Polk County Public Schools

Annual Retiree Open Enrollment Benefits Guide

2019 Plan Year

Make Wise Insurance Choices!

Last Day of Open Enrollment is November 2, 2018

Please review your health plan options very carefully!

All forms must be returned to the Risk Management & Employee Benefits Department by November 2nd, 2018.

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

Mail:
Polk County Public Schools
Attn: 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

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.

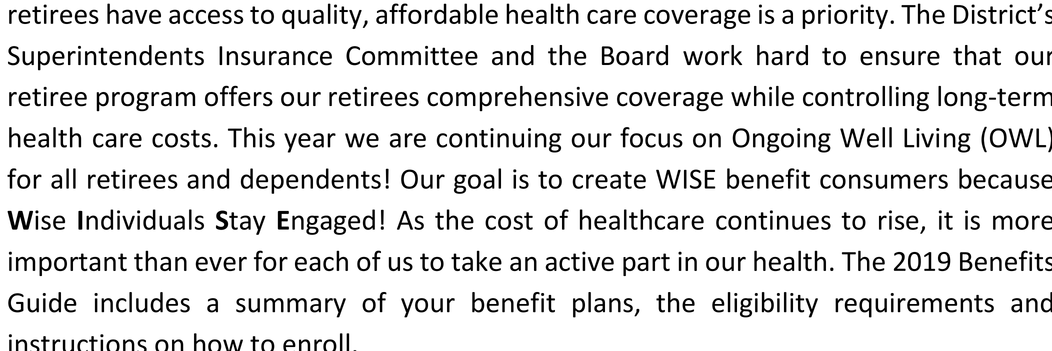
If you are not currently receiving email notifications from our department, please be sure to send an email to us at PCSB.Retiree@polk-fl.net to join the list.

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

Welcome from Risk Management

Greetings Polk County Public Schools Retirees:

It is our pleasure to welcome you to the 2019 Open Enrollment. At Polk County Public Schools, 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. This year we are continuing our focus on Ongoing Well Living (OWL) for all retirees and dependents! Our goal is to create WISE benefit consumers because **W**ise **I**ndividuals **S**tay **E**ngaged! 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 2019 Benefits Guide includes a summary of your benefit plans, the eligibility requirements and instructions on how to enroll.



In 2015, Polk County Public School District 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 Polk County Public Schools Medicare eligible retirees and dependents will be transitioned to the FSRBC for health, dental and vision benefit administration. This transition allows for increased benefit opportunities for those Medicare eligible.

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.

The Risk Management staff strives to deliver prompt, current and accurate information to enable you to make informed choices. If you have any questions or need any assistance, please call us, email us, or stop by to see us. We are here to assist you.

Sincerely,

Risk Management and Employee Benefits

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Open Enrollment for the 2019 Plan Year

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, 2019, 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 School Board of Polk County in the future.
Deadline for Open Enrollment	Forms must be returned to the Risk Management and Employee Benefits Department by November 2, 2018. Forms received after the due date will not be accepted. **NO FAXES WILL BE ACCEPTED.**

Eligibility & Documents

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

Required Documentation

It is your responsibility to show that your dependent meets the eligibility requirements and to remove them when eligibility ends. Eligibility ends on the last day of the month in which the requirements are no longer met. The premium will be deducted for the entire plan year; however, dependents will not be covered until the documentation is received. You must provide the following documentation to the Risk Management & Employee Benefits Department for any dependents being added during Open Enrollment:

Dependent Relationship	Documentation Requirements*	
Spouse	Copy of Marriage License	
Natural Child	Copy of Birth Certificate (must list employee as a parent)	
Stepchild	Copy of Birth Certificate (must list employee's spouse as a parent) and Marriage Certificate	
Adopted Child	Adoption Certificate	
Legal Custody or Guardianship	Court Order establishing legal guardianship	
Disabled Dependents Over Age 26	Social Security Disability Documentation. Disabled dependents are eligible only if covered by the PCSB Health Plan prior to age 26.	
Adult Child (ages 19-26)	Copy of Birth Certificate	
Grandchildren (EE's child must be listed as parent on birth cert. & remain covered)	UNDER 18 MONTHS OLD Copy of Birth Certificate	OVER 18 MONTHS OLD Legal Custody or Guardianship documentation

*The previous year's U.S. Tax Return showing you claimed the dependent can also be used to establish eligibility.

Options for Eligible Retirees & Dependents

Purpose	In 2015, Polk County Public School District joined the **Florida School Retiree Benefit Consortium (FSRBC)**, an organization that assists School Districts throughout the state with benefit and retirement-related initiatives.
Why the FSRBC?	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.
2019 Changes for Medicare Eligible Retirees and Dependents	Effective January 1, 2019 any Medicare eligible retiree or retiree dependent covered under a Polk County Public Schools health plan will be transitioned to the FSRBC. In addition, Medicare eligible retirees and their covered dependents on the Polk County Public Schools retiree dental and vision plans will be transitioned to the FSRBC. **Retiree life insurance coverage will remain with Polk County Public Schools regardless of Medicare eligibility.**
What happens when I or my dependent becomes Medicare eligible after January 1, 2019?	Prior to Medicare eligibility information will be sent to your address on file from the FSRBC. This information will provide you with direction on plans that will become available under the FSRBC. **Health Insurance:** Please note once you or your dependent become eligible for Medicare coverage for participants on the self-funded health will be terminated. Eligibility to remain on the retiree dental or vision coverage is based upon the retiree's Medicare eligibility. **Dental and Vision Coverage:** As long as the retiree remains ineligible for Medicare coverage the retiree and their covered dependents may remain on the retiree dental or vision coverage. Once the retiree becomes eligible for Medicare coverage the retiree and covered dependents on dental or vision coverage will terminate and coverage may be continued through plans offered by the FSRBC.
When can I expect to start receiving information from the FSRBC prior to turning 65?	Approximately 13 months prior to a retiree or retiree dependent turning 65 your information will be provided to the FSRBC. In the months leading up to turning 65 retiree plan participants can anticipate receiving periodic communications regarding the plans available and your enrollment period.

Health Plan Changes

Effective 1/1/2019, the PCSB health plan, administered by Blue Cross and Blue Shield of Florida, will be making a platform change. This includes a new website, ID card, and customer service number. The following FAQs are designed to prepare you for the upcoming transition. You will be receiving additional information throughout the remainder of the year.

Q: What does this change mean?

A: On January 1, 2019, the PCSB health plan is moving to a new Blue Cross and Blue Shield of Florida (BCBSFL) platform, which includes a new member portal! You will need to register for this new member portal after 1/1/2019 to access your contract and benefit information. This change brings a variety of new tools and resources that will be helpful to you and your family. Even though the look and feel of these tools is different, the way your benefits are administered through BCBSFL is not. You can continue to see your current in network physicians, and access the broadest national network when traveling.

Keep reading to learn more about the new website and mobile app!

Q: Why am I getting a new ID card?

A: BCBSFL is issuing you a new ID card because your contract number is changing. Please discard your current card and begin using this new card on or after 1/1/2019. To ensure that your claims process correctly, remember to show your new ID card to your provider at your next visit. If you have any questions or need additional cards, call us at the customer service number listed on the back of your new BCBSFL ID card.

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

A: If you have a question about your 2019 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: After 1/1/2019, the ExploreMyPlan Member Portal will be 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 will also be available for download on the App Store and Google Play after 1/1/2019.
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

Self-funded Plan Benefit Summary

BlueOptions – Plan 03566	In-Network	Out-of-Network
Member Deductible		
Per Person	$900	$1,500
Per Family Aggregate	$1,800	$3,000
Coinsurance (Member Responsibility)	20%	40%
Out of Pocket Maximum	Includes Deductible, Coinsurance, and Copays	N/A
Per Person	$5,000	Unlimited
Per Family Aggregate	$9,000	Unlimited
Lifetime Maximum	No Maximum	No Maximum
EMPLOYEE CLINICS		
Polk County School Board Employee Health Clinic Office Visit, Labs, On-site Prescriptions	$0	N/A
PROFESSIONAL PROVIDER SERVICES		
Allergy Testing and Treatment	$10	Deductible + 40%
E-Office Visit Services – Family Physician or Specialist	$10	
Office Services		
Family Physician or Specialist (including Chiropractor	$50	Deductible + 40%
Specialist Maternity Care	Deductible + 20%	Deductible + 40%
ER Physician	Deductible + 20%	In-Ntwk Deductible + 20%
Inpatient Visits & Consultations	Deductible + 20%	Deductible + 40%
Radiology, Pathology and Anesthesiology Provider Svcs		
Ambulatory Surgical Center	Deductible + 20%	In-Ntwk Deductible + 20%
Hospital	Deductible + 20%	In-Ntwk Deductible + 20%
Medical Pharmacy (Provider-Administered Rx in the Office)	Included in Office Visit Copay	Deductible + 40%
PREVENTIVE CARE		
Adult Wellness Office Svcs - 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	40%
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance (ground, air and water)	20% of billed charges	20% of billed charges
Convenient Care Centers (CCC)	$50	Deductible + 40%
Emergency Room Facility Services	Deductible + 20%	Deductible + 20%
Urgent Care Centers (UCC)	$50	Deductible + $40 copay
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. 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	

Self-funded Plan Benefit Summary

MENTAL HEALTH AND SUBSTANCE ABUSE	In-Network	Out-of-Network
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 Physician	Deductible + 20%	Deductible + 20%
Physician Office Visit - Family Physician or Specialist	$50	Deductible + 40%
Inpatient Physician Visits and Consultations	Deductible + 20%	Deductible + 20%
OTHER SPECIAL SERVICES AND LOCATIONS		
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)	
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

PCSB Self-Funded Retiree Health Plan	
Coverage	**Rate Per Month**
Retiree	**$594**
Spouse	**$594**
1 Child	**$105**
2 Children	**$210**
3 + Children	**$245**

Pharmacy Plan Changes

Effective 1/1/2019, the PCSB Prescription Drug plan integrated with your Blue Cross and Blue Shield of Florida health coverage will be making a formulary and network change. The following FAQs are designed to prepare you for the upcoming transition. You will be receiving additional information throughout the remainder of the year.

Q: What does this change mean?

A: On 1/1/2019, the PCSB plan will be moving to the SourceRX 1.0 Drug List – 6 tiers. This Drug List offers coverage for a wide variety of medications, but your current prescription may change tiers or become non-covered. Please be sure to check the SourceRX 1.0 Drug List to see if any of your drugs have changed under the new program.

On 1/1/2019, the PCSB plan will also be implementing a more narrow pharmacy network that excludes CVS. However, the new network, called the Value One Network, does include popular retail pharmacies such as Publix, Sam's Club, Walgreens and Walmart.

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.

Deductible: There is a $50.00 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	$160
Maximum Out-of-Pocket $1,600			
*10% of the cost of the prescription minus the deductible.			

Pharmacy Plan Changes

Q: Will the formulary be the same?

A: **IMPORTANT:** The 2019 formulary will not be exactly the same as last year. If you are currently taking a medication, please be sure to check the SourceRx 1.0 Drug List to see if your medication tier has changed.

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

A: The SourceRx 1.0 Drug List is available at FL.ExploreMyPlan.com/SourceRxDrugList6T.

Q: Will the new formulary also require prior authorization and step therapy on certain drugs?

A: The new 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.

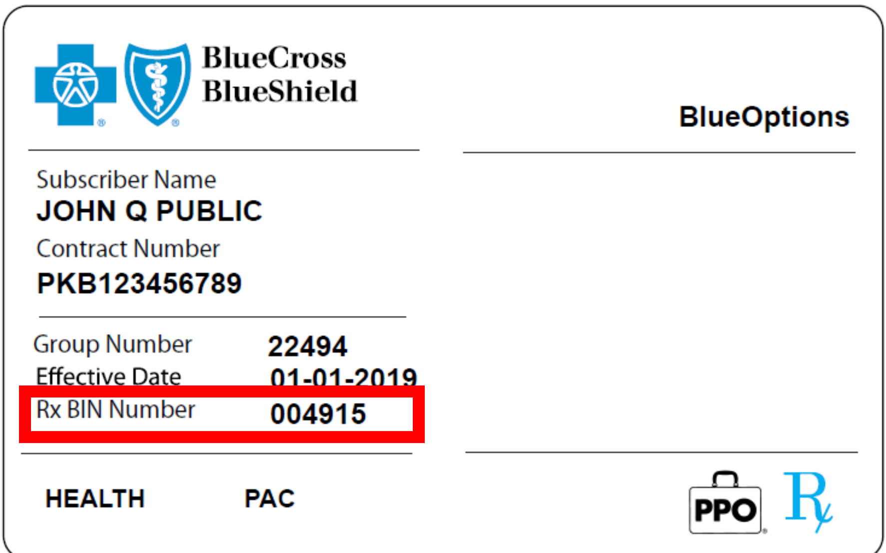
Please watch for information being mailed to your home address on how these programs may impact your current medications.

Be sure Risk Management has your correct mailing address.

Pharmacy Plan Changes

Q: What will I need to tell my pharmacy?

A: You will need to let your pharmacy know that your prescription drug coverage is changing on 1/1/2019. Just present your new BCBSFL ID card to the pharmacy. Everyone will receive new ID cards in December 2018. **BE SURE YOU ARE PRESENTING THE CORRECT ID CARD after 1/1/2019.**



Q: What are the changes to the pharmacy network?

A: Starting 1/1/2019, the PCSB health plan will be moving to the Value One Network, which excludes CVS. This means that only pharmacies in the Value One Network (Publix, Sam's Club, Walgreens and Walmart) will be the chain pharmacies in the network. If you choose to use a pharmacy other than those in the network there will be no coverage. To locate the nearest pharmacy to you, visit the "Find a Doctor" tab at FL.ExploreMyPlan.com after 1/1/2019.

Q: Can I still get a 90-day supply of maintenance medications at my retail pharmacy?

A: The Value One Network allows you to fill your 90-day supply of maintenance medications at a participating in-network pharmacy. Effective 1/1/2019, CVS will no longer be a participating in-network pharmacy.

Pharmacy Plan Changes

Q: Can I still use Mail Order?

A: Mail-order will be provided though the Home Delivery Network for maintenance medications. If you are currently filling at mail order and have a valid prescription, there will be no action required.

Q: How will I know which medications are considered maintenance?

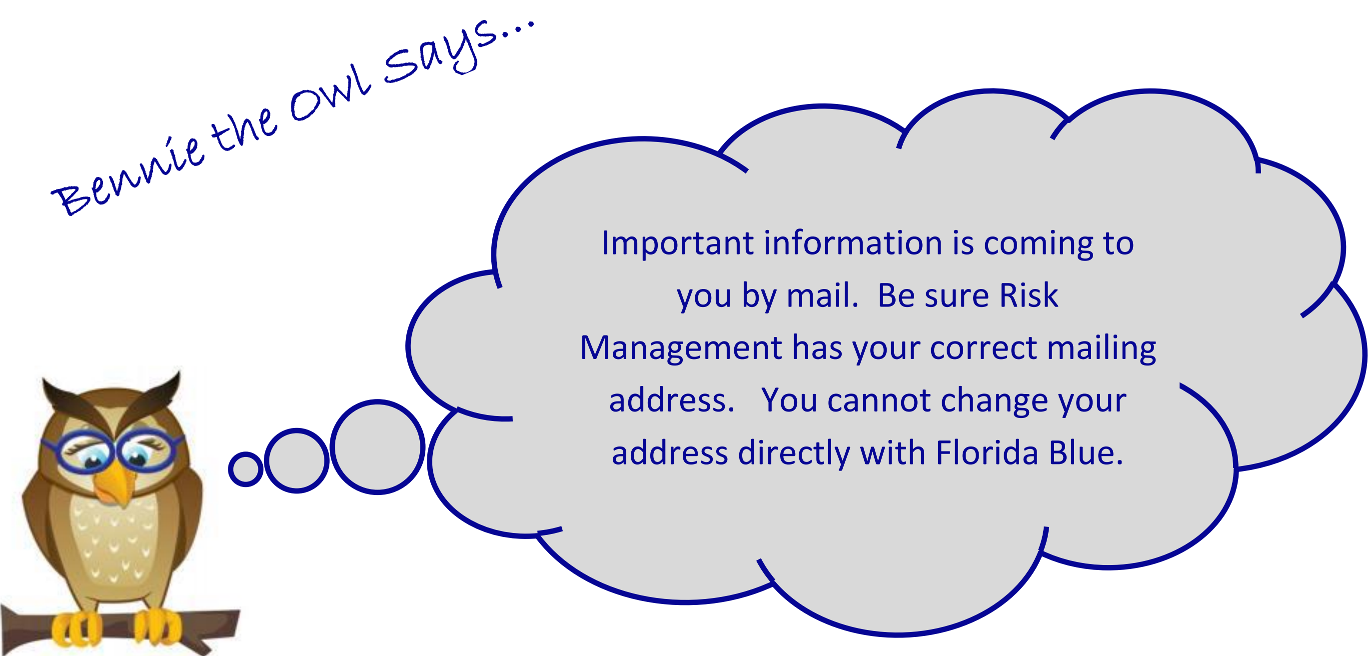
A: You can locate a list of current maintenance medications at FL.ExploreMyPlan.com/MaintenanceDrugList.

Q: Who will I contact for my self-administered specialty medications?

A: The main participating specialty pharmacy under the Blue Cross Blue Shield Select Network program is **AllianceRx Walgreens Prime**. There are other participating specialty pharmacies for certain limited distribution drugs as well. If you are currently taking a self-administered specialty medication, you will need to transition your medication to a Pharmacy Select Network pharmacy. **NOTE:** there will be action required on your part, so please be sure to watch for ongoing communications.

Q: How will this impact the ABCs of Diabetes Program?

A: The change in formulary will result in certain medications no longer being covered so you will need to change to a medication covered on the formulary. We are committed to working with you to make this transition as smooth as possible. We will communicate directly with all ABCs of Diabetes members to provide additional details and instructions.



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, 2019 based on your age as of January 1, 2019 according to the age chart shown here.

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

AGE AS OF 01/01/2019	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

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 01/01/2019	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 01/01/2019	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

DELTA DENTAL®

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 MPA*
Type B[2]	Schedule‡	Schedule‡	**Type B[2]**	80% of PPO fee	80% of PPO fee	**Type B[2]**	80% of PPO fee	80% of 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 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	$1000	$1000	Per Person	$1000	$1000	Per Person	$1500	$1500
Orthodontia Not Covered			Orthodontia Lifetime Max child only to age 19			Orthodontia Lifetime Max child only to age 19		
N/A			Per Person	$1000	$1000	Per Person	$1000	$1000

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.

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

† Deductibleuctible 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.

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

Vision Insurance

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network. A vision plan from UnitedHealthcare makes it easy to maintain good sight and healthy eyes, and save money while you're at it.

Vision Plan Benefits

In-network, covered-in-full benefits (after applicable copay) include a comprehensive annual exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating1 and the frame, or contact lenses in lieu of eye glasses. The plan provides:

- Eye exams
- Complete set of eyeglasses or contacts
- 20% to 40% discount on popular lens options
- Access to discounts on laser vision correction
- Discounts on extra pairs of eyewear

Refer to your benefit summary for plan specifics.

Frame* Benefit

When you visit a retail or private practice provider within the large UnitedHealthcare vision network, you will receive an allowance that can be applied to the cost of your frames. This allowance covers in full, after your copay, many of the most popular frames on the market today.

Lens Upgrades

Popular lens options, like progressive lenses, tints, anti-reflective coating and more, if not covered by your plan, are available at discounts of up to 40%. Standard scratch resistant coating is applied to all lenses at no charge.

Additional Pairs of Glasses

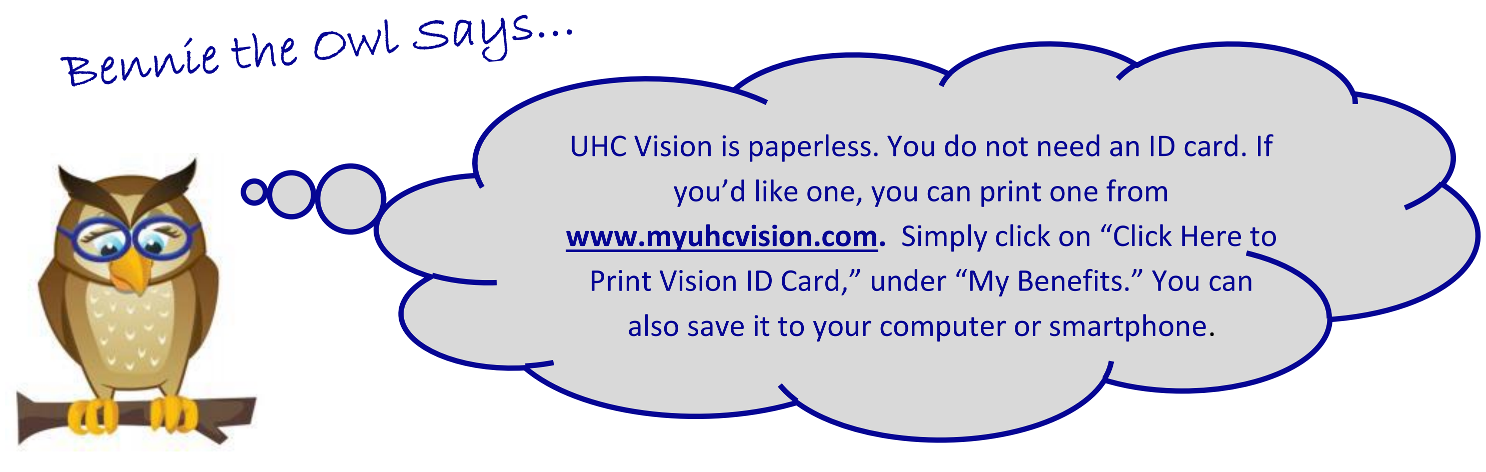
You get a 20% discount on any additional pairs of eyeglasses, including prescription sunglasses.

*Frame discounts do not apply when prohibited by frame manufacturer.

Contact Lens Benefit

You receive full coverage, after applicable copay, at a network vision provider. UnitedHealthcare covers the fitting and evaluation fees for covered-in-full contact lenses (including disposables) and up to 2 follow-up visits with your eye doctor. If you choose contacts that are not covered in full, you'll get an allowance toward the purchase price.

Once you have received your prescription for contact lenses from your eye care provider, you can use our online discount ordering program to save even more money. Just log into **www.myuhcvision.com** and click on the "Order Contact Lenses" button.



Vision Insurance

UnitedHealthcare

Discounted laser Vision Correction

You get access to discounted laser vision correction procedures. You can choose a credentialed surgeon from Laser Vision Network of America's (LVNA) nationwide network of more than 500 laser vision correction surgeons.

Online - Always

Our easy-to-use, self-service member website lets you easily verify your benefits and eligibility, find answers to frequently asked questions, locate a provider, access online offers and services, print a member ID card, and much more.

www.myuhcvision.com

One Size Does NOT Fit All

That's why we created a network that features both private practice and retail providers to allow you a choice for your eye care.

Simply go to our website and use the provider locator tool for a complete list, including door-to-door directions. You can also call 1-800-638-3120 to speak with a Customer Service representative.

A sample of some of the available contracted retail chain providers:

- Eye Express
- Costco Optical
- Crown Optical
- Eye Express
- EYE-MART
- VisionFirst
- Eye Care Associates
- Eyeglass World
- Eye Doctors Optical Outlet
- Vision4Less
- Visionworks
- Whylie Eye Care Center

Important to Remember

- Your $105.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- You can log on to our website to print off your personalized ID card. An ID card is not required for service, but is available as a convenience to you should you wish to have an ID card to take to your appointment.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision, Attn. Claim Dept., P.O. Box 30978, Salt Lake City, UT 84130 FAX: 248.733.6060.

At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

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.

Vision Insurance

Monthly Rates	
Employee	$6.81
Employee + Spouse	$12.33
Employee + Child	$12.80
Employee + Family	$19.73
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 Eye Glasses	Once in 12 months

Examples of Possible Savings			
Exam and Materials Covered by UHC Vision Plan	**Estimated Cost Without Plan[5]**	**Less Employee Cost**	**Total Savings with UHC Vision**
Employee Only*	$275.00	$95.38	$179.62
EE + Spouse*	$550.00	$178.37	$371.63
EE + Child *	$825.00	$212.88	$612.12
EE + Family*	$1,100.00	$309.41	$790.59
* Exam, Single Vision & Covered-in-Full Frames			

Lens Options

Standard scratch-resistant coating, Standard progressive lenses, Ultraviolet coating, 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

Covered-in-full elective contact lenses[8]
The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to 4 boxes are included when obtained from a network provider.

All other elective contact lenses
A $105.00 allowance is applied toward the fitting & evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts.

Necessary contact lenses[3]
Covered in full after applicable copay.

Laser Vision Benefit

UHC Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at Lasik *Plus* locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.

1. On all orders processed through a company owned and contracted Lab network.
2. The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.
3. Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, ask your provider to contact UHC Vision confirming reimbursement that UHC Vision will make before you purchase such contacts.
4. Actual tax savings will depend upon your individual tax bracket.
5. Approximate retail value illustrated: Exam & Refraction ($65), Single Vision Lenses ($80), and Frames ($130). Average retail costs may vary by provider.
6. For purposes of this calculation, Employee + Child(ren) is calculated with three (3) members.
7. For purposes of this sample calculation, Employee + Family is calculated with four (4) members.
8. Coverage for Covered Contact Lens Selection does not apply at Costco, Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

Polk County School Board Employee Health Clinic

Providing high-quality clinic staff dedicated to all Polk County School Board employees, spouses, dependents, and retirees on the medical plan by focusing on their health and well-being at no cost to the participant!

www.polk-fl.net **keyword: clinic**

Center Hours and Location

Monday:	**7:00 AM – 6:00 PM**
Tuesday:	**7:00 AM – 6:00 PM**
Wednesday:	**7:00 AM – 6:00 PM**
Thursday:	**7:00 AM – 6:00 PM**
Friday:	**7:00 AM – 6:00 PM**
Saturday:	**8:00 AM – 12:00 PM**

Make an Appointment for....

- ✓ Annual Physicals
- ✓ DOT Physicals
- ✓ Sports Physicals
- ✓ Allergy Care
- ✓ Bladder, Ear and Sinus Infections
- ✓ Manage most Chronic Medical Conditions

The clinic also....

- Provides certain generic medications to you at **NO COST**
- Houses an onsite Clinical Care Coordinator (In partnership with Florida Blue)
- Provides for Lab Work/Tests

To make an appointment, please call (863)419-3322

Clinic Locations:

Haines City
641 US HWY 17-92 West
Haines City, FL 33844

Lakeland
3215 Winter Lake Road
Lakeland, FL 33803

PCSB Employee Wellness Program

The New ABCs of Diabetes program is a comprehensive program provided by the PCSB Wellness Program and Florida Blue at no cost to all diabetic employees, spouses and dependents enrolled in the PCSB Health Plan. Diabetes awareness is promoted through:

Educational Classes

We provide FREE diabetes education. Topics include:

- Medical Issues with Diabetes
- Diabetes Advanced Meal Planning
- Managing Diabetes with Nutrition and Exercise
- Managing Heart Disease and High Blood Pressure

Participants now have the option of attending four 2-hour classes OR one 8-hour Saturday class at the PCSB Employee Health Clinic. Contact the Wellness Department at 648-3057 for the schedule. Classes and screenings are available to ALL PCSB insured employees and dependents, regardless of diagnostic status. HIPAA laws are strictly enforced for your protection.

Screenings

Quarterly lab work includes: (HbA1C & lipid profile), urinalysis for kidney function (random microalbumin, urine creatinine and microalbumin/creatinine ratio), blood pressure, and foot & eye exams. Screenings are available in Winter Haven and Lakeland. Participants are required to attend four per year unless otherwise indicated, or may provide the same from a personal healthcare provider.

Goal Setting & Health Coaching

Participants must participate in health coaching either in person or by phone, refresher classes and follow-up screenings based on individual goals set during health coaching sessions.

Prescription Drug Savings

Health Plan members who have been diagnosed by their physician with diabetes and complete all program requirements will receive a glucose monitor, as well as diabetic medications and supplies (test strips, lancets, syringes and pens) at **NO COST!** Participants will also be eligible to receive approved blood pressure and cholesterol medications at **NO COST!**

ABC's of Diabetes participants must be enrolled on the PCSB Self-Funded Health Plan to receive prescription drug savings.

Premium Payments

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.

Important Legal Notice

HIPAA Notice of Privacy Practices

The Polk County School Board is concerned about your privacy, and maintains a strict privacy policy. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the School Board of Polk County 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.

The right to obtain a paper copy of the Notice of Privacy Practices at any time.

A copy of the Privacy Policy can be found on the Risk Management & Employee Benefits page of the Polk County School Board website at:
http://polkschoolsfl.com/retirement

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

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. The Polk County School Board 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.

The Risk Management & Employee Benefits Department of the Polk County School Board, Florida collects beneficiary social security numbers for specific purposes, including life insurance claims processing. A copy of this notice should be given to all parties you have listed as beneficiaries for your life insurance through the Employee Group-Term Life Insurance policy with the Polk County School Board, Florida.

The full written policy is available on the Risk Management & Employee Benefits page of the Polk County School Board website at: **http://polkschoolsfl.com/retirement**

Important Legal Notice

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 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

Important Legal Notice

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 1-800-810-2583 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 School Board 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 School Board 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 School Board has determined that the prescription drug coverage offered by Polk County School Board's 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 School Board 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 School Board Medical Plan.***

The Polk County School Board 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 + 10%* (max $420)
Mail 90 Days		
$20	$125	$200
Specialty		
$80	$80	$160
*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 generic co-payment, 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 Polk County School Board 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 Polk County School Board changes. You also may request a copy of this notice at any time.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at: www.socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

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: Polk County School Board
Contact: Kathy Faulkner
Address: 1915 Floral Avenue, Bartow, FL 33830
Phone Number: 863-519-3858

If you join a non-School Board of Polk County Medicare drug plan and drop your current School Board of Polk County health plan, be advised that you and your dependents will no longer be eligible for the School Board of Polk County Retiree Health Plan.

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 2018 for coverage starting as early as January 1, 2019. • Health insurance plans under the Exchange are not offered on a pre-tax basis. • **Please note that the Marketplace provides access to health insurance that is separate from the coverage offered by Polk County Public Schools.**
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 PCSB health plan. • Open enrollment for Polk County Public School's health insurance coverage begins October 22, 2018 through November 2, 2018 for coverage effective January 1, 2019.
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 Market Place	If you have any questions regarding the Health Insurance Marketplace Call 1-800-318-2596 (TTY: 1-855-889-4325) or go to www.HealthCare.gov.
Questions about PCSB Health Plan	If you have any questions regarding PCSB's group health plan: Call PCSB 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 PCSB 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 the web at: http://www.polkschooslsfl.com/retirement. 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 1-31-2017)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact **Risk Management and Employee Benefits Department at 863-519-3858 or RiskManagement-AllStaff@polk-fl.net.**

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		4. Employer Identification Number (EIN)
School Board of Polk County		596000807
5. Employer address		**6. Employer phone number**
1915 S Floral Avenue		863-519-3858
7. City	**8. State**	**9. ZIP code**
Bartow	FL	33830
10. Who can we contact about employee health coverage at this job?		
Risk Management and Employee Benefits Department		
11. Phone number (if different from above	**12. Email address**	
863-519-3858	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 eligible for 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** 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.

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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

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• 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 and definitions 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

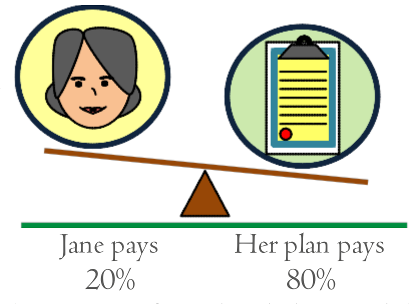
A request for your health insurer or plan to review a decision or a grievance again.

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 amount 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.



(See page 4 for a detailed example.)

Complications of Pregnancy

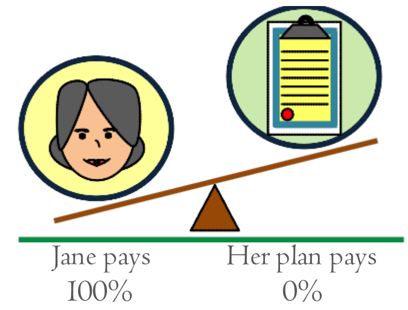
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

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.



(See page 4 for a detailed example.)

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.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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.

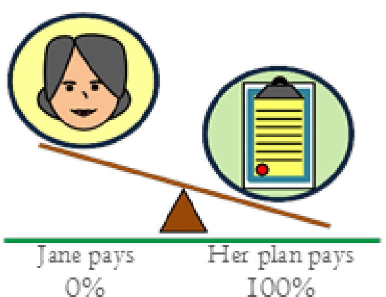
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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.



(See page 4 for a detailed example.)

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.

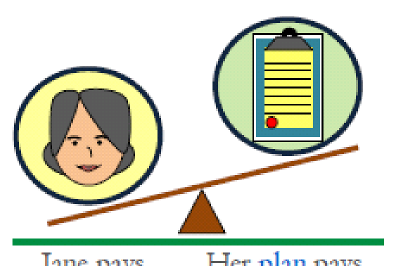
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to *require emergency room*

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



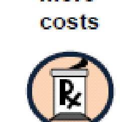
Jane pays 100% Her plan pays 0%

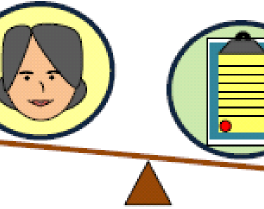
Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

- **Office visit costs:** $125
- **Jane pays:** $125
- **Her plan pays:** $0

more costs





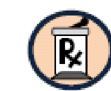
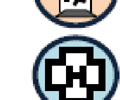
Jane pays 20% Her plan pays 80%

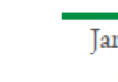
Jane reaches her $1,500 deductible, co-insurance begins

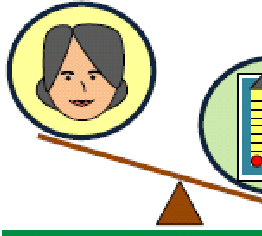
Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

- **Office visit costs:** $75
- **Jane pays:** 20% of $75 = $15
- **Her plan pays:** 80% of $75 = $60

more costs





Jane pays 0% Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

- **Office visit costs:** $200
- **Jane pays:** $0
- **Her plan pays:** $200