BREVARD PUBLIC SCHOOLS

COBRA BENEFITS

2023 COBRA INSURANCE BENEFITS GUIDE

CUSTOMER SERVICE INFORMATION

Brevard Public Schools
Office of Employee Benefits
Mon-Fri, 8:00am – 4:30pm ET
1-321-633-1000, x11216
www.brevardschools.org

TASC
Mon-Fri, 8:00am – 5:00pm ET
Toll free phone: 1-800-422-4661
Toll free fax: 1-608-663-2753

Benefits Education Call Center
Mon-Fri, 9:00am – 8:00pm ET
321-800-4490

Medical & Pharmacy & Mental Health
CIGNA -Third-party Administrator (TPA) for
Brevard Public Schools Health Plan
1-800-244-6224
www.cigna.com

Dental
Humana Dental Care
Member Services
1-800-233-4013
www.humana.com

Vision
Humana Vision Care
Member Services
1-877-398-2980
www.humana.com

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IMPORTANT ENROLLMENT INFORMATION

For more information, contact TASC/Total Administrative Services Customer Service at tool free phone: 1-800-422-4661, Monday through Friday, 8:00 a.m. – 5:00 p.m. ET

Who is Eligible?
Under certain qualifying events, covered employees may be eligible for continuation of group health plans coverage under COBRA law. Please contact TASC Customer Service at 1-800-422-4661 for more information.

COBRA Coverage
A Qualified Beneficiary's (QB) period of coverage is January 1 through December 31 unless a QB's scheduled COBRA expiration date is sooner. QBs who have elected to continue eligible group health plans under COBRA will be given the same opportunity to change coverage options, add or drop eligible dependents at Open Enrollment as similarly-situated active employees and beneficiaries.

A QB's Medical Expense FSA will not be continued beyond the plan year in which the qualifying COBRA event occurs.

HIPAA's special enrollment rights may apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add dependents if such person acquires a new dependent or if an eligible dependent declines coverage because of alternative coverage and later loses such coverage due to certain qualifying reasons. Spouse or dependents who are added under this law do not become Qualified Beneficiaries—and their coverage will end at the same time coverage ends for the person who elected COBRA and later added them. If there's a loss of coverage for a group health plan, due to one of the triggering events below, then COBRA rights may have been created:

For Covered Employees upon:

- Termination of employment (other than for gross misconduct) or
- A reduction in hours of employment

For Spouses or Dependent Child(ren) upon:

- A covered employee's termination of employment (other than for gross misconduct)
- A covered employee's reduction in hours of employment
- A covered employee's death
- A divorce or legal separation (if recognized by state law) of a spouse from a covered employee
- A covered employee's entitlement to Medicare, or
- A child's loss of dependent status

Medicare and COBRA
A voluntary drop of coverage in favor of Medicare enrollment is not a COBRA qualifying event and does not entitle your dependents to elect COBRA or extend their continuation timeframe.

Contact the medical plan administrator with questions regarding interaction between Medicare and COBRA coverage and refer to your COBRA Election Notice for related information.

Method of Payment
A COBRA Participant's initial payment, including all back premiums, is due within 45 days of COBRA continuation election. Subsequent monthly premium payments are due on the first of every month. COBRA law allows for a 30-day grace period after the due date for monthly payments. If a full premium payment is not received from a COBRA Participant by 30 days after the due date, COBRA coverage will be cancelled retroactive to the first day of the month for which the full premium payment is due. A cancellation notice will be sent to the COBRA Participant if full premium payment is not received. Once coverage is cancelled for nonpayment it will not be reinstated.

The Brevard Public Schools Benefit Plan Year begins January 1 and ends December 31.

In 2023, BPS will continue its partnerships with Surgery Plus, Hinge Health, and Hello Heart, as well as with Marathon Health for the employee Well-Care Centers, and employees will have a choice between two medical plans: Gold and Silver.

The district remains committed to helping and supporting efforts toward good health. As such, Tobacco-use cessation coaching will continue to be offered. Also, completing the two wellness activities – an **ANNUAL PHYSICA**L (which now *replaces* a biometric screening), and a Health Assessment at myCigna.com -- will result in substantial reductions to in-network medical plan deductibles. You can have an **Annual Physical** performed at any of our Well-Care Centers at no cost to you. You may also have an **Annual Physical** (which *replaces* a biometric screening) completed by your own doctor. If using an In-network doctor, the Annual Physical is at no cost to you. August 31, 2023 is the deadline to complete the two wellness activities for a reduced 2024 medical plan deductible.

Benefits education will be available throughout the new plan year:

- The Benefits Education & Call Center counselors are available to answer any question you may have about your benefits and/or to explain them to you overall. Their number is 321.800.4490 and their hours are 9am to 8pm Monday – Friday.

- Cigna (our medical and Rx plan administrator) may at times reach out to you by US mail, e-mail, or phone to offer cost-effective services and programs available to you as a plan member. In many instances, the information will be customized just for you. We encourage you to engage in their outreach efforts; you may be pleasantly surprised at what you learn.

This guide highlights the options available to you as a COBRA continued-coverage participant and includes rates and vendor contact information. Please don't hesitate to use the contact information to reach representatives who can help ensure you get the most value for your benefit dollar.

Your Employee Benefits & Risk Management Team

2023 MEDICAL PLAN OPTIONS

CIGNA

TYPE OF SERVICE	Gold Plan Cigna's Open Access Plan In-network	Gold Plan Out-of-network	Silver Plan Parrish & Steward Hospital Systems & their Affiliates plus Independent Physicians in Brevard County and all Cigna Ancillary[1] Providers Schedule 1	Silver Plan Health First & other Cigna network providers (excluding Schedule 1 providers), plus Non-network providers Schedule 2
Annual Deductible (Indiv/Fam)	Wellness: $1,500/$3,000	Wellness: $3,000/$6,000	Wellness: $750/$1,500	Wellness: $1,250/$2,500
	1/2 Wellness: $2,000/$4,000	1/2 Wellness: $4,000/$8,000	1/2 Wellness: $1,250/$2,500	1/2 Wellness: $2,250/$4,500
	Non-Wellness: $2,500/$5,000	Non-Wellness: $5,000/$10,000	Non-Wellness: $1,750/$3,500	Non-Wellness: $3,250/$6,500
Coinsurance (mbr paid)	20%	50%	20%	40%
Annual out-of-pocket Maximum (Indiv/Fam)	$5,500/$11,000 (Medical)	$12,500/$25,000 (Medical)	$4,500/$9,000 (Medical)	$6,500/$13,000 (Medical)
OFFICE VISITS				
Primary Care office visit	Tier 1*: $30/ Non-Tier 1: $45	50% AD[3]	$30	40% AD
Specialist office visit	Tier 1*: $50/ Non-Tier 1: $75	50% AD	$50	40% AD
BPSEmployee Well-Care Centers	$0	Not Covered	$0	Not Covered
Preferred Health Center	$30	Not Covered	$30	Not Covered
Advanced Radiology/ Outpatient Facility at a Preferred Facility	$200	50% AD	$125	40% AD
HOSPITAL SERVICES				
Inpatient Hospital	$900 copay + 20% AD	50% AD	$600 copay + 20% AD	40% AD
Outpatient Surgery	20% AD	50% AD	20% AD	40% AD
EMERGENCY & LAB				
Emergency Room	$450 copay + 20% AD		$300 copay+ 20% AD	
Urgent Care	$75	$75	$50	$50
Major Diagnostics (CT/ PET scans, MRI) Outpt/ Non-preferred	20% AD	50% AD	20% AD	40% AD

NOTES:

*Tier 1 = For lower copay, provider must have the Tier 1 symbol — ✓ Tier 1 Provider next to their name in Cigna's provider directory.

1. Ancillary Providers, e.g., labs, imaging centers, and outpatient surgical facilities
2. "Non-contracted" means has no contract with Cigna
3. AD = After Deductible

This schedule is subject to change. This benefit summary is for informational purposes and is not to be construed as a contract or complete analysis of the coverage. The provisions of the actual policy as described in the Summary Plan Description (SPD) will prevail. The SPD can be found on the BPS Benefits website: www.brevardschools.org/Page/18699

CIGNA PHARMACY SERVICES

PHARMACY BENEFITS	In-network	Out-of-network	In-network	Out-of-network
Separate Out-of-Pocket Maximum (OOPM)	Indiv/Family: $2,200/$4,400	Not Covered	Indiv/Family: $2,200 /$4,400	Not Covered
Generic	$20	Not Covered	$20	Not Covered
Preferred Brand	$50	Not Covered	$50	Not Covered
Non-Preferred Brand	$150	Not Covered	$150	Not Covered
Mail Order Pharmacy	2x 30-day Retail	Not Covered	2x 30-day Retail	Not Covered

Cigna Home Delivery Pharmacy

Using Cigna Home Delivery Pharmacy[SM] is an easy, reliable way to get your medications. In most cases, your cost will be lower than at a retail pharmacy.

Benefits of Cigna Home Delivery Pharmacy

Home Delivery is designed especially for individuals who take prescription medications on an ongoing basis.

When you choose Cigna Home Delivery Pharmacy to fill your ongoing medications, you can take advantage of the following:

- Licensed pharmacists available 24/7.
- Save money and valuable time by ordering up to a 90-day supply of your prescriptions at one time.
- Standard delivery to your home or other location at no additional cost.
- Reminders if you forget to refill your prescriptions.

Cigna Specialty Pharmacy is for specialty medications which are different from traditional pharmacy medications. They are used to treat long-term, life-threatening or rare conditions. To find out more about specialty medications, to download the prescription form, and to watch a video with additional pharmacy coverage information, visit www.Cigna.com.

For additional information regarding pharmacy benefits and services, call CIGNA at 1-800-244-6224.

Frequently Asked Questions and Answers

What is Calendar-Year-Deductible (CYD)?

The amount you must pay before the BPS Health Plan will begin paying anything. This only applies if you use an out-of-network provider. You will pay this once per plan year.

What is a Copay?

A flat fee you pay at the time you receive a medical service. For example, if you visit your in-network primary care doctor, you might pay $30, i.e., a flat dollar amount for that office visit. The remaining balance will be paid by the BPS

What is Coinsurance?

A percentage of the total allowed charge that you must pay. For example, if the in-network allowed charge is $100 and your coinsurance is 20%, you will pay $20, which is 20% of $100, and the BPS Health Plan will pay the remaining $80 balance.

What is the Out-Of-Pocket (OOP) Maximum?

This is the maximum amount of money you are required to pay in copays, deductibles, and coinsurance for covered medical services during the plan year. Once you reach this level during any plan year, the BPS Health Plan will cover all necessary medical expenses at 100% for the remainder of the plan year. Please note that pharmacy copays do not apply to the medical out-of-pocket maximum.

Who is included in the Calendar-Year-Deductible and Out-of-Pocket (OOP) Maximum when you refer to an "Individual" or "two or more"?

To fulfill the requirements of the CYD and/or OOP Maximum, an individual BPS Health Plan member must incur the total amount for the "Individual." However, when you cover "two or more" members through the BPS Health Plan, any combination of incurred amount by any member will count toward the total amount.

An example of reaching the in-network two or more OOP Maximum of $6,000 would be: Mary covers her spouse, John, her son, Joe, and her daughter, Jane, under the BPS Health Plan. Mary incurs $1,500 of coinsurance and copay charges. John incurs $2,000, Joe incurs $2,000 and Jane incurs $500. The plan will now pay 100% of all in-network covered services for the remainder of the plan year. Using the same family, an example of reaching the in-network individual OOP Maximum of $3,000 would be: Mary incurs $1,500 of coinsurance and copay charges, John incurs $500, Joe incurs $3,000 and Jane incurs $250. In this case, the plan will pay 100% of all in-network covered services for the remainder of the plan year for JOE ONLY until Mary, John, and Jane incur $750 more in combined charges to reach the $6,000 two or more OOP Maximum.

What is meant by the Out-of-network Maximum Reimbursable Charge?

The Maximum Reimbursable Charge (MRC) is determined by the Third-Party Administrator (TPA), CIGNA. The MRC is based on the average provider charges for the area and it is the amount that is used to determine your coinsurance and the amount that will be paid by the plan. The MRC is not always the total amount billed by the out-of-network provider. You may be liable for the difference between the MRC and the billed charges.

How are laboratory and x-ray services charged to the member?

Allowed in-network laboratory expenses are paid by the plan after the office visit copay is paid. This includes labs done in the physician's office or at an in-network laboratory facility. Out-of-network labs are subject to coinsurance after the CYD. Allowed in-network x-rays performed in a physician's office are paid by the plan after the office visit copay is paid. X-rays performed at an in-network facility will be subject to In-network coinsurance; out-of-network x-rays are subject to the out-of-network coinsurance after the CYD.

DENTAL — PPO

HUMANA

Humana®

www.humana.com

Member Services: 800.233.4013

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less. **If you choose an out-of-network provider, you may be billed the difference between what Humana pays, and what your out-of-network provider charges for the services**. To locate an in-network provider, please visit www.humana.com.

	Low PPO Plan		High PPO Plan	
	Member Pays			
	In-network	Out-of-network	In-network	Out-of-network
Annual deductible(Individual/Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual maximum (per person)	$750	$750	$1,250	$1,250
Diagnostic and preventive care Includes cleanings, fluoride treatments, sealants and x-rays	0%	0%	0%	0%
Basic services Includes fillings, periodontics, scaling and root planning, and oral surgery	30% AD	30% AD	20% AD	20% AD
Major services Includes crowns, bridges and full and partial dentures	60% AD	60% AD	50% AD	50% AD
Orthodontia	60% AD	60% AD	50% AD	50% AD
Orthodontia Lifetime maximum	$1,000	$1,000	$1,000	$1,000
Non-network reimbursement	N/A	UCR 90th (Preventive/ UCR 80-85 (Basic & Major)	N/A	Maximum Allowable Fee

Plan includes out-of-network benefits, see plan summary for additional details.

Program Features:

- 4 cleanings per year
- 4 periodontal cleanings covered 100% 4 times per year
- Extended maximum: If you meet your dental plan maximum and you need additional dental services within the plan year, you will receive a discount rather than paying 100% out-of-pocket.

DENTAL — HMO

HUMANA

Humana.

www.humana.com

Member Services: 800.233.4013

To locate an in-network provider, please visit www.humana.com. When enrolling for this this plan, you'll need to put the put the office ID number of your selected office in the designated field of the enrollment screen. **IMPORTANT:** Office Visit copay ($15 Low plan; $10 High plan) will be charged even if service received is listed at No Charge.

	Low DHMO Plan	High DHMO Plan
	Member Pays	
	In-network	In-network
Calendar Year Deductible	None	None
Calendar Year Maximum/Member	None	None
Preventative Services	See Schedule	See Schedule
Cleanings	No Charge	No Charge
Cleaning Frequency	Twice in any 12 calendar months	Twice in any 12 calendar months
Oral Exams	No Charge	No Charge
Sealants (age restrictions)	$20 copay, up to age 16	$15 copay, up to age 16
Fluoride	No Charge, for child up to age 16 (limited to twice in any 12 calendar months)	No Charge, for child up to age 16 (limited to twice in any 12 calendar months)
Bitewing – four images	No Charge (limited to twice in any 12 calendar months)	No Charge (limited to twice in any 12 calendar months)
Basic services	See Schedule	See Schedule
Fillings (one surface)	$45	$35
Space Maintainers	$95	$75
Extractions	$60	$55
Crown	$410	$350
Root Canal	$390	$310
Major services	See Schedule	See Schedule
Bridges	$410	$350
Dentures	$550	$475
Inlay (two surface)	$380	$320
Onlay (two surface)	$395	$335
Implants	Not Covered	Not Covered
Orthodontia services	See Schedule	See Schedule
Orthodontia(Child/Adult)	Orthodontic Treatment $1,900	Orthodontic Treatment $1,900

You can find the benefit schedules for the DHMO plans at the district's benefits page: www.brevardschools.org/Page/3511

DENTAL — HMO

HUMANA

How to Find a Primary Dentist – Go to www.Humana.com

1. Choose "Shop for Plan" and click "Find a Dentist" from the drop down menu.
2. Click "Find a Dentist"
3. Enter your in Zip Code
4. Choose "Look up by Coverage Type". For the PPO, select PPO/Traditional Preferred.

For the Low DMO, select HD215 DHMO/Prepaid Network. For the High DHMO, select HS210 DHMO/ Prepaid Network. 5. Search by Name or Specialty Dentist and the system will provide a list of dentists near you who are part of the network. **Pro-Tip**: Be sure to select a Dentists who is accepting new patients! Refer to page 34 for some FAQ's related to the DHMO plan.

If I am enrolled in the DHMO, what if I don't choose a Primary Care Dentist (PCD)?

You will receive a letter from Humana informing you that a PCD needs to be assigned. Your member ID card will indicate "unassigned" until you select a Primary Care Dentist. The member services phone number will be on the ID card. Any Primary Care Dentist requests received from a member who has never selected a facility, will be given an effective date of the first of the current month. If you select a Primary Care Dentist but choose to change it, it must be changed prior to the 15th of the month to be effective 1st of the following month. If you change the Primary Dentist after the 15th of the month, your new Primary Dentist selected will go into effect the 1st of the following next month. New ID cards are sent to members when adding or changing Primary Care Dentists.

VISION

HUMANA

Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around the Humana providers, who have higher benefits at a lower cost to you.

Humana

www.humana.com

Member Services: 877.398.2980

When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. To locate an in-network provider, wvisit www.humana.com.

	Basic Plan		Enhanced Plan	
	In-network	Out-of-network	In-network	Out-of-network
Examination (every 12 months)	100% after $0 copay	up to $35	100% after $0 copay	up to $35
Lenses	(every 24 months)		(every 12 months)	
Single	100% after $0 copay	$20	100% after $0 copay	$20
Bifocal		$40		$40
Trifocal		$60		$60
Frames	(every 24 months)		(every 12 months)	
New frames	$120 allowance	$30	$120 allowance	$30
Contact lenses	(every 24 months)		(every 12 months)	
Elective	$100 preferred	$100	$100 preferred	$100
Medically necessary*	Covered 100%	$100	Covered 100%	$150

* Medically necessary (prior authorization required) is defined as 1) following cataract surgery w/o intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/ or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life

PRIVACY NOTICE

This notice applies to products administered by TASC. TASC takes your privacy very seriously. As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of TASC. This notice explains how TASC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. TASC's privacy policyis as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. TASC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of informationcollected generally varies depending on the products or services you request and may include

- Information provided on enrollment and related forms— for example: name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, suchas products and services purchased transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, you have certain rights with respect to your protected health information. You have rights to see and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Plan in care of TASC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our Web site: www.tasconline.com. You have a right to a paper copy at any time. Contact TASC Customer Service at 1-888-869-2518.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic, and procedural safeguards for protecting personal information.

We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We may also disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator in response to a subpoena or to prevent fraud. We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from TASC that is to be used primarily for personal or family purposes.

NOTICE OF ADMINISTRATOR'S CAPACITY

PLEASE READ: This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder, and the insurer:

1. TASC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, TASC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. TASC is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. The insurance companies noted herein have been selected by your employer and are liable for the funds to pay your insurance claims. If TASC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against TASC than would otherwise be afforded to you by law. TASC is not an insurance company.

2023 Benefit Premiums for COBRA Participants Monthly

HEALTH	SILVER PLAN	GOLD PLAN
Medical BPS Health Plan – Employee Only	$ 762.48	$ 794.85
Medical BPS Health Plan - EE + Spouse	$ 1681.75	$ 1781.36
Medical BPS Health Plan - EE + Children	$ 1374.23	$ 1436.48
Medical BPS Health Plan - EE + 2 or more	$ 2292.28	$ 2404.33
Overage Dependent Charge	$ 358.88	$ 358.88
Spousal Surcharge	$ 250.00	$ 250.00
Tobacco Surcharge	$ 50.00	$ 50.00
DENTAL - HUMANA		
Dental PPO High – Employee Only	$ 30.95	
Dental PPO High - EE + 1	$ 62.46	
Dental PPO High - EE + 2	$ 92.25	
Dental PPO Low - Employee Only	$ 24.30	
Dental PPO Low - EE + 1	$ 49.13	
Dental PPO Low - EE + 2 or more	$ 72.68	
Dental DHMO High - Employee Only	$ 10.69	
Dental DHMO High - EE + 1	$ 21.15	
Dental DHMO High - EE + 2 or more	$ 37.62	
Dental DHMO Low – Employee Only	$ 6.52	
Dental DHMO Low - EE + 1	$ 12.90	
Dental DHMO Low - EE + 2 or more	$ 22.93	
VISION - HUMANA	**BASIC**	**ENHANCED**
Humana Vision – Employee Only	$ 4.00	$ 6.03
Humana Vision - EE + 1	$ 9.95	$ 14.98
Humana Vision - EE + 2 or more	$ 17.05	$ 25.69