INSURANCE

LIFESTYLE / HEALTH

RETIREMENT

ADDITIONAL

EMPLOYEE BENEFIT HIGHLIGHTS

October 2017 - September 2018

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This booklet is merely a summary of benefits. For a full description, refer to the plan document. Where conflict exists between this summary and the plan document, the plan document controls. Pinellas Suncoast Transit Authority reserves the right to amend, modify or terminate the plan at any time. This booklet should not be construed as a guarantee of employment.

Contact Information

Benefit	Contact	Information
EEOC	Larry Longenecker, Director of Human Resources	Phone: (727) 540-1854 Email: llongenecker@psta.net
Benefits	Erin Gauby, The Benefits Department	Phone: (727) 540-1987 Email: benefits@psta.net
Drug & Alcohol	Liz Young, HR Services Coordinator	Phone: (727) 540-1808 Email: eyoung@psta.net
Payroll	Erin Gauby, Payroll Hotline	Phone: (727) 540-1908 Email: Payroll@psta.net
Online Enrollment	BenTek	Customer Service: (888) 5-BenTek (523-6835) www.mybentek.com/psta Email: support@mybentek.com
Medical and Dental Insurance	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Prescription Mail-Order Program	Cigna Home Delivery	Customer Service: (800) 285-4812 www.mycigna.com
Health Savings Account	HSA Bank	Customer Service: (800) 244-6224 www.cigna.com
Vision Insurance	Advantica	Customer Service: (866) 425-2323 www.advanticabenefits.com
Flexible Spending Accounts	Cigna	Customer Service: (800) 244-6224 www.cigna.com
Basic Term Life, AD&D and Voluntary Life Insurance	Minnesota Life	Customer Service: (800) 392-7295 www.minnesotalife.com
Long Term Disability Insurance	The Hartford	Customer Service: (888) 747-8819 www.thehartford.com
Supplemental Insurance	Aflac	Customer Service: (800) 992-3522 www.aflac.com
Employee Assistance Program	Bensinger, DuPont & Associates (BDA)	Customer Service: (800) 272-2727 www.bdaeap.com Password: psta
Health Advocacy	Health Advocate	Customer Service: (866) 799-2728 www.healthadvocate.com/members
Legal Insurance & Identity Theft Protection	Legal Shield	Customer Service: (800) 654-7757 www.legalshield.com
Retirement Plan	Florida Retirement System	Phone: (844) 377-1888 www.myfrs.com
Deferred Compensation Plan	ICMA-RC	Phone: (800) 669-7400 www.icmarc.org

Introduction

Pinellas Suncoast Transit Authority (PSTA) provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Highlights Booklet provides a general summary of these benefit options as a convenient reference. Please refer to PSTA's Personnel Policies, applicable Union Contracts and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein. If further explanation or assistance is needed regarding claims processing, please refer to the customer service phone numbers under each benefit description or contact the The Benefits Department for further information.

Online Benefit Enrollment

PSTA provides employees with an online benefits enrollment platform through BenTek's Employee Benefits Center (EBC). The EBC provides benefits-eligible employees the ability to select or change insurance benefits online during the annual open enrollment period, new hire orientation or qualifying events.

Accessible 24 hours a day throughout the year, employee may log in and review comprehensive information regarding benefits plans and view and print an outline of benefit elections for employee and dependent(s). Employee has access to important forms and carrier links, can report qualifying life events and review and make changes to life insurance beneficiary designations.

To Access the Employee Benefits Center:

- ✓ Log on to **www.mybentek.com/psta**
- ✓ Sign in using a previously created username and password or click "Create an Account" to set up a username and password.
- ✓ If employee has forgotten username and/or password, click on the link "Forgot Username/Password" and follow the instructions.
- ✓ Once logged on, navigate to the menu in order to review current elections, learn about benefit options, and make elections, changes or beneficiary designations.

For technical issues directly related to using the EBC please call (888) 5-BenTek (523-6835) or email BenTek Support at support@mybentek.com, Monday through Friday, during regular business hours.

To access group insurance benefits online, log on to:
www.mybentek.com/psta

Please Note: *Link must be addressed exactly as written (Due to security reasons, the website cannot be accessed by Google or other search engines.)*

Group Insurance Eligibility

PSTA group insurance plan year is October 1 through September 30.

Employee Eligibility

Employees are eligible to participate in PSTA's insurance plans if they are designated full-time employees and are regularly scheduled to work over 30 hours or more per week. If employee is an eligible, newly hired Bus Operator, benefits will begin on the first of the month following 30 days after commencement graduation of the New Hire Bus Operator Training Program. For example, if the graduation date is April 11, benefits will be effective June 1. For newly hired benefit-eligible Non-Bus Operator positions, benefits will begin on the first of the month following 30 days of employment. For example, if employee is hired on April 11, then the effective date of coverage will be June 1.

Termination

If employee separates employment from PSTA, insurance will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law.

Dependent Eligibility

A dependent is defined as the legal spouse and/or a dependent child(ren) of the participant or the spouse. A dependent child may be covered through the end of the calendar year in which the child reaches age 26 for medical, dental, and vision. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A stepchild
- A newborn child (up to the age of 18 months old) of a covered dependent (Florida).
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse.

Dependent Age Requirements

Medical Coverage: A dependent child may be covered through the end of the calendar year in which the child turns 26. An over-age dependent may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:

- Unmarried with no dependents; and
- A Florida resident, or full-time or part-time student: and
- Otherwise uninsured; and
- Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Please see Taxable Dependents if covering eligible dependents over age 26.

Dental Coverage: A dependent child may be covered through end of calendar year in which child turns 26.

Vision Coverage: A dependent child may be covered through end of calendar year in which child turns 26.

Group Insurance Eligibility *(Continued)*

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent is otherwise eligible for coverage under the group medical plan; and
- The dependent has been continuously insured; and
- Coverage with PSTA began prior to age 26.

Proof of disability will be required upon request. Please contact the Benefits Department if further clarification is needed.

Taxable Dependents

Employee covering adult child(ren) under their medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which the child reaches age 26. Beginning January 1 of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, imputed income for the value of the applicable adult child's coverage for the coverage period must be reported on the employee's W-2. Imputed income is the dollar value of insurance coverage attributable to covering the adult child. There is no imputed income if an adult child is eligible to be claimed as a dependent for federal income tax purposes on the employees tax return. Check with the Benefits Department for further details if covering adult child who will turn 27 any time in the upcoming calendar year or for more information.

Documentation Requirements

All dependents must have an established legal relationship to the employee to be covered under the benefit program. The types of documentation accepted are as stated in the table below. Employee with dependent(s) enrolled in the group insurance plans are advised the employee will be required to comply with this process or continued coverage for dependent(s) may be jeopardized.

Dependent Relationship	Documentation Required
Spouse	• *Copy of legal government issued marriage certificate,* • *Copy of state issued birth certificate,* • *Copy of Social Security card,* • ***AND** copy of most recent IRS tax return – front & back.*
Dependent child(ren) under age 26	• *Copy of Social Security card,* • ***AND** copy of state issued birth certificate(s) **OR** copy of legal guardianship court documents listing the employee as legal guardian.*
Step-child(ren) under age 26	• *Copy of state issued birth certificate(s),* • *Copy of Social Security card,* • ***AND** copy of state issued marriage certificate*
Child(ren) under legal guardianship, custody or foster care under age 26	• *Copy of state issued birth certificate,* • *Copy of Social Security card,* • ***AND** copy of court documents showing legal guardianship **OR** legal custody **OR** foster care placement.*
Child(ren) adopted or in the process of adoption under age 26	• *Copy of state issued birth certificate,* • *Copy of Social Security card,* • ***AND** copy of court documents of the legal adoption showing relationship to and placement in the employee's house **OR** adoption certificate.*

***Please Note:** Religious documents and registration cards are not acceptable proof. Employee may "black out" financial information.*

Qualifying Events and IRS Code Section 125

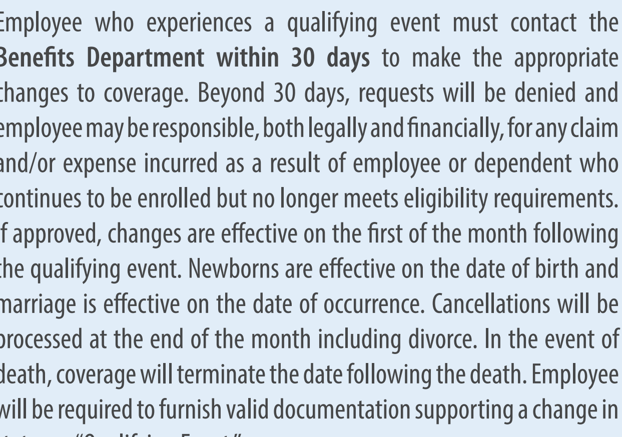
IRS Code Section 125

Premiums for medical, dental, vision, and/or certain supplemental policies and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-taxed to the extent permitted. Under Section 125, changes to employee's pre-tax benefits can be made ONLY during the Open Enrollment period unless employee or qualified dependent(s) experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, employee may be allowed to make changes to benefit elections during the plan year, if the event affects employee, spouse, dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125. Any requested changes must be consistent with and due to the qualifying event.

Examples of Qualifying Events:

- Employee gets married or divorced
- Birth of a child
- Employee gains legal custody or adopts a child
- Employee's spouse and/or other dependent(s) die(s)
- Employee, employee's spouse or dependent(s) terminate or start employment
- An increase or decrease in employee's work hours causes eligibility or ineligibility
- A covered dependent no longer meets eligibility criteria for coverage
- A child gains or loses coverage with an ex-spouse
- Change of coverage under an employer's plan
- Gain or loss of Medicare coverage
- Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period)
- Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period)



IMPORTANT NOTES

Employee who experiences a qualifying event must contact the **Benefits Department within 30 days** to make the appropriate changes to coverage. Beyond 30 days, requests will be denied and employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of employee or dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes are effective on the first of the month following the qualifying event. Newborns are effective on the date of birth and marriage is effective on the date of occurrence. Cancellations will be processed at the end of the month including divorce. In the event of death, coverage will terminate the date following the death. Employee will be required to furnish valid documentation supporting a change in status or "Qualifying Event."

Medical Insurance

PSTA offers medical insurance through Cigna to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the medical plan, please refer to the summary of coverage document or contact Cigna's customer service.

Medical Insurance Premiums – Cigna Option 1 Plan

26 Bi-Weekly Deductions - Per Pay Period Cost

Buy-Up	Employee Bi-Weekly Deductions	Employer Bi-Weekly Contribution
Employee	$66.41	$445.98
Employee + Spouse	$276.68	$509.01
Employee + Child	$177.07	$482.28
Employee + Family	$336.07	$524.90

Medical Insurance Premiums – Cigna Option 2 Plan

26 Bi-Weekly Payroll Deductions - Per Pay Period Cost

Base	Employee Bi-Weekly Deductions	Employer Bi-Weekly Contribution
Employee	$29.00	$445.98
Employee + Spouse	$218.98	$509.00
Employee + Child	$128.75	$482.27
Employee + Family	$272.77	$524.90

Medical Insurance Premiums – Cigna Option 3 Plan

26 Bi-Weekly Deductions - Per Pay Period Cost

HDHP	Employee Bi-Weekly Deductions	Employer Bi-Weekly Contribution
Employee	$0	$452.75
Employee + Spouse	$138.46	$554.85
Employee + Child	$69.23	$512.87
Employee + Family	$161.54	$598.03

Cigna | Customer Service: (800) 244-6224 | www.cigna.com

Summary of Benefits and Coverage

A **Summary of Benefits & Coverage (SBC)** for the medical plan is **provided as a supplement** to this booklet being distributed to new hires and existing employees during open enrollment. The summary is an important item in understanding benefit options. A free paper copy of the SBC document may be requested or is available as follows:

From: The Benefits Department

Address: 3201 Scherer Drive N.
St. Petersburg, FL 33716

Phone: (727) 540-1987

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Benefits Department.

If there are any questions about the plan offerings or coverage options, please contact the Benefits Department at (727) 540-1987.

Other Available Plan Resources

Cigna offers all enrolled members and dependent(s) additional services and discounts through value added programs. For more details regarding other available plan resources, please refer to the Summary of Benefits and Coverage (SBC).

24 Hour Help Information Hotline (800) CIGNA-24

The Cigna 24-Hour Health Information Line provides access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do if a child has a fever in the middle of the night? Not sure if treatment from a doctor is necessary for an injury? There are over 1,000 topics in the Health Information Library that include free audio, video and printed information on aging, women's health, nutrition, surgery and specific medical conditions to help employees weigh the risks and advantages of treatment options. The call is free and is strictly confidential.

Healthy Rewards

Cigna's Healthy Rewards is provided automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members may log on to www.mycigna.com and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- ✓ Vision Care
- ✓ Lasik Vision Correction Services
- ✓ Fitness Club Discounts
- ✓ Nutrition Discounts
- ✓ Hearing Care
- ✓ Tobacco Cessation
- ✓ Alternative Medicine

The myCigna Mobile App

The myCigna mobile app is an easy way to organize and access important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myCigna mobile app, members can:

- ✓ Find a doctor, dentist or health care facility
- ✓ Access maps for instant driving directions
- ✓ View ID cards for the entire family
- ✓ Review deductibles, account balances and claims
- ✓ Compare prescription drug costs
- ✓ Speed-dial Cigna Home Delivery Pharmacy™
- ✓ Store and organize all important contact info for doctors, hospitals and pharmacies
- ✓ Add health care professionals to contact list right from a claim or directory search
- ✓ And much more!

Telehealth

Cigna provides access to two telehealth services as part of the medical plan – AmWell and MDLIVE. Telehealth is a convenient phone and video consultation company that provides immediate medical assistance for many conditions.

This benefit is provided to all enrolled members. This program allows members 24/7 on-demand access to affordable medical care via phone and online video consultations when needing immediate care for non-emergent medical issues. Telehealth should be considered when employee's primary care doctor is unavailable, after-hours or on holidays for non-emergency needs. Many urgent care ailments can be treated with Telehealth, such as:

- ✓ Sore Throat
- ✓ Headache
- ✓ Stomachache
- ✓ Fever
- ✓ Cold And Flu
- ✓ Allergies
- ✓ Rash
- ✓ Acne
- ✓ UTIs And More

Telehealth doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care and ER visits. For further information please see Benefits Department or contact Cigna.

Cigna
AmWell | Customer Service: (855) 667-9722 | www.AmWellforCigna.com
MDLIVE | Customer Service: (888) 726-3171 | www.MDLIVEforCigna.com

Cigna Option 1 Plan At-A-Glance

Network	Open Access Plus	
Plan Year Deductible (PYD)	**In-Network**	
Single	$750	
Family	$1,500	
Coinsurance		
Member Responsibility	20%	
Plan Year Out-of-Pocket Limit		
Single	$4,000	
Family	$8,000	
What Applies to the Out-of-Pocket Limit?	Coinsurance, Deductible, Copays	
Physician Services		
Primary Care Physician *(PCP)* Office Visit	$20 Copay	
Specialist Office Visit	$30 Copay	
Telehealth Services	$20 Copay	
Non-Hospital Services; Freestanding Facility		
Clinical Lab *(Blood Work)**	No Charge	
X-rays	No Charge	
Advanced Imaging *(MRI, PET, CT)*	20% After PYD	
Outpatient Surgery in Surgical Center	20% After PYD	
Physician Services at Surgical Center	20% After PYD	
Urgent Care *(Per Visit)*	$50 Copay	
Hospital Services		
Inpatient Hospital *(Per Admission)*	20% After PYD	
Outpatient Hospital *(Per Visit)*	20% After PYD	
Physician Services at Hospital	20% After PYD	
Emergency Room *(Per Visit; Waived if Admitted)*	$100 Copay	
Mental Health/Alcohol & Substance Abuse		
Inpatient Hospitalization *(Per Admission)*	20% After PYD	
Outpatient Office Visit	20% After PYD	
Outpatient Services *(Per Visit)*	$20 Copay	
Prescription Drugs *(Rx)*		
Plan Year Out-of-Pocket Limit for Rx Costs	Single: $1,000	Family: $2,000
Generic	$10 Copay	
Preferred Brand Name	$30 Copay	
Non-Preferred Brand Name	$50 Copay	
Mail Order Drug *(90-Day Supply)*	$25/$75/$125	

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.cigna.com. When completing the necessary search criteria, select **Open Access Plus** network.

Plan References

**Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

Important Notes

- ***There is a separate $1,000 / $2,000 per plan year, Pharmacy out-of-pocket limit, that does not accumulate towards the medical plan year out-of-pocket limit.***
- *Services received by providers and facilities not in the **Open Access Plus Network** will be denied.*

Cigna Option 2 At-A-Glance

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.cigna.com. When completing the necessary search criteria, select **Open Access Plus** network.

Plan References

**Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

Important Notes

- *Services received by providers and facilities not in the **Open Access Plus Network** will be denied.*

Network	Open Access Plus
Plan Year Deductible (PYD)	**In-Network**
Single	$1,500
Family	$3,000
Coinsurance	
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	
Single	$5,000
Family	$10,000
What Applies to the Out-of-Pocket Limit?	Coinsurance, Deductible, Copays, and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit	$35 Copay
Specialist Office Visit	$50 Copay
Telehealth Services	$35 Copay
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Blood Work)**	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	20% After PYD
Outpatient Surgery in Surgical Center	20% After PYD
Physician Services at Surgical Center	20% After PYD
Urgent Care *(Per Visit)*	$75 Copay
Hospital Services	
Inpatient Hospital *(Per Admission)*	20% After PYD
Outpatient Hospital *(Per Visit)*	20% After PYD
Physician Services at Hospital	20% After PYD
Emergency Room *(Per Visit; Waived if Admitted)*	$300 Copay
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospitalization *(Per Admission)*	20% After PYD
Outpatient Office Visit	20% After PYD
Outpatient Services *(Per Visit)*	$20 Copay
Prescription Drugs *(Rx)*	
Generic	$15 Copay
Preferred Brand Name	$30 Copay
Non-Preferred Brand Name	$50 Copay
Mail Order Drug *(90-Day Supply)*	$25/$75/$125

Cigna Option 3 Plan At-A-Glance

Network	Open Access Plus
Plan Year Deductible (PYD)	**In-Network**
Single	$1,500
Family	$3,000
Coinsurance	
Member Responsibility	20%
Plan Year Out-of-Pocket Limit	
Single	$6,000
Family	$12,000
What Applies to the Out-of-Pocket Limit?	Coinsurance, Deductible, Copays, and Rx
Physician Services	
Primary Care Physician *(PCP)* Office Visit	20% After PYD
Specialist Office Visit	20% After PYD
Telehealth Services	20% After PYD
Non-Hospital Services; Freestanding Facility	
Clinical Lab *(Blood Work)**	No Charge
X-rays	No Charge
Advanced Imaging *(MRI, PET, CT)*	20% After PYD
Outpatient Surgery in Surgical Center	20% After PYD
Physician Services at Surgical Center	20% After PYD
Urgent Care *(Per Visit)*	20% After PYD
Hospital Services	
Inpatient Hospital *(Per Admission)*	20% After PYD
Outpatient Hospital *(Per Visit)*	20% After PYD
Physician Services at Hospital	20% After PYD
Emergency Room *(Per Visit; Waived if Admitted)*	20% After PYD
Mental Health/Alcohol & Substance Abuse	
Inpatient Hospitalization *(Per Admission)*	20% After PYD
Outpatient Office Visit	20% After PYD
Outpatient Services *(Per Visit)*	20% After PYD
Prescription Drugs *(Rx)*	
Generic	$15 After PYD
Preferred Brand Name	$30 After PYD
Non-Preferred Brand Name	$50 After PYD
Mail Order Drug *(90-Day Supply)*	$25/$75/$125 After PYD

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.cigna.com. When completing the necessary search criteria, select **Open Access Plus** network.

Plan References

**Quest Diagnostics and LabCorp are the preferred labs for bloodwork through Cigna. When using a lab other than LabCorp or Quest, please confirm they are contracted with Cigna's Open Access Plus Network prior to receiving services.*

Important Notes

- *Services received by providers and facilities not in the **Open Access Plus Network** will be denied.*

Health Savings Account

PSTA's High Deductible Health Plan (HDHP) complies with the Internal Revenue Service (IRS) requirements and qualifies employees **enrolled in the Cigna Option 3 Plan** to open a Health Savings Account (HSA). An HSA is an interest-bearing account where funds can be used to help pay your deductible, coinsurance and any medical expenses not covered by the plan. For a complete list of eligible expenses, please visit www.cigna.com/expenses.

2017-2018 Funding	
Employee	$200
Employee + Spouse	$300
Employee + Child	$300
Employee + Family	$400

Employees can opt to fund their HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to an HSA can also be made on an after-tax basis and taken as an above-the-line deduction on their tax return (making such contributions tax-free).

- ✓ **2017 IRS Contribution Limitations:** $3,400 (individual coverage) $6,750 (family coverage)
- ✓ **2018 IRS Contribution Limitations:** $3,450 (individual coverage) $6,900 (family coverage)
- ✓ Individuals ages 55 and older can also make additional "catch-up" contributions up to $1,000 annually.

Guidelines regarding the HSAs are established by the IRS.

What you need to know about your HSA

- Employee owns the HSA funds from day 1 and decides how and when to spend the money.
- No "use it or lose it" rules like an FSA; funds are in the account when needed, now or in the future. **Participants cannot fund into a traditional medical FSA - it must be a Limited Purpose FSA for dental and vision expenses only!**
- HSA funds earn interest.
- The HSA may be partially funded with employer contributions. If the employee desires to fund the remaining deductible balance they may do so with pre-tax payroll deductions.
- Employer contributions will be funded monthly.
- HSA dollars can be used tax-free for all eligible medical expenses.
- HSA funds are portable from one employer to another. Accumulated funds can help employee plan for retirement.
- An account holder can withdraw funds with a Health Savings Account Debit Card.
- Some account service fees, determined by the bank, may apply.
- To be eligible to open an HSA, employee must be covered by the Option 3 high deductible medical plan. **Please note: Eligibility status to qualify for an HSA is specifically driven by the PSTA employee and NOT the dependents.**
- Over-age dependents are not able to use HSA funds for qualified expenses, even if dependent is covered under the medical plan as federal law does not recognize them as a qualified dependent.
- If employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits PSTA from contributing HSA funds into employee's account. If employee is not enrolled in Medicare, TRICARE or TRICARE for Life, then employee is eligible to enroll and contribute into the HSA up to the 2017/2018 maximum contribution amounts.
- **Active employees NOT on Medicare but have a spouse enrolled in Medicare:** Any active employee who is covering a spouse that is enrolled in Medicare will receive PSTA's HSA funding, and may fund their account to the family coverage limit, less PSTA's contribution. These funds can be utilized for the active employee and spouse expenses.
- **Active employees ON Medicare and have a spouse NOT enrolled in Medicare:** Any active employee who is enrolled in Medicare and covering a spouse will not receive any HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.
- Terms and agreements may vary, please contact the Benefits Department for more details.

Please Note: *Employee's HSA account will automatically be set up when employee enrolls into the Cigna HDHP medical plan.*

HSA Bank
Customer Service: (800) 244-6224 | www.mycigna.com

Health Savings Account: Understanding HSAs *(Continued)*

Question	Health Savings Accounts (HSA)
What is an HSA?	Employee enrolled in the Cigna Option 3 will receive a Health Savings Account (HSA) funded by PSTA and employee can also fund the account with tax-free dollars. HSA funds can be used for qualified IRS 213 expenses. Go to http://www.irs.gov for a listing of 213 expenses.
How much is funded into the account?*	**2017-2018 Funding** **Employee**: $200 **Employee + Spouse**: $300 **Employee + Child**: $300 **Employee + Family**: $400 Employee may opt to fund their HSA via pre-tax evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to HSA can also be made on an after-tax basis and taken as an above-the-line deduction on their tax return (making such contributions tax-free). ✓ **2017 IRS Contribution Limitations:** $3,400 (individual coverage) $6,750 (family coverage) ✓ **2018 IRS Contribution Limitations:** $3,450 (individual coverage) $6,900 (family coverage) ✓ Individuals ages 55 and older can also make additional "catch-up" contributions up to $1,000 annually. Guidelines regarding the HSAs are established by the IRS.
How are the funds accessed?	HSA funds can be accessed by: 1) Automatic claim forwarding to Cigna (claims paid directly from HSA by Cigna); 2) Cigna HDHP HSA debit card; 3) Check book
What happens to unused funds at the end of the 2017-2018 Plan Year?	The year-end balance remains in the HSA Account and continues to earn interest. The member does not lose it at the end of the year if it is not used.
What happens to unused funds if employee discontinues participation in an HSA Plan, separate employment, or retire from PSTA?	Employee owns the HSA funds from day one and decide how and when to spend them. HSA funds are portable from one employer to another.
What are some examples of qualified expenses that would be eligible for reimbursement?	HSA funds can be used to meet the plan year deductible. Most covered services count toward the deductible, including prescriptions costs, physician visits, hospital visits, laboratory work, etc. All expenses must be medically necessary.
Can an employee have an HSA AND a Flexible Spending Account (FSA)?	Yes, employee may have an FSA in addition to an HSA, but the member's ability to utilize a Health Care FSA for certain expenses may be limited. For more information on FSAs, please refer to the Flexible Spending Accounts page.

The allowable funding amounts may differ based on contribution amounts from PSTA.

HSA Bank | Customer Service: (800) 244-6224 | www.cigna.com

Dental Insurance

Cigna Dental Care DHMO Plan

PSTA offers two (2) dental insurance plans through Cigna to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plans, please refer to the summary plan document or contact Cigna's customer service.

Dental Insurance Premiums
Cigna Dental Care DHMO Plan

26 Bi-Weekly Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Bi-Weekly Deductions	Employer Bi-Weekly Contribution
Employee Only	$0.00	$6.43
Employee + 1	$4.42	$6.43
Employee + Family	$11.86	$6.43

In-Network Benefits

The Dental Care DHMO is an in-network only plan that requires all services be received by a Primary Dental Provider (PDP). Employee and dependents may select any participating dentist in the Cigna Dental Care HMO Network to receive covered services. There is no coverage for services received out-of-network.

The DHMO plan's schedule of benefits is set forth by the Patient Charge Schedule (fee schedule) which is highlighted on the following page. Please refer to the plan's summary of coverage document for a detailed listing of charges and what is covered.

Out-of-Network Benefits

The DHMO plan does not cover any services rendered by out-of-network facilities or providers.

Plan Year Deductible

There is no plan year deductible.

Plan Year Benefit Maximum

There is no benefit maximum.

IMPORTANT NOTES !

- *Each covered family member may receive up to two (2) FREE cleanings per plan year. Members can also receive two (2) additional cleanings at the charge of a $55 copay.*
- *Referrals and prior authorization are required for specialists within the network.*
- *Coverage and age limitations may apply.*
- *Pediatric dentists are covered for children under age seven (7). Contact Cigna for a list of Pediatric dentists in the network.*

Cigna | Customer Service: (800) 244-6224 | www.cigna.com

Cigna Dental Care DHMO Plan At-A-Glance

Network	Dental Care HMO	
Plan Year Deductible (PYD)	**In-Network Only**	
Per Member	Does Not Apply	
Per Family		
Plan Year Benefit Maximum		
Class I Services: Diagnostic & Preventive Care	**Code**	**In-Network**
Routine Oral Exam	0150	$0
Routine Cleanings *(2 Per Calendar Year)*	1110/1120	$0
Bitewing X-rays *(2 Films)*	0274	$0
Complete X-rays *(1 Every 3 Years)*	0210	$0
Fluoride Treatments to Age 19 *(2 Per Calendar Year)*	1203	$0
Sealants *(Per Tooth)*	1351	$12
Emergency Care to Relieve Pain *(Minor Procedure)*	9110	$6
Class II Services: Basic Restorative Care		
Fillings *(Amalgam)*	2140	$0
Fillings *(Composite, Anterior)*	2330	$0
Fillings *(Composite — 2 Surfaces, Posterior)*	2392	$80
Simple Extractions	7140	$6
Surgical Extractions *(Soft Tissue)*	7220	$65
Root Canal Therapy *(Molar; Excluding Final Restoration)*	3330	$305
Deep Cleaning *(1 Per Lifetime)*	4355	$50
Periodontal Scaling *(1 to 3 Teeth Per Quadrant; Limit 4 Quadrants Per 12 Months)*	4342	$40
Periodontal Scaling (*4 or More Teeth; Limit 4 Quadrants Per 12 Months)*	4341	$50
General Anesthesia *(First 30 Minutes; Per Visit)*	9220	$160
Class III Services: Major Restorative Care*		
Crowns *(Porcelain Fused to Metal)*	2750	$270
Bridges (Pontic)	6240	$250
Dentures	5110/5120	$225
Class IV Services: Orthodontia - 24 Month Treatment Fee*		
Benefit *(Dependent Children Up To Age 19)*	8670	$1,608
Benefit *(Adult and Dependent Children 19 and Over)*	8670	$2,592

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.cigna.com When completing the necessary search criteria, select **Cigna Dental Care HMO** network.

Plan References

**Additional charges may apply for some services. Please see your plan summary or contact Cigna's customer service for details specific to the procedure.*

Dental Insurance

Cigna Dental Care PPO Advantage Plan

PSTA offers two (2) dental insurance plans through Cigna to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the dental plans, please refer to the summary plan document or contact Cigna's customer service.

Dental Insurance Premiums
Cigna Dental PPO Advantage Plan

26 Bi-Weekly Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Bi-Weekly Deductions	Employer Bi-Weekly Contribution
Employee Only	$4.86	$6.43
Employee + 1	$15.62	$6.43
Employee + Family	$32.15	$6.43

In-Network Benefits

The PPO plan provides benefits for services received from in-network and out-of-network providers. It is also an open access plan which allows for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plan utilizes is the Cigna Advantage Network. These participating dental providers have contractually agreed to accept Cigna's contracted fee or "allowed amount." This fee is the maximum amount a Cigna dental provider can charge a member for a service. The member is responsible for a Plan Year Deductible (PYD) and then coinsurance based on the plan's charge limitations.

Please Note: *If employee is not able to use a Cigna Advantage Dental Provider, employee may receive services from a Cigna Dental DPPO Provider. DPPO Providers are considered out-of-network dentists. This group of providers have agreed to charge no more than the Dental DPPO Provider's "Approved Amount" however, DPPO Providers may balance bill members the difference of the Advantage Network's Contracted Fee and the DPPO's approved amount. Employee is responsible for verifying whether the treating dentist is an Advantage Dentist or a PPO Dentist.*

Out-of-Network Benefits

Out-of-network benefits are used when members receive services by a non-participating Cigna Dental PPO Advantage Plan provider. Cigna reimburses out-of-network services based on what it determines is the Maximum Reimbursable Charge (MRC). The MRC is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member will pay the out-of-network benefit plus the difference between the amount Cigna reimburses (MRC) for such services and the amount charged by the dentist. This is known as balance billing. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Plan Year Deductible

The dental PPO plan requires a $50 individual or a $150 family deductible to be met for in-network or out-of-network services before most benefits will begin. The deductible is waived for preventive services.

Plan Year Benefit Maximum

The maximum benefit (coinsurance) the dental PPO plan will pay for each covered member is $1,000 for in-network and out-of-network services combined. All services, including preventive services accumulate towards the benefit maximum.

Cigna | Customer Service: (800) 244-6224 | www.cigna.com

Cigna Dental Care PPO Advantage Plan At-A-Glance

Network	PPO Advantage	
Plan Year Deductible (PYD)	**In-Network**	**Out-of-Network***
Per Member	$50	
Per Family	$150	
Waived for Class I Services?	Yes	
Plan Year Benefit Maximum		
Per Member *(Includes Class I Services)*	$1,000	
Class I Services: Diagnostic & Preventive Care		
Routine Oral Exam *(1 Every 6 Months)*	Plan Pays: 90% Deductible Waived	Plan Pays: 90% Deductible Waived *(Subject to Balance Billing)*
Routine Cleanings *(1 Every 6 Months)*		
Bitewing X-rays *(4 Films)*		
Class II Services: Basic Restorative Care		
Fillings *(Amalgam and Composite)***	Plan Pays: 70% After Deductible	Plan Pays: 70% After PYD *(Subject to Balance Billing)*
Complete X-rays		
Simple Extractions		
Root Canal Therapy/Endodontics		
Periodontics		
Emergency Care to Relieve Pain		
Class III Services: Major Restorative Care		
Oral Surgery *(Except Simple Extractions)*	Plan Pays: 50% After Deductible	Plan Pays: 50% After Deductible *(Subject to Balance Billing)*
Anesthetics		
Crowns		
Bridges		
Dentures		
Class IV Services: Orthodontia		
Lifetime Maximum	$1,000	
Benefit *(Dependent Children Up To Age 19)*	50% After Deductible	50% After Deductible *(Subject to Balance Billing)*

Locate a Provider

To search for a participating provider, contact Cigna's customer service or visit www.cigna.com When completing the necessary search criteria, select **PPO Advantage** network.

Plan References

***Out-Of-Network Balance Billing:** For information regarding out-of-network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the out-of-network benefits section on the previous page.*

***Restrictions may apply to composite fillings.*

Important Notes

- *Each covered family member may receive up to two (2) cleanings per plan year. Each cleaning must be six (6) months apart from one another.*
- *Late entrant provisions, age limitations and waiting periods may apply.*
- *Missing Tooth Clause - Teeth missing prior to coverage with Cigna are not covered.*
- *Pre-treatment review is recommended when dental services are expected to exceed $500. Members must request that the dentist submit the pre-treatment review to Cigna, since it is recommended and not required.*

Vision Insurance

Advantica Select Plus 150 Plan

PSTA offers vision insurance Advantica to benefit-eligible employees. The costs per pay period for coverage are listed in the premium table below and a brief summary of benefits is provided on the following page. For more detailed information about the vision plan, please refer to the summary plan document or contact Advantica's customer service.

Vision Insurance Premiums
Advantica Select Plus 150 Plan
26 Bi-Weekly Payroll Deductions - Per Pay Period Cost

Tier of Coverage	Employee Bi-Weekly Deductions	Employer Bi-Weekly Contribution
Employee Only	$0.00	$2.04
Employee + Family	$3.30	$2.04

In-Network Benefits

The vision plan offers employee and covered dependent(s) coverage for routine eye care, including eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered employee and dependent(s) can select any network provider who participates in the Advantica Vision Network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Employee and covered dependent(s) may also choose to receive services from vision providers who do not participate in the Advantica Vision Network. When going out of network, the provider will require payment at the time of appointment. Advantica will then reimburse based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Plan Year Deductible

There is no plan year deductible.

Plan Year Out-of-Pocket Maximum

There is no out-of-pocket maximum. However, there are benefit reimbursement maximums for certain services.

Advantica | Customer Service: (866) 425-2323 | www.advanticabenefits.com

Advantica Select Plus 150 Plan At-A-Glance

Network	Select Plus 150	
Services	**In-Network**	**Out-of-Network**
Eye Exam	$10 Copay	Up to $40 Reimbursement
Contact Lense Exam *(Fitting and Follow-up)*	$40 Allowance	No Reimbursement
Frequency of Services		
Examination	12 Months	
Lenses	12 Months	
Frames	24 Months	
Contact Lenses	12 Months	
Lenses		
Single	$10 Copay	Up to $20 Reimbursement After $10 Copay
Bifocal	$10 Copay	Up to $40 Reimbursement After $10 Copay
Trifocal	$10 Copay	Up to $60 Reimbursement After $10 Copay
Frames		
Non-Special Frame Selection	Up to $150 Allowance *(Less $10 Copay)*	Up to $60 Reimbursement After $10 Copay *(No Copay if Included with Lenses)*
Contact Lenses*		
Non-Elective *(Medically Necessary; Prior Authorization Required)*	Up to $250 Allowance After $10 Copay	Up to $250 Reimbursement After $10 Copay
Elective *(Fitting, Follow-up & Lenses)*	Up to $150 Allowance After $10 Copay	Up to $80 Reimbursement After $10 Copay

Locate a Provider

To search for a participating provider, contact Advantica's customer service or go to www.advanticabenefits.com. When completing the necessary search criteria, select **Advantica Vision** network.

Plan References

** Contact lenses are in lieu of spectacle lenses and a frame. The allowance/reimbursement amount is paid only once during the benefit period and must be fully utilized at the time of purchase.*

Important Notes

- *Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.*

Flexible Spending Account

PSTA offers Flexible Spending Accounts (FSA) administered through Cigna. The FSA plan year is from January 1 to December 31.

If employee or family member(s) have predictable health care or work-related day care expenses, then employee may benefit from participating in an FSA. An FSA allows employee to set aside money from employee's paycheck for reimbursement of health care and day care expenses they regularly pay. The amount set aside is not taxed and is automatically deducted from the employee's paycheck and deposited into the FSA. During the year, employee has access to this account for reimbursement of some expenses not covered by insurance. Participation in an FSA allows for substantial tax savings and an increase in spending power. Participating employee must re-elect the dollar amount to be deducted each plan year.

The County offers: Health Care Reimbursement FSA, Limited Purpose FSA, and Dependent Care Reimbursement FSA

- **Health Care Reimbursement FSA:** Available to eligible employees who are **not** enrolled in the Option 3 with an HSA. The Health Care FSA covers medical, dental, and vision expenses that are not paid by insurance.
- **Limited Purpose FSA:** Available to eligible employees who are enrolled in the Option 3 with an HSA. A Limited Purpose Health FSA may be used for qualified dental, vision and hearing expenses.
- **The Dependent Care FSA:** Covers day care expenses for qualified dependents necessary for employee and legal spouse, if married, to work.

Health Care FSA

This account allows participant to set aside up to an annual maximum of $2,600. This money will not be taxable income to the participant and can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs. Participating employee can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic).

Examples of common expenses that qualify for reimbursement are listed below.

Please Note: The entire Health Care FSA election is available for use on the first day coverage is effective.

Dependent Care FSA

This account allows participants to set aside up to an annual maximum of $5,000 if single or married and file a joint tax return ($2,500 if married and file a separate tax return) for work-related day care expenses. Qualified expenses include day care centers, preschool, and before/after school care for eligible children and adults.

Please note, if family income is over $20,000, this reimbursement option will likely save participants more money than the dependent day care tax credit taken on a tax return. To qualify, dependents must be:

- A child under the age of 13, or
- A child, spouse or other dependent that is physically or mentally incapable of self-care and spends at least eight (8) hours a day in the participant's household.

Please Note: Unlike the Health Care FSA, reimbursement is only up to the amount that has been deducted from the participant's paycheck for the Dependent Care FSA.

A sample list of qualified expenses eligible for reimbursement include, but not limited to, the following:

- ✓ Ambulance Service
- ✓ Chiropractic Care
- ✓ Dental and Orthodontic Fees*
- ✓ Diagnostic Tests/Health Screenings*
- ✓ Physician Fees and Office Visits
- ✓ Drug Addiction/Alcoholism Treatment*
- ✓ Experimental Medical Treatment
- ✓ Corrective Eyeglasses and Contact Lenses*
- ✓ Hearing Aids and Exams*
- ✓ Injections and Vaccinations*
- ✓ LASIK Surgery*
- ✓ Mental Health Care
- ✓ Nursing Services
- ✓ Optometrist Fees*
- ✓ Prescription Drugs
- ✓ Medically Necessary Sunscreen
- ✓ Wheelchairs

**These items are eligible expenses under the Limited Purpose FSA.*

Log on to http://www.irs.gov/publications/p502/index.html for additional details regarding qualified and non-qualified expenses.

Flexible Spending Account *(Continued)*

FSA Guidelines

- Employee may roll over $500 of unused Health Care FSA funds into the next plan year after a plan year ends and all claims have been filed. Dependent Care funds cannot be carried over.
- The Health Care FSA has a run out period at the end of the year (90 days) to submit reimbursement on eligible expenses incurred during the period of coverage within the plan year (January 1 through December 31).
- Any unused funds, after a plan year ends and all claims have been filed, cannot be returned or carried forward to the next plan year.
- When a plan year ends and all claims have been filed, with the exception of the $500 rollover for the Health Care FSA, all unused funds will be forfeited and will not be returned.
- Employee can enroll in either or both of the FSAs only during the open enrollment period, a qualifying event or new hire eligibility.
- Money cannot be transferred between FSAs.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot be reimbursed for services not received.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses reimbursed through an FSA.
- Domestic Partners are not eligible as federal law does not recognize them as a qualified dependent.

Filing a Claim

Claim Form

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

Debit Card

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. Cigna may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to PSTA. Additional or replacement cards may be requested, however, a small fee may apply.

HERE'S HOW IT WORKS!

Employee earning $30,000 elects to place $1,000 into their FSA Health Care Savings Account, with payroll deductions being $38.46 based on a 26 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.

	With a Health Care FSA	Without a Health Care FSA
Salary	$30,000	$30,000
FSA Contribution	- $1,000	- $0
Taxable Pay	$29,000	$30,000
Estimated Tax 22.65% = 15% + 7.65% FICA	- $6,568	- $6,795
After Tax Expenses	- $0	- $1,000
Spendable Income	$22,432	$22,205
Tax Savings	**$227**	

Please Note: *Be conservative when estimating medical and/or dependent care expenses. IRS regulation states any unused funds which remain in a FSA, after a plan year ends and after all claims have been filed, cannot be returned or carried forward to the next plan year with the exception of the $500 carry over allowed for the Health Care FSA. This rule is known as "use it or lose it."*

Contributing to an FSA account, whether Health or Dependent Care, will reduce the amount of reported salary to the Social Security Administration. Please read all IRS issued publications regarding this benefit.

Cigna | Customer Service: (800) 244-6224 | www.cigna.com

Basic Life and AD&D Insurance

Basic Term Life

PSTA provides Basic Term Life insurance for all benefit-eligible employees through Minnesota Life, at no cost to employee. All eligible employees are covered for an amount equal to one (1) times employee's annual earnings, rounded to the next higher multiple of $1,000, not to exceed $200,000. Coverage is reduced to 75% at age 75. Age reductions occur based on employee's age at the beginning of the calendar year.

Accidental Death & Dismemberment

Also at no cost to employee, PSTA provides Accidental Death & Dismemberment (AD&D) insurance, which pays in addition to the Basic Life benefit when death occurs as a result of an accident. The AD&D benefit amount equals the Basic Term Life benefit and follows the same age reduction schedule.

Always remember to keep beneficiary forms updated. Employees may update beneficiary information at anytime in BenTek.

Voluntary Life and AD&D Insurance

Eligible employee may elect to purchase additional life insurance on a voluntary basis through Minnesota Life. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages. Voluntary Life Insurance offers coverage for employee, spouse or child(ren) at different benefit levels.

Voluntary Employee Life and AD&D Insurance

- Units can be purchased in increments of one time or two times employee's annual earnings, rounded to the next higher $1,000, not to exceed $300,000.
- All increases in Voluntary Life require Evidence of Insurability.
- Voluntary AD&D coverage matches the Voluntary Life amount elected.

New Hires may purchase Voluntary Employee Life insurance without having to go through Medical Underwriting, also known as Evidence of Insurability (EOI), **to the Guaranteed Issue amount of up to two times employee's annual earnings (not to exceed $300,000)**.

Spouse/Dependent Term Life Insurance

- Spouse Coverage: $5,000 to a maximum of $150,000. If employee elects coverage in excess of $25,000 (Guaranteed Issue), the excess will be subject to medical underwriting approval.
- A spouse is not eligible if they are eligible as an employee.
- Employee may purchase coverage for employee's unmarried child(ren), from six (6) months up to age 21, or to age 25 if a full-time student, in the amount of a $10,000 benefit.
- Child(ren) under six (6) months may be covered for a $1,000 benefit.
- Coverage for dependent child(ren) is $1.30 per month regardless of the number of children covered.

Please Note: *Rate changes will be effective January 1 each year; however, deductions will begin with the corresponding pay period.*

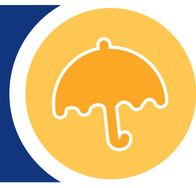
Employee/Spouse Voluntary Life/AD&D Monthly Rate Table

Rate Per $1,000 of Benefit

Age Bracket *(Based On Employee Age)*	Voluntary Life Rate
Under 35	$0.145
35-39	$0.165
40-44	$0.205
45-49	$0.285
50-54	$0.425
55-59	$0.715
60-64	$0.955
65-69	$1.465
70-74	$1.905
75+	$1.905

Minnesota Life

Customer Service: (800) 392-7295 | www.minnesotalife.com



Long Term Disability

All benefit-eligible PSTA employees can purchase Long-Term Disability (LTD) through the Hartford. The LTD benefit pays employee a percentage of gross monthly earnings if employee becomes disabled due to an illness or non-work related injury. Please see the Benefits Department for more information or to enroll in the plan. A summary of the plan's benefits is provided below.

Long Term Disability (LTD) Benefits

- The LTD benefit pays 60% of employee's monthly earnings up to a monthly maximum of $10,000.
- Employee must be disabled for 60 days prior to becoming eligible for the LTD benefit (benefits would begin on the 61st day).
- If employee returns to work on a part-time basis, employee may continue to be eligible for partial benefits.
- Periodic evaluations will occur at the discretion of the Hartford.
- The duration of the LTD benefit payable is based on employee's age at the time the disabling event occurs.
- Benefits may be reduced by other income.

Nelson Benefits Group
Customer Service: (813) 948-7310 | www.nelsonbenefitsgroup.com

The Hartford
Customer Service: (888) 747-8814 | www.thehartford.com

Employee Assistance Program

A comprehensive Employee Assistance Program (EAP) is available to employee and each member of the employee's family through Bensinger, Dupont & Associates (BDA) at no cost. BDA offers access to licensed mental health professionals through a confidential program protected by State and Federal laws. The EAP program is available to assist in understanding problems that affect employee or family member, locate the best professional help for a particular concern and decide upon a plan of action. All EAP counselors are professionally trained and are certified and licensed. The EAP Plan provides up to five (5) confidential face-to-face counseling sessions with a Master's Level Clinician in the local area. If employee or family member requires long term therapy, employee will be referred to a qualified local resource to continue care. Master-level counselors are available 24 hours a day, seven (7) days a week.

What is an Employee Assistance Program?

An Employee Assistance Program (EAP) offers covered employee and family member(s) free and convenient access to a range of confidential and professional services to help them address a variety of problems that can negatively affect well-being such as:

- ✓ Anxiety
- ✓ Child & Elder Care
- ✓ Depression
- ✓ Life Improvement
- ✓ Family and/or Marriage Problems
- ✓ Stress
- ✓ Grief and Bereavement
- ✓ Legal & Financial Consultation

Are EAP Services Confidential?

Yes. Receipt of EAP services is completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), EAP will ask permission to communicate certain aspects of the employee's care (attendance at sessions, adherence to treatment plans, etc.) to the referring supervisor/manager. The referring supervisor will not, however, receive specific information regarding the referred employee's case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

Bensinger, DuPont & Associates (BDA)
Customer Service: (800) 272-2727 | www.bdaeap.com
Password: psta

Legal Insurance & Identity Theft Protection

Life Events Family Legal Plan

PSTA employees have the opportunity to enroll in a voluntary, pre-paid legal program provided by LegalShield. By enrolling in this plan, a participant will have direct access to attorneys who will provide legal assistance, for a variety of situations that include:

- ✓ Divorce
- ✓ Child Custody & Support
- ✓ Adoption
- ✓ Civil Litigation
- ✓ Bankruptcy
- ✓ Name Changes
- ✓ Criminal Defense
- ✓ Moving Traffic Tickets
- ✓ Wills & Living Trusts
- ✓ Real Estate
- ✓ Credit Report Issues
- ✓ Contract Review

Emergency legal access for covered situations is available 24 hours a day, seven (7) days a week.

The cost to the employee to participate in this legal plan is $15.95 per month. This includes coverage for the entire household including spouse and dependent child(ren) regardless of the number of eligible dependent(s) enrolled in the plan. Plan benefits include unlimited phone consultations.

Identity Theft Shield

LegalShield has also teamed up with Kroll Background America to offer comprehensive Identity Theft Monitoring AND Restoration Service. This plan will give employee and spouse access to credit reports, plus daily monitoring of employee credit report. If employee is a victim of identity theft, this membership will provide an investigator to help with the restoration process. This includes contacting the State DMV, the Medical Information Bureau, all three (3) Credit Repositories, Financial Institutions, the Social Security Administration, and even Criminal Records. This plan can be added to employee's legal plan for only $9.95 per month. This is not a stand alone plan, it can only be enrolled in if employee is currently enrolled or plans to enroll in the Legal Plan. Please note that the rate increases if at any point employee drops the Legal Plan but continues Identity Theft Sheild. To learn more, about the benefits of this plan, contact Craig & Virginia Miller by using the contact information provided below.

LegalShield
Customer Service: (800) 654-7757 | www.legalshield.com

Supplemental Insurance

Aflac offers a variety of voluntary supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction on a post-tax basis. Aflac pays money directly to employee, regardless of what other insurance plans employee may have. Dependents, up to age 26, may be included on any plan. To learn more about these Aflac plans and/or to schedule a personal appointment, contact the local Aflac agent. Details regarding available Aflac plans and services are also available online at www.aflac.com.

Available Aflac plans include coverages for:

- ✓ Accident Indemnity
- ✓ Cancer Care
- ✓ Hospital Care
- ✓ Critical Illness
- ✓ Term and Whole Life Insurance
- ✓ Short Term Disability

Aflac
Customer Service: (800) 992-3522 | www.aflac.com

Retirement Plan (FRS)

Florida Retirement System (FRS)

The Florida Retirement System is a state-administered retirement program for employees who are employed in regularly established positions. Employee may choose to participate in the FRS Pension Plan or the FRS Investment Plan. Employee must contribute 3% of gross compensation on a pre-tax basis toward retirement plan.

The **FRS Pension Plan** is a traditional, defined-benefit retirement plan. Vesting occurs after eight (8) years of service. Pension plan benefits are based on a formula that considers years of service, employee class participation and income history.

The **FRS Investment Plan** is a defined contribution plan where employee allocates employer and employee contributions to available investments. Vesting occurs after one (1) year of service. The benefit for this plan is based on how much money is contributed to an employee's account and how well that money grows over time when invested.

For further information regarding the FRS Pension or Investment Plan, please contact customer service or visit www.myfrs.com.

Florida Retirement System
Customer Service (Toll Free): (844) 377-1888
Customer Service: (850) 907-6500 | Fax: (850) 410-2010
www.myfrs.com

Deferred Compensation Plan

The 457 Deferred Compensation Programs allows employee to set aside tax deferred dollars toward retirement savings through automatic payroll deductions. The ICMA accounts are offered to all benefit-eligible employees. There is no employer matching for this program.

The money contributed into this type of account, including earnings; accumulate on a tax deferred basis. Employee can consolidate retirement savings by rolling other eligible retirement assets into this type of account.

For further information, please contact ICMA's customer service or the Benefits Department.

ICMA Retirement Corporation
Customer Service: (800) 669-7400 | www.icmarc.org

Authority Programs

Direct Deposit

PSTA operates a direct deposit payroll system, which allows employee to authorize automatic payroll deposits into checking or savings accounts. To enroll in direct deposit, complete an Enrollment Authorization form, available at the Benefits Department. Once account information has been verified, pay will automatically be deposited, and employee will receive a non-negotiable pay stub via email summarizing payroll information for that period.

Employee's pay may be deposited into three (3) different financial institutions, if employee so chooses; however, the entire amount of pay will be direct deposited with no portion presented in check form.

Changes to direct deposit can be made at any time, by visiting the Benefits Department.

Fitness Center

PSTA employees may join the on-site Fitness Center, where staying in shape is convenient and inexpensive. The Fitness Center is located on the second floor of the Operations Building, and includes various machines, free weights and other exercise equipment. It also has a television and current selection of fitness magazines to keep employee entertained and provide information on workouts and fitness strategies.

Membership is available to employees only, for a cost of $5.00 per month. There is no contract term, so employee may start or stop membership at any time. Visit the Benefits Department department to learn more, or to join.

YMCA Partnership

PSTA has partnered with YMCA of Pinellas County to offer a special membership deal for employees. Join YMCA, bring proof of PSTA employment (ID badge or paystub), and YMCA will waive the join fee, and give a 10% off monthly membership fees. If employee is already a YMCA member, go to the local branch and ask to be added to the corporate member group under PSTA to start receiving the 10% discount. Visit www.ymcatampabay.org for locations and hours of operation.

Health Advocacy

PSTA is proud to provide full-time employees, that are covered under the medical plan, access to Health Advocate. This service helps resolve claims issues and navigate through the complexities of the health care system at no cost!

- Working with a team of doctors and nurses, Health Advocate will help members get the most from their health care experience, saving time, stress, hassle and frustration.
- Health Advocate understands the health care system clinically and the ins and outs of the rules and procedures.
- Health Advocate is objective and independent and provide members the privacy and confidentiality as needed.
- Employee may use the services of Health Advocate for employee, spouse, child(ren), parent(s) and spouse's parent(s).

Employee can call as often as they wish, at no cost. Feel free to check out the website at www.HealthAdvocate.com/members or call: 1-866-799-2728.

Below are a few of the many services that Health Advocate can assist with:

- Resolve eligibility problems and benefit and claims issues.
- Find the appropriate doctors and hospitals/schedule appointments with hard to reach specialists.
- Identify renowned medical institutions regarding serious illness or injury.
- Location and coordination of varied medical/health related services.
- Locate/navigate services for eldercare.
- Coordinate benefits between physicians and with insurance companies.
- Secure second opinions to help provide peace of mind.
- Coordinate care for a member with complicated medical issues.

Health Advocate
Customer Service: (866) 799-2728 | www.healthadvocate.com/member

COBRA Premiums

PSTA offers COBRA coverage for medical, dental and vision benefits if coverage is terminated or changed due to a qualifying event. The monthly premium rates are listed below. For more information, contact the Benefits Department.

COBRA Monthly Cigna Option 1 Plan Premiums

Tier of Coverage	Monthly Premium
Employee Only	$1,132.39
Employee + Spouse	$1,736.37
Employee + Child(ren)	$1,457.15
Employee + Family	$1,902.74

COBRA Monthly Cigna Option 2 Plan Premiums

Tier of Coverage	Monthly Premium
Employee Only	$1,049.71
Employee + Spouse	$1,608.83
Employee + Child(ren)	$1,350.36
Employee + Family	$1,762.84

COBRA Monthly Cigna Option 3 Plan Premiums

Tier of Coverage	Monthly Premium
Employee Only	$1,000.58
Employee + Spouse	$1,532.20
Employee + Child(ren)	$1,286.43
Employee + Family	$1,678.64

COBRA Monthly DHMO Dental Premiums

Tier of Coverage	Monthly Premium
Employee Only	$14.22
Employee + 1	$23.98
Employee + Family	$40.42

COBRA Monthly DPPO Dental Premiums

Tier of Coverage	Monthly Premium
Employee Only	$24.96
Employee + 1	$48.74
Employee + Family	$85.26

COBRA Monthly Vision Premiums

Tier of Coverage	Monthly Premium
Employee Only	$4.50
Employee + Family	$11.78

Notes

Use this section to make notes regarding personal benefit plans or to keep track of important information such as doctor's names and addresses or prescription medications.

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