IMPORTANT INFORMATION FOR
MEDICARE ELIGIBLE RETIREES
Polk County Public Schools
Annual Open Enrollment Benefits Guide
2016 Plan Year

Wise

Retirement Choices!

Last Day
Nov. 18th
Please review your health plan options very carefully! We strongly encourage you to attend one of the Retiree Open Enrollment Meetings if you have any questions regarding the benefit offerings.

All forms must be returned to the Risk Management & Employee Benefits Department by November 18th, 2015.

**In Person:**
Polk County School Board  
1915 S. Floral Avenue  
Bartow, FL 33830

**Mail:**
Polk County School Board  
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

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**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 2016 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 Individuals Stay Engaged! 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 2016 Benefits Guide includes a summary of your benefit plans, the eligibility requirements and instructions on how to enroll. This year we are pleased to continue to offer EXPANDED CHOICES FOR RETIREES ELIGIBLE FOR MEDICARE!

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.

Through the FSRBC, Medicare eligible retirees have the option to enroll in Medicare Supplement plans A, F or N as well as a choice between four Medicare Part D prescription plans. This is in addition to the BlueMedicare Medicare Advantage plans that have been offered since 2009 by FloridaBlue.

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
## 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, 2016, and how they may impact you and your covered dependents. At PCSB, 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?

**Retirees NOT Eligible for Medicare:** If you do not return your Open Enrollment Form, your current benefit elections will automatically continue for you and your eligible covered dependents.

**Retirees Eligible for Medicare:** 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 PCSB 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 BlueMedicare Group PPO plan, 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 18, 2015. Forms received after the due date will not be accepted.

**NO FAXES WILL BE ACCEPTED.**
Becoming Eligible for Medicare

What's covered by Original Medicare?

Medicare covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) considered medically necessary to treat a disease or condition.

If you're in a Medicare Advantage Plan or other Medicare plan, you may have different rules, but your plan must give you at least the same coverage as Original Medicare. Some services may only be covered in certain settings or for patients with certain conditions.

In general, Part A covers:

- Hospital care
- Skilled nursing facility care
- Nursing home care (as long as custodial care isn't the only care you need)
- Hospice
- Home health services

Part B covers 2 types of services:

- **Medically necessary services:** Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
- **Preventive services:** Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.
- You pay nothing for most preventive services if you get the services from a health care provider who accepts assignment.

Part B covers things like:

- Clinical research
- Ambulance services

- Durable medical equipment (DME)
- Mental health
  - Inpatient
  - Outpatient
  - Partial Hospitalization
- Getting a second opinion before surgery
- Limited outpatient prescription drugs

Some people get Part A & Part B automatically

You may qualify for Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) if one of the following applies to you:

You’re already getting benefits from Social Security or the Railroad Retirement Board (RRB).
In most cases, you'll automatically get Part A and Part B starting the first day of the month you turn 65. If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.

You’re under 65 and have a disability.
You automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months.

You have ALS (Amyotrophic Lateral Sclerosis, also called Lou Gehrig’s disease).
You automatically get Part A and Part B the month your disability benefits begin.

You live in Puerto Rico and get benefits from Social Security or the Railroad Retirement Board (RRB).
You automatically get Part A. If you want Part B, you need to sign up for it.

Information on this page was obtained from [www.medicare.gov](http://www.medicare.gov). Please visit this website for additional information.
Becoming Eligible for Medicare

If you get Medicare automatically

If you're automatically enrolled, you'll get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or your 25th month of disability.

Some people need to sign up for Part A & Part B

You need to sign up for Part A and Part B if:

- You aren't getting Social Security or Railroad Retirement Board benefits (for example, because you're still working).
- You qualify for Medicare because you have End-Stage Renal Disease (ESRD).

Factors that affect Original Medicare out-of-pocket costs

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor, other health care provider, or supplier accepts assignment.
- The type of health care you need and how often you need it.
- Whether you choose to get services or supplies Medicare doesn't cover. If you do, you pay all the costs unless you have other insurance that covers it.
- Whether you have other health insurance that works with Medicare.
- Whether you have Medicaid or get state help paying your Medicare costs.
- Whether you have a Medicare Supplement Insurance (Medigap) policy.
- Whether you and your doctor or other health care provider sign a private contract.
- You live in Puerto Rico and want to sign up for Part B (you automatically get Part A). You must already have Part A to apply for Part B. Get this form and instructions in Spanish.

How to sign up for Part A & Part B

- Apply online at Social Security.
- Visit your local Social Security office.
- Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
- If you worked for a railroad, call the RRB at 1-877-772-5772.
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 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:

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

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

### What are my options?

Through the FSRBC, Medicare eligible retirees have the option to enroll in Medicare Supplement plans A, F or N as well as a choice between four Medicare Part D prescription plans. These plan options are offered in addition to the current two fully insured BlueMedicare Medicare Advantage Plans.

These will be the only plan options for Medicare eligible members. Medicare eligible members are not be able to remain on the self-funded health plan.
Options for Medicare Eligible Retirees & Dependents

If.... | Then....
---|---
You are happy with your current plan (BlueMedicare or UnitedHealthcare) and do not want to make any changes | Stay informed by reviewing the 2016 rate and benefit changes applicable to your plan. No Action is Required You will remain enrolled in your current plan.

You are enrolled in the BlueMedicare Group PPO Plan 1 and wish to change to the BlueMedicare LPPO | Complete the BlueMedicare Individual LPPO application and the PCSB Enrollment Form

You are enrolled in the BlueMedicare LPPO and wish to change to the BlueMedicare Group PPO Plan 1 | Complete the BlueMedicare Group PPO application and the PCSB Enrollment Form

You are enrolled in a BlueMedicare Plan and wish to enroll in a UnitedHealthcare Medicare Supplement Plan | Contact UnitedHealthcare at 1-877-776-1466. Be sure to enroll in BOTH a Medicare Supplement Plan and a Prescription Drug Plan (PDP)

You are enrolled in a UnitedHealthcare plan and wish to change to a BlueMedicare Plan | Complete either the BlueMedicare Individual LPPO or the BlueMedicare Group PPO application AND the PCSB Enrollment Form

Premiums

The premiums for the plans being offered are below:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueMedicare Plan 1</td>
<td>$283.00</td>
</tr>
<tr>
<td>BlueMedicare LPPO</td>
<td>$147.80</td>
</tr>
<tr>
<td>UnitedHealthcare Supplement Plans</td>
<td>Rates vary by age and state of residence. Please contact UnitedHealthcare directly at 1-877-776-1466.</td>
</tr>
<tr>
<td>Comprehensive Prescription Plan (UHC)</td>
<td>$100.01</td>
</tr>
<tr>
<td>Premier Prescription Plan (UHC)</td>
<td>$249.35</td>
</tr>
<tr>
<td>AARP Medicare Rx Saver Plus</td>
<td>$27.50</td>
</tr>
<tr>
<td>AARP Medicare Rx Saver Preferred</td>
<td>$63.80</td>
</tr>
</tbody>
</table>
Where can I find the summary of benefits?

Please see the table below for where you can find a summary of benefits for each plan being offered:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Summary Plan Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueMedicare Group PPO Plan 1</td>
<td>See Medicare Eligible Section in this booklet</td>
</tr>
<tr>
<td>BlueMedicare Individual LPPO</td>
<td>See Medicare Eligible Section in this booklet</td>
</tr>
<tr>
<td>United Healthcare Supplement Plans</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Prescription Plan (UHC)</td>
<td></td>
</tr>
<tr>
<td>Premier Prescription Plan (UHC)</td>
<td>Please contact UnitedHealthcare directly at 1-877-776-1466.</td>
</tr>
<tr>
<td>AARP Medicare Rx Saver Plus</td>
<td></td>
</tr>
<tr>
<td>AARP Medicare Rx Preferred</td>
<td></td>
</tr>
</tbody>
</table>

How do I enroll in a UHC Supplement Plan?

If you or your Medicare eligible dependent are interested in enrolling in one of the Medicare Supplement plans A, F or N or one of the two Medicare Part D prescription plans you will need to contact UnitedHealthcare directly at 1-877-776-1466.

The enrollment for these plans will not be handled through Polk County Public Schools Risk Management and Employee Benefits Department.

Resources/Meetings

We strongly encourage all Medicare eligible retirees and dependents to speak with a representative about the choices available. The following meetings will be held during Open Enrollment:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, Nov. 11th</td>
<td>Spessard Holland Elementary Media Center</td>
<td>10:00 AM</td>
</tr>
<tr>
<td></td>
<td>2342 EF Griffin Rd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bartow, FL 33830</td>
<td></td>
</tr>
<tr>
<td>Wednesday, Nov. 18th</td>
<td>Lake Region High School Auditorium</td>
<td>4:30 PM</td>
</tr>
<tr>
<td></td>
<td>1995 Thunder Rd</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eagle Lake, FL 33839</td>
<td></td>
</tr>
</tbody>
</table>

Questions?

If you have any questions regarding the retiree health plan options for the 2016 plan year, please contact Risk Management and Employee Benefits Department at (863) 519-3858.
**IMPORTANT**

ELIGIBLE for Medicare means that you have met all of the government requirements to enroll in Medicare (even if you have not enrolled). To determine if you are eligible, visit www.medicare.gov and use the Eligibility & Premium calculator. ELIGIBLE for Medicare is **not** the same as “Enrolled” in Medicare. ELIGIBLE for Medicare is **not** the same as “Over 65”.

If you had or have the option of enrolling in Medicare, **regardless of cost or penalties**, but choose not to enroll or were terminated for non-payment – you are still considered ELIGIBLE for Medicare when determining your eligibility for retiree coverage through the Polk County School Board.

Retirees and Dependents who are ELIGIBLE for both Medicare Part A and Part B will **NOT** be permitted to remain enrolled in the Polk County School Board Self-funded health plan. **You will have other coverage options sponsored by the Polk County School Board available to you.**

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**PCSZ Self-Funded Health Plan**

$535.00 per month

**Eligibility & Enrollment**

- If you are ENROLLED in **both** Parts of Medicare, you are not eligible for the PCSB Self-funded health plan.
- If you are currently enrolled in this plan and are **NOT Eligible for Medicare**, you do not need to do anything. You will remain enrolled in this plan.
- If you are ENROLLED in both Part A and Part B of Medicare, you **MUST** choose another plan or you will be automatically moved to BlueMedicare Group PPO Plan 1.
- If you are ELIGIBLE for both parts of Medicare but are **NOT ENROLLED** in both parts, you can stay enrolled in the self-funded health plan. **However, you will pay the non-Medicare eligible premium of $535.00 and will be subject to a reduction in benefits.**
- If you are **NOT ELIGIBLE** for both parts of Medicare but are 65 or older, you can stay enrolled in the self-funded health plan. You will pay the non-Medicare eligible premium of $535.00. **You will be subject to a reduction of benefits until you provide documentation from CMS or Social Security detailing the reason for your ineligibility.** Depending on the reason, the reduction of benefits penalty may be waived.
- If YOU ARE ELIGIBLE for Medicare but your **dependents are NOT** eligible for Medicare, you must choose another plan for yourself. Your dependents will automatically remain enrolled in the self-funded health plan.
- If you are **NOT ELIGIBLE** for both parts of Medicare, but your **dependent(s) are eligible for Medicare**, you may stay on this plan but your Medicare-eligible dependents must select a BlueMedicare or UnitedHealthcare plan.
### Available Plans & Premiums

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueMedicare Group PPO Plan 1</td>
<td>$283.00 per month</td>
</tr>
<tr>
<td>BlueMedicare Individual LPPO</td>
<td>$147.80 per month</td>
</tr>
</tbody>
</table>

**BlueMedicare Group PPO Plan 1**

The BlueMedicare Group PPO Plan 1 plan is offered to all Medicare eligible retirees and their Medicare eligible dependents that are currently enrolled in both Medicare Parts A and B. This plan is available nationwide. The prescription drug coverage that is included with this plan provides member copays for Medicare approved generic, brand, and specialty medications during the initial phase of coverage, and those copays will continue for the member throughout the Coverage Gap (Donut Hole) for Medicare approved generic, brand and specialty medications. There are minor benefit changes for 2016. The new premium for this plan for 2016 is $283.00 per month.

**Eligibility & Enrollment**

- Any retiree or dependent who is **ENROLLED** in both Medicare Part A and Part B is eligible for this plan.
- If you are currently enrolled in this plan and would like to continue this plan for the next year, you do not need to do anything. You will remain enrolled for 2016.
- If you are not currently enrolled in this plan and would like to, you should submit your Retiree Open Enrollment Form AND a completed application for BlueMedicare Group PPO Plan 1 to the Risk Management and Employee Benefits Department no later than November 20, 2016.

**BlueMedicare Individual LPPO**

The BlueMedicare Individual LPPO Plan is also available to all Medicare eligible retirees and their Medicare eligible dependents that are currently enrolled in both Medicare Parts A and B. You must reside in one of the following counties in order to be eligible for the BlueMedicare Individual LPPO Plan: Alachua, Broward, Charlotte, Collier, Escambia, Hernando, Highlands, Hillsborough, Lee, Manatee, Marion, Okaloosa, Osceola, Palm Beach, Pasco, Pinellas, Polk and Sarasota. However, once you are enrolled, you will have coverage nationwide. **There are benefit changes you need to be aware of for 2016; please review the schedule of benefits carefully.** You are strongly encouraged to attend a meeting. The new premium for this plan for 2016 is $147.80 per month.

**Eligibility & Enrollment**

- Any retiree or dependent who is **ENROLLED** in both Medicare Part A and Part B, and resides in one of the following counties is eligible for this plan: Alachua, Broward, Charlotte, Collier, Escambia, Hernando, Highlands, Hillsborough, Lee, Manatee, Marion, Okaloosa, Osceola, Palm Beach, Pasco, Pinellas, Polk or Sarasota. **Please Note:** even though you must RESIDE in one of these counties to enroll, your coverage is not limited to these counties. Coverage is nationwide.
- If you are currently enrolled in this plan and would like to continue this plan for the next year, you do not need to do anything. You will remain enrolled for 2016.
- If you are not currently enrolled in this plan and would like to, you should submit your Retiree Open Enrollment Form AND a completed application for BlueMedicare Individual LPPO to the Risk Management and Employee Benefits Department no later than November 18, 2015.
Available Plans & Premiums

<table>
<thead>
<tr>
<th>United Healthcare (UHC) Medicare Supplement</th>
<th>Premium Varies</th>
</tr>
</thead>
<tbody>
<tr>
<td>This option is available to certain retirees and dependents enrolled in Medicare. If you are eligible for this option, and would like to receive a personalized enrollment kit via mail directly from United Healthcare contact the FSRBC at 1-877-776-1466.</td>
<td></td>
</tr>
<tr>
<td>If you choose this option, all enrollment paperwork should be returned directly to United Healthcare. DO NOT send the United Healthcare applications to Risk Management and Employee Benefits. However, you must be sure to complete the PCSB Retiree Open Enrollment form and return to the Risk Management and Employee Benefits Department no later than November 18, 2015. If you have any questions regarding enrollment into this plan please contact 1-877-776-1466.</td>
<td></td>
</tr>
</tbody>
</table>

Retiree Open Enrollment Meetings
(meetings are open to ALL retirees)

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Room</th>
</tr>
</thead>
</table>
| Wednesday November 11th | Spessard Holland Elementary School  
2342 EF Griffin Rd  
Bartow, FL 33830 | 9:30am-11:30am  
Media Center |
| Wednesday November 18th | Lake Region High School  
1995 Thunder Road  
Eagle Lake, FL 33839 | 4:30pm-6:30pm  
Auditorium |
United Healthcare Plan Options

Your priorities may change, but health care is always on the list. This year, the Polk County School Board is offering an additional option to our Medicare-primary population through United Healthcare.

Health care is personal. It’s about you. You want to have the freedom to visit doctors and pharmacies without network limitations, and know that you can get the care you need. UnitedHealthcare Insurance Company (UnitedHealthcare) understands. That’s one of the reasons why the Polk County School Board chose to offer AARP® Medicare Supplement Insurance Plans, and the UnitedHealthcare MedicareRx for Groups (PDP) plan, insured by UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York, for NY residents), as an option to assist you with your health care and prescription drug coverage costs.

An AARP Medicare Supplement Insurance Plan, like all standardized Medicare supplement plans, helps you control health care expenses by paying for some of the out-of-pocket medical costs that Medicare Parts A and B don’t pay. In addition, these types of plans give you the freedom you want:

- Keep your own doctor. You can go to any doctor who accepts Medicare patients.
- No physician referrals needed. You don’t need a referral to see a specialist, so you won’t have to deal with the hassles and paperwork of referrals.
- No hospital networks. You can choose any hospital that accepts Medicare patients.
- Coverage that travels with you anywhere in the United States.
- No annual enrollment periods: If your health care needs change, you may apply for a change in your coverage.

The UnitedHealthcare® MedicareRx for Groups (PDP) plan helps protect you from unexpected changes in your prescription drug costs. Some of the plan highlights include:

- Most of the drugs covered by Medicare Part D.
- More than 65,000 pharmacies in the network, including national and regional stores.
- Convenience of home delivery when you use OptumRx mail service pharmacy.

If you are eligible for this plan, and would like to get additional information contact UHC at 1-877-776-1466 to request an enrollment kit directly from United Healthcare with plan and premium information.

How This Affects You

Polk County Public Schools will collect the monthly insurance premium from you and remit it to UnitedHealthcare for your eligible dependent(s). Be sure to enroll in these plans by November 18, 2015 if you want to be enrolled effective January 1, 2016.

If you would like more information about the UnitedHealthcare Group MedicareRx plan or to receive a complete pre-enrollment plan guide, call UnitedHealthcare at 1 877-776-1466 TTY 711, 8 a.m. – 8 p.m. local time, seven days a week.
United Healthcare Plan Options

Medicare Supplement Insurance Plans

Because Medicare doesn’t cover everything.
All standardized Medicare supplement insurance plans help pay for some of the costs Medicare Parts A and B don’t pay. They also offer access to doctors, specialists and hospitals that accept Medicare patients, whether you are at home or traveling in the United States. Benefits and premiums vary by plan.

The benefits of Medicare Supplement Insurance.
Like all standardized Medicare supplement insurance plans, AARP® Medicare Supplement Plans insured by UnitedHealthcare Insurance Company (UnitedHealthcare) help pay for some of the costs Medicare Parts A and B don’t pay.

Choose the plan to meet your needs.
Remember, it is your choice whether you wish to purchase a Medicare supplement plan. Like all standardized Medicare supplement plans, an AARP Medicare Supplement Plan may be what you’re looking for to help pay some of the costs that Medicare doesn’t pay.

How Medicare supplement insurance fits in with Parts A and B.

AARP endorses the AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company. UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers.

SA25423STGRS
United Healthcare Plan Options

All standardized Medicare Plans let you choose any doctor or hospital in the United States as long as they accept Medicare patients.

AARP Medicare Supplement Insurance Plans are available in all states, so if you move, your plan will go with you anywhere in the United States.

You are not limited to an annual enrollment period and may change to another available AARP Medicare Supplement Insurance Plan at any time.*

AARP Medicare Supplement Insurance Plans, insured by UnitedHealthcare Insurance Company, offer services and support you may depend on:

• 95% member satisfaction rate of those surveyed with AARP Medicare Supplement Plans.**
• 98% of customers surveyed who had a claim filed automatically are satisfied with how their claims were processed.**
• With millions of AARP members insured, AARP Medicare Supplement Insurance Plans experience low annual base rate increases on average from one year to the next.***

Get additional protection with a Medicare Supplement Insurance Plan.

Questions? Call a Licensed Insurance Agent/Producer.

[1-877-791-9964], TTY 711
8 a.m. – 8 p.m. local time, 7 days a week

A UnitedHealthcare® Medicare Solution

*If you choose to change plans, you may be underwritten and may not be accepted into the plan.


Insured by UnitedHealthcare Insurance Company Horsham, PA (UnitedHealthcare Insurance Company of New York, Islandia, NY for New York residents). Policy Form No. GRP 7917 1GPS-1 (G-36000-4). In some states plans may be available to persons under age 65 who are eligible for Medicare by reason of disability or End-Stage Renal Disease. Not connected with or endorsed by the U.S. Government or the federal Medicare Program.

This is a solicitation of insurance. A licensed insurance agent/producer may contact you.

AARP does not employ or endorse agents, brokers or producers.

You must be an AARP member to enroll in an AARP Medicare Supplement Plan.

Call a licensed insurance agent/producer at the telephone number in this advertisement to receive complete information including benefits, costs, eligibility requirements, exclusions and limitations.
United Healthcare Plan Options

UnitedHealthcare®
MedicareRx for Groups (PDP)

Your plan sponsor has selected the UnitedHealthcare MedicareRx for Groups plan for your Medicare Part D prescription drug coverage. Choosing the right prescription drug plan involves looking at the costs, benefits, access to pharmacies, covered prescription drugs and so much more. We want to help you get the most out of your dollar, so you can feel good about your plan.

Here are some of the highlights of your new plan:

Get dedicated service.
We’re here for you. Our Customer Service team has been specially trained to know all the ins and outs of your plan.

Commonly used drugs.
The plan’s drug list (formulary) includes 100% of the drugs covered by Medicare Part D. Your plan may include additional drug coverage beyond what Medicare allows.

Visit the pharmacies you want.
Choose from more than 65,000 national, regional and local chains, as well as thousands of independent neighborhood pharmacies nationwide. Visit the one that is easiest for you.

More than just drug coverage.

Get help for hearing loss.
As a member of this plan, it is easier than ever to take control of your health and your hearing. hi HealthInnovations™ makes hearing aids affordable. Each hearing aid is programmed to your unique hearing needs.1

1The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the UnitedHealthcare grievance process.

Call us if you have any questions.

1-877-776-1466, TTY 711
8 a.m. – 8 p.m. local time, 7 days a week

www.UHCRetiree.com
Learn more online
United Healthcare Plan Options

Save on your prescription drugs

Your plan includes 100% of the drugs covered by Medicare Part D. Be sure to review the plan drug list to make sure your prescription drugs are covered. Here are some ways that you may be able to save on your prescription drug costs.

Explore lower cost options.
The drug list includes information about tiers. Generally, the lower the tier, the less you pay. If you’re taking a higher-tier drug, talk to your doctor to find out if there is a lower-tier drug you could take instead.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Cost</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Low</td>
<td>Includes all generic prescription drugs.</td>
</tr>
<tr>
<td>Tier 2</td>
<td></td>
<td>Includes many common brand name drugs.</td>
</tr>
<tr>
<td>Tier 3</td>
<td></td>
<td>Includes non-preferred brand name drugs.</td>
</tr>
<tr>
<td>Tier 4</td>
<td>High</td>
<td>Includes unique or very high-cost drugs.</td>
</tr>
</tbody>
</table>

Save on generic prescriptions.
Get generic drugs for as low as $2 at thousands of pharmacies nationwide with our Pharmacy Saver™ program. Visit www.UnitedPharmacySaver.com to find prescription drugs, pharmacies and prices.

You could save on the medications you take regularly.
You may be able to save money on 90-day supplies of maintenance medications while enjoying the convenience of home delivery, access to helpful pharmacists and automatic refill reminders with OptumRx.

1Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, copay amounts may be higher. Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

2Your plan sponsor may provide coverage beyond 90 days. Please refer to the Summary of Benefits for more information.

3You are not required to use OptumRx to obtain a 90-day supply of your maintenance medications, but you may pay more out-of-pocket compared to using OptumRx, your plan’s Preferred Mail Service Pharmacy. New prescriptions should arrive within ten business days from the date the completed order is received by the Mail Service Pharmacy. Completed refill orders should arrive in about seven days. OptumRx will contact you if there will be an extended delay in the delivery of your medications.
United Healthcare Plan Options

More ways to save

Choose generic drugs.
Many of the most commonly used drugs have a generic form. Ask your doctor if any of your drugs are available as a generic.

Stay in the preferred network.
To get the most from your pharmacy benefit, use a network pharmacy.

And here are a few of the most popular pharmacies in our network:

Note: Other pharmacies are available in our network.

Call Medicare to see if you qualify for Extra Help.
If you have a limited income, you may be able to get Extra Help from Medicare. If you qualify, Medicare could pay up to 75 percent or more of your drug costs. Many people qualify and don’t know it. There’s no penalty for applying and you can re-apply every year.

1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048
24 hours a day, 7 days a week
United Healthcare Plan Options

Know when to enroll

You can only enroll or make changes in Medicare Part D coverage during certain times of the year as determined by your plan sponsor. If you don’t enroll when you first become eligible, you may have to pay a Late Enrollment Penalty. That’s an extra amount added to your premium every month — for as long as you’re in a Medicare Part D plan. This may be your only opportunity to enroll for 2014 coverage.

<table>
<thead>
<tr>
<th>When to enroll:</th>
<th>Your coverage will begin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You turn 65 or become Medicare eligible. This is your initial enrollment</td>
<td>If you’re turning 65, you can enroll within three months before and three months after the</td>
</tr>
<tr>
<td>period. It’s your first chance to enroll in Medicare Part D.</td>
<td>month you turn 65. If you enroll before your birthday month, your coverage will begin the</td>
</tr>
<tr>
<td></td>
<td>first day of your birthday month. If you enroll during your birthday month or later, your</td>
</tr>
<tr>
<td></td>
<td>coverage will begin the first day of the following month.</td>
</tr>
<tr>
<td>You need a Medicare Part D plan but never had one before. Or, you want to</td>
<td>Your new coverage will begin on the date set by your plan sponsor.</td>
</tr>
<tr>
<td>change to a different group-sponsored plan. Enroll during your plan sponsor’s</td>
<td></td>
</tr>
<tr>
<td>annual Open Enrollment Period.</td>
<td></td>
</tr>
<tr>
<td>You retire and move out of a group-sponsored plan. Or, you move out of the</td>
<td>Call us to learn more.</td>
</tr>
<tr>
<td>plan’s service area. These are examples of Special Election Periods and</td>
<td></td>
</tr>
<tr>
<td>may happen for various reasons.</td>
<td></td>
</tr>
</tbody>
</table>

- Make sure you are signed up for Medicare.
  You must be enrolled in Medicare Part A and purchase Medicare Part B to be eligible to enroll in this plan. If you’re not sure if you are enrolled, check with your local Social Security office. You must continue paying your Medicare Part B premium to keep your coverage under this group-sponsored plan. If you stop your payments, you may be disenrolled from this plan.

- Are you enrolled in Medicare Part A?
- Have you purchased Medicare Part B?
- Keep paying your Medicare Part B premium
<table>
<thead>
<tr>
<th>Benefits</th>
<th>PPO Plan 1</th>
<th>LPPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium (per member per month)</td>
<td>$283.00</td>
<td>$147.80</td>
</tr>
<tr>
<td>Calendar Year Deductible (CYD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$1,000</td>
<td>$0</td>
</tr>
<tr>
<td>OUT-OF-POCKET MAXIMUM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$1,000 Combined In and Out of Network</td>
<td>$5,900</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>OFFICE SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network Family Physician / PCP</td>
<td>$10 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>In-Network Specialist</td>
<td>$30 copay</td>
<td>$45 copay</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>CYD &amp; 20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>HOSPITAL SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient In-Network</td>
<td>$150 per day (days 1-7)</td>
<td>$225 per day (days 1-7)</td>
</tr>
<tr>
<td>Inpatient Out-of-Network</td>
<td>$0 (after 7th day)</td>
<td>$200 per day (days 1-27)</td>
</tr>
<tr>
<td>Outpatient In-Network</td>
<td>$150 copay</td>
<td></td>
</tr>
<tr>
<td>Outpatient Out-of-Network</td>
<td>CYD &amp; 20% coinsurance</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Emergency Services (In or Out of Network, USA)</td>
<td>$75 copay</td>
<td>$75 copay</td>
</tr>
<tr>
<td>OTHER SERVICES – (In-Network)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgical Center (In-Network)</td>
<td>$100 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Ambulatory Surgical Center (Out-of-Network)</td>
<td>CYD &amp; 20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Preventive Health (Medicare Approved)</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Independent Clinical Labs</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>X-rays – IDTF / Outpatient Hospital</td>
<td>$50 copay / $150 copay</td>
<td>$50copay / $150 copay</td>
</tr>
<tr>
<td>Physical, Occupational &amp; Speech Benefit Max</td>
<td>$1,940 Annual Benefits Max</td>
<td>$1,940 Annual Benefits Max</td>
</tr>
<tr>
<td>Ambulance Services (In or Out of Network)</td>
<td>$150 copay</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$30 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>$0 per day (days 1-20)</td>
<td>$0 per day (days 1-20)</td>
</tr>
<tr>
<td></td>
<td>$75 per day (days 21-100)</td>
<td>$160 per day (days 21-100)</td>
</tr>
<tr>
<td>Supplemental Benefit</td>
<td>Dental, Vision, Fitness &amp; Hearing</td>
<td>Dental, Vision, Fitness &amp; Hearing</td>
</tr>
</tbody>
</table>
### BlueMedicare Benefit Summary

#### Rx Prescription Drugs Retail – 31-day Supply

<table>
<thead>
<tr>
<th>Tier</th>
<th>Deductible</th>
<th>Tier 1 – Preferred Generics</th>
<th>Tier 2 – Non-Preferred Generics</th>
<th>Tier 3 – Preferred Brand</th>
<th>Tier 4 – Non-Preferred Brand</th>
<th>Tier 5 – Specialty Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ 0</td>
<td>$ 5 copay</td>
<td>$ 5 copay</td>
<td>$ 35 copay</td>
<td>$ 65 copay</td>
<td>$ 110 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$ 285</td>
<td>$14 copay / $19 copay</td>
<td>$42 copay / $47 copay</td>
<td>$95 copay / $100 copay</td>
<td>26% coinsurance</td>
</tr>
</tbody>
</table>

#### Rx Prescription Drugs Mail Order – 90-day Supply with PRIME Mail Order

<table>
<thead>
<tr>
<th>Tier</th>
<th>Deductible</th>
<th>Tier 1 – Preferred Generics</th>
<th>Tier 2 – Non-Preferred Generics</th>
<th>Tier 3 – Preferred Brand</th>
<th>Tier 4 – Non-Preferred Brand</th>
<th>Tier 5 – Specialty Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$ 0 copay</td>
<td>$ 0 copay</td>
<td>$ 70 copay</td>
<td>$130 copay</td>
<td>$110 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$ 42 copay</td>
<td>$ 45 copay</td>
<td>$126 copay</td>
<td>$285 copay</td>
<td>26% coinsurance</td>
</tr>
</tbody>
</table>

#### Rx GAP Coverage (Donut Hole)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Deductible</th>
<th>All Medicare Approved Drugs</th>
<th>Medicare Approved Generics Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier 1 – Preferred Generics</td>
<td>Member: 58% Plan: 42%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2 – Non-Preferred Generics</td>
<td>$ 5 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3 – Preferred Brand</td>
<td>Member: 45% Plan: 5% Manufacturer: 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 4 – Non-Preferred Brand</td>
<td>$ 65 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 5 – Specialty Drugs</td>
<td>Member: 58% Plan: 42%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Catastrophic</td>
<td>Greater of $2.95 or 5% / Greater of $7.40 or 5%</td>
</tr>
</tbody>
</table>

Prescription drug copays do not accumulate towards the health plan calendar year out-of-pocket maximum.

---

**Important Information Regarding Prescriptions**

Your mail order prescription refills will not transfer if you change insurance companies. You may also have to recertify Prior Authorizations or step-therapy requirements for your new carrier.
**Am I Eligible?**

If you are 65 or older and were **NEVER ELIGIBLE** for both parts of Medicare you can stay enrolled in the self-funded health plan. In order to receive the full benefits of the self-funded health plan, you will need to prove that you were never eligible to enroll in Medicare Part A and/or Part B. The full benefits of the self-funded health plan are listed in this guide.

If you **were eligible** for both parts of Medicare at one time and **chose not to enroll** because of cost, lost that eligibility due to your **failure to enroll in a timely manner** or lost your eligibility due to your **failure to pay premiums**, you are still considered to have been “eligible”. You may enroll in the PCSB self-funded health plan; however, you will receive the **reduced benefits** show in the summary below.

**Benefit Reduction Penalty**

When Medicare is the primary payer, the standard Medicare Part B plan pays 80% of all Medicare approved amounts. The PCSB self-funded health plan then pays up to the 20% coinsurance that remains after Medicare Part B pays. If Medicare Part B is not purchased, the PCSB self-funded health plan will process claims as if Medicare Part B was the primary payer. If a Plan Participant does not enroll in Medicare Part B when Medicare should be primary, the PCSB self-funded health **plan will not pay the initial 80%** of the eligible charges. The PCSB Health Plan will only pay up to 20% of the eligible charges, the remainder is non-covered.

**What To Do**

For those **NEVER ELIGIBLE**, you must provide a letter from Social Security Administration (SSA) or Centers for Medicare & Medicaid Services (CMS) stating the **reason you are ineligible**. This must be submitted to the Risk Management and Employee Benefits Office. Until verification is received that you were never eligible for Medicare Part A and/or Part B, the reduced benefits will apply.

---

### Self-funded Health Plan – Benefits with Penalty

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (DED)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>Per Family Aggregate</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Penalty (Member pays)</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Coinsurance (Plan pays)</strong></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Out of Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes DED, Coins, Copays and Rx*</td>
<td>Per Person $5,000 Per Family Aggregate $9,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Does NOT include non-covered services or penalty amounts</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>No Maximum</td>
<td>No Maximum</td>
</tr>
</tbody>
</table>

**PREVENTIVE CARE** is available at no cost in-network

* see WellDyneRx section for Prescription Drug benefits
# BlueOptions – Plan 03566

<table>
<thead>
<tr>
<th>Deductible (DED)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Person</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>Per Family Aggregate</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coinsurance (Member Responsibility)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Pocket Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes DED, Coins, and Copays</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Per Person</td>
<td>$5,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Per Family Aggregate</td>
<td>$9,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lifetime Maximum</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Maximum</td>
<td>No Maximum</td>
<td></td>
</tr>
</tbody>
</table>

## EMPLOYEE CLINICS

<table>
<thead>
<tr>
<th>Polk County School Board Employee Health Clinic</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit, Labs, On-site Prescriptions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$0</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Better Now Health Center Operated by Watson Clinic</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit, Labs, X-rays, On-site Prescriptions</td>
<td>$20</td>
<td>N/A</td>
</tr>
</tbody>
</table>

## PROFESSIONAL PROVIDER SERVICES

<table>
<thead>
<tr>
<th>Allergy Injections - Family Physician or Specialist</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10</td>
<td>DED + 40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-Office Visit Services - Family Physician or Specialist</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10</td>
<td>DED + 40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Office Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Physician or Specialist</td>
<td>$40</td>
<td>DED + 40%</td>
</tr>
<tr>
<td>Specialist Maternity Care</td>
<td>$40 for Initial OB Prenatal Visit only</td>
<td>DED + 40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Services at Hospital and ER</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DED + 20%</td>
<td>In-Ntwk DED + 20%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Services at Other Locations</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DED + 20%</td>
<td>DED + 40%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Radiology, Pathology and Anesthesiology Provider Svcs</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Center</td>
<td>DED + 20%</td>
<td>In-Ntwk DED + 20%</td>
</tr>
<tr>
<td>Hospital</td>
<td>DED + 20%</td>
<td>In-Ntwk DED + 20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Pharmacy (Provider-Administered Rx in the Office)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Included in Office Visit Copay</td>
<td>DED + 40%</td>
<td></td>
</tr>
</tbody>
</table>

## PREVENTIVE CARE

<table>
<thead>
<tr>
<th>Adult Wellness Office Svcs - Family Physician or Specialist</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>DED + 40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Colonoscopies (Routine) Age 50+ then Frequency Schedule Applies</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mammograms (Routine and Diagnostic)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Well Child Office Visits - Family Physician or Specialist</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

## EMERGENCY/URGENT/CONVENIENT CARE

<table>
<thead>
<tr>
<th>Ambulance (ground, air and water - per day)</th>
<th>20% of billed charges</th>
<th>20% of billed charges</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Convenient Care Centers (CCC)</th>
<th>$40</th>
<th>DED + 40%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Facility Services</th>
<th>DED + 20%</th>
<th>OON DED + 20%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Urgent Care Centers (UCC)</th>
<th>$40</th>
<th>DED + 40%</th>
</tr>
</thead>
</table>

## FACILITY SERVICES - HOSP/SURG/ICL/IDTF

Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.

<table>
<thead>
<tr>
<th>Ambulatory Surgical Center</th>
<th>DED + 20%</th>
<th>DED + 40%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Independent Clinical Lab</th>
<th>$0</th>
<th>DED + 40%</th>
</tr>
</thead>
</table>
## BlueOptions – Plan 03566

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Diagnostic Testing Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xrays and AIS (Includes Physician Services)</td>
<td>DED + 20%</td>
<td>DED + 40%</td>
</tr>
<tr>
<td>Advanced Imaging Services (AIS)</td>
<td>DED + 20%</td>
<td></td>
</tr>
<tr>
<td>Other Diagnostic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital (per admit)</strong></td>
<td>Option 1 - DED + 20%</td>
<td>DED + 40%</td>
</tr>
<tr>
<td></td>
<td>Option 2 - DED + 25%</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Rehab Maximum</strong></td>
<td></td>
<td>21 Days</td>
</tr>
<tr>
<td><strong>Outpatient Hospital (per visit)</strong></td>
<td>Option 1 - DED + 20%</td>
<td>DED + 40%</td>
</tr>
<tr>
<td></td>
<td>Option 2 - DED + 25%</td>
<td></td>
</tr>
<tr>
<td><strong>Therapy at Outpatient Hospital</strong></td>
<td>Option 1 - DED + 20%</td>
<td>DED + 40%</td>
</tr>
<tr>
<td></td>
<td>Option 2 - DED + 25%</td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH AND SUBSTANCE ABUSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>Option 1 or 2: DED + 20%</td>
<td>DED + 40%</td>
</tr>
<tr>
<td>Outpatient Hospitalization (per visit)</td>
<td>Option 1 or 2: DED + 20%</td>
<td>DED + 40%</td>
</tr>
<tr>
<td>Provider Services at Hospital and ER</td>
<td>DED + 20%</td>
<td>DED + 20%</td>
</tr>
<tr>
<td><strong>Physician Office Visit - Family Physician or Specialist</strong></td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Facility Services (per visit)</strong></td>
<td>DED + 20%</td>
<td>INN DED + 20%</td>
</tr>
<tr>
<td>Provider Svs - Locations other than Hospital, ER &amp; Office</td>
<td>$40</td>
<td></td>
</tr>
<tr>
<td><strong>OTHER SPECIAL SERVICES AND LOCATIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Imaging Services in Physician’s Office</td>
<td>DED + 20%</td>
<td></td>
</tr>
<tr>
<td><strong>Colonoscopies (Diagnostic)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory Surgical Center</td>
<td>Option 1 – 20% (DED Waived)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>Option 2 – 25% (DED Waived)</td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment, Prosthetics, Orthotics BPM</strong></td>
<td>DED + 20%</td>
<td></td>
</tr>
<tr>
<td>Enteral Formulas:$2,500 All Other: No Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong> - 20 Visits per Benefit Period</td>
<td>DED + 20%</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>DED + 20%</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Therapy and Spinal Manipulations BPM</strong></td>
<td>35 Visits (Includes up to 26 Spinal Manipulations)</td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility BPM - 60 Days per Benefit Period</strong></td>
<td>DED + 20%</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Rate Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree</td>
<td>$535</td>
</tr>
<tr>
<td>Spouse</td>
<td>$423</td>
</tr>
<tr>
<td>1 Child</td>
<td>$95</td>
</tr>
<tr>
<td>2 Children</td>
<td>$190</td>
</tr>
<tr>
<td>3 + Children</td>
<td>$215</td>
</tr>
</tbody>
</table>
Prescription Drug Coverage

Accessing Services

Please read the following information carefully to help you understand your benefits and maximize the advantage of the mail service and retail prescription benefits available to you through WellDyneRx.

WellDyneRx has over 64,000 in-network pharmacies across the US which includes all major chains & most independent pharmacies. To locate a pharmacy near you go to http://pcsb.welldynerx.com.

As we move into our second year with WellDyneRx, we would like to remind everyone how important it to register on WellDyneRx’s website. You will be pleasantly surprised at how easy it is to manage all aspects of your prescription benefit program.

To begin, go to http://pcsb.welldynerx.com and follow these three simple steps for Secure Registration:

Secure Registration

**Step 1: Register Online**
Register now to access online refills, transferred prescriptions, view your mail order history, and more.

**Step 2: Enroll for Mail Order**
Provide us your mailing address and phone number and tell us if you have any known drug allergies to enroll for mail order prescriptions delivered right to your door.

**Step 3: Set Up Express Pay**
Set up express pay by providing a major credit card. The number will be stored securely in our database and can be used to quickly and conveniently pay for prescriptions.

Registering will allow you to access benefit information, order refills, check your order status, and more.

If you have questions about your prescription benefits, please visit http://pcsb.welldynerx.com or call WellDyneRx toll-free at 1-855-748-2661.

On-line Services

- Access your personal profile
- Locate in-network pharmacies
- Refill a mail order prescription
- Check your order status
- Print a temporary ID card for you and your covered dependents
- Obtain a complete prescription history
- Print your prescription expense record for tax purposes
- See what drugs are on the Formulary
- Compare the cost of similar medications
- Use the Co-pay Calculator
- Access and print forms
- Access drug and health information

Member Costs

Your plan will require a copay or coinsurance for covered prescription drugs. Your copay may depend on whether the drug is a brand or a generic and if applicable, whether it is a formulary (preferred) or a non-formulary (non-preferred) status. There is a $25.00 per person annual deductible at retail for brand name medications only. 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 generic co-payment, plus the difference in cost between the brand and the generic.

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>NON – preferred Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail 30</td>
<td>$8</td>
<td>$30+10%* (max $60)</td>
<td>$50+10%* (max $100)</td>
</tr>
<tr>
<td>Retail 90</td>
<td>$8</td>
<td>$90+10%* (max $180)</td>
<td>$150+10%* (max $300)</td>
</tr>
<tr>
<td>Mail 90</td>
<td>$8</td>
<td>$75</td>
<td>$125</td>
</tr>
</tbody>
</table>

*10% of the cost of the prescription minus the deductible.

Maximum Out-of-Pocket is $1,600 per member each year.
Generic Drugs

Generic drugs are approved by the Food and Drug Administration (FDA) as safe and effective. Generics contain the same active ingredients in the same amounts as brand drugs, although they may differ in color, size or shape.

Formulary Drugs

A formulary is a list of preferred drugs that have been shown to be safe, effective and have the best cost value. WellDyneRx’s formulary only includes drugs that have been approved by the FDA. For the most up-to-date formulary, visit our website at http://pcsb.welldynerx.com.

Mail Order

Mail order provides an easy and cost-effective way to order medications for delivery to your home. To get started: go to http://pcsb.welldynerx.com, complete and send in a Mail Order form or call Member Services at 1-855-748-2661.

If you have new prescriptions, send all original prescriptions with your copay for each drug directly to:

WellDyneRx
PO Box 90369
Lakeland, FL 33804-0369

For your safety, always review your prescription for accuracy and completeness. Orders will process and ship once the prescriptions are received, unless noted otherwise.

For a quicker turnaround, physicians may call-in the prescription to 1-855-748-2661 or fax it to 1-877-221-1259.

WellDyneRx cannot legally accept called or faxed prescriptions from patients. Transferring your existing prescriptions to mail order is also easy! After signing up for the Mail Order Program, simply complete an ExpressSwitch™ form, which can be found online at http://pcsb.welldynerx.com, and follow the instructions on the form or contact customer service at 1-855-748-2661.

Be sure to order refills about three weeks before you run out of your medication. Refills can be ordered anytime on our website at http://pcsb.welldynerx.com, by calling our automated prescription line at 1-855-748-2661 (selection option 2), or by completing and returning the reorder form sent with your previous order.

Bennie the Owl Says...

Specialty drugs are usually high cost medications which require special handling and close supervision. Specialty drugs are available through WellDyneRx as part of your pharmacy benefit.

Contact WellDyneRx at 1-855-748-2661
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, 2015 based on your age as of January 1, 2015 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

You now have the option to elect 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.

**Calculate Your Premium**

\[
\frac{\text{(elected amount)}}{\$1,000} \times \$\text{(rate from chart)} = \$\text{(monthly cost)}
\]
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:

<table>
<thead>
<tr>
<th>AGE AS OF 01/01/2016</th>
<th>RATE PER $1,000</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td>$0.39</td>
<td>$3.90</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.56</td>
<td>$5.60</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.84</td>
<td>$8.40</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.07</td>
<td>$10.70</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.69</td>
<td>$16.90</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.69</td>
<td>$26.90</td>
</tr>
<tr>
<td>75-79</td>
<td>$4.44</td>
<td>$44.40</td>
</tr>
<tr>
<td>80-84</td>
<td>$7.03</td>
<td>$70.30</td>
</tr>
<tr>
<td>85-89</td>
<td>$11.21</td>
<td>$112.10</td>
</tr>
<tr>
<td>90+</td>
<td>$36.88</td>
<td>$368.80</td>
</tr>
</tbody>
</table>

**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:

<table>
<thead>
<tr>
<th>AGE AS OF 01/01/2016</th>
<th>RATE PER $1,000</th>
<th>Monthly Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td>$0.39</td>
<td>$7.80</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.56</td>
<td>$11.20</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.84</td>
<td>$16.80</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.07</td>
<td>$21.40</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.69</td>
<td>$33.80</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.69</td>
<td>$53.80</td>
</tr>
<tr>
<td>75-79</td>
<td>$4.44</td>
<td>$88.80</td>
</tr>
<tr>
<td>80-84</td>
<td>$7.03</td>
<td>$140.60</td>
</tr>
<tr>
<td>85-89</td>
<td>$11.21</td>
<td>$224.20</td>
</tr>
<tr>
<td>90+</td>
<td>$36.88</td>
<td>$737.60</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Low Plan</th>
<th>Middle Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PDP In-Network</td>
<td>Out-of-Network</td>
<td>PDP In-Network</td>
</tr>
<tr>
<td>Type A¹</td>
<td>Schedule‡</td>
<td>Schedule‡</td>
<td>Type A¹</td>
</tr>
<tr>
<td>Type B²</td>
<td>Schedule‡</td>
<td>Schedule‡</td>
<td>Type B²</td>
</tr>
<tr>
<td>Type C³</td>
<td>Schedule‡</td>
<td>Schedule‡</td>
<td>Type C³</td>
</tr>
</tbody>
</table>

Individual Deductible†
- $50
- $50
- $50

Family Deductible†
- $150
- $150
- $150

Annual Benefit Max
- Per Person $1000
- Orthodontia Not Covered
- N/A

Monthly Premiums
<table>
<thead>
<tr>
<th></th>
<th>Low Plan</th>
<th>Middle Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retiree Only</td>
<td>$11.83</td>
<td>$20.33</td>
<td>$38.93</td>
</tr>
<tr>
<td>Retiree &amp; Spouse</td>
<td>$23.37</td>
<td>$40.64</td>
<td>$75.36</td>
</tr>
<tr>
<td>Retiree &amp; Child(ren)</td>
<td>$29.03</td>
<td>$51.24</td>
<td>$91.34</td>
</tr>
<tr>
<td>Retiree, Spouse &amp; Child(ren)</td>
<td>$35.15</td>
<td>$70.36</td>
<td>$121.44</td>
</tr>
</tbody>
</table>

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

† 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.
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 coating 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.

Bennie the Owl Says...

UHC Vision is paperless. You do not need an ID card. If you’d like one, you can print one from www.myuhcvision.com. Simply click on “Click Here to Print Vision ID Card,” under “My Benefits.” You can also save it to your computer or smartphone.
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**

<table>
<thead>
<tr>
<th>Monthly Rates</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$6.81</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$12.33</td>
</tr>
<tr>
<td>Employee + Child</td>
<td>$12.80</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$19.73</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Copays for In-Network Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$10.00</td>
</tr>
<tr>
<td>Materials</td>
<td>$20.00</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Retail Frame Allowance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Practice Provider</td>
<td>$150.00</td>
</tr>
<tr>
<td>Retail Chain Provider</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit Frequency</th>
<th>Calendar Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Exam</td>
<td>Once in 12 months</td>
</tr>
<tr>
<td>Spectacle Lenses</td>
<td>Once in 12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>Once in 24 months</td>
</tr>
<tr>
<td>Contact Lenses in Lieu of Eye Glasses</td>
<td>Once in 12 months</td>
</tr>
</tbody>
</table>

### 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**
  - 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**
  - 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.

### Examples of Possible Savings

<table>
<thead>
<tr>
<th>Exam and Materials Covered by UHC Vision Plan</th>
<th>Estimated Cost Without Plan</th>
<th>Less Employee Cost</th>
<th>Total Savings with UHC Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only*</td>
<td>$275.00</td>
<td>$95.38</td>
<td>$179.62</td>
</tr>
<tr>
<td>EE + Spouse*</td>
<td>$550.00</td>
<td>$178.37</td>
<td>$371.63</td>
</tr>
<tr>
<td>EE + Child *</td>
<td>$825.00</td>
<td>$212.88</td>
<td>$612.12</td>
</tr>
<tr>
<td>EE + Family*</td>
<td>$1,100.00</td>
<td>$309.41</td>
<td>$790.59</td>
</tr>
</tbody>
</table>

* Exam, Single Vision & Covered-in-Full Frames

---

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: 9:00 AM – 7:00 PM
Wednesday: 7:00 AM – 6:00 PM
Thursday: 9:00 AM – 7:00 PM
Friday: 8:00 AM – 6:00 PM
Saturday: 7:00 AM – 12:00 PM

And remember that 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 Location:  Coming Soon in January 2016:
641 US HWY 17-92 West  Lakeland Location
Haines City, FL 33844  @ Traviss Career Center

Since June 2012
Clinic Visits 29,262
Employee Savings $1,170,480

Powered by
healthstat
inspiring healthy change
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. See [www.polk-fl.net](http://www.polk-fl.net) keyword “wellness” or call 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**!
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

<table>
<thead>
<tr>
<th>FLAIR ACCOUNT CODE</th>
<th>OLO</th>
<th>SITE</th>
<th>DOCUMENT NUMBER</th>
<th>OBJECT</th>
<th>DATE</th>
<th>EFT NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

SUMMARY OF BENEFITS AND DEDUCTIONS
MISCELLANEOUS DEDUCTIONS

<table>
<thead>
<tr>
<th>RETIREMENT BENEFIT</th>
<th>THIS PAYMENT</th>
<th>CALENDAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH INSURANCE SUBSIDY</td>
<td>$5</td>
<td>$5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CODE DESCRIPTION</th>
<th>THIS PAYMENT</th>
<th>YEAR-TO-DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>008 POLK COUNTY SCHOOL B</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>201 POLK COUNTY SCHOOL B</td>
<td>$5</td>
<td>$5</td>
</tr>
</tbody>
</table>

TOTAL OF MISC DEDUCTIONS $5

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.rofl.frs.state.fl.us/forms/Retiree-FAQ.pdf or by contacting FRS at: (888) 738-2252

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.

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.

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

The Polk County School Board is enrolling you in BlueMedicare Group PPO Plan 1 as your retiree health benefit plan beginning January 1, 2015, unless you tell us by November 14, 2014 that you don’t want to join this plan. BlueMedicare Group PPO Plan 1 is a Medicare Advantage plan. This enrollment will automatically cancel your enrollment in a different Medicare Advantage plan or a Medicare Prescription Drug (Part D) plan. Please call us if you think you might be enrolled in a different Medicare Advantage plan or a Medicare Prescription Drug plan.

What do I need to know as a member of BlueMedicare Group PPO Plan 1?
This mailing includes important information about this plan and the coverage it offers, including a summary of benefits document. Please review this information carefully. If you want to be enrolled in this Medicare health plan, you don’t have to do anything, and your enrollment will automatically begin on January 1, 2015.

Once you are a member of BlueMedicare Group PPO Plan 1, you have the right to appeal plan decisions about payment or services if you disagree. Read the Evidence of Coverage document from BlueMedicare Group PPO Plan 1 when you get it to know which rules you must follow to get coverage with this Medicare Advantage Plan. Enrollment in this plan is generally for the entire year.

Beginning on the date BlueMedicare Group PPO Plan coverage begins, you must get all of your health care from BlueMedicare Group PPO Plan 1, with the exception of emergency or urgently needed services or out-of-area dialysis services. Services authorized by BlueMedicare Group PPO Plan 1 and other services contained in my BlueMedicare Group PPO Plan 1 Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered.

Without authorization, NEITHER MEDICARE NOR BLUEMEDICARE GROUP PPO PLAN 1 WILL PAY FOR SERVICES.

You will need to keep Medicare Parts A and B as BlueMedicare Group PPO Plan 1 is a Medicare Advantage Plan. You can be in only one Medicare Advantage Plan at a time. It is your responsibility to inform BlueMedicare Group PPO Plan 1 of any prescription drug coverage that you have or may get in the future.

By joining this Medicare health plan, you acknowledge that the Medicare health plan will release your information to Medicare and other plans as is necessary for treatment, payment and health care operations. You also acknowledge that BlueMedicare Group PPO Plan 1 will release your information including your prescription drug purchase history to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations.

What happens if I don’t join BlueMedicare Group PPO Plan 1?
You aren’t required to be enrolled in this plan. You may instead elect to join BlueMedicare Local PPO (LPPO) or United Health Care Medicare Supplement plan. You can also decide to join a different Medicare plan. Call 1-800-MEDICARE for help in learning how. However, if you decide not to be enrolled in any of the three plans offered through the Polk County School Board, you will not be able to rejoin a plan sponsored by Polk County School Board at a later date. To request not to be enrolled by this process you must submit an application for either the BlueMedicare Local PPO (LPPO) or the United Health Care Medicare Supplement plan. You may also submit the enclosed Request for Cancellation form to the Risk Management and Employee Benefits Department of the Polk County School Board. For questions, please contact the Risk Management and
(Continued from page 38 for Medicare Eligible Retirees)

Employee Benefits Department at 863-519-3858 Monday through Friday from 8:00 AM to 5:00 PM.

What if I want to leave BlueMedicare Group PPO Plan 1?
You may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to the Risk Management and Employee Benefits Department of the Polk County School Board.

BlueMedicare Group PPO Plan 1 serves a specific service area. If you move out of the area that BlueMedicare Group PPO Plan 1, you need to notify the plan so you can disenroll and find a new plan in your new area.

Remember that if you leave this plan and don’t have creditable prescription drug coverage (as good as Medicare’s prescription drug coverage), you may have to pay a late enrollment penalty if you enroll in Medicare prescription drug coverage in the future.

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.
Important Legal Notice

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: www.polk-fl.net, keyword “Insurance”.

A copy of the Privacy Policy can be found on the Risk Management & Employee Benefits page of the Polk County School Board website at: www.polk-fl.net, keyword “Insurance”.

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

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, Ceridian. 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 service, i.e. a spouse in the case of a divorce, must also be offered the option to continue coverage.

<table>
<thead>
<tr>
<th>REASON FOR LOSS OF COVERAGE</th>
<th>EMPLOYEE</th>
<th>SPOUSE</th>
<th>CHILD(REN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee separation from service</td>
<td>18 MONTHS</td>
<td>18 MONTHS</td>
<td>18 MONTHS</td>
</tr>
<tr>
<td>Employee reduction of hours (no longer eligible for coverage through employer)</td>
<td>18 MONTHS</td>
<td>18 MONTHS</td>
<td>18 MONTHS</td>
</tr>
<tr>
<td>Employee, spouse or dependent become legally disabled</td>
<td>29 MONTHS</td>
<td>29 MONTHS</td>
<td>29 MONTHS</td>
</tr>
<tr>
<td>Death of Employee</td>
<td>36 MONTHS</td>
<td>36 MONTHS</td>
<td>36 MONTHS</td>
</tr>
<tr>
<td>Divorce or Legal Separation</td>
<td>36 MONTHS</td>
<td>36 MONTHS</td>
<td>36 MONTHS</td>
</tr>
<tr>
<td>Entitled to Medicare</td>
<td>36 MONTHS</td>
<td>36 MONTHS</td>
<td>36 MONTHS</td>
</tr>
<tr>
<td>Child no longer qualifies</td>
<td></td>
<td></td>
<td>36 MONTHS</td>
</tr>
</tbody>
</table>
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.
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 $25 per year per individual deductible for Brand Name drugs in addition to the follow copayments:

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Preferred Brand</th>
<th>Non-Preferred Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail 30 Days</td>
<td>$8.00</td>
<td>$30.00 +10%*</td>
<td>$50.00 +10%*</td>
</tr>
<tr>
<td>(max $60.00)</td>
<td></td>
<td>(max $100.00)</td>
<td></td>
</tr>
<tr>
<td>Retail 90 Days</td>
<td>$8.00</td>
<td>$90.00 +10%*</td>
<td>$150.00 +10%*</td>
</tr>
<tr>
<td>(max $180.00)</td>
<td></td>
<td>(max $300)</td>
<td></td>
</tr>
<tr>
<td>Mail 90 Days</td>
<td>$8.00</td>
<td>$75.00</td>
<td>$125.00</td>
</tr>
</tbody>
</table>

*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.

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 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….

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 Marketplace 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 2013 for coverage starting as early as January 1, 2014.
- 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 12, 2014 through October 30, 2014 for coverage effective January 1, 2015.

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 Marketplace
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.polk-fl.net keyword: “Insurance”. A paper copy is also available, free of charge, by calling 863-519-3858.
New Health Insurance Marketplace Coverage Options and Your Health Coverage

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.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Board of Polk County</td>
<td>596000807</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915 S Floral Avenue</td>
<td>863-519-3858</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bartow</td>
<td>FL</td>
<td>33830</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Who can we contact about employee health coverage at this job?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Management and Employee Benefits Department</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Phone number (if different from above)</th>
<th>12. Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>863-519-3858</td>
<td><a href="mailto:RiskManagement-AllStaff@polk-fl.net">RiskManagement-AllStaff@polk-fl.net</a></td>
</tr>
</tbody>
</table>

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:
  - [x] 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:
  
  - [x] 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.

- [x] 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)
   - No (STOP and return this form to employee)

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)

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 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-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.

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 cesarean section aren’t complications of pregnancy.
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.
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

Out-of-Pocket Limit: $5,000

Janet's Plan Deductible: $1,500

Co-Insurance: 20%

Costs more...

Out-of-Pocket Limit: $5,000

Janet's Plan Deductible: $1,500

Co-Insurance: 20%

Costs more...