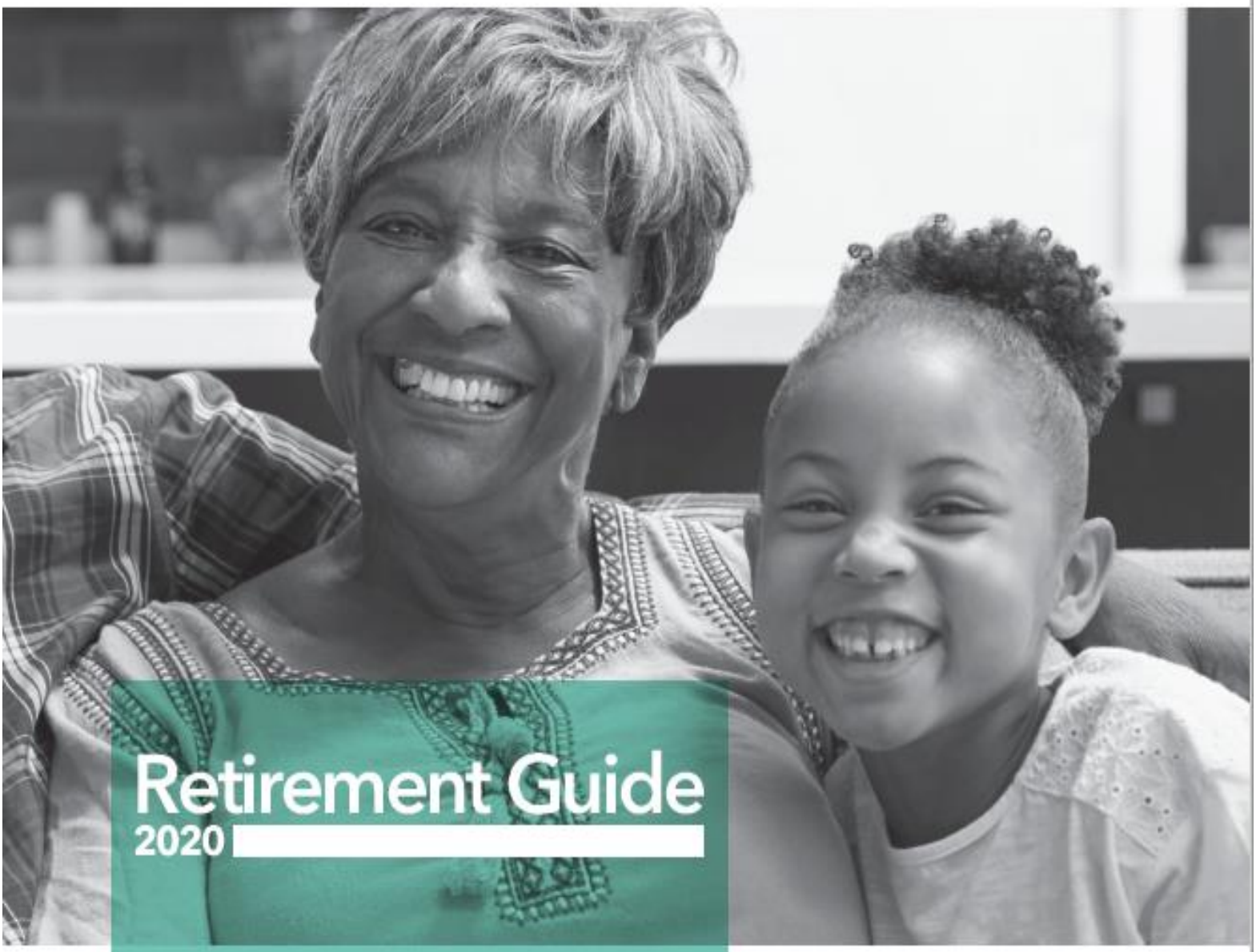
POLK COUNTY PUBLIC SCHOOLS
STUDENTS FIRST



Retirement Guide
2020

polkschoolsfl.com/retirement

All forms must be returned to the Risk Management & Employee Benefits Department by **November 8, 2019**. Send forms to the Risk Management Department by:

In Person:

Polk County Public Schools
1915 S. Floral Avenue
Bartow, FL 33830

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 17)

Retiree Email Program

The Risk Management and Employee Benefits Department currently uses a retiree email address list to communicate important information about your retiree benefits and new opportunities available to you.

If you are not currently receiving email notifications from our department, please be sure to send an email to us at PCSB.Retiree@polk-fl.net to join the list.

Joining the email list will not prevent you from receiving important information by mail.

Welcome from Risk Management

Greetings Fellow Polk County Public Schools Retirees:

It is our pleasure to welcome you to the 2020 Open Enrollment. At Polk County Public Schools (PCPS), making sure our retirees have access to quality, affordable health care coverage is a priority. The District's Superintendents Insurance Committee and the Board work hard to ensure that our retiree program offers our retirees comprehensive coverage while controlling long-term health care costs. As the cost of healthcare continues to rise, it is more important than ever for each of us to take an active part in our health. The 2020 Benefits Guide includes a summary of your benefit plans, the eligibility requirements and instructions on how to enroll.

In 2015, PCPS joined the **Florida School Retiree Benefit Consortium (FSRBC)**, an organization that assists School Districts throughout the state with benefit and retirement-related initiatives. The goal of FSRBC is to help Medicare-eligible members gain access to high-quality medical plans at cost-effective premium rates. The FSRBC concept was presented to hundreds of our retirees at meetings held at various locations in Polk County. Based on retiree feedback, and following a process to select cost-effective plan options, Polk elected to move forward in offering these products.

Effective January 1, 2019 any PCPS Medicare eligible retirees and dependents transitioned to the FSRBC for health, dental and vision benefit administration. This transition allows for increased benefit opportunities for those Medicare eligible. As current retirees and covered dependents that are non-Medicare eligible become eligible for Medicare health, dental and vision benefits under the PCPS retiree benefit plans will end and information regarding continued coverage under the FSRBC benefit plans is provided by AON. Life insurance benefits will continue to be administered by PCPS.

We are excited to announce that effective January 1, 2020 the PCPS vision plan will be changing from UnitedHealthcare Vision to Avesis Vision Plan, a Guardian company. With this change in vision carriers participants will see a 4% reduction in premiums while experiencing the same or enhanced benefits. All other benefit plan premiums will remain the same for the 2020 plan year.

Please read the information contained in this guide carefully before making your decisions. The Annual Open Enrollment period is your once-a-year opportunity to make changes to your current benefit election and to review which family members you are including on your plans. The plan year begins on January 1 and continues through December 31.

What Should I Do?

What is Open Enrollment?

Open Enrollment is your yearly 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 Polk County Public Schools, you are important! That's why we work hard to provide affordable benefit options for you and your family.

What should I do first?

Review the Open Enrollment Guide to ensure you have your Open Enrollment Form, located in the center of your guide. If you are missing this form, please contact Employee Benefits at 863-519-3858 or by email at: RiskManagement-AllStaff@polk-fl.net

What happens if I do not return the enrollment form?

If you do not return your Open Enrollment Form, your current benefit elections will automatically continue for you and your eligible covered dependents.

What if I want to cancel the health insurance offered?

If you are covered by another health plan and do not wish to be enrolled in the Polk County Public Schools Health Plan circle the indicated spot on your form to cancel coverage for health insurance and return it to the Risk Management and Employee Benefits Department.

Important note:
If you choose to cancel all plans offered by the School Board of Polk County, including the FSRBC plans, then you will not be able to come back to any plan offered by the Polk County Public Schools in the future.

Deadline for Open Enrollment

Forms must be returned to the Risk Management and Employee Benefits Department by November 8, 2019. Forms received after the due date will not be accepted.

NO FAXES WILL BE ACCEPTED.

Eligibility

Who Is Eligible?

Retirees

Benefit eligible employees who retire are eligible to continue health insurance coverage. Retirees must elect coverage at the time of retirement. If you do not elect retiree coverage or leave one of the retiree health plans sponsored by the Polk County School Board, you will not be permitted to elect coverage at a later date.

Retirees who are eligible for retiree insurance coverage may also enroll their eligible dependents.

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.

Children

A covered retiree's children are eligible for coverage until the end of the calendar month in which they turn 26. An eligible child includes the retiree's natural born, adopted, foster, or step child(ren), and a child for whom the covered retiree 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 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 and retirees with dependent coverage **will be** required to submit the required documentation.

During the 2020 Open Enrollment PCPS employees and retirees 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.
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	Copy of state or county issued birth certificate showing parents' names for child and grandchild.

POLK COUNTY PUBLIC SCHOOLS
STUDENTS FIRST

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.

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

powered by: healthstat

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?

PCPS retirees on the PCPS Self-Funded Health Plan and their covered dependents.

SERVICES: (Primary Care & Disease Management)

- Allergies
- Cold/flu Conjuctivitis
- 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!

Employee Wellness Programs

ABCs of Diabetes

The ***ABCs of Diabetes*** program is provided for all employees, retirees, 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

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

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, Pathology. 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 Therapy—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.

2020 Health Plan Retiree under 65 Premiums	
Coverage Level	**Monthly Premium**
Retiree or Spouse Only	$594
Retiree & Spouse	$1,188
Retiree & 1 Child	$699
Employee & 2 Children	$804
Employee & 3+ Children	$839
Employee, Spouse & 1 Child	$1,293
Employee, Spouse & 2 Children	$1,398
Employee, Spouse & 3+ Children	$1,433

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
- ✓ View or email your ID card
- ✓ Access contract details
- ✓ 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 my benefits change?

A: Your plan will continue to require a copay or coinsurance for covered prescription drugs. Your copay will depend on whether the drug is a generic, preferred brand, non-preferred brand, preferred specialty or non-preferred specialty. The preferred status 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

Coverage & Rates

Retirees are given the option at the time of retirement to continue Group Term Life Insurance coverage from Standard Insurance Company. If you did not elect to continue Group Term Life Insurance at the time of retirement, you may not elect coverage at this time. If you are currently enrolled in the Standard Term Life Insurance your rate may change effective January 1, 2020 based on your age as of January 1, 2020 according to the age chart shown here.

2020 Retiree Life Rate Chart

Age as of 01/01/2020	Rate: Per $1,000
<51	$0.406
51-54	$0.582
55-59	$0.874
60-64	$1.113
65-69	$1.758
70-74	$2.798
75-79	$4.618
80-84	$7.311
85-89	$11.658
90+	$38.355

Additional Life Coverage Features

- Repatriation Benefit: Provides up to $5,000 for transportation expenses of the deceased's body.
- MEDEX® Travel Assist: Offers simplified access to medical care and other emergency services for eligible Retirees traveling more than 100 miles from home – even in foreign countries.
  - U.S, Canada, Puerto Rico, U.S. Virgin Islands & Bermuda 1-800-527-0218
  - Other locations worldwide 1-410-453-6330

Current Retirees: If you wish to decrease the amount of your retiree life insurance coverage you have the option to reduce your retiree term life insurance coverage in increments of $1,000. Please review your life insurance needs and make any election changes needed on your Open Enrollment Form.

New Retirees: You have the option to elect retiree term life insurance coverage in increments of $1,000 up to the amount of coverage you carried as an active employee. Please review your life insurance needs and make any election change needed on your Open Enrollment Form.

Calculate Your Premium

_____ ÷ $1,000 x $ _____ = $ _____

(elected amount) (rate from chart) (monthly cost)

Term Life Insurance

These examples are based on the Basic Life Coverage amounts of $10,000 or $20,000 dependent on your retirement date.

If you elected to take any additional life insurance coverage you had at the time of your retirement, please use the calculation on the previous page to help you determine the premium.

If you retired prior to 10/01/04 and you elected to continue the $10,000 Basic Life Coverage provided at the time, the following chart is an example of your premium rates:

AGE AS OF 01/01/2020	RATE PER $1,000	Monthly Rate
<51	$0.406	$4.06
51-54	$0.582	$5.82
55-59	$0.874	$8.74
60-64	$1.113	$11.13
65-69	$1.758	$17.58
70-74	$2.798	$27.98
75-79	$4.618	$46.18
80-84	$7.311	$73.11
85-89	$11.658	$116.58
90+	$38.355	$383.55

Age Reductions

Under this plan, coverage reduces by 35 percent at age 65, by 50 percent at age 70, and by 65 percent at age 75. After an age reduction, the amount of your Additional Life and AD&D Insurance will be rounded up to the next higher multiple of $1,000, if not already a multiple of $1,000.

If you were a Retiree who elected Term Life Insurance prior to Plan Year 2013 your Term Life Insurance coverage has been 'grandfathered in" and the age reductions will not affect you.

If you retired 10/01/04 or after and you elected to continue the $20,000 Basic Life Coverage provided at the time, the following chart is an example of your premium rates:

AGE AS OF 01/01/2020	RATE PER $1,000	Monthly Rate
<51	$0.406	$8.12
51-54	$0.582	$11.64
55-59	$0.874	$17.48
60-64	$1.113	$22.26
65-69	$1.758	$35.16
70-74	$2.798	$55.96
75-79	$4.618	$92.36
80-84	$7.311	$146.22
85-89	$11.658	$233.16
90+	$38.355	$767.10

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

DELTA DENTAL

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

Standard Spectacle Lenses

Your plan covers standard single-vision, lined bifocal, or lined trifocal lenses, with standard stratch-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, Qualsight, saves members up to 25 percent on the provider's lowest advertised price. For participating providers, visit http://www.qualsight.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 OPTIONS[3]

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 Lenses[5]

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, Qualsight, 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.qualsight.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.

Premium Payments—FRS Pension

Premium Payments

Payment for premiums on all elected plans is due on the first of each month. If your FRS check is large enough to support it, premiums will be deducted monthly from your FRS check. The following sample is provided to give you an idea of what your FRS payment stub will look like in regard to your retiree insurance coverage.

STATE OF FLORIDA
DEPARTMENT OF FINANCIAL SERVICES
STATEMENT OF RETIREMENT BENEFIT PAYMENTS

FLAIR ACCOUNT CODE	OLO	SITE	DOCUMENT NUMBER	OBJECT	DATE	EFT NUMBER

REMITTED BY	PAYEE	WITHHOLDING STATUS
DIVISION OF RETIREMENT P.O. BOX 3090 TALLAHASSEE, FLORIDA 32315-3090	PAYEE: PAYEE: MEMBER: MEMBER:	MARITAL STATUS: ALLOWANCES: STATED W/H TAX: ADDL W/H TAX: W/H TAX:

SUMMARY OF BENEFITS AND DEDUCTIONS

	THIS PAYMENT	CALENDAR YEAR-TO-DATE
RETIREMENT BENEFIT	$	$
HEALTH INSURANCE SUBSIDY	$	$
GROSS BENEFITS	$	$
WITHHOLDING TAX	$	$
MISC DEDUCTIONS	$	$
NET BENEFITS	$	$

MISCELLANEOUS DEDUCTIONS

CODE	DESCRIPTION	THIS PAYMENT	CALENDAR YEAR-TO-DATE
008	POLK COUNTY SCHOOL B	$	$
201	POLK COUNTY SCHOOL B	$	$
	TOTAL OF MISC DEDUCTIONS	$	$

CODE 008 includes the premium deduction for any of the following plans that you may have elected:
Health*
Dental
Vision

*If you elected health, this is the total premium for your retiree health insurance election. You can see where your HIS amount has been added to your check in the Summary of Benefits and Deductions box. The deduction for your health plan election is shown separately in this box.

CODE 201 includes the premium deduction for Retiree Group Term Life.

What is the Health Insurance Subsidy (HIS) Program benefit?

The Health Insurance Subsidy (HIS) is a monthly supplemental payment that you may be eligible to receive if you have health insurance coverage. This monthly payment, WHICH YOU MUST APPLY FOR, is calculated by multiplying your total years of service at retirement (up to a maximum of 30 years) by $5. HIS is only available after you have six years of service (if enrolled in the FRS prior to July 1, 2011) or eight years (if enrolled in the FRS on or after July 1, 2011). HIS can be found at the FRS website at: https://www.rol.frs.state.fl.us/forms/Retiree-FAQ.pdf or by contacting FRS at: (888) 738-2252

NOTE: Please review your FRS paystub to make sure you are receiving your HIS. If you are not receiving this subsidy, please contact FRS.

If your FRS check is not sufficient to support your elected plan(s) premiums, you will be required to pay your premiums directly to PCSB. A letter will be sent to you with your premium payment information.

Premium payments are due the first day of the month, subject to cancellation after the tenth of the month.

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 Count 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 atthe time of the employee's separation of service that is eligible and that continues to be eligible for coverage. Any qualifying beneficiary that experiences 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

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?	The Health Insurance Marketplace also known as the "Exchange" offers individuals the option to find and compare private health insurance plans. • 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	Polk County Public Schools will continue to provide quality health insurance that meets and exceeds the minimum value standards of the Affordable Care Act. • 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	***There is no action required from employees; this is for informational purposes only.***
Who is the Marketplace for?	The Marketplace is for non-benefit eligible employees and/or any employee dependents may wish to consider options offered in the Marketplace. 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.
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 employeees.

- 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 dtails 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** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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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