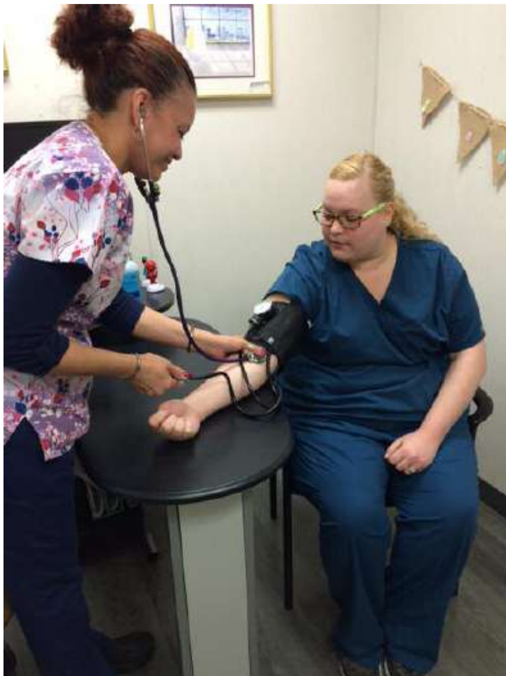
Free Medical Care!
- No deductibles
- No co-pays
- No out-of-pocket costs to you

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

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

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

Available Vaccines
- Recombivax (Hep B) series
- Mantoux PPD (TB test)
- TDap (Tetans, Diptheria, Pertussis)
- Zostavax (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 logging onto www.carehere.com or calling 1(877)423-1330 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 (HIPPA/Privacy compliant) at your CareHere Health and Wellness Centers! Your private health information and visit activity will never be shared with anyone at the school district.

Flu Vaccines

CareHere offers 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, CareHere suggests patients receive the vaccine during the fall (beginning October/November) to provide maximum coverage throughout flu season. Talk with your CareHere provider to learn more about the vaccine, or call 1.877.423.1330 for more information.

Wellness Programs

There are a number of wellness programs available for free to Health and Wellness Center participants. Onsite and online options via CareHere Connect include:

- Cholesterol Management
- Weight Management
- Diabetes Management
- Beginners Exercise
- Healthy Eating/Pre-diabetes
- Tobacco Cessation
- Hypertension Management
- Stress Management
- Healthy Body/ Healthy Mind
- Snail-to-trail (Couch to 5K program)

Health Coaches

CareHere Certified Health Coaches are available to Health and Wellness Center participants at no cost. They are professionals from varied backgrounds and education who will partner with you to help you achieve your health and wellness goals.

- If you're tired of following the latest fads only to end up where you started, join forces with your personal health coach.
- CareHere Health Coaches use research-based knowledge and skills to build upon your strengths and give you resources to support lasting change.
- We feel that you are an expert of your own life. Your coach will assist you on your journey to health in a respectful and non-judgmental way.
- Whether you are interested in losing weight, managing stress, increasing exercise, quitting tobacco, improving sleep, maximizing your health or just feeling better – your personal CareHere Health Coach is here for you!

Email Support@CareHere.com or call 1.877.423.1330 to schedule an appointment with a health coach today!

CareHere Connect (CareHere Wellness Portal)

Sometimes getting healthy may seem overwhelming. It is hard to know where to start or how much progress you're making toward meeting your health goals. CareHere Connect is here to help. CareHere Connect will help you set goals and will break them down into actionable tasks. On the CareHere Connect system, you will be able to login in order to see your health data (provided by CareHere) and learn what you can do, step by step, to achieve better health. Once on the homepage, you will have access to several helpful tabs, including:

- My Plans: A plan is a set of recommendations to guide your day-to-day activities, helping you reach your goals.
- My Targets: Targets will show how you're progressing with each goal.
- My Updates: This button displays important information, such as your overall accomplishments
- My Network: This tab tells you how others in your network are dealing with some of the same issues you're facing. You can help create a health-oriented company culture by getting and giving support to your colleagues as you progress through the system.

To access CareHere Connect:

1. Go to www.CareHere.com and select Member Login.
2. You will enter your personal username and password to be directed to your CareHere homepage.
3. Once on your homepage, choose the *CareHere Connect* button in order to access the site.
4. The first time a new user logs into CareHere Connect, they will be asked to *Join Now* in order to access the site.
5. Once you select *Join Now* and agree to the terms on the site, you will be directed to your CareHere Connect home page.

If you have any questions about using the site, check out the instructional tutorials located in the *Help* section of the site. The link to the *Help* tutorials is located in the upper right corner of your home screen.

Scheduling Appointments

1. Go to www.CareHere.com and log on with your username and password (click "I forgot my username or password" if you do not remember.)
2. Click **Appointments-SS** in the green navigation bar to the left of your screen
3. Click **More Selections**
    a. When: Select a date range that fits your schedule
    b. What: Select your appointment type
    c. Where: Select the HWC location that works for you
    d. Who: Select your preferred provider
4. Click **Get Appointments**
5. Find an open appointment, click **Make Appointment**
6. Enter the reason for your visit in the comments section
7. Click **Confirm Your Appointment**
   OR
   Call 877.423.1330 to schedule your appointment through the CareHere Help Desk

First-time User?

1. Visit www.CareHere.com
2. Click **Member Login** at the top of the page
3. Click **I need to register for the first time with my access code**
4. Enter access code "PCFSD7" and click **go**
    a. You should receive this message, "Access Code is for: Pasco County School District"
    b. If you receive this message, click **next**
    c. If not, click **re-enter access code** and re-enter code
5. Review the privacy consent page and click **I agree with the above statements** to continue

CREATE USERNAME AND PASSWORD

1. Enter your social security number (required for identification purposes)
2. Enter your date of birth (required for identification purposes)
3. Create your username
4. Create your password
5. Enter your email address (personal email preferred; however, work email is acceptable)
6. Review for accuracy and click **update**
7. Complete the health questionnaire page; you may skip any questions you cannot answer

A confirmation email will be sent to the email address that you provide. You may now log in as a member by visiting www.CareHere.com and clicking **Member Login**.

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 (All Centers)

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

Saturday Schedule

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

Retirement Benefits

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

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

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

Source 1: You Get Social Security

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

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

Source 2: You Get A Retirement PLAN

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

Florida Retirement System (FRS) Employee Contributions

Pasco County Schools contributes the majority of your FRS retirement plan savings. In addition, all members (except those in DROP) contribute a mandatory 3% pretax contribution from your paycheck into your retirement account, regardless of the Plan you choose. Your 3% contribution will be deducted from your gross salary each paycheck before taxes.

How to Decide on a Plan

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

Plan Type.

The Pension Plan is a traditional plan for longer services employees. The Pension Plan pays a guaranteed monthly lifetime benefits based on your years of service and salary.

The Investment Plan is for employees who change jobs more frequently (every 1 – 7 years). Your retirement benefit is based on your account balance at retirement.

Warning: You have 5 months from your hire date to decide which retirement plan is best for you . If you do not decide by the deadline, you are automatically enrolled in the Pension Plan.

Vesting

Vesting simply refers to the date that you first own your retirement plan and qualify for retirement benefits. Once you choose a plan, you must meet the vesting requirement of that plan to be eligible to receive a retirement benefit from that plan.

Pension Plan:

- Enrolled before July 1, 2011 after 6 years of credible service
- Enrolled on or after July 1, 2011 after 8 years of credible service

Investment Plan

- After 1 year of credible service

Normal Retirement

Normal Retirement is the date you first become eligible to receive a benefit from your retirement plan without penalty.

Pension Plan:

- Enrolled before July 1, 2011 Age 62 with 6 years of service or 30 years of service regardless of age
- Enrolled after July 1, 2011 Age 65 with 8 years of service or 33 years of service regardless of age

Investment Plan:

Age 59½ and vested based on the date you first enrolled in the Florida Retirement System.

Participating in DROP

To participate in DROP, you must be vested and eligible for normal retirement. Once eligible to participate in DROP, you may enroll for up to 60 months or 5 years. You may first begin participating in DROP on either:

- The first of the month that you reach your normal retirement based on age or
- The first of the month following the month you complete 30 years of service You have a 12-month window from the first date that you become eligible to participate in DROP to enroll. For each month your delay enrollment, you reduce the number of months that you are eligible to participate in DROP. If you have not enrolled by the end of your 12-month window, you cannot participate in DROP. There are two exceptions, which will allow you postpone enrollment in DROP:

1. If you reach 30 years of service before age 57, you may postpone your enrollment until the month you reach age 57.
2. Instructional staff may postpone their enrollment in DROP to any future date and still be eligible to participate for the full 60 months.

You Can Switch Plans. Once.

During your working career as an FRS member, you can switch your plan from the Pension Plan to the Investment Plan or vice versa. But you can only do it once. This is called your Second Election. Once you do it, your decision is final. You can never change again. Call the FRS Financial Guidance line at 866-446-9377 to obtain unbiased financial advice before you make a change.

You May Get Credit for Other Service.

If you're enrolled in the Pension Plan and you have been a public service employee (in-state or out-of-state), you may be able to buy up to 5 years of FRS service credit. You may also be able to buy up to 4 years of military service. It's a good way to increase your retirement income. Now, of course, to buy service credits, you have to follow the rules. The rules dictate job type, position, location, retirement coverage and so on. So it's best to check with the Florida Division of Retirement.

When You are Close to Retirement

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

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

Thinking of Returning to Work After Retirement?

After retiring under the Florida Retirement System or concluding DROP participation, you may work for any private employer or for any public employer that does not participate in the FRS without affecting your FRS retirement benefits. However, you are subject to certain limitations with respect to your employment with any FRS employer during the first twelve months of retirement. If you are a retired member of the FRS Pension Plan, you should always contact the Bureau of Retirement Calculations at (888) 738-2252 before returning to employment in any capacity with any FRS employer in your first year of retirement. Investment Plan members should contact the FRS Financial Guidance Line at (866) 446-9377 before returning to employment.

Source 3: Your Retirement Savings Plan

Here's a startling statement. If you want to live well in retirement, you can no longer rely on your Social Security and pension benefits alone! You must save more. Fortunately, you have many excellent retirement savings plan options available here. However, you must take action. You must get into one or more of these plans. You must save as much as you can, as early as you can. There are several retirement plan vendors that have been approved by the Board. You can feel comfortable with any one of them.

The Rewards of a Personal Savings Plan

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

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

Your Retirement Projections

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

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

Scenario 1.
Sally retired at age 62 with 20 years of service. She was a Pension Plan participant, with no additional savings. Her final salary in 2006 was $58,000. She wants to collect Social Security immediately. Plans replace 58% of her income.

Scenario 2.
Nancy is in the same situation (retiring at 62, with 20 years, same salary, pension plan, and Social Security) except that she has saved $200,000 in her Retirement Savings Plan. Plans replace 85% of her income. Clearly, Nancy will live more comfortably in retirement, and will have a more flexible lifestyle, and will be better able to accomplish her goals for the future. This is a brief summary of your available sources of retirement income. Consult your financial advisor about your future plans.

Sally 58%

Sally 85%

Voluntary Retirement Savings Program

As an employee of the Pasco County Schools (District), you have a unique opportunity to invest a portion of your income for retirement. Depending on the plan you choose, you do not have to pay income tax on the amount you contribute or any earnings, until you retire or withdraw funds. You can start with as little as $10.00 per pay and increase your contributions up to the maximum amount allowed by the Internal Revenue Service (IRS). The investment options include a wide selection of mutual funds, fixed accounts, and variable annuities managed by authorized investment companies. All regularly scheduled employees, with the exception of school board members, may elect to contribute to a personal retirement savings account through salary reduction. Upon employment, you are immediately eligible to participate.

What is the Voluntary Retirement Savings Program?

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

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

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

3. A 457(b) plan is a type of tax-advantaged deferred compensation retirement plan that is available for governmental and certain non-governmental employers. You defer portions of your current salary into the 457(b) plan on a pre-tax basis. For the most part, the plan operates similarly to a 403(b) plan.

The key difference is that, unlike the 403(b) plan, there is no 10% penalty for withdrawal before age 59 ½. Withdrawals are subject to ordinary income taxation.

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

You may request additional information concerning the specific provisions of each plan. It is important to select an account and company best suited to your specific needs and goals. Once you have selected a company, you must meet with a representative and complete a salary reduction agreement (SRA). Both the company's authorized representative and you must sign the SRA. The representative is responsible for forwarding the signed agreement to Employee Benefits for processing. Please read the agreement carefully before signing. Be sure to retain a copy of the agreement for your records.

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

Authorized Investment Companies

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

Plan Administration

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

Plan Distribution Transactions

Distribution transactions may include any of the following:

- Exchanges, Hardship Distributions, Loans, Rollovers, Transfers of Assets, Withdrawal of Funds (Distribution).

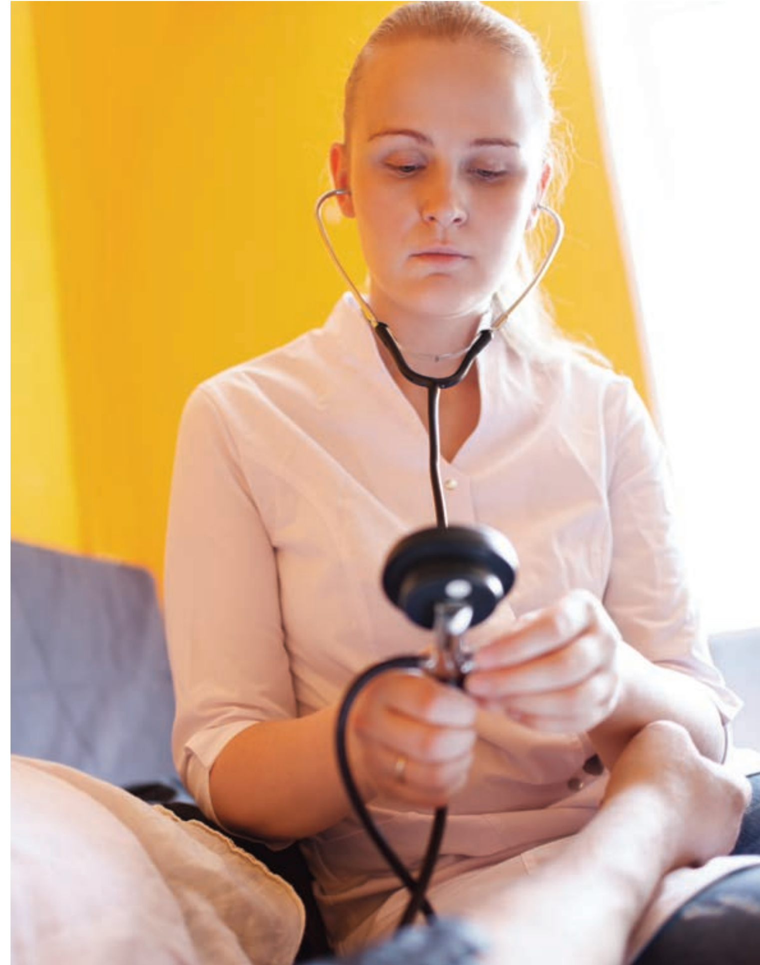
Employees/Participants may request these distributions by completing the necessary forms obtained from the provider and plan administrator as required. Submit all completed forms to TSACG, the plan administrator, for processing.

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

For additional information about TSACG's role in the District's plan, visit TSA Consulting Group's website at www.tsacg.com or call (888) 796-3786, Option 4.

About Worker's Compensation Work Related Accidents

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



What are your rights and responsibilities?

1. Immediately report all work-related accidents to your supervisor.
2. If your work-related accident results in the need for medical treatment, and is not an emergency, you must immediately report the injury to your supervisor before seeking medical treatment.
   - If your accident is serious and requires immediate medical treatment, go to the nearest hospital for treatment or call 911.
   - After treatment, have a representative from the facility call Johns Eastern Company at 1-800-749-3044.
3. Contact the Workers' Compensation (WC) Designee at your worksite to complete a "Notice of Injury" report and obtain authorization for medical services. **If you are injured during normal business hours, you must seek initial treatment at a Health and Wellness Center (HWC) nearest to your work location.**
4. Obtain all medical services from a provider within the District's authorized workers' compensation provider network. If your treating physician approves treatment by another physician, you must obtain authorization from Johns Eastern Company at 1-800-749-3044 before your first date of treatment.
5. Keep all scheduled appointments and be on time for all medical treatments and evaluations. You are encouraged to schedule appointments before or after your normal work schedule.
6. If you choose to cancel or do not keep your scheduled appointment(s), you may be considered in non-compliance which may affect your eligibility for workers' compensation benefits. Contact the nurse case manager or adjuster assigned to your case before canceling or rescheduling an approved appointment.
7. Return to work as soon as your treating physician releases you.
8. Cooperate and respond to all requests from Johns Eastern Company regarding your work-related injury.

Medical Treatment After Normal Business Hours

If you are involved in a work-related accident that occurs after normal business hours and require immediate medical treatment, go to the nearest urgent care facility, hospital emergency room or call 911. Whenever possible, you should attempt to access one of the District-approved urgent care facilities or hospitals first. However, if the injury is life threatening, go to the nearest hospital emergency room for treatment. A list of approved facilities is available at www.pasco.k12.fl.us/ebarm/comp. Examples of when you should use an urgent care facility or hospital emergency room as initial treatment for a work-related injury or illness:

1. The injury or illness is life threatening.

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

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

IMPORTANT
After receiving treatment at an urgent care facility or hospital emergency room, you must follow up with the on-site Health and Wellness Center nearest your work location before returning to work. Within 24 hours of emergency treatment, call Johns Eastern Company at 1-800-749-3044 to coordinate all follow up medical treatment.

Fraud Statement

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

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

Return-to-Work Program

The District's Return-to-Work (RTW) Program promotes successfully returning an employee who has experienced a work- related injury to his or her normal duties as quickly as medically possible. All efforts are made to return an injured employee to his or her current position; however, occasionally it may be necessary to reassign an injured employee to alternate duty. Your participation in the RTW Program is **required** when you are offered modified or alternate duties within the functional limitations and restrictions identified by your authorized treating provider. **Refusal to participate in the RTW Program may negatively impact your workers' compensation benefits, as well as possible discipline up to and including termination from the District.** The RTW Program applies to all employees, substitutes and interns who sustain a work related injury.

Workers Compensation Contacts

District School Board of Pasco County
Phone: (813) 794-2520 or 2084
Fax: (813) 794-2039

Johns Eastern Company

Phone: (800) 749-3044
Fax: (813) 402-7922

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.

ACA Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

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

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

ACA Notice

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name			4. Employer Identification Number (EIN)
District School Board of Pasco County			59-60000792
5. Employer address 7227 Land O' Lakes, Blvd			6. Employer phone number (813) 794-2253
7. City Land O' Lakes		8. State FL	9. ZIP code 34638
10. Who can we contact about employee health coverage at this job? Office for Human Resources and Educator Quality, Employee Benefits Section			
11. Phone number (if different from above) (813) 794-2253	12. Email address jrusha@pasco.k12.fl.us		

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

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

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

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

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

  - ☐ We do not offer coverage.

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

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

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

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

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 infor-mation. For each category of uses and disclosures, there is an explanation and examples. Not every use or disclo-sure 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 School 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 t he 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.

2018 Pasco County School Board Plan Comparison

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare Basic HMO	BlueCare Premium HMO	BlueOptions Standard PPO
Deductible (DED) (Per Person/Family Agg)			
In-Network	$2,000/$6,000	$0	$1000/$3000
Out-of-Network	Not Covered	Not Covered	$3000/9000
Hospital Per Admission Deductible (PAD)			
In-Network	$100	$0	$0
Coinsurance (Member Responsibility)			
In-Network	20%	0%	20%
Out-of-Network	Not Covered	Not Covered	40%
Out of Pocket Maximum (Per Person/Family Agg) (Includes DED/Coins./Copays,)			
In-Network	$5500/$11000	$3000/$9000	$3000/$9000
Out-of-Network	Not Covered	Not Covered	$6000/$12000
Lifetime Maximum	Unlimited	Unlimited	Unlimited
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections			
In-Network Family Physician	$10	$20	$20
In-Network Specialist	$10	$20	$20
Out-of-Network	Not Covered	Not Covered	DED + 40%
E-Office Visit Services			
In-Network Family Physician	$10	$30	$10
In-Network Specialist	$10	$50	$10
Out-of-Network	Not Covered	Not Covered	DED + 40%
Office Services			
In-Network Family Physician	$35	$30	$30
In-Network Specialist	$65	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Provider Services at Hospital and ER			
In-Network Family Physician	DED + 20%	$0	$50
In-Network Specialist	DED + 20%	$0	$50
Out-of-Network	Not Covered	Not Covered	$50
Provider Services at Other Locations			
In-Network Family Physician	$35	$0	$30
In-Network Specialist	$65	$0	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center			
In-Network Specialist	$65	$0	$50
Out-of-Network	Not Covered	Not Covered	$50
PREVENTIVE CARE			
Adult Wellness Office Services			
In-Network Family Physician	$0	$0	$0
In-Network Specialist	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
Colonoscopies (Routine/Diagnostic) (Age criteria applies: Routine 50+, High Risk, N/A)			
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0

2018 Pasco County School Board Plan Comparison

Florida Blue

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare Basic HMO	BlueCare Premium HMO	BlueOptions Standard PPO
Mammograms (Routine and Diagnostic)			
In-Network	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	$0
Well Child Office Visits (No BPM)			
In-Network Family Physician	$0	$0	$0
In-Network Specialist	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	40% Coinsurance
EMERGENCY/URGENT/CONVENIENT CARE			
Ambulance Services (Air, Ground			
In-Network	DED + 20%	$100	DED + 20%
Out-of-Network	DED + 20%	$100	INN DED + 20%
Convenient Care Centers (CCC) (Par Take Care Health Clinics inside Walgreens Rx)			
In-Network	$35	$30	$30
Out-of-Network	Not Covered	Not Covered	DED + 40%
Emergency Room Facility Services (per visit) (Copayment waived if admitted) (also see Professional Provider Services)			
In-Network	$300	$200	$100
Out-of-Network	$300	$200	$100
Urgent Care Centers (UCC)			
In-Network	$70	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + $50
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.			
Ambulatory Surgical Center (ASC)			
In-Network	$250	$400	$200
Out-of-Network	Not Covered	Not Covered	DED + 40%
Independent Clinical Lab (Par Lab is Quest Diagnostics)			
In-Network	$0	$0	$0
Out-of-Network	Not Covered	Not Covered	DED + 40%
Independent Diagnostic Testing Facility (IDTF) - X-rays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS) (I.E., MRI's, CT Scans, Nuclear Medicine)	$300	$50	$200
In-Network - Other Diagnostic Services	$50	$0	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Inpatient Hospital (per admit)			
In-Network	$100 + DED + 20%	$500 per day,$2500 max	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Hospital (per visit) (Surgical or Non-Surgical Svcs., i.e., lab work/ Dx Testing)			
In-Network	DED + 20%	$500	$300
Out-of-Network	Not Covered	Not Covered	DED + 40%
Therapy at Outpatient Hospital			
In-Network	$65	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%

2018 Pasco County School Board Plan Comparison

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueCare Basic HMO	BlueCare Premium HMO	BlueOptions Standard PPO
OTHER SPECIAL SERVICES AND LOCATIONS			
Advanced Imaging Services in Physician's Office			
In-Network Family Physician	$300	$50	$200
In-Network Specialist	$300	$50	$200
Out-of-Network	Not Covered	Not Covered	DED + 40%
Birthing Center			
In-Network	DED + 20%	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Diabetic Equipment * (Insulin Pump & Supplies) (Coordinated via CareCentrix)			
In-Network	$0	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics (Coordinated via CareCentrix)			
In-Network	$0/$500 Motorized Wheelchair	$0/$500 Motorized Wheelchair	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Home Health Care BPM (Coordinated via Par Vendor, CareCentrix)	20 visits per BP	Unlimited	20 visits per BP
In-Network	$0	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Hospice			
In-Network	DED + 20%	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Therapy and Spinal Manipulations BPM	35 visits per BP	62 lifetime visits per BP	35 visits per BP
Outpatient Rehab Therapy Center			
In-Network	$65	$30	$30
Out-of-Network	Not Covered	Not Covered	DED + 40%
Outpatient Hospital Facility Services (per visit)			
In-Network	$65	$50	$50
Out-of-Network	Not Covered	Not Covered	DED + 40%
Skilled Nursing Facility BPM	60 days per BP	60 days per BP	60 days per BP
In-Network	DED + 20%	$0	DED + 20%
Out-of-Network	Not Covered	Not Covered	DED + 40%
Medical Pharmacy (Physician Administered)			
In-Network Monthly Out of Pocket Max** for medication only	$200	$0	$0
In-Network Provider (cost of medication)	20%	$0	$0
Out-of-Network Provider	Not Covered	Not Covered	DED + 40%

* Diabetic Supplies (lancets, strips, meters, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

** (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.

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

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.