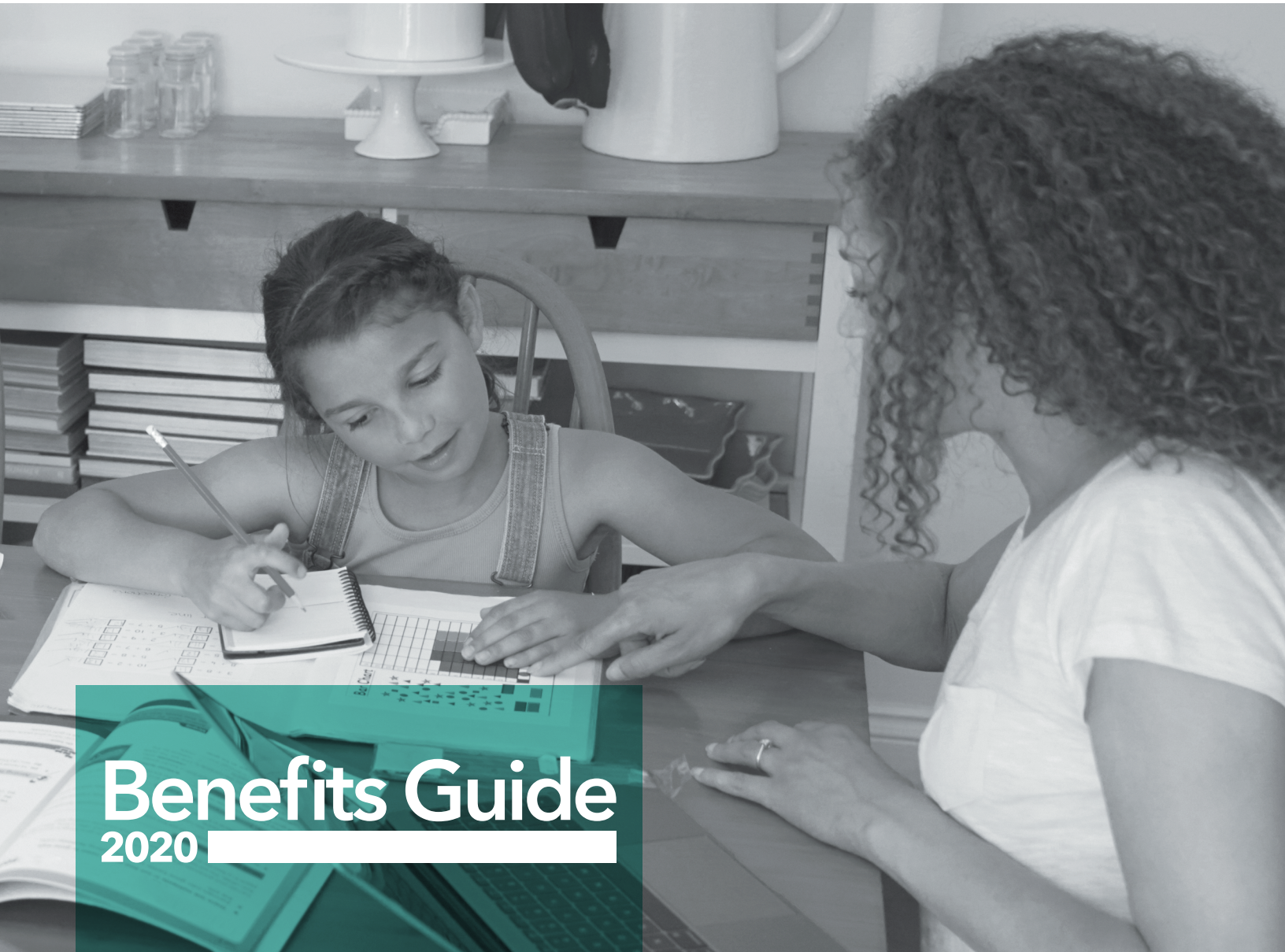




POLK COUNTY
PUBLIC SCHOOLS
STUDENTS FIRST



Benefits Guide

2020

polkschoolsfl.com/benefits

The Annual Benefits Guide and personalized enrollment form will be available on the Staff Portal. Open Enrollment forms and booklets will not be mailed to all employees.

All forms must be returned to the Risk Management & Employee Benefits Department by **October 11th, 2019**. Send forms to the Risk Management Department by:

Courier:

Benefits Department
District Office, Route E

Mail:

Polk County Public Schools
Atten: Benefits Department
P.O. Box 391
Bartow, FL 33831

For additional assistance please contact the Risk Management and Employee Benefits Department at:

Phone: 863-519-3858

Email: RiskManagement-AllStaff@polk-fl.net

New for 2020

- Dependent Verification (page 5)
- New vision carrier—Avesis (page 22)
- Open Enrollment Benefits Meetings

Open Enrollment Meetings—2020 Plan Year

Saturday September 28, 2019

Time: 08:30 am - 11:30 am

Haines City Senior High—auditorium

2800 Hornet Dr

Haines City, FL 33844

Saturday October 5, 2019

Time: 08:30 am - 11:30 am

Jim Miles PDC

4270 Wallace Rd

Lakeland, FL 33812

Reminder:

Deductions for January coverage will be taken from your December paycheck. Be sure to check both your December and January paychecks to ensure 2020 elections are correct.

Welcome from Risk Management

Greetings Fellow Polk County Public Schools Employees:

It is our pleasure to welcome you to the 2020 Open Enrollment. The Annual Open Enrollment period is your once-a-year opportunity to make changes to your current benefit election and to review your covered dependents. The plan year begins on January 1 and continues through December 31. Benefit elections made during Open Enrollment are generally binding for the entire plan year.

Polk County Public Schools is committed to providing high quality benefits for you and your family. The diligent effort of the Superintendent of Schools, School Board Members, employee unions and Risk Management continue to demonstrate the results of an excellent partnership. Your benefits are a valuable part of your employment with Polk County Public Schools. Be sure you are making the most of them!

We are excited to announce that effective January 1, 2020 the Polk County Public Schools vision plan will be changing from UnitedHealthcare Vision to Avesis Vision Plan, a Guardian company. With this change in vision carriers employees will see a 4% reduction in premiums while experiencing the same or enhanced benefits. **Please be sure to watch out for communications sent to your PCPS email address.**

The enclosed 2020 Benefits Guide includes a summary of your benefit plans, the eligibility requirements and instructions on how to enroll. The Risk Management and Employee Benefits Department will be conducting an audit beginning in the fall of 2019 of all dependents enrolled on the PCPS group health, dental and vision plans. Employees with dependents on any of these plans are encouraged to review dependent eligibility guidelines and documentation required and submit the required documentation during the 2020 Open Enrollment. **Employees that do not submit this information during Open Enrollment or the dependent verification will have their dependents removed from coverage.**

Remember, your individualized enrollment form will be available on the Staff Portal. The 2020 Benefits Guide will be available through the PCPS hub at thehub.polk-fl.net/riskmanagement/insurance-benefits.

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What Should I Do?

Review this Booklet

Open Enrollment is your one-time opportunity to review your current benefit elections and make any changes that may be needed for you and your family. Please take the time to familiarize yourself with the guide's contents. We hope that after you review this guide you will have a clear understanding of the changes that will be effective January 1, 2020, and how they may impact you and your covered dependents. At PCPS, you are important! That's why we work hard to provide you with affordable benefit options for you and your family.

Access Your Personalized Enrollment Form

Accessing the Staff Portal is easy. All you have to do is visit our website at www.polkschoolsfl.com, click the "Login" tab at the top right and then click on "Staff Portal" in the drop-down menu. Enter your username (firstname.lastname) and your password (your email/network password) then click the "Log In" button. Once logged in to the Staff Portal click on the Employee Benefits tab on the left side. You are able to access and print your personalized enrollment form from this page.

Make 2020 Elections

Risk Management is pleased to announce the District continues to fund employee health coverage 100%. Please ensure you review the information in the guide carefully for these changes. If you do not wish to make any changes, you do not need to do anything. **However, if you are enrolled in a Flexible Spending Account, you must re-enroll if you want to continue participating in**

2020. The IRS requires that FSA elections be made each year.

Print & Submit your Form

Forms must be returned to the Risk Management and Employee Benefits Department by **October 11, 2019**. If you do not submit a completed enrollment form your benefits will remain the same for 2019 with the exception of Flexible Spending Accounts, which will be discontinued without a new enrollment election.

Employees without regular access to computers will be permitted to use PCPS computers at school locations. Each location will also have a person designated to help print personalized forms for those without computers. You may also visit the Risk Management and Employee Benefits Department for assistance. Forms received after the due date cannot be accepted. **ORIGINALS ONLY – NO FAXES PLEASE.**

What if I want to waive the health insurance?

If you are covered by another health plan and do not wish to enroll in the PCPS Health Plan, please check the box to waive coverage and return it to the Risk Management & Employee Benefits Department. **Important note:** If you are covered under another group health plan, failure to waive the PCPS Health Plan means that the PCPS Health Plan is considered your primary insurance and your other plan will be your secondary insurance.

Eligibility

Who Is Eligible?

Employees

Employees who work at least 30 hours per week and have completed the necessary waiting period, including those active employees eligible for coverage under Medicare, are eligible for benefits. All employees are automatically enrolled in the Group Health Plan unless they submit the appropriate waiver.

Spouses

Spouses are eligible for coverage when they met all requirements of a legal marriage in the state of Florida. An ex-spouse does not meet eligibility criteria even if insurance coverage is specified by a judge in a divorce decree.

If you and your spouse are both school board employees and eligible for coverage, you may select the “Board Spouse” option. This allows employees to take advantage of the family deductible and out-of-pocket maximum while ensuring both employees receive the full board contribution for your coverage.

Children

A covered employee’s children are eligible for coverage until the end of the calendar month in which they turn 26. An eligible child includes the employee’s natural born, adopted, foster, or step child(ren), and a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian.

There are provisions for continuing coverage for disabled dependent children beyond the age of 26. If you feel you have a dependent who may meet this criteria and have not already submitted documentation to Risk Management, please contact our office at 863- 519-3858 so that we can assist you with this process.

Grandchildren

Grandchildren can only be covered up to 18 months of age and are only eligible if the parent remains covered.



Dependent Eligibility

The Risk Management and Employee Benefits Department will be performing a full dependent verification of its insurance plans in 2020. This audit will verify the continued eligibility of all dependents enrolled on the District's group health, dental and vision plans. All PCPS employees with dependent coverage **will be** required to submit the required documentation.

During the 2020 Open Enrollment PCPS employees with dependent coverage need to review their covered dependents. Please remember the following types of dependents are examples of those relationships that are not eligible: ex-spouse (even if court ordered in divorce), ex-stepchild(ren) and significant others (not legally married). If you find that you are covering a dependent that is no longer eligible please ensure they are removed during Open Enrollment.

| Dependent Relationship | Documentation Required |
|---|--|
| Spouse | Copy of marriage certificate and copy of your joint 2018 federal tax return or both of your tax returns if you file separately. Include the front page through line 6 of Form 1040. Please black out any financial information and the first 5 digits of the Social Security numbers. |
| Natural Child or legally adopted child | Copy of state or county issued birth certificate showing employee's name or signed court order. If birth certificate lists employee's maiden name, please provide a copy of marriage certificate or other documentation proving current name. |
| Stepchild | Copy of state or county issued birth certificate showing parents' names, copy of your marriage certificate, and a copy of your joint 2018 federal tax return (Include the front page through line 6 of Form 1040. Please black out any financial information and the first 5 digits of the Social Security numbers.) |
| Legal Custody or Guardianship | Signed Court Order and 2018 tax return claiming the child as a dependent. |
| Disabled Dependents over Age 26 | Copy of state or county issued birth certificate showing employee's name or signed court order. If birth certificate lists employee's maiden name, please provide a copy of marriage certificate. In addition, you must submit a copy of your 2018 federal tax return claiming the child (Include the front page through line 6 of Form 1040. Please black out any financial information and the first 5 digits of the Social Security numbers.) |
| Grandchildren (EE's child must be listed as parent on birth cert. & remain covered) | Copy of state or county issued birth certificate showing parents' names for child and grandchild. |



**POLK COUNTY
PUBLIC SCHOOLS**
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Employee Health Clinic

The Polk County Public Schools Employee Health Clinics are operated by Healthstat, which offers primary care and prevention services, health risk intervention, health coaching, chronic disease management and occupational medicine.

Healthstat operates more than 300 health and wellness centers across the country, serving more than 300,000 employees, retirees and dependents.

Healthstat's passion for promoting overall well-being helps patients to form bonds with their clinicians. These relationships inspire healthier habits, help employees to stay focused on their health goals, and improves the patient experience.

TWO CONVENIENT LOCATIONS:

| | |
|-----------------------|-----------------------|
| Lakeland | Haines City |
| 3215 Winter Lake Road | 641 US HWY 17-92 W. |
| Lakeland, FL 33803 | Haines City, FL 33844 |

HOURS:

| | |
|---------------|---------------|
| 7 a.m.—6 p.m. | Monday—Friday |
| 8 a.m.—12p.m. | Saturday |

Who is eligible?

All PCPS employees from date of hire regardless of health coverage and dependents over age two on the PCPS health plan.

SERVICES: (Primary Care & Disease Management)

- Allergies
- Cold/flu Conjunctivitis
- Cuts
- Headache/migraine
- Well Woman Exams
- Mental Health
- Registered Dietician
- Annual Physicals
- Asthma
- Physical Therapy
- Hypertension
- Diabetes

ACCESS & SERVICE REMINDERS:

- ALL clinic services are available at NO COST to you!
- Certain generic medications are dispensed on-site.
- Walk-in appointments are available for episodic care!

Do not hesitate! Call 863-419-3322 today to make your appointment.

powered by:

healthstat®

Employee Wellness Programs

ABCs of Diabetes

The **ABCs of Diabetes** program is provided for all employees, spouses and dependents enrolled in the PCPS self-funded health plan who have been diagnosed with diabetes. Self-management education and support is offered at no cost to prevent complications and enhance well-being. HIPAA laws are strictly enforced.

The **ABCs of Diabetes** provides on-going educational opportunities, screenings, exams, health coaching, and free pre-approved diabetes supplies and prescription drug savings. For details contact our Wellness Coaches at 863-648-3057.



Baby Yourself® Program

If you are pregnant the Baby Yourself® Program is for you.

Baby Yourself® is a Florida Blue program, which provides access to clinical support and a free mobile app to track your babies growth and your personal journey to motherhood. Eligible employees and spouses who attend this program will receive a **\$200** incentive after the baby is born... Contact our Wellness Coaches at 863-648-3057 for detail or visit the Baby Yourself® webpage.



Worksite 3-D Mammograms

Breast cancer screenings made easy! Get on the Tampa Bay Mobile Unit at your worksite for a 3-D mammogram at no cost with PCPS group insurance. Visit the Cancer Resources webpage to view the schedule.

Wellness Programs

Improve your lifestyle with districtwide health education, receive incentives and valuable information. Individual and group health coaching is also available at no cost.

Programs available:

- **Condition Management Programs**
 - Diabetes Prevention Program, Diabetes Self-Management Program & Health Behaviors for Diabetes Management
 - Hypertension Education Series
 - Hyperlipidemia Education Series
- **Wellness Programs**
 - Weight Management and Weight Maintenance Programs
 - Tobacco Cessation Program
- **Nutrition Programs**
 - Medical Nutrition Therapy
 - Food log programs for Diabetes, Hypertension & Hyperlipidemia
- **Health & Wellness Coaching Services**
 - Face-to-face & Telephonic Coaching
 - Meal Planning & Preparation Workshops
 - Cooking Classes and Demonstrations
 - Campaigns & Challenges
 - "Maintain No Gain" Holiday Weight Management Program
 - Health Awareness Campaigns
 - Lunch & Learns
 - Health & Wellness Challenges

Stay Informed

Learn about Wellness events and enhance your health literacy with **Wellness Weekly**, a weekly e-newsletter.

The PCPS Employee Wellness Program is now a part of the HealthStat team.

IMPORTANT INFORMATION

IRS Section 125 & Benefit Changes

Section 125 of the IRS code allows employees to use pretax dollars to pay the premiums on certain group insurance products. These deductions are taken prior to Social Security and Federal Income Taxes being deducted from your paycheck, which can lead to significant savings. **Benefits elections must remain in effect until the next Open Enrollment Period unless you experience a qualifying event.**

A qualifying event is a change in status to your life that meets IRS approved definitions. Examples are marriage, divorce, birth, death, adoption, legal guardianship, gain or loss of stepchildren, gain or loss of coverage. If you need to make a change to your coverage due to a Qualifying Event, you must submit the Change of Status Form along with required supporting documentation no more than 31 days after the qualifying event has taken place. Change of Status Forms are available on the Risk Management and Employee Benefits page of the Polk County School Board website: www.polkschoolsfl.com or by contacting Risk Management at:

RiskManagement-AllStaff@polk-fl.net

If I resign when will my insurance end?

For 10 and 11 month employees: If you resign prior to the end of the school year your benefits will end the last day of the month in which you paid for coverage from your last paycheck. If you work to the end of the contract year, your benefits will end on August 31st.

For 12 month employees: Your benefits will end the last day of the month in which you pay for coverage from your last paycheck.

What Benefits Do Employees Receive

The School Board is pleased to announce there continues to be no cost for employee health insurance. Health insurance includes medical coverage and prescription coverage which are both administered by Blue Cross Blue Shield. This also includes access to the Polk County School Board Employee Health Clinic at no cost to all school board employees regardless of health plan coverage from date of hire. The School Board also provides each benefits-eligible employee with \$20,000 of Group Term Life and \$10,000 of Accidental Death and Dismemberment.

Payroll Deductions

Benefit premiums are paid in advance; therefore, deductions begin one month before coverage is effective. **Please view your December paycheck to ensure your 2020 deductions are correct.**

| 2020 Health Plan Premiums | |
|--------------------------------|-----------------|
| Coverage Level | Monthly Premium |
| Employee Only | \$0 |
| Employee & Spouse | \$594 |
| Employee & 1 Child | \$105 |
| Employee & 2 Children | \$210 |
| Employee & 3+ Children | \$245 |
| Employee, Spouse & 1 Child | \$699 |
| Employee, Spouse & 2 Children | \$804 |
| Employee, Spouse & 3+ Children | \$839 |

Health Insurance— Benefit Summary 2020 Plan Year

| BlueOptions—Plan 22494 | In-Network | Out-of-Network |
|---|--|--------------------------------|
| Member Deductible | | |
| Individual | \$900 | \$1,500 |
| Family | \$1,800 | \$3,000 |
| Coinsurance (member responsibility after deductible) | 20% | 40% |
| Out of Pocket Maximum | Includes Deductible, Coinsurance and Copays | |
| Individual | \$5,000 | No Maximum |
| Family | \$9,000 | No Maximum |
| Lifetime Maximum | No Maximum | No Maximum |
| EMPLOYEE CLINICS | | |
| Polk County Public Schools Employee Health Clinic | | |
| Office Visits, Labs, X-Rays, Therapies and On-site Prescriptions | \$0 | N/A |
| PROFESSIONAL PROVIDER SERVICES | | |
| Allergy Testing and Treatment | \$10 Copay | Deductible + 40% |
| E-Office Visit Services—Family Physician or Specialist | \$10 Copay | Deductible + 40% |
| Office Services | | |
| Family Physician or Specialist (including Chiropractor) | \$50 Copay | Deductible + 40% |
| Maternity Care | \$50—First Visit Deductible + 20% | Deductible + 40% |
| ER Physician | Deductible + 20% | Deductible + 40% |
| Inpatient Visits & Consultations | Deductible + 20% | Deductible + 40% |
| Radiology, Pathology and Anesthesiology Providers Services | | |
| Ambulatory Surgical Center | Deductible + 20% | In-Network Deductible + 20% |
| Hospital | Deductible + 20% | In-Network Deductible + 20% |
| Medical Pharmacy (provider-administered Rx in the office) | Included in Office Copay | Deductible + 40% |
| PREVENTATIVE CARE | | |
| Adult Wellness Office Services—Family Physician or Specialist | \$0 | Deductible + 40% |
| Colonoscopies (Routine) Age 50+ then Frequency Schedule Applies | \$0 | \$0 |
| Mammograms (Routine and Diagnostic) | \$0 | \$0 |
| Well Child Office Visits—Family Physician or Specialist | \$0 | \$0 |

Health Insurance — Benefit Summary 2020 Plan Year

| EMERGENCY/URGENT CARE/CONVENIENT CARE | In-Network | Out-of-Network |
|---|--|-----------------------|
| Ambulance (ground, air and water) | 20% of billed charges | 20% of billed charges |
| Convenient Care Centers (CCC) | \$50 copay | Deductible + 40% |
| Emergency Room Facility Services | Deductible + 20% | Deductible + 20% |
| Urgent Care Centers (UCC) | \$50 copay | 40% |
| FACILITY SERVICES | | |
| Unless otherwise noted, physician services are in addition to facility services. Please see Professional Provider Services. | | |
| Ambulatory Surgical Center | Deductible + 20% | Deductible + 40% |
| Independent Clinical Lab | \$0 | Deductible + 40% |
| Outpatient Chemotherapy, Dialysis, IV Therapy, Diagnostic Lab, Pa- thology. Radiation Therapy & X-Ray | Deductible + 20% | Deductible + 40% |
| Inpatient Hospital and Residential Treatment Facilities | Deductible + 20% | Deductible + 40% |
| Inpatient Rehab Maximum | 21 days per Benefit Period | |
| MENTAL HEALTH AND SUBSTANCE ABUSE | | |
| Inpatient Hospitalization | Deductible + 20% | Deductible + 40% |
| Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services | Deductible + 20% | Deductible + 40% |
| ER Physicians | Deductible + 20% | Deductible + 20% |
| Physician Office Visit— Family Physician or Specialist | \$50 | Deductible + 40% |
| Inpatient Physician Visits and Consultations | Deductible + 20% | Deductible + 20% |
| OTHER COVERED SERVICES | | |
| Advanced Imaging Services in Physician’s Office | Deductible + 20% | Deductible + 40% |
| Colonoscopies (Diagnostic) | | |
| Ambulatory Surgical Center | \$0 | Deductible + 40% |
| Outpatient Hospital | 20% (deductible waived) | Deductible + 40% |
| Durable Medical Equipment, Prosthetics, Orthotics BPM | Deductible + 20% | Deductible + 40% |
| Home Health Care— 20 Visits per Benefit Period | Deductible + 20% | Deductible + 40% |
| Chiropractor, Physical Therapy, Occupational Therapy, Speech Ther- apy—Outpatient Therapy and Spinal Manipulations | 35 Visits (Includes up to 26 Spinal Manipulations) | |
| Physician’s Office or Outpatient Rehab Center | \$50 copay | Deductible + 40% |
| Inpatient Rehab Center | Deductible + 20% | Deductible + 40% |
| Skilled Nursing Facility BPM—60 Days per Benefit Period | Deductible + 20% | Deductible + 40% |
| SLEEP STUDIES | | |
| Office Visit Setting | \$50 Copay | Deductible + 40% |
| Sleep Study Facility/Center | Deductible + 20% | Deductible + 40% |

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 your Health Plan. For a complete description of benefits and exclusions, please refer to the Summary Plan Description (SPD). The written terms of the SPD prevail.

Staying Healthy Just Got Less Expensive!

Great discounts and valuable information you can use all year long—Blue365

You can save BIG on a wide variety of healthy products and services through our members-only discount program— **Blue365***. Take advantage of exclusive discounts at select local companies and leading, national brands for your everyday health and wellness or family care—even healthy vacation destinations! Save up to 60% on fitness clubs, exercise equipment, contact lenses or glasses, nutrition and weight management programs and so much more! All included as part of your Blue membership.

It's easy to find details for these exclusive savings—the information is available online 24/7 for your convenience.

Simply log in at FL.ExploreMyPlan.com. New discounted products and services are being added all the time – so check back often for new savings opportunities.

It pays to stay in-network

Our coverage includes a strong network of quality providers located in the communities where you live and work.

- We've **negotiated lower rates** with our in-network providers to keep your out-of-pocket low and help you get the most value for every health care dollar.
- **No referrals** are required, so you'll find it convenient to access specialists for the care you need, while saving money, too.
- Plus, in-network providers usually obtain the **prior authorizations** for certain services and help protect you from balance billing.

When you travel, you're still covered

Wherever you go, through our BlueCard® program, your health care coverage goes with you. You'll get access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country and worldwide – and you shouldn't have to pay more than the rates they have negotiated with doctors and hospitals in their areas.

To find participating doctors and hospitals outside of Florida, call 1-800-810-BLUE (2583) or visit bcbs.com and click on "Find a Doctor or Hospital".

Health Plan Changes

Effective 1/1/2019, the PCPS health plan, administered by Blue Cross and Blue Shield of Florida, made a platform change. This platform change for claim payment included a new website, ID card, and customer service number. This platform will remain in place for 2020. The following FAQs are designed to answer questions you may have about the 2020 plan year.

Q: What are the changes for 2020?

A: There are no benefit changes for the 2020 plan year. The PCPS plan will continue to offer coverage through copays and coinsurance for covered services. For questions about benefit levels, please see the benefit summary above, or call Customer Service at 1-855-630-6824.

Q: Will I receive a new card for the 2020 plan year?

A: No, new cards will not be issued for the 2020 plan year. All employees enrolled on the PCPS health plan in 2019 received an insurance card. If you need additional cards, please contact Customer Service at 1-855-630-6824.

Q: I have a question about my benefits. Whom do I call?

A: If you have a question about your 2020 benefits, please call the number on the back of your BCBSFL ID card. A customer service representative will be able to assist you in answering your questions. They can also help you find an in network provider, recommend routine preventive screenings, and put you in touch with a case manager if needed. A customer service representative is available to help you from 8 a.m. to 7 p.m. Eastern Time.

Q: What online tools and resources are available to me?

A: The ExploreMyPlan Member Portal is available online at FL.ExploreMyPlan.com!

You will need to register for ExploreMyPlan to have 24/7 access to personalized tools and resources to help you save time and efficiently manage your account. Registering is fast, easy and free! You will find plan details within your benefit booklet and *Summary of Benefits and Coverage*. You can also:

- ✓ View claim statements
- ✓ Access virtual ID cards
- ✓ View contract and dependent information
- ✓ Find in network providers with the Find a Doctor tool
- ✓ Estimate and compare procedure costs with the Treatment Cost Estimator tool

The ExploreMyPlan Mobile App is also be available for download on the App Store and Google PlayStore.

Available for both Apple and Android devices, the free ExploreMyPlan mobile app helps you manage account and health information when you're on the go. You can:

- ✓ Check your benefits
- ✓ Access contract details
- ✓ View or email your ID card
- ✓ Find in network providers

Pharmacy Frequently Asked Questions & Coverage

The PCPS Prescription Drug plan integrated with your Blue Cross and Blue Shield of Florida health coverage will not be making a formulary and network change. Please see the FAQs below for additional information.

Q: Will my benefits change?

A: For the 2020 plan year, there are no benefit changes. Your plan will continue to require a copay or coinsurance for covered prescription drugs. Your copay will depend on whether the drug is generic, preferred brand, non-preferred brand, preferred specialty or non-preferred specialty. The preferred specialty will be based on the SourceRx 1.0 Drug List—6 tiers.

Q: Will the formulary be the same?

A: The 2020 formulary will be the same as last year (SourceRX 1.0 – 6 Tier). While the formulary is the same, medications can change tiers throughout the year usually quarterly. If you are currently taking a medication, please be sure to check the SourceRx 1.0 Drug List to which tier your medication falls in.

Q: Where can I view the SourceRx 1.0 Drug List?

A: The SourceRx 1.0 Drug List is available at FL.ExploreMyPlan.com/SourceRx1DrugList6T

Q: Does prior authorization and step therapy apply on certain drugs?

A: The SourceRX 1.0 formulary will continue to have the drug management programs which are summarized below. The medications subject to these programs will be based on the SourceRx 1.0 Drug List. Please review the guide for your medications to see if these programs will apply.

Step Therapy: Certain drugs are not covered unless you try another FDA-approved drug first. A lower cost drug may have been proven to be as clinically effective in treating your condition. If an alternate drug is not recommended for you, your doctor can submit an authorization form to request an exception.

Prior Authorization: For certain medications, your doctor will need to submit medical documentation and an approval form before a drug will be covered by your plan. Your doctor will submit the appropriate prior authorization form when required.

Quantity Limits: Some drugs have a maximum quantity that is covered for a given time period. These safety limits are based on dosing guidelines from drug manufacturers and the FDA

Deductible: There is a \$50 per person annual deductible at **retail** and **mail order** for brand name medications.

Brand Name Drugs: If you purchase a brand-name medication when a generic medication is available or if your doctor requests a brand-name when a generic is available, you will pay the appropriate cost share for the drug based on the current formulary, plus the difference in cost between the brand and the generic.

| | Generic | Preferred Brand | Non—Preferred Brand |
|-----------|---------|--------------------------|--------------------------|
| Retail 30 | \$8 | \$40 + 10%* (max \$80) | \$80 + 10%* (max \$160) |
| Retail 90 | \$20 | \$120 + 10%* (max \$240) | \$210 + 10%* (max \$420) |
| Mail 90 | \$20 | \$125 | \$200 |
| Specialty | \$80 | \$80 | \$180 |

Maximum Out-of-Pocket \$1,600

*10% of the cost of prescription minus the deductible



Term Life Insurance

Basic Life

The time you spend with your family is priceless, full of fun times and precious memories. But what would happen to them if you suddenly died? Would those memories be enough to sustain them through this difficult period?

It's not pleasant to think about, but your death could potentially leave your family unable to meet existing and unexpected financial obligations. In addition to paying the everyday bills, there may be the unexpected expenses of final medical treatment and funeral costs. To help you prepare for the unexpected, Polk County Public Schools provides each benefit-eligible employee with \$20,000 of life insurance coverage. This coverage includes \$10,000 of Accidental Death and Dismemberment (AD&D).

Additional Life

You may also request additional coverage up to 5 times your annual earnings.

You may elect one of the following Additional Life coverage options:

Option 1: 1 X Annual Earnings

Option 2: 2 X Annual Earnings

Option 3: 3 X Annual Earnings

Option 4: 4 X Annual Earnings

Option 5: 5 X Annual Earnings

Life insurance is rounded to the next higher multiple of \$1,000, if not already a multiple of \$1,000. The maximum amount is \$300,000.

A new election or an increased amount of coverage during Open Enrollment will be subject to Medical Underwriting. Once we receive your form requesting enrollment for new enrollment or additional coverage, we will send you an Evidence of Insurability form to complete and submit directly to The Standard for approval.

Age Reductions

Under this plan, coverage reduces by 35% at age 65, by 50% at age 70, and by 65% at age 75. Age Reduction does not apply to Basic Life.

Rates

There are no benefit changes for the additional life plan. These products have age-banded rates. If you have moved from one age-band to the next, you may see an increase in your premium. Rates are based on your age as of January 1, 2020 and do not change mid-year.

The Pre-tax benefit for Group Term Life is available for amounts up to \$50,000 in coverage. This total includes the \$20,000 paid for by Polk County Public Schools for each benefit-eligible employee. Employees may elect additional coverage; however deductions for amounts over the total of \$50,000 will be taken on a post-tax basis.

2020 Additional Life and AD&D

Rate Chart

| Age as of 01/01/2020 | Rate: |
|-------------------------|---------|
| ≤ 29 | \$0.073 |
| 30-34 | \$0.084 |
| 35-39 | \$0.105 |
| 40-44 | \$0.143 |
| 45-49 | \$0.198 |
| 50-54 | \$0.266 |
| 55-59 | \$0.280 |
| 60-64 | \$0.302 |
| 65+ | \$0.340 |



Term Life Insurance

Waiver of Premium Provision

The Standard may continue your Life insurance without premium payments if you:

- Become *totally disabled* while insured under the *group policy*
- Are under the age of 65
- Complete the *waiting period* of 180 days
- Give us satisfactory *proof of loss*

Waiver of Premium does not apply to AD&D insurance.

Eligibility

To be eligible for this plan:

- You must be insured for Basic Life
- You must be an active employee of Polk County Public Schools, excluding Superintendent, Retirees, temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors
- You must be regularly working at least 30 hours per week.

Group Insurance Certificate

If you become insured, you can obtain a group insurance certificate containing a detailed description of the insurance coverage at thehub.polk-fl.net/riskmanagement/insurance-benefits.

The information presented above is controlled by the group policy and does not modify it in any way. The controlling provisions are in the group policy issued by Standard Insurance Company.

Dependent Life

You may elect Dependent Life insurance for your *spouse* and eligible *child(ren)* at a flat amount of \$10,000 for your *spouse* and \$5,000 for your eligible *child(ren)*.

“Child” means your unmarried child from live birth through age 20 (through age 24 if a registered student

in full-time attendance at an accredited educational institution), or your unmarried child who meets the definition of Disability in the group policy. **A new election during Open Enrollment will be subject to Medical Underwriting.**

If both spouses work for PCPS, only one may elect dependent life and only the child(ren) will be covered. Employees cannot cover each other as dependent spouses. Also, your spouse or children must not be full-time member(s) of the armed forces.

It is the employee's responsibility to cancel dependent life coverage during Open Enrollment once they no longer have any eligible dependents.

When Dependent Life Coverage Ends

Dependent Life coverage for your spouse and child (ren) will automatically end on the earliest of the following:

- Five months after the date you die
- The date your Life insurance ends
- The date Dependents Life insurance terminates under the group policy
- The date your employer's coverage under the group policy for Dependent Life insurance terminates
- The date the last period ends for which a premium was paid for your Dependent Life insurance
- When the dependent ceases to be an eligible dependent
- For your spouse, the date of your divorce or legal separation
- For a child who is disabled, 90 days after we mail you a proof of disability request, if proof is not given.

Dependent Life Premium \$6.24

Accidental Death & Dismemberment



Accidental Death and Dismemberment (AD&D)

With Additional AD&D insurance from Standard Insurance Company, you or your beneficiaries may be eligible to receive an additional amount in the event of death or dismemberment as a result of an accident.

The amount of this AD&D Insurance Benefit for loss of life is equal to the amount payable for Additional Life insurance coverage on the date of the accident.

The amount of this AD&D Insurance Benefit for other covered losses is a percentage of the amount payable for Additional AD&D insurance coverage on the date of the accident, as shown in the following table:

| Type of Loss | Percentage Payable |
|---|--------------------|
| One hand or one foot | 50% |
| Sight in one eye, (speech. Or hearing in both ears) | 50% |
| Two or more of the losses listed above | 100% |
| Thumb and index finger of the same hand.* | 25% |
| Quadriplegia | 100% |
| Hemiplegia | 50% |
| Paraplegia | 50% |
| * This benefit is not payable if an AD&D Insurance Benefit is payable for the | |

When Coverage Ends

AD&D insurance will automatically end on the earliest of the following:

- The date your Life insurance ends
- The date your Waiver of Premium begins
- The date AD&D insurance terminates under the group policy
- The date the last period ends for which a premium was paid for your AD&D insurance
- The date your employer's coverage under the group policy for AD&D insurance terminates
- The date your employment terminates

Additional Features

The following are brief descriptions of features included in this plan. These features offer additional benefits when an AD&D Insurance Benefit is payable.

The **Seat Belt Benefit** provision provides an additional benefit in the event of a covered automobile accident.

The **Air Bag Benefit** provision provides an additional benefit in the event of a covered automobile accident for which a Seat Belt Benefit is payable.

With the **Family Benefits Package** provision, your eligible family members may be entitled to receive additional financial help for child care, college or career training. Included are the Child Care Benefit, Higher Education Benefit and Career Adjustment Benefit.

The **Occupational Assault** provision provides an additional benefit if you suffer death or dismemberment as a result of an act of workplace physical violence that is punishable by law.

The **Public Transportation** provision provides an additional benefit in the event of death as a result of an accident that occurs while you are riding as a fare-paying passenger on public transportation.

A Special Opportunity to Strengthen Your Personal Safety Net



Standard Insurance Company provides Short Term Disability (STD) and Long Term disability (LTD) insurance to eligible employees of Polk County Public Schools. You are in good company. The Standard is a nationally recognized provider of employee benefits products and services and provides insurance to more than 26,000 groups, covering over 6 million employees nationwide. The Standard has been providing disability coverage to Polk County Public Schools employees since 2003.

Disability Insurance Offers Extra Peace of Mind

Many people would not be able to meet their financial obligations if they became disabled and could not work for an extended period of time. Disability insurance can help you create a secure financial future for yourself and your loved ones by providing partial income replacement if you become disabled and can't work. Your employer offers you the opportunity to purchase STD and LTD insurance, if you have not already done so.

Most people probably think a disability happens only to other people. Consider these facts:

- Every 90 seconds someone files for bankruptcy in the wake of a serious illness.
- Just over 1 in 4 of today's 20 year-olds will become disabled before they retire.
- Can your family live on \$1,146 a month? That's the average monthly benefit paid by Social Security Disability Insurance (SSDI) in 2014.

Learn More and Take the Next Step

Review your 2020 enrollment guide for costs and complete details of the coverage and how to enroll. Make the most of this open enrollment opportunity and take the next step to help protect your income.

Disability Insurance Requires Medical Underwriting

Please note **NEW** short or long term disability insurance enrollment during Open Enrollment requires Medical Underwriting approval. In addition, employees looking to **INCREASE** short term disability coverage (i.e. moving to a shorter waiting period) must have Medical Underwriting approval before a change is processed. Once we received Risk Management your form requesting enrollment for new enrollment or increased disability coverage, we will send you an Evidence of Insurability form to complete and submit directly to The Standard for approval. If you wish to complete this form online you can find the link on the Risk Management theHub page at.

thehub.polk-fl.net/riskmanagement/insurance-benefits

Once on this page you will find the link in the *Life and Disability* section. This link is available in English and Spanish.

Medical History Statement

Spanish Medical History Statement

Group number: 625950



Short Term Disability

Coverage Options

Chances are you may already own home, auto and life insurance to protect yourself against the threat of loss. And you probably have health insurance to guard against costly medical bills. But what steps have you taken to help shield yourself and those who count on you from an unexpected loss of income? To help you plan for the unexpected, the Polk County Public Schools offers both Short and Long Term Disability coverage through The Standard. You can elect one of three short-term disability coverage options. The options have varying benefit waiting periods and maximum benefit periods as show below:

| Option | Benefit Waiting Period | Maximum Benefit Period |
|----------|------------------------|------------------------|
| Option A | 7 days | up to 25 weeks |
| Option B | 14 days | up to 24 weeks |
| Option C | 30 days | up to 22 weeks |

The benefit waiting period is the period of time that you must be continuously disabled before benefits become payable. The Maximum Benefit Period is the maximum amount of time can receive benefits. **You must exhaust all of your accumulated sick leave before collecting Short Term Disability payments.**

Benefit Amount

The weekly benefit is up to 60% of your insured pre-disability earnings based upon yearly salary split over 52 weeks. The maximum weekly benefit is \$1,750 and the minimum weekly benefit is \$15. This amount is then reduced by other income you receive or are eligible to receive while STD benefits are payable. This other income is referred to as deductible income.

Deductible income is income you receive or are eligible to receive while STD benefits are payable. It includes but is not limited to the following:

- Benefits under any state disability income benefit law or similar law.
- Earnings from work activity while *disabled*.
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above.

| Short Term Disability Rate Chart | | | |
|----------------------------------|-------------------|--------------------|--------------------|
| Age as of 01/01/2020 | Option A 7 Day | Option B 14 Day | Option C 30 Day |
| ≤ 29 | \$1.18 | \$0.83 | \$0.58 |
| 30-34 | \$1.31 | \$0.90 | \$0.63 |
| 35-39 | \$0.85 | \$0.56 | \$0.39 |
| 40-44 | \$0.63 | \$0.40 | \$0.26 |
| 45-49 | \$0.68 | \$0.42 | \$0.28 |
| 50-54 | \$0.72 | \$0.45 | \$0.30 |
| 55-59 | \$0.93 | \$0.58 | \$0.38 |
| 60+ | \$1.18 | \$0.73 | \$0.48 |

Premium

| | |
|--|----------|
| Enter average weekly earnings, not to exceed \$1,750 on Line 1. | 1: _____ |
| Multiply Line 1 by 0.60 and enter on Line 2. | 2: _____ |
| Select your rate from the table below and enter on Line 3. | 3: _____ |
| Multiply Line 2 by the amount entered on Line 3. | 4: _____ |
| Divide the amount on Line 4 by 10 and enter on Line 5. | 5: _____ |
| The amount shown on Line 5 is your estimated monthly payroll deduction. | |

Long Term Disability



Group Long Term Disability (LTD) insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you to meet your financial commitments in a time of need.

The Long Term Disability (LTD) benefit level is up to 60% of pre-disability earnings. The maximum monthly benefit is \$7,500 and the minimum monthly benefit is \$100. This is then reduced by other income you receive or are eligible to receive while LTD benefits are payable. This other income is referred to as deductible income.

Deductible income is income you receive or are eligible to receive while LTD benefits are payable. It includes but is not limited to the following:

- Benefits under any state disability income benefit law or similar law.
- Earnings from work activity while *disabled*.
- Social Security Benefits
- Disability or retirement benefits you receive or are eligible to receive under your employer's retirement plan.
- Any amount you receive by compromise, settlement or other method as a result of a claim for any of the above.

If your claim for Long Term Disability benefits is approved by The Standard, benefits become payable after you have been continuously disabled for 180 days and remain continuously disabled. Benefits are not payable during the benefit waiting period. **You must exhaust all of your accumulated sick leave.**

Maximum Benefit Period

If you become disabled before age 62, LTD benefits may continue during disability until you reach age 65. If you become disabled at age 62 or older, the benefit duration is determined by your age when disability begins:

| Age | Maximum Benefit Period | Age | Maximum Benefit Period |
|-----|------------------------|-----|------------------------|
| 62 | 3 years 6 months | 66 | 1 year 9 months |
| 63 | 3 years | 67 | 1 year 6 months |
| 64 | 2 years 6 months | 68 | 1 year 3 months |
| 65 | 2 years | 69+ | 1 year |

| Long Term Disability Rate Table | |
|---------------------------------|--------|
| Age as of 01/01/2020 | Rate |
| <=29 | \$0.17 |
| 30-34 | \$0.20 |
| 35-39 | \$0.25 |
| 40-44 | \$0.35 |
| 45-49 | \$0.53 |
| 50-54 | \$0.79 |
| 55-59 | \$1.00 |
| 60-64 | \$1.03 |
| 65-69 | \$1.14 |
| 70-74 | \$1.23 |
| 75+ | \$1.94 |

Premium

You can estimate your monthly payroll deduction by using the worksheet below:

| | |
|--|----------|
| Enter your average monthly earnings not to exceed \$12,500 on Line 1. | 1: _____ |
| Select your rate from the rate table and divide this by 100. | 2: _____ |
| Multiply Line 1 by the amount shown on Line 2. | 3: _____ |
| The amount shown on Line 3 is your estimated monthly payroll deduction. | |

If you become insured, you can print a copy of the group insurance certificate containing a detailed description of the insurance coverage on the PCPS Risk Management Hub page. The information presented in this book is controlled by the group certificate and does not modify it in any way. The controlling provisions are in the group certificate issued by Standard Insurance Company.

theHub.polk-fl.net/riskmanagement/insurance-benefits

Dental Insurance



Why Choose Dental?

Going to visit the dentist is a worthwhile investment in your family's oral and overall health. Studies suggest that people with dental benefits are almost 50 percent more likely to visit the dentist every six months to get the care they need. Having dental benefits helps pay for visits to your dentist for regular checkups and cleanings. When you choose Delta Dental benefits, you can prevent a dental problem or get treatment before it becomes more serious, and save money on your dental care costs. Delta Dental offers you a large choice of dentists to receive the most from your benefits.

Improved oral health

Dental benefits emphasize preventive care. Regular dental visits can help you avoid serious problems because most dental disease is preventable.

- Regular dental care can help you and your family stay healthy and pain-free.
- You can get treatment before a problem becomes more serious.
- You and your family can avoid losing time from work or school because of dental-related problems.

Improved overall health

Studies suggest that the state of your dental health can affect other health conditions such as diabetes and heart disease. And many health conditions have oral symptoms that provide clues to their onset.

Although seeing a dentist is no substitute for a visit to a physician, regular dental checkups may tell the dentist much about your overall health.

- A regular oral examination can point to signs of disease, chronic illness or health risk.
- If a dentist finds a potential health issue, he or she may refer you to your physician for follow-up.

Cost savings

Delta Dental helps you save money on dental costs:

- Delta Dental benefits provide you and your family with financial assistance for preventive or routine dental services.
- Delta Dental benefits provide coverage for many major dental procedures.

You'll get the most value from your plan when you visit a Delta Dental dentist in your plan's network.

ID Cards

You don't need an ID card. When visiting a Delta Dental Premier or Delta Dental PPO dentist, simply provide your social security or identification number. The dental office can use that information to verify your eligibility and benefits.

If you still would like an ID card, you can print a customized ID card on demand. Log in to Online Services (on right), click the "Eligibility & Benefits" tab to view your eligibility and benefits information and to print an ID card. If you haven't registered for Online Services, click on "Register Today" for an easy three-step registration process.

Delta Dental Customer Service

1-800-521-2651 or online at

www.deltadentalins.com

Dental Insurance



| Low Plan | | | Middle Plan | | | High Plan | | |
|--------------------------|------------------------|----------------|---|-----------------|-----------------|---|----------------|-----------------|
| Coverage Type | PDP In-Network | Out-of-Network | Coverage Type | PDP In-Network | Out-of-Network | Coverage Type | PDP In-Network | Out-of-Network |
| Type A ¹ | Schedule‡ | Schedule‡ | Type A ¹ | 100% of PPO Fee | 100% of PPO Fee | Type A ¹ | 80% of PPO Fee | 80% of PPO MPA* |
| Type B ² | Schedule‡ Schedule‡ | Schedule‡ | Type B ² | 80% of PPO Fee | 80% of PPO Fee | Type B ² | 80% of PPO Fee | 80% of PPO MPA* |
| Type C ³ | Schedule‡ | Schedule‡ | Type C ³ | 50% of PPO Fee | 50% of PPO Fee | Type C ³ | 80% of PPO Fee | 80% of PPO MPA* |
| Individual Deductible† | \$50 | \$50 | Individual Deductible† | \$50 | \$50 | Individual Deductible† | \$50 | \$50 |
| Family Deductible† | \$150 | \$150 | Family Deductible† | \$150 | \$150 | Family Deductible† | \$150 | \$150 |
| Annual Benefit Max | | | Annual Benefit Max | | | Annual Benefit Max | | |
| Per Person | \$1,000 | \$1,000 | Per Person | \$1,000 | \$1,000 | Per Person | \$1,500 | \$1,500 |
| Orthodontics Not Covered | | | Orthodontia Lifetime Max child only to age 19 | | | Orthodontia Lifetime Max child only to age 19 | | |
| N/A | | | Per Person | \$1,000 | \$1,000 | Per Person | \$1,000 | \$1,000 |

1—Type A: cleanings, oral examinations, fluoride, x-rays

2—Type B: fillings, simple extractions, endodontics, general anesthesia, oral surgery, periodontal maintenance, sealants

3—Type C: bridges, dentures, crowns, periodontal surgery

† Deductible applies to Type B&C services only—waived on Type A services

‡ For the most updated Schedule of Benefits for the Low Dental Plan contact Delta Dental Customer Service.

*MPA—Maximum Plan Allowance

This is only a brief summary of the plans. Benefits are subject to limitations and exclusions of the plan. The dental health plan contract must be consulted to determine the exact terms and conditions of coverage.

If you've got questions about oral health, be sure to check out our SmileWay Wellness Site for answers. We've compiled an extensive library of articles on oral health topics from amalgam fillings to x-rays and just about everything in between.

- ◆ Mouth-body connection
- ◆ Preventive Care
- ◆ Emergency Care
- ◆ Kids & teens
- ◆ Seniors
- ◆ Dental Treatments
- ◆ Conditions

| Monthly Premiums | Low Plan | Middle Plan | High Plan |
|-------------------------------|----------|-------------|-----------|
| Employee Only | \$11.83 | \$20.33 | \$38.93 |
| Employee & Spouse | \$23.37 | \$40.64 | \$75.36 |
| Employee & Child(ren) | \$29.03 | \$51.24 | \$91.34 |
| Employee, Spouse & Child(ren) | \$35.15 | \$70.36 | \$121.44 |

Vision Insurance



About Avēsis

For more than 40 years, Avēsis has matched vision professionals with those who need their care. In 2016, we joined The Guardian Life Insurance Company of America, becoming their wholly owned subsidiary. Now our benefits are backed by the strength and values of Guardian.

Avēsis Vision Benefits at a Glance

Understanding what's available to you and how to get the most out of your Avēsis vision plan will help keep your out-of-pocket expenses low. Your plan includes the following benefits.

Routine Eye Exam

Your plan covers an in-network eye exam in full each year. Eye exams can reveal many details about your overall health. It can even uncover underlying issues such as autoimmune disorders, diabetes, hypertension, and more.¹

Frames

Your plan entitles you to a pair of frames up to your frame allowance. You can choose from *any* frame on the market, from any designer. Simply pay the difference between your allowance and the final cost.

Participating Retail Providers

- America's Best Contacts & Eyeglasses™
- Nationwide™ Vision
- Cohen's Fashion Optical®
- Pearle Vision®
- Costco® Wholesale
- Sam's Club®
- Eyeglass World®
- Sears Optical®
- Eyemart Express™
- Sterling Optical®
- For Eyes
- Target® Optical
- JCPenney Optical
- Visionworks®
- Midwest Vision Centers
- Walmart
- MyEyeDr

Standard Spectacle Lenses

Your plan covers standard single-vision, lined bifocal, or lined trifocal lenses, with standard scratch-resistant coating applied at no extra charge.

Lens Options

Your plan also covers popular lens options, like progressive lenses, tints, anti-reflective coatings, and more.

Additional Pairs of Glasses

Take an extra 20 percent off additional pairs of glasses, including prescription sunglasses, once your frame and lens benefit have been exhausted. (Not all providers offer this discount. Please check to see whether your provider participates. Frame discounts do not apply when prohibited by the frame manufacturer.)

Contact Lenses, Fitting, and Follow-up (CLEFFU)

Contact lenses from any in-network provider are covered in full. We also cover the fitting and up to follow-up visit for covered-in-full contacts (including disposables). For contacts not covered in full, we offer a \$130 allowance toward the cost of non-select contact lenses, and the copay is waived. Discounts on contact lenses vary by provider.

With your prescription, you can use our online discount ordering program at www.lensbenefits.com/avesis to save even more.

LASIK

A one-time \$150 reimbursement for LASIK is in addition to, not in lieu of, eyeglass or contact lens benefits. Using our LASIK partner, Quallsight, saves members up to 25 percent on the provider's lowest advertised price. For participating providers, visit <http://www.quallsight.com/-avesis>.

See your benefits clearly.

See and manage your benefits at www.avesis.com. From there, you can print a personal ID card, though it is not required for service. Out-of-network reimbursement claims forms may be downloaded from our website. Just follow the simple instructions for submitting them. For questions about your vision care benefits, please contact your HR department. For Avēsis Customer Care, call 800-828-9341.

¹ <http://yoursightmatters.com/7-health-problems-eye-exams-can-detect/>, accessed May 2018.

Vision Insurance



| Monthly Premiums | |
|--------------------------------------|-------------------|
| Employee | \$6.54 |
| Employee & Spouse | \$11.84 |
| Employee & Child | \$12.29 |
| Employee & Family | \$18.94 |
| Copays for In-Network Services | |
| Exam | \$10.00 |
| Materials | \$20.00 |
| Retail Frame Allowance | |
| Private Practice Provider | \$150.00 |
| Retail Chain Provider | \$150.00 |
| Benefit Frequency | Calendar Year |
| Comprehensive Exam | Once in 12 months |
| Spectacle Lenses | Once in 12 Months |
| Frames | Once in 24 months |
| Contact Lenses in Lieu of Eyeglasses | Once in 12 months |

LENS OPTIONS³

Standard scratch-resistant coating, standard progressive lenses, ultraviolet coating, and tints—covered in full. Deluxe and premium progressive lens options are now available. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)

CONTACT LENS BENEFITS AND FITTING & FOLLOW-UP (CLEFFU)⁴

Medically Necessary Contact Lenses⁵

Covered in full.

LASER VISION BENEFIT (LASIK)

A one-time \$150 reimbursement for LASIK is in addition to, not in lieu of, eyeglass or contact lens benefits. Using our LASIK partner, Quallsight, saves members up to 25 percent on the provider's lowest advertised price (discount based on overall cost, with higher discounts for higher cost procedures).

For participating providers, visit:

<http://www.quallsight.com/avesis>

| Examples of Possible Savings ¹ | | | |
|---|--|--------------------|---------------------------|
| Exam and Materials Covered by Avēsis | Estimated Cost Without Plan ² | Less Employee Cost | Total Savings with Avēsis |
| Employee Only* | \$356.00 | \$78.48 | \$277.52 |
| EE + Spouse* | \$712.00 | \$142.08 | \$569.92 |
| EE + Child(ren)* | \$1,068.00 | \$147.48 | \$920.52 |
| EE + Family* | \$1,424.00 | \$227.28 | \$1,195.72 |
| *Exam, single-vision lenses, and covered-in-full frames | | | |

1 For this illustration, Employee + Children is calculated with three members; Employee + Family is calculated with four members.

2 Approximate retail value illustrated: exam and refraction—\$65; single-vision lenses—\$85; Frames—\$130. Average retail costs vary by provider.

3 At in-network providers, only.

4 Coverage for covered contact lenses does not apply at Costco, Walmart or Sam's Club locations. The allowance for non-select contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

5 Medically necessary contact lenses are covered in full, in lieu of frame and spectacle lenses. The following are some of the conditions that constitute eligibility for medically necessary contact lenses: following cataract surgery, certain conditions of Anisometropia and/or Keratoconus, or to correct extreme visual conditions that cannot be corrected with spectacle lenses. Medically necessary contact lenses require prior authorization from Avēsis. Copays do not apply to this benefit.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations. The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

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Flexible Savings Accounts



How FlexSystem Works

FlexSystem FSA is offered through your employer and is administered by TASC. When you choose to enroll in a FlexSystem FSA Healthcare and/or Dependent Care, you choose the dollar amount you want to contribute to each account based on your estimated expenses for the upcoming Plan Year. Your contributions will be deducted in equal amounts from each paycheck, pretax, throughout the Plan Year. The more you contribute to these accounts, the more you save by paying less in taxes!

Multiple Methods for Account Management

You may use any of the following self-service options to access your FlexSystem accounts and TASC Card transaction:

- **MyTASC Online:** www.tasconline.com
- **MyCash Manager:** within MyTASC at www.tasconline.com
- **MyTASC Mobile App:** free download at www.tasconline.com/mobile
- **MyTASC text Messaging:** elect through your MyTASC account online (You can use “profile” to steer to the right tab.)

Important Considerations

FSA Funds DO NOT Rollover

It is important to be conservative in making elections because any unused funds left in your FSA at the close of the Plan Year are not refundable to you. You are urged to take precautionary steps, such as tracking account balances on the FlexSystem website and/or using the Interactive Voice Response system, to avoid having funds remaining in your account at year-end. Purchasing eligible over-the-counter items are ways to utilize leftover FSA funds. Just remember, those over the counter items will require a prescription. ***Employees have 90 days from the date Flexible Spending Account benefits terminate to file claims to utilize funds for the benefit period.***

Changing Elections During the Plan Year

You may change your FSA elections during the Plan year only if you experience a change of status such as:

- A marriage or divorce
- Birth or adoption of a child , or
- A change in employment status

FSA Funds MUST Be Re-Elected Each Year

You must make your FSA election each year. Please indicate your annual election amount on your 2020 Open Enrollment Form and return the form to the Risk Management & Employee Benefits Department by October 11, 2019. Failure to submit an annual election on your 2020 Open Enrollment Form will result in a no FSA benefits for the 2020 Plan Year!

Flexible Savings Accounts



Medical Savings Account

Medical Savings Accounts may be used for a variety of medical expenses. Below is a partial list of permissible expenses reimbursable through a Medical Flexible Savings Account. A more extensive list is available on theHub.

thehub.polk-fl.net/riskmanagement/insurance-benefits

- Co-Pays
- Deductible & Co-Insurance
- Bandages
- Eye Exams
- Prescription glasses, contacts, or safety glasses
- Diabetic Supplies
- Hearing aids and hearing aid batteries
- Laser eye surgery (LASIK)
- Prescription drugs
- Smoking cessation programs
- Certain OTC medications & drugs
- Bengay, Flexall
- Calamine lotion
- Sinus medications
- Teething gel

Maximum Annual Contribution for Medical FSA is **\$2,750**

Minimum Annual Contribution for Medical FSA is **\$300**

Childcare Reimbursement Account

A Section 125 Cafeteria Plan (FlexSystem FSA) allows for the inclusion of Dependent Care (Section 129 of the Internal Revenue Code) benefits. Eligibility for the dependent care benefit requires that certain criteria be met with respect to the expense, the provider etc.

The dependent care expenses must be work related. The care must be necessary for the employee and the employee's spouse to work, to look for work, to attend school full-time or are physically unable to care for their children. The dependent care expenses provided during a calendar year cannot exceed \$5,000. In the case of a separate return by a married individual, the limit is \$2,500. This amount may be less if the employee's earned income or spouse's earned income is less than \$5,000.

Dependent Care expenses eligible for reimbursement

- Eligible dependent care expenses must be employment related.
- Day camp—primary purpose must be custodial care and not educational in nature
- Dependent care expenses that are necessary for you (and your spouse) to work, actively look for work, or attend school full-time.
- Dependent care for a child under age 13
- FICA/FUTA taxes of day care provider
- Late pickup fees
- Nanny expenses attributed to dependent care
- Nursery school (pre-school)
- Registration fees—when allocated to dependent care services that have been provided

Employee Assistance Program

Aetna Resources for Living

Aetna Resources For Living™

aetna™

Benefits Overview

Aetna Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional well-being support

You can call us 24 hours a day for in-the-moment emotional well-being support. You can also access up to 7 counseling sessions per issue each year.

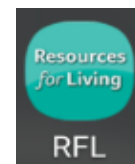
Visit with a counselor face to face, online with televideo or get in-the-moment support by phone. Services are free and confidential. We're always here to help with a wide range of issues including:

- Relationship support
- Stress Management
- Family Issues
- Work/family balance
- Grief and loss
- Depression
- Anxiety
- Substance misuse and more
- Self-esteem and personal development

Online Resources/Mobile App

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Life and recorded webinars



You'll also find access to these helpful tools:

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel and more.

Fitness Discounts

Save on gym memberships at over 9,000 locations nationwide and home fitness equipment. Participating gyms and programs include 24 Hour Fitness, LA Fitness, Anytime Fitness, Zumba Fitness, Nutrisystem and more.

myStrength

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain, mindfulness, sleep and health parenting.

CONFIDENTIAL

1-800-272-7252

Employee Assistance Program

www.resourcesforliving.com

Login: PCS Password: PCS

Employee Assistance Program

Legal Services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal Law
- Elder law and estate planning
- Divorce
- Wills and other document
- Separation
- Real estate transactions
- Mediation services



If you opt for services beyond the initial consultation you can get a 25 percent discount.

*Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Aetna Resources For Living™

aetna™

Financial Services

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions and preparation



You can also get a 25 percent discount on tax preparation services.

*Services must be for financial matters related to the employee and eligible household members.

Other Services

Identity theft services – One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.

Aetna Resources For Living is the brand name used by products and services offered through the Aetna group of subsidiary companies (Aetna). The EAP is administered by Aetna Behavioral Health, LLC and in California for Knox-Keene plans, Aetna Health of California, Inc. and Health and Human Resources Center, Inc.

*All calls are confidential, except as required by law. This material is for informational purposes only. It contains only a partial, general description of programs and services and does not constitute a contract. EAP instructors, educators and network participating providers are independent contractors and are neither agents nor employees of Aetna. Aetna does not direct, manage, oversee or control the individual services provided by these persons and does not assume any responsibility or liability for the services they provide and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **aetna.com**.*

Authorized Investment Providers

Retirement Savings Plans

Polk County Public Schools currently supports a 403(b) retirement savings plan. These plans are available only to employees of public school systems and certain other non-profit organizations. These employee accounts are commonly referred to as Tax Sheltered Annuities or TSAs because at one point only standard interest annuities and variable annuities were allowable account types. In 1974 the passage of the Employee Retirement Income Security Act (ERISA) added mutual funds under custodial arrangements as an additional investment option. All regularly scheduled employees may elect to contribute a limited portion of their salary before taxes to one of the authorized plans available through their employer. For more information on contribution limits, see the "Calculations" section of our website.

In addition to 403(b) retirement plans, Polk County Public Schools offers 457(b) deferred compensation plans to its employees. These plans are available to certain tax-exempt and governmental employers. With the passage of the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA), contribution limits were dramatically changed. In addition, 457(b) plans now have separate limits which are not reduced by employee contributions into either a 403(b) or 401(k) plan.

All Authorized Investment Providers listed have entered into information sharing agreements with the plan sponsor. Board Policy and District administrative requirements allow companies which meet certain standards and maintain a minimum number of employee accounts to provide 403(b) TSA accounts to employees. The companies listed below are currently authorized under administrative guidelines to establish 403 and 457(b) accounts for the employees of Polk County Public Schools. This list does not reflect any opinion as to the financial strength or quality of product or service for any company. Employees should contact a local representative to obtain specific information on plans available.

| Authorized Investment Providers | | Authorized Investment Types | | |
|---|---|----------------------------------|-------------|------------------------------------|
| Companies | Phone Number | 403(b) Accounts | ROTH 403(b) | 457(b) Deferred Compensation Plans |
| American Century Investments | 1-800-345-3533 | X | X | |
| Ameriprise Financial | 1-863-688-6863 | X | | |
| ASpire Financial Services | Allen & Company CPS Investment Advisors | 1-863-688-9000 1-877-564-6277 | | |
| AXA Equitable Life Insurance Co. | 1-800-628-6673 | X | X | X |
| Great American Financial Resources | 1-800-854-3649 | X | X | X |
| Horace Mann Insurance Company | 1-800-999-1030 | X | X | X |
| Life Insurance Company of the Southwest | 1-800-579-2878 | X | X | X |
| PlanMember Services | 1-800-874-6910 | X | X | X |
| Reliastar Life Insurance Co. (ING Retirement) | 1-877-884-5050 | X | X | X |
| VALIC | 1-800-369-0314 | X | X | X |
| Waddell & Reed, Inc. | 1-813-348-0097 | X | | |

BENCOR Special Pay Plan

The BENCOR Special Pay Plan is an IRS Section 401(a) qualified retirement plan that permits district employees to take maximum advantage of Federal tax laws by deferring Federal withholding taxes and permanently avoiding Social Security and Medicare taxes on eligible accumulated sick and annual leave payments. More information concerning this plan is available in your "Annual Retirement Benefits Guide."

Know Your Rights

HIPAA Notice of Privacy Practices

Polk County Public Schools is concerned about your privacy, and maintains a strict privacy policy. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Polk County Public Schools has implemented procedures to ensure full compliance with all federal privacy protection laws and regulations.

What is HIPAA? A comprehensive federal legislation regarding health insurance which is comprised of four key areas:

1. Portability protects health insurance coverage for workers and their families when they change or lose their jobs. It also prevents discrimination against an employee and their families due to preexisting medical conditions.
2. Privacy provides the first comprehensive federal protection for the privacy of an individual's health information (PHI*). This gives individuals more control over their health information, and it sets boundaries on the use and disclosure of their health information.
3. Security establishes safeguards that must be achieved to protect the privacy of protected health information and holds violators accountable with civil and criminal penalties that can be imposed if they violate an individual's privacy rights.
4. Standardize electronic health care transactions

*PHI -Protected Health Information – Information that relates to the past, present, or future physical or mental health of the individual; the provision of health care to an individual; or the past, present, or future payment for the provision of healthcare. This includes information that can be used to identify the individual. You have the following rights regarding your health information under HIPAA:

1. The right to request restrictions.
2. The right to receive confidential communications.
3. The right to inspect and copy.
4. The right to amend your health information.

5. The right to receive an accounting of disclosures.
6. The right to obtain a paper copy of the Notice of Privacy Practices at any time.
7. The right to choose someone to act for you.

Social Security Number Collection Policy

This statement serves as notification of the purpose and usage of social security numbers in compliance with Chapter 119 of the Florida Statutes. Polk County Public Schools Risk Management & Employee Benefits Department acknowledges that a social security number is a unique identifier and can be used to obtain sensitive information; however, social security numbers must be collected under certain circumstances for the department to properly and accurately perform its duties as part of an educational institution.

A copy of the Privacy Policy can be found on theHub Risk Management & Employee Benefits page at:

theHub.polk-fl.net/riskmanagement

A copy of this policy can also be obtained by contacting your Risk Management & Employee Benefits Department.

Know Your Rights

COBRA Rights Notice

Insurance coverage terminates on the last day of the month in which you paid for coverage from your last paycheck. An information packet, including written notice explaining the terminated employee's rights under COBRA will be sent by the Polk County School Board COBRA administrator, TASC. This information will be sent to the address on file in SAP, so it is very important to update your contact information anytime you have an address change. The Consolidated Omnibus Budget Reconciliation Act of 1993 (COBRA) allows you to continue the coverage you had as an active employee if you elect to continue the coverage by paying the full amount of the premium plus an administrative charge of 2 percent. Each qualified beneficiary must be offered the option to continue coverage following a qualifying event. Qualifying beneficiaries include any eligible dependent that is covered on the insurance coverage at the time of the employee's separation of service that is eligible and that continues to be eligible for coverage. Any qualifying beneficiary that experi-

ences a qualifying event separate from the employee separating from the employee separating from service, i.e. a spouse in the case of a divorce, must also be offered the option to continue coverage.

| REASON FOR LOSS OF COVERAGE | EMPLOYEE | SPOUSE | CHILD (REN) |
|--|-----------|-----------|-------------|
| Employee separation from service | 18 MONTHS | 18 MONTHS | 18 MONTHS |
| Employee reduction of hours (no longer eligible for coverage through employer) | 18 MONTHS | 18 MONTHS | 18 MONTHS |
| Employee, spouse or dependent become legally disabled | 29 MONTHS | 29 MONTHS | 29 MONTHS |
| Death of Employee | | 36 MONTHS | 36 MONTHS |
| Divorce or Legal Separation | | 36 MONTHS | 36 MONTHS |
| Entitled to Medicare | | 36 MONTHS | 36 MONTHS |
| Child no longer qualifies | | | 36 MONTHS |

Family & Medical Leave Act / Leave of Absence

According to the Family and Medical Leave Act of 1993 eligible employees must be granted up to 12 work weeks of unpaid leave by their employer for any of the following reasons occurring during a 12 month period:

- Birth of employee's child
- Adoption or placement of a foster child
- Caring for ill or injured immediate family member (spouse, child, parent)
- Serious illness or Injury of employee (employee unable to work)

Effective January 16, 2009 the FMLA regulations have been updated to include implementation of new military family leave entitlements enacted under the National Defense Authorization Act for FY 2008. This change permits any of the following family members to take up to 26 work weeks of leave to care for a member of any of the Armed Forces; Active, Reserve or National Guard, undergoing medical treatment or recuperation (including therapy), for serious injury or illness: Spouse, Parent, Child, or Next of Kin.

While you are out on a Leave of Absence, it is your responsibility to contact the Risk Management & Employee Benefits Department at 863-519-3858 regarding the continuation of your insurance benefits provided by the Board, and any other voluntary insurance benefits in which you are enrolled. If the necessary arrangements are not made to continue your benefits, interruption or cancellation of the benefits may result.

Know Your Rights

Medicaid & the Children's Health Insurance Program (CHIP)

Offer Free or Low-Cost Health Coverage to Children & Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

You may be eligible for assistance paying your employer health plan premiums. Contact the Florida Medicaid / CHIP Office at www.fdhc.state.fl.us/Medicaid/index.shtml or by phone: 1-866-762-2237. To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Division

www.dol.gov/ebsa

1-866-444-EBSA (3272)

OR

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

www.cms.hhs.gov

Know Your Rights

NOTICE REGARDING WELLNESS PROGRAM

PCPS offers voluntary wellness programs available to all employees. The programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Employees who choose to participate in the PCPS wellness programs may receive a financial or plan design incentive. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Wellness Program at 863-648-3057.

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Risk Management and Employee Benefits at 863-519-3858.

Know Your Rights

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator, Florida Blue, at 1-855-630-6824 for more information.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:

48 hours following a vaginal delivery or 96 hours following a cesarean section

Determination of when the hospital stay begins is based on the following:

- ❖ For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the **last delivery**.
- ❖ For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited if the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- ❖ Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- ❖ Try to encourage the mother to take less by providing payments or rebates.
- ❖ Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.
- ❖ These rules do not mandate hospital stay benefits on a plan that does not provide that coverage.

MEDICARE PRESCRIPTION DRUG COVERAGE (PART D)

CREDITABLE COVERAGE NOTICE

Important Notice from Polk County Public 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 Polk County Public 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 at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Polk County Public Schools has determined that the prescription drug coverage offered by Polk County Public Schools medical plan 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 November 15th through December 31st. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage

If You Decide to Join A Medicare Drug Plan?

Your current Polk County Public Schools coverage pays for other health expenses, in addition to prescription drugs, and If you decide to join a Medicare drug plan, please keep in mind that ***you cannot also be enrolled in the Polk County Public Schools Medical Plan.***

The Polk County Public Schools plan provides comprehensive prescription drug coverage through retail and mail providers. There is a \$50 per year per individual deductible for Brand Name drugs in addition to the follow copayments:

| Generic | Preferred Brand | Non-Preferred Brand |
|--|-----------------------------|-------------------------------|
| Retail 30 Days | | |
| \$8 | \$40+10%* (max \$80) | \$80+10%* (max \$160) |
| Retail 90 Days | | |
| \$20 | \$120. +10%* (max \$240) | \$210.00 +10%* (max \$420) |
| Mail 90 Days | | |
| \$20 | \$125 | \$200 |
| Specialty | | |
| \$80 | \$80 | \$160 |
| Maximum Out-of-Pocket \$1,600 | | |
| *10% of the cost of the prescription minus the deductible. | | |

IMPORTANT NOTE: If you purchase a brand-name medication when a generic medication is available or when your doctor requests a brand-name medication when a generic medication is available, you will pay the brand co-payment based on the current formulary, plus the difference in cost between the brand and the generic.

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 coverage with the School Board of Polk County and don't enroll in a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage....Contact the Risk Management & Employee Benefits Department for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the School Board of Polk County changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048

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).

Date: August 1, 2013

Name of Entity/Sender: The School Board of Polk County

Contact: Risk Management & Employee Benefits Department

Address: 1915 Floral Avenue, Bartow, FL 33830

Phone Number: 863-519-3858

If you have a limited income and resources, extra help 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 800-772-1213 (TTY 800-325-0778).

Required Notice on Health Insurance Market Place Options

| | |
|--|---|
| Purpose | In order to comply with the federal Patient Protection and Affordable Care Act (ACA), Polk County Public Schools is required to send the enclosed notice to every employee. The attached notice provides you with instructions on how to access information about the Health Insurance Marketplace. |
| What is the Health Insurance Marketplace? | <p>The Health Insurance Marketplace also known as the “Exchange” offers individuals the option to find and compare private health insurance plans.</p> <ul style="list-style-type: none"> • Open enrollment for health insurance coverage through the Marketplace begins in October 2019 for coverage starting as early as January 1, 2020. • Health insurance plans under the Exchange are not offered on a pre-tax basis. • <u>Please note that the Marketplace provides access to health insurance that is separate from the coverage offered by Polk County Public Schools.</u> |
| Important Information | <p>Polk County Public Schools will continue to provide quality health insurance that meets and exceeds the minimum value standards of the Affordable Care Act.</p> <ul style="list-style-type: none"> • Benefit eligible employees are automatically enrolled in the PCPS health plan. • Open enrollment for Polk County Public School’s health insurance coverage begins September 30, 2019 through October 11, 2019 for coverage effective January 1, 2020. |
| Required Action | <i>There is no action required from employees; this is for informational purposes</i> |
| Who is the Marketplace for? | <p>The Marketplace is for non-benefit eligible employees and/or any employee dependents may wish to consider options offered in the Marketplace.</p> <p>Depending on certain factors, non-benefit eligible employees may be eligible for a tax credit and/or premium assistance to help reduce the cost of health coverage obtained through the Marketplace.</p> |
| Questions about PCPS Health Plan | If you have any questions regarding PCPS’s group health plan: Call PCPS Risk Management and Employee Benefits Department at 863-519-3858 or email RiskManagement-AllStaff@polk-fl.net. |

Availability of Summary Health Information

Understanding the benefits offered through the PCPS Health Plan is very important. To help guide you through the items covered, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about health coverage in a standard format.

The SBC is available on theHub at: theHub.polk-fl.net/riskmanagement/insurance-benefits. A paper copy is also available, free of charge, by calling 863-519-3858.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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 PCPS Risk Management & Employee Benefits Department 863-519-3858.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

| | | | |
|--|-----------------------|---|--|
| 3. Employer name The School Board of Polk County, Florida | | 4. Employer Identification Number (EIN) 59-6000807 | |
| 5. Employer address PO Box 391 | | 6. Employer phone number 863-519-3858 | |
| 7. City Bartow | 8. State FL | 9. ZIP code 33831 | |
| 10. Who can we contact about employee health coverage at this job? Risk Management & Employee Benefits | | | |
| 11. Phone number (if different from above) | | 12. Email address RiskManagement-AllStaff@polk-fl.net | |

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:

Employees who work at least 30 hours per week and have completed the necessary waiting period, including those active employees subject to coverage under Medicare, subject to the terms and conditions of the plan. Coverage is not offered to substitute employees.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

The covered employee's natural, newborn, adopted, foster, or step child(ren) until the end of the month in which he or she turns 26., the newborn child of a covered dependent child for 18 months after birth, and handicapped children beyond age 26. Please see Summary Plan Description for more details on coverage criteria.

☐ 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

A request for your health insurer or plan to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may not balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance plus any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your [health insurance](#) or [plan](#) doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a [premium](#).

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the [allowed amount](#) for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network co-insurance usually costs you less than [out-of-network co-insurance](#).

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your [health insurance](#) or [plan](#). In-network co-payments usually are less than [out-of-network co-payments](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Non-Preferred Provider

A [provider](#) who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your [health insurance](#) or [plan](#), or if your health insurance or plan has a "tiered" [network](#) and you must pay extra to see some providers.

Out-of-network Co-insurance

The percent (for example, 40%) you pay of the [allowed amount](#) for covered health care services to providers who do not contract with your [health insurance](#) or [plan](#). Out-of-network co-insurance usually costs you more than [in-network co-insurance](#).

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your [health insurance](#) or [plan](#). Out-of-network co-payments usually are more than [in-network co-payments](#).

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your [health insurance](#) or [plan](#) begins to pay 100% of the [allowed amount](#). This limit never includes your [premium](#), [balance-billed](#) charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your [co-payments](#), [deductibles](#), [co-insurance](#) payments, out-of-network payments or other expenses toward this limit.

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment](#) is [medically necessary](#). Sometimes called prior authorization, prior approval or precertification. Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A [provider](#) who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your [health insurance](#) or [plan](#) has a "tiered" [network](#) and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your [health insurance](#) or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

[Health insurance](#) or [plan](#) that helps pay for prescription drugs and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a [provider](#) who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room](#).



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