



2014

St. Lucie County Schools

FLEXIBLE BENEFITS PLAN
REFERENCE GUIDE

2014 St. Lucie County Schools

What's New?

- **This is a mandatory enrollment. All employees of St. Lucie County Schools (SLCS) must enroll between October 7, 2013 and November 1, 2013.** Make an appointment to meet with a Professional Benefits Counselor or enroll online prior to November 1, 2013. To make an appointment, go to www.myenrollmentschedule.com/stlucie. If you do not enroll, you will not receive health benefits for plan year 2014.
- **The School District is now offering two BlueOptions Plans, including one that offers a high-deductible health plan.** Employees that choose the high-deductible health plan may also add a Health Savings Account (HSA).
- For the 2014 Plan Year only, SLCS will contribute \$750 to your HSA account as an incentive for you to take advantage of an HSA. You must enroll in the St. Lucie County Schools sponsored High Deductible Health Plan (BlueOptions 05180/05181) to receive this contribution.
- St. Lucie County Schools is now offering “dual employee” family health plan coverage. See page 14 for additional information about this benefit. The enrollment process is different from the standard procedure. You must enroll in the health plan together with a Professional Benefits Counselor. Please contact the Risk Management Office for instructions on scheduling your special enrollment session.
- BlueOptions 3748, 3769 and BlueChoice 706 are no longer available, effective January 1, 2014. If you are currently enrolled in one of these plans, you must choose from one of the two, other BlueOptions plans available for the 2014 Plan Year.
- SLCS has changed dental carriers. If you are currently enrolled in FCL Dental and wish to continue dental coverage, you must select the Delta Dental, Low or High PPO plan.
- **St. Lucie County Schools now offers Trustmark LifeEvents, Universal Life insurance which combines permanent life insurance and long-term care into one affordable product.**
- SLCS employees can also choose from two plan offerings in 2014 – Critical Illness or Accident insurance, offered through Trustmark. See pages 33-35 for more information.
- TransAmerica Universal Life and Long-Term Care are no longer available, effective January 1, 2014. Employees with existing Universal Life and Long-Term Care coverage through TransAmerica must contact the provider directly to increase or decrease coverage, purchase riders or cancel benefits.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 40 for more details.

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Enrollment at a Glance

Important Dates to Remember

Your Open Enrollment dates are:

October 7, 2013 through November 1, 2013.

Your Period of Coverage for Pre-Tax Benefits dates are:

January 1, 2014 through December 31, 2014.

Voluntary Benefits Period of Coverage for Post-Tax Benefits are:

February 1, 2014 through January 31, 2015.

Important Enrollment Information

- **Complete your enrollment online or with the assistance of a Professional Benefits Counselor by November 1, 2013. To make an appointment with a Professional Benefits Counselor, go to www.myenrollmentschedule.com/stlucie.**
- Attend your consultation with your Professional Benefits Counselor to learn about your flexible benefits. You may ask any plan questions at this time.
- Remember to bring all necessary dependent and beneficiary information to your enrollment session, including your dependent(s) Social Security number.
- **Note:** Your contributions to the Flexible Benefits Plan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS. Any salary directed to your Flexible Benefits Plan is included in the compensation reported to the Florida Retirement System.
- For more information, visit www.myFBMC.com or contact the FBMC Service Center at 1-855-LUCIE4U (1-855-582-4348), Monday - Friday, 7 a.m. - 8 p.m. ET.

Premium Conversion

Premium Conversion lets you set aside money from your pretax salary to cover insurance premiums for yourself and your dependents. That way, you don't have to pay taxes on the money you spend on these expenses. The end result? Less tax paid and more money in your pocket.

For which products can I use premium conversion?

- Your portion of the school board-provided major medical premiums and
- Medical coverage for your dependents.

Appeal Process

If you have a request for a mid-plan year election change, FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to **WageWorks (Attn: Appeals Committee)**.

Your appeal must include:

- The name of your employer
- The date of the services for which your request was denied
- A copy of the denied request
- The denial letter you received
- Why you think your request should not have been denied and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt and its supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer's, insurance provider's and IRS regulations governing the plan.

Changes in Status

You can only make benefit changes outside of the open enrollment period if you have a qualified Change in Status. Qualified Changes in Status include events like marriage or divorce, birth or adoption of a child, loss of coverage with other group plan and more. You must complete a Change in Status (CIS)/Election Form with the Risk Management Office and provide supporting documentation within **60 days** of a qualifying event. For more information on qualifying events and changing your coverage, see page 38.

Eligibility Requirements

Period of Coverage

If you enroll during annual Open Enrollment, your period of coverage is January 1, 2014, through December 31, 2014 for your “core” benefits. However, during the plan year, your period of coverage will be affected if the following applies:

- If you terminate employment or go on approved unpaid leave, your period of coverage ends on the last day of the month in which you terminate, or your leave of absence without pay begins, unless otherwise provided by law. Refer to the “Who Is Eligible?” section that follow for more information.
- If you are a newly hired employee, your period of coverage for:
 - the SLCS Health Plan begins on the first day of the month, following two payroll deductions.
 - the Flexible Benefits Plan begins on the first day of the month, following the submission of an enrollment form.
 - Voluntary benefits begins **February 1, 2014, through January 31, 2015.**
- Upon certain qualifying events, a covered employee, spouse and dependents may be eligible for group health plan continuation coverage under the Consolidated Omnibus Reconciliation Act (COBRA).
- If you do not enroll within 60 days of hire date or during an annual open enrollment, you must wait until the next plan year or until you experience an event that permits a mid-plan year election change under your employer’s plans. Refer to the Changing Your Coverage section for more information on qualifying events.

Who is eligible to participate in the Flexible Benefits Plan?

All full-time employees actively at work on the plan effective date (January 1) are eligible. For new benefits to be effective, eligible employees must be permanently and actively at work full time (physically capable of performing the functions of your job) on the first day of work concurrent with the plan year effective date. If you are not actively at work, but return to active work status within 10 working days from the plan effective date, your benefits will cover you when you return to work. Remember, if you are not actively at work on the plan effective date due to extended sick days or leave, your new benefits are not effective until you return to active status. However, if you are out on leave and are paying your benefit premiums through the personal pay leave billing, your benefits will remain effective while you are out on leave.

Who is eligible to participate in the SLCS Group Health and Dental plans?

All full-time employees actively at work on the plan effective date (January 1) are eligible. For new benefits to be effective, eligible employees must be permanently and actively at work full time (physically capable of performing the functions of your job) on the first day of work concurrent with the plan year effective date. If you are not actively at work, but return to active work status within 10 working days from the plan effective date, your benefits will cover you when you return to work. As required by the Health Insurance Portability and Accountability Act (HIPAA), employees absent due to health reasons are treated as being actively at work for purposes of benefit eligibility.

Dependent eligibility for Group Health and Dental Plan (pretax):

An individual who meets the eligibility criteria specified below is an eligible dependent and is eligible to apply for coverage under this reference guide:

1. The Covered Employee’s spouse under a legally-valid existing marriage;
2. The Covered Employee’s natural, newborn, adopted, foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) who:
 - a) has reached the end of the calendar year in which he or she becomes 26, but has not reached the end of the calendar year in which he or she becomes 30 and who:
 - i. is unmarried and does not have a dependent;
 - ii. is a Florida resident or a full-time or part-time student;
 - iii. is not enrolled in any other health coverage policy or plan; and
 - iv. is not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.
 - b) in the case of a handicapped dependent child, such child is eligible to continue coverage beyond the limiting age of 30 as a Covered Dependent if the dependent child is:
 - i. otherwise eligible for coverage under the Group Master Policy;
 - ii. incapable of self-sustaining employment by reason of mental or physical handicap; and
 - iii. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child’s handicap existed prior to the child’s 30th birthday. This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

or

3. The newborn child of a Covered Dependent child who has not reached the end of the calendar year in which he or she becomes 26. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Eligibility Requirements

Note: If a Covered Dependent child who has reached the end of the calendar year in which he or she becomes 26 obtains a dependent of their own (e.g. through birth or adoption), such newborn child will not be eligible for this coverage. It is your sole responsibility as the Covered Employee to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

New Employees

New employees are eligible to enroll in the Flexible Benefits Plan and SLCS Health Plan on the first day of employment. New employees must enroll within 60 days of hire. The effective date for the SLCS Health Plan and Voluntary Benefits begin on the first day of the month following two payroll deductions. The effective date of coverage for the Flexible Benefits Plan is on the first day of the month following the submission of an Enrollment Form.

Dependent Eligibility for Other Plans

Refer to the benefit description pages in this reference guide for information on each benefit. You may cover your eligible dependents under every benefit that shows a premium amount for dependent coverage provided you participate in the same benefit (refer to the rate charts that appear with each benefit description). An eligible dependent is: your legal spouse, an unmarried dependent child of either you or your legal spouse (including a stepchild, legally adopted child, foster child placed and approved for adoption in your home, or a child for whom you have been appointed legal guardian), provided they reside in your household and primarily depend on you for support.

Until the following conditions are reached, eligible dependents will be covered from birth, adoption or time of guardianship:

- Group Cancer Insurance and Hospital Indemnity Insurance – coverage will cease at the end of the calendar year in which the child reaches age 25 if the child lives in your home and depends on you for support, or attends school full- or part-time.
- Vision - coverage will cease at the end of the calendar year in which the child reaches age 19 (or 25 if the child lives in your home and depends on you for support or attends school full or part time).
- Unmarried insured children who are physically or mentally handicapped and fully incapable of self-care, will be covered until disablement becomes other than total. Proof of disability must be submitted annually to your insurance provider following the child's 19th birthday.

Refer to the specific dependent eligibility criteria on the individual benefit information pages of this reference guide.

Special Enrollment Rights Pertaining to Medical Benefits

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependent in your employer's plan provided that you request enrollment within sixty (60) days after the other coverage ends.

Employees on Leave

During the Plan Year, what happens to your benefits and Flexible Spending Accounts depends upon established IRS guidelines, your employer's plans and whether your approved leave falls under the Family and Medical Leave Act (FMLA). Prior to going on leave, if you wish to make arrangements to continue coverage while on leave, you must contact the Risk Management Department at (772) 429-5521.

Terminating Employees

During the Plan Year, except as otherwise provided by law and in accordance with your employer's plan(s), terminating employees are covered until the last day of the month in which: (i) employment ends (interim employees are in this category), and (ii) an employee ceases being in a benefited position. Exceptions:

- you are a regular, but less than a 12-month employee, and you work through the last day of your contract period. In this case, coverage ends the last day of the month following the last month in which a full month's premium payment was deducted from your paycheck.
- you are a regular 12-month employee and eligible for immediate retirement benefits through the Florida Retirement System (FRS) and work through the last day of your employment contract. In this case, coverage ends the last day of the month following the last month in which a full month's premium payment was deducted from your paycheck.

Contact:

- your Risk Management Department, prior to termination of employment, to increase your Medical Expense FSA salary reductions to complete the balance of your contributions on a pretax basis.
- FBMC's Service Center at 1-855-LUCIE4U (1-855-582-4348), within 30 days of termination of employment or other COBRA-qualifying event, to apply for continuation to the extent that COBRA applies, on an after-tax basis, to your Medical Expense FSA, Dental, Vision, Medical and Group Cancer Protection plans.

Eligibility Requirements

Note: If you have not overspent your Medical Expense FSA at the time of your termination or other COBRA-qualifying event (taking into account all processable claims submitted before your termination date), you are entitled to continue your period of coverage under COBRA for the remainder of the plan year in which your COBRA-qualifying event occurs, provided you pay the full annual contribution amount.

- each benefit provider immediately to apply for conversion and for information regarding payment of premiums if you had a Disability Income Protection and/or Group Term Life plan. Refer to the benefit description pages in this reference guide for more information.
- You must directly pay to maintain individual coverage for your post-tax voluntary benefits.

During the same plan year, unless otherwise provided by law or your employer's plans, if you terminate your employment and are re-hired:

- within 30 days or less of termination, you will automatically be reinstated into the benefit elections you had prior to termination (with access to your Medical Expense FSA balance up to the full annual limit, reduced by prior submitted and approved reimbursements, for eligible medical expenses incurred after your return to work).
- after 30 days or more from the date of your termination, you will be permitted to make new elections for the remainder of the plan year.

Retiring Employees

A retiree is a former full-time employee of the School Board who is currently receiving income under the Florida Retirement System (FRS). Unless otherwise provided by law and in accordance with your employer's plans, an employee who retires during the plan year may continue the benefits he or she had while actively at work, with the exception of the Disability Income Protection Plan and the Dependent Care FSA. Some plans may be continued at the same premium rates while others require conversion to an individual policy and may have an increase in premium rates. Premiums for continued coverage can be deducted from your Florida Retirement System (FRS) benefit check on a monthly basis, or you can elect to pay via personal check or ACH debit. After you have applied for retirement, you will receive a continuation of benefits application.

FSA Eligibility

Your Medical Expense Flexible Spending Account may be used to reimburse eligible expenses incurred by yourself, your spouse, your qualifying child or your qualifying relative. You may use your Dependent Care Flexible Spending Account to receive reimbursement for eligible dependent care expenses for qualifying individuals. **Please see the Flexible Spending Account Frequently Asked Questions (FAQs) at www.myFBMC.com.**

Note: There is no age requirement for a qualifying child if he or she is physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Expense FSA. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

Medicaid and the Children's Health Insurance Program (CHIP)

Medicaid and CHIP offers free or low-cost health coverage to children and families. If you are eligible for health coverage from your employer, but are unable to afford the premiums, the State of Florida has premium assistance programs that can help pay for coverage. Funds from the Medicaid program are used to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in Florida, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact Florida's Medicaid office at 1-866-762-2237 or go to www.fdhc.state.fl.us/Medicaid/index.shtml to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for your employer-sponsored plan.

Once it is determined that you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan — as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

How to Enroll

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is to your advantage to thoroughly review your enrollment materials. If you are ready to enroll, but need assistance, contact FBMC Service Center at 1-855-LUCIE4U (1-855-569-3262). Once you have the answers you need, you may begin the enrollment process.

Be sure to have the following information available before you begin the enrollment process:

- **Social Security Numbers (SSN)** for all of your dependents.
- **Dates of Birth** for all your dependents.
- **Beneficiaries'** Name, Date of Birth, Relationship, Social Security Number, Address and Telephone Number.

How to Enroll Online

1 Log on

Go to the FBMC homepage at www.myFBMC.com. Enter your username and password.

Username and Password

To access your account, you will need to register for a username and password. You will need your name, your mailing Zip Code, a valid e-mail address and one of the following: Your SSN, Employee ID or your Member ID. You will use your e-mail address and a password you select to access your enrollment and account information on www.myFBMC.com.

If you forget your password, click the "Forgot your password?" link for help or you may contact FBMC Service Center at 1-855-LUCIE4U (1-855-569-3262).

The screenshot shows the FBMC website's login interface. At the top, there's a navigation menu with links for Home, My Benefits, My Account, My Profile, My Resources, and Contact Us. Below this, a 'Resources' sidebar on the left lists 'Ask our Customer Care Center', 'Call direct: 800-342-8017', and 'FBMC Learning Center'. The main content area is titled 'Welcome to myFBMC.com' and includes sections for 'Have a Registration Code?', 'Registered Users' (with fields for Email Address and Password, and a Submit button), 'Forgot your password?', 'Need help logging into System?', 'Frequently Asked Questions', and 'New Users' (with a link to register a new account). A photo of a smiling woman on a headset is on the right. The footer contains copyright information, navigation links, and a BBB logo.

Record your password here.

Remember, this will be your password for Web access.

Note: Please be sure to keep this Reference Guide in a safe, convenient place, and refer to it for benefit information.

How to Enroll

2 Access your Web Enrollment

After entering your Username and Password at www.myFBMC.com, click the "Open Enrollment" link.

Log Out

Contact Us

Member: JANE PUBLIC
St. Lucie County School Board

Welcome to myFBMC

CUSTOMER ALERTS

Online Enrollment:

- Open Enrollment

Online FSA Claims Submission:

FBMC is pleased to announce online FSA claims submission through www.myFBMC.com. This process allows FSA participants the opportunity to submit, via the Web, a scanned image of a completed claim form along with scans of supporting documentation.

Submitting claims online gets reimbursement requests to FBMC faster than traditional mail, thus expediting the release of reimbursement funds back to participants.

Further details and instructions are available here.

If you have any questions, please contact FBMC's Customer Care Center.

Quality Commitment:

Customer service is the cornerstone of our business. Our focus on customers centers around providing easy access to information and solutions to meet your needs. Consider this page your personal guide to valuable benefits information.

Contact FBMC:

For information about options for contacting FBMC, please visit the Contact Customer Care section of this website.

3 Enroll Now

To begin enrolling you can click on the "Enroll Now" button. You may also view your current plan year benefits, review your enrollment session confirmations, check out our learning center, contact FBMC, or view and update your profile by clicking on the corresponding buttons.

St. Lucie PUBLIC SCHOOLS

Home My Benefits Enroll Now My Resources Learning Center

JANE PUBLIC

Welcome JANE PUBLIC

My Messages View Now

Benefits Management Center

You can enroll in your benefits, view the learning center, and more!

- Current Benefits
- Enroll Now
- Enrollment Confirmations
- Learning Center
- Contact Us
- My Profile

4 Confirm Employee Information and Edit/Update Dependent and Beneficiary Information

On the Welcome pages you can review your Current Benefits, confirm your Employee Information, and edit your dependents or beneficiaries. To add a beneficiary or dependent, click the "Add Beneficiary" or "Add Dependent" tab and complete the form. To edit or update dependent or beneficiary information, click on the dependent/beneficiary name and update the form as needed. To remove a dependent or beneficiary, click on the "X" icon.

Enroll Now for 2014 / Dependent/Beneficiary Information

Welcome

Add a New Dependent

Please enter the information for this dependent in the fields provided. Click "Save" to apply the changes and return to the list of dependents/beneficiaries.

Fields marked with an asterisk (*) are required.

* First Name:

Middle Initial:

* Last Name:

Suffix:

* Relationship:

* Date of Birth:

* SSN:

* Gender/Sex: Male Female

* Full-time Student: Yes No

* Disabled: Yes No

Mailing Address

Same as Employee:

Address 1:

Address 2:

City:

State:

Zip:

Step 1: Welcome Step 2: Benefit Selection Step 3: Checkout Step 4: Confirmation

How to Enroll

5 Begin the Enrollment Process

Start Tour: You may click on the “Start Tour” button at any time during your enrollment for additional information and enrollment instructions.

The “Start Tour” icon on each page will guide you through the specifics of that page.

Choose Benefits

For each benefit, choose your coverage level or election amounts by clicking “Select” in the benefit box of your choice. The selected benefit will move to the top of the page. Be sure to click the “Save” button to save each benefit selection before continuing to the next benefit page. To continue to the next benefit page, click “Next” at the bottom right of the screen.

You may save your enrollment session progress and return later to complete the enrollment at any point, once you have started the benefit selections by clicking the “Save” button and then click “Exit Enrollment” at the bottom of the screen. Exiting your enrollment early will record your previously saved benefit selections.

If you are interested in electing or making a change to your voluntary benefits, please make an appointment with an Enrollment Counselor at <https://www.myenrollmentschedule.com/stlucie>

Enroll Now for 2014 / Step 2: Medical

Would you like to start a guided tour of your enrollment?
Start tour No thanks, please minimize the guided tour prompt.

Current Medical Selection

Plan Name	Selected	Cost
Florida Blue Medical - BC/BS - 5771	<input checked="" type="radio"/>	\$38.00
Florida Blue Medical - BC/BS - 5180	<input type="radio"/>	\$38.25
Florida Blue Medical - BC/BS - 5181	<input type="radio"/>	\$278.64

Checkout

Category	Amount
TOTAL	\$65.87
PRE-TAX	
Medical	\$ 38.00
Dental	\$ 11.75
Short Term Disability	\$ 13.39
Medical Flex Credit	(\$ 16.67)
SUBTOTAL	\$ 46.47
POST-TAX	
Universal Life TransLegacy UL	\$ 19.40
SUBTOTAL	\$ 19.40
AVAILABLE FLEX CREDIT	\$0.00

6 Payroll Deductions

Upon selecting a benefit, be sure to click the “Save” button. Your saved benefit will appear under Payroll Deductions with the appropriate benefit cost. This will allow you the opportunity to view your total payroll deductions as you continue through your enrollment session. Once you have made all of your benefit selections for the 2014 Plan Year, you can checkout by clicking the “Checkout” button.

Enroll Now for 2014 / Step 2: Benefit Selection

Would you like to start a guided tour of your enrollment?
No thanks, please minimize the guided tour prompt.

Current Dental Selection

Plan Name	Selected	Cost
Florida Blue Dental - Low PPO	<input checked="" type="radio"/>	\$11.75
Florida Blue Dental - High PPO	<input type="radio"/>	\$24.68

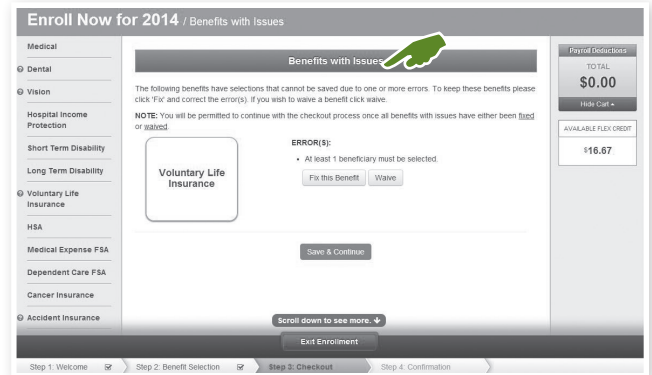
Checkout

Category	Amount
TOTAL	\$22.00
PRE-TAX	
Medical	\$ 24.35
Dental	\$ 14.32
Medical Flex Credit	(\$ 16.67)
SUBTOTAL	\$ 22.00
AVAILABLE FLEX CREDIT	\$0.00

How to Enroll

7 Benefit Issues

You will not be able to save your enrollment if the “Benefit with Issues” page appears before you reach the confirmation page. This means that you have a benefit that requires a correction. For example, if you have enrolled in family coverage, but did not select dependent(s), or enrolled in a Life plan, but did not complete the beneficiary information. The application will prompt you to review the benefits that need further review or editing. You must check to ensure each benefit is accurately completed in order to proceed to checkout.



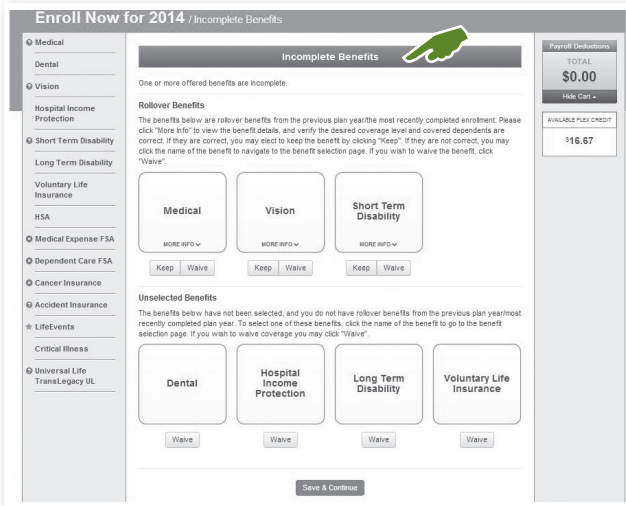
8 Incomplete Benefits

The checkout process is designed to ensure that you effectively “Save” or “Waive” each benefit, based on your needs. If you did not save or waive a benefit during your enrollment session, it will appear here. The Incomplete Benefits page includes two sections:

Rollover Benefits: If you have a current benefit and forgot to save it during your enrollment session, you must click the “Keep” button for the benefit to rollover to the 2014 Plan Year.

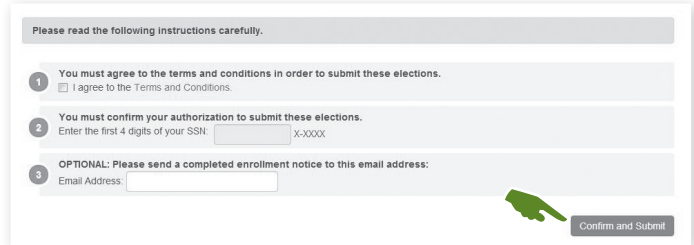
Unselected Benefits: Any other benefits you did not save during your enrollment session will appear here. You may click the benefit button to return to the corresponding benefit page and select the benefit, or click “Waive” to waive the benefit and continue to checkout.

Remember, you must save or waive each benefit to proceed to checkout.



9 Agreement and Authorization

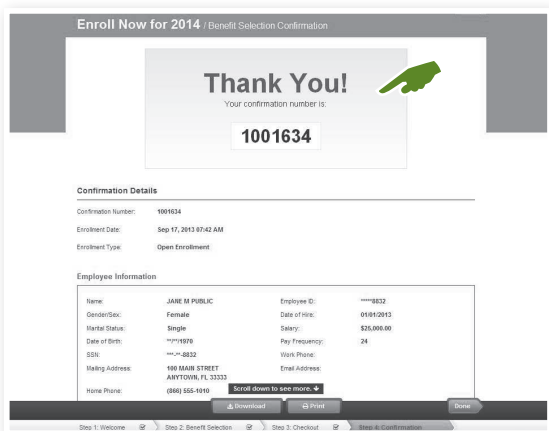
In order to complete your enrollment, you must check the box to agree to the Terms and Conditions, type in the last four digits of your SSN and you have the option to include your e-mail address to receive an enrollment confirmation notification online.



10 Print and Keep Your Confirmation Notice

Once you have completed the enrollment process, you will receive a confirmation number and you will be able to print a confirmation notice for your records.

You may access the web enrollment 24 hours a day, 7 days a week to make changes to your benefit selections. You have until the end of the Open Enrollment period, which ends on November 1, 2013, to make any changes to your benefits.



Florida Blue

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions 05771 "Network Blue" Only Available to Employees hired prior to 1/1/14	BlueOptions HSA-Compatible 05180 (Single Coverage) "Network Blue"	BlueOptions HSA-Compatible 05181 (Family Coverage) "Network Blue"
Deductible (DED) (Per Person/Family Agg)			
In-Network	\$1,500 / \$4,500	\$1,500 / Not Applicable	\$3,000 / \$3,000
Out-of-Network	\$4,500 / \$13,500	\$3,000 / Not Applicable	\$6,000 / \$6,000
Coinsurance (Member Responsibility)			
In-Network	20%	10%	10%
Out-of-Network	50% of Allowed Amount + Subject to Balance Billing Charges	40% of Allowed Amount + Subject to Balance Billing Charges	40% of Allowed Amount + Subject to Balance Billing Charges
Out of Pocket Maximum (Per Person/Family Agg)			
In-Network	Includes DED, Coins, & Copays \$4,500 / \$9,000	Includes DED, Coins, & Copays \$3,000 / Not Applicable	Includes DED, Coins, & Copays \$6,000 / \$6,000
Out-of-Network	\$9,000 / \$18,000	\$6,000 / Not Applicable	\$12,000 / \$12,000
Lifetime Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections			
In-Network Primary/Family Care Physician	\$10	DED + 10%	DED + 10%
In-Network Specialist	\$10	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
E-Office Visit Services			
In-Network Primary/Family Care Physician	\$10	DED + 10%	DED + 10%
In-Network Specialist	\$10	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Office Services			
In-Network Primary/Family Care Physician	\$30	DED + 10%	DED + 10%
In-Network Specialist	\$55	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Provider Services at Hospital and ER			
In-Network Primary/Family Care Physician	DED + 20%	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Provider Services at Other Locations			
In-Network Primary/Family Care Physician	\$30	DED + 10%	DED + 10%
In-Network Specialist	\$55	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center			
In-Network Specialist	ASC: \$55 Hospital: DED + 20%	DED + 10%	DED + 10%
Out-of-Network	ASC: \$55 Hospital: In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
PREVENTIVE CARE			
Adult Wellness Office Services			
In-Network Primary/Family Care Physician	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0
Out-of-Network	50% (No DED)	40% (No DED)	40% (No DED)
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies
In-Network	\$0	\$0	\$0
Out-of-Network	\$0	\$0	\$0
Mammograms (Routine)			
In-Network	\$0	\$0	\$0
Out-of-Network	\$0	\$0	\$0
Well Child Office Visits (No BPM)			
In-Network Primary/Family Care Physician	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0
Out-of-Network	50% (No DED)	40% (No DED)	40% (No DED)

Florida Blue

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions 05771	BlueOptions HSA-Compatible 05180 (Single Coverage)	BlueOptions HSA-Compatible 05181 (Family Coverage)
EMERGENCY/URGENT/CONVENIENT CARE			
Ambulance Maximum (per day)	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Convenient Care Centers (CCC)			
In-Network	\$30	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Emergency Room Facility Services (also see Professional Provider Services)			
In-Network	\$250	DED + 10%	DED + 10%
Out-of-Network	\$250	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Urgent Care Centers (UCC)			
In-Network	\$60	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
FACILITY SERVICES - HOSP/SURG/ICL/IDTF			
Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.			
Ambulatory Surgical Center			
In-Network	\$200	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Independent Clinical Lab			
In-Network (Quest Diagnostics)	\$0	DED	DED
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS)	\$250	DED + 10%	DED + 10%
In-Network - Other Diagnostic Services	\$50	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Inpatient Hospital (per admit)			
In-Network	Option 1 - DED + 20%	Option 1 - DED + 10%	Option 1 - DED + 10%
Out-of-Network	Option 2 - DED + 20%	Option 2 - DED + 10%	Option 2 - DED + 10%
	\$500 PAD + DED + 50%	DED + 40%	DED + 40%
Inpatient Rehab Maximum (PBP)	21 Days	21 Days	21 Days
Outpatient Hospital (per visit)			
In-Network	Option 1 - DED + 20%	Option 1 - DED + 10%	Option 1 - DED + 10%
Out-of-Network	Option 2 - DED + 20%	Option 2 - DED + 10%	Option 2 - DED + 10%
	DED + 50%	DED + 40%	DED + 40%
Therapy at Outpatient Hospital			
In-Network	Option 1 - \$55	Option 1 - DED + 10%	Option 1 - DED + 10%
Out-of-Network	Option 2 - \$80	Option 2 - DED + 10%	Option 2 - DED + 10%
	DED + 50%	DED + 40%	DED + 40%
OTHER SPECIAL SERVICES AND LOCATIONS			
Advanced Imaging Services in Physician's Office			
In-Network Primary/Family Care Physician	\$250	DED + 10%	DED + 10%
In-Network Specialist	\$250	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Birth Center			
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics BPM	No Maximum	No Maximum	No Maximum
In-Network (Carecentrix)	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Home Health Care BPM	20 Visits	20 Visits	20 Visits
In-Network (Carecentrix)	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%

An Independent Licensee of the Blue Cross and Blue Shield Association



Florida Blue

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions 05771	BlueOptions HSA-Compatible 05180 (Single Coverage)	BlueOptions HSA-Compatible 05181 (Family Coverage)
Hospice LTM	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
Skilled Nursing Facility BPM	60 Days	60 Days	60 Days
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 40%
PRESCRIPTION DRUGS			
Deductible	\$0	In-Network Plan Deductible Applies	In-Network Plan Deductible Applies
In-Network (Mandatory Generic Program)			
Retail (30 days)			
Generic/Preferred Brand/Non-Preferred	\$10 / \$30 / \$50	\$10 / \$30 / \$50	\$10 / \$30 / \$50
Mail Order/Retail (90 days)			
Generic/Preferred Brand/Non-Preferred	\$20 / \$60 / \$100	\$25 / \$75 / \$125	\$25 / \$75 / \$125

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.

The information contained in this proposal includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary.

Additionally, Interim rules released by the Federal Government February 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE). Benefits and rates reflected in the proposal are subject to change based on the outcomes of the test.

Florida Blue

2014 Per Pay Employee Payroll Contributions

Employees - Per Pay Period		
	BlueOptions 05180/05181	BlueOptions 05771 Only available to employees hired before January 1, 2014.
Employee Only	\$7.20	\$24.35
Employee + 1 Dependent	\$322.50	\$360.93
Employee + Family	\$476.60	\$525.98
Dual Employee + Family	\$114.81 each employee per pay period	\$139.50 each employee per pay period

If both you and your spouse are employed by SLCS and have benefit eligible dependent children, you are defined as a “dual employee family”. One employee is considered “primary” insured and the other spouse becomes a dependent of the primary spouse along with the child(ren). Premiums for “dual employee” family coverage are shared between both employees with each receiving the employer health plan contribution and each having an equal payroll deduction for the employee paid portion of the premium.

Health Savings Account (HSA) Program

Health Savings Account (HSA)

A health savings account (HSA) is a tax free savings account that belongs to you. The account is set up with a qualified HSA trustee (typically a bank or insurance company, or anyone already approved by the IRS to be a trustee). The account is used to pay or reimburse for qualified medical expenses you or your dependents incur. You must be an eligible individual to qualify for an HSA.

The benefits of an HSA are:

- Contributions are excluded from income (pre-tax)
- Contributions remain in your account from year to year until you use them
- The interest or other earnings on the assets in the account are tax free
- Distributions are tax free if used to pay for qualified medical expenses, including Rx, dental and vision
- Spouse/dependent expenses are eligible, even if on another health plan
- HSA funds can be invested once a certain threshold of savings is met
- An HSA is portable; it stays with you if you change employers or leave the work force.

Note: funds must be deposited into your account before use (works like a checking account.)

Qualifying for an HSA (Eligibility):

- You must be covered under a high deductible health plan (HDHP)
- You cannot have other health coverage except what's permitted by the IRS (see IRS Publication 969)
- You cannot be enrolled in Medicare
- You cannot be claimed as a dependent on someone else's tax return.

2014 maximum HSA contributions allowed by the IRS:

- Single coverage \$3,300.00
- Family coverage \$6,550.00
- "Catch-up" Contribution, age 55+ \$1,000.00

Catch up contributions are for individuals who are age 55 or older and not on Medicare. This is in addition to the single or family contribution amounts.

Eligible or "Qualified Medical Expenses" under an HSA:

- Eligible expenses include medical, prescribed medications, dental and vision expenses that are not eligible for reimbursement under an insurance plan.
- For a current and complete list of eligible expenses go to: www.irs.gov/publications/p502/index.html

Use of HSA Funds for Non-Qualified Medical Expenses

- HSA funds can be used for non-qualified medical expenses; however, if under the age of 65 you'll be taxed on the money you use at your income tax rate and assessed a 20% penalty.
- Once you turn age 65, you'll be taxed for HSA funds used for non-qualified expenses, but won't pay any additional penalty (20%).

How to Fund Your HSA:

- Make pre-tax contributions through payroll deductions.
- Modify payroll contributions anytime after your HSA account is open.
- Make after-tax contributions directly through the HSA Administrator.

HealthEquity, Inc. – HSA Administrator for St. Lucie County Schools Employees

- In partnership with Florida Blue, Health Equity is the HSA administrator for those employees enrolled in the high deductible health plan (HDHP).
- HDHP plan participants will be issued an HSA welcome kit with a debit card.
- Online availability and phone support all day, every day.
- Online access to account balances, transaction history, claims and management of your personal information.
- Online education and support tools.
- FDIC insured cash deposits.
- Competitive interest rates.
- Free investment options with no transaction fees.

Learn more about HSAs at www.healthequity.com/HSA or call HealthEquity 24/7/365 at 866.346.5800.

May I have an HSA and Medical FSA?

Yes, individuals may enroll in a Limited-Use Medical FSA to pay certain eligible expenses. The Limited-Use Medical FSA may be used to pay expenses not covered by your HSA or a high deductible health plan, including dental, vision and preventive care expenses not covered by healthcare plan. Dependent Care Spending Account eligibility is not affected by your HSA participation. You can save money and pay less tax too by enrolling in an Limited Use Medical FSA, HSA or both. These are Pre-tax benefits that you can take advantage of either independently of each other or together.

Remember, Limited-Use Medical FSAs are available to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

Dental Plan

St. Lucie County Schools is pleased to partner with Delta Dental to offer a PPO+ plan that makes it easy for you to find a dentist and control your costs when you visit a network dentist.

Here are some of the great things you'll need to know about enrolling with Delta Dental:

- Save with a PPO dentist. Our PPO network dentists accept reduced fees for covered services, so you'll usually pay the least when you visit a PPO network dentist. Non-Delta Dental dentists may balance bill you the difference between the contracted fee and their usual fee.
- Large dentist network. Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of PPO dentists near your home or office. Use your desktop or mobile device to search for a dentist at deltadentalins.com.

- Visit the dentist of your choice. Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest with a PPO dentist.
- Log in to Online Services. Check benefits, eligibility and claims status, view or print an ID card and use our "Fee Finder" tool to check average costs in your area. You can also change your Profile preference to go paperless. Use your mobile device to access many of these tools on the go; show the dental office your ID card information instead of carrying a printed card.

Visit the SmileWay® Wellness section of our site for dental health articles, videos, quizzes and a risk assessment tool. You can also subscribe to our free dental health e-newsletter.

Your Saving with a PPO Dentist



Dental Plan

Delta Dental PPO

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26, or to age 30 if the specific conditions of eligibility are met.
Deductibles*	\$50 per person / \$150 per family each calendar year
Deductibles waived for D & P?	Yes
Maximums*	Low Plan: \$1,000 per person each calendar year High Plan: \$1,500 per person each calendar year
D & P counts toward maximum?	No

RATES EFFECTIVE 1/1/2014 to 12/31/2015	ACTIVE (Semi-Monthly)	
	Low	High
EE Only	\$11.75	\$14.32
EE + One	\$24.68	\$30.12
EE + Two or more	\$42.51	\$53.10

Benefits and Covered Services**	Low Plan		High Plan	
	Delta Dental PPO dentists [†]	Non-Delta Dental PPO dentists [†]	Delta Dental PPO dentists [†]	Non-Delta Dental PPO dentists [†]
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays, sealants	100 %	100 %	100 %	90 %
Basic Services Fillings, simple tooth extractions	80 %	80 %	90 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %	90 %	80 %
Non- Surgical Periodontics Covered Under Basic Services	80 %	80 %	90 %	80 %
Surgical Periodontics Covered Under Major Services	50 %	50 %	60 %	50 %
Oral Surgery Covered Under Basic Services	80 %	80 %	90 %	80 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures, implants	50 %	50 %	60 %	50 %
Orthodontic Benefits dependent children	50 %	50 %	50 %	50 %
Orthodontic Maximums Lifetime	\$ 500	\$ 500	\$ 1,000	\$ 1,000

* If you switch plans during the calendar year your Deductible and Annual Maximum may be adjusted accordingly.

** Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

† Fees are based on PPO contracted fees for PPO dentists, PPO contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists.

Delta Dental Insurance Company 1130 Sanctuary Parkway, Suite 600 Alpharetta, GA 30009	Customer Service 800-521-2651	Claims Address P.O. Box 1809 Alpharetta, GA 30023-1809
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Vision Care

There are two vision care options available, the In-Network Option and the Out-of-Network Option.

- In-Network Option: You choose a doctor from the panel provider list. Services are provided at predetermined rates.
- Out-of-Network Option: You can choose any eye doctor. You are reimbursed a percentage of your costs.

Plan Features

- No deductible
- Examination — Once every 12 months
- Lenses — Once every 12 months, if necessary
- Frames — Once every 12 months, if necessary
- Contact Lenses — Once every 12 months (in place of exam, lenses and frames)
- Refractive Care — VCP offers the LASIK procedure for plan members who are nearsighted or have astigmatism and wear glasses or contacts. VCP contracted with LASIK facilities and eye doctors to offer LASIK to covered employees and family members at substantially reduced fees. Plan members will pay no more than \$1,800 for treating one eye, or \$3,600 for both eyes.

To utilize the Refractive Care program, members first contact VCP to request a LASIK ID card and a list of network eye doctors for initial screening to determine if the patient is a candidate for LASIK. If the patient qualifies, the doctor can also make arrangements for the procedure with one of the LASIK centers that participates in this program. Plan members can also go directly to one of the participating RefractiveCare ophthalmologists.

Exclusions

- Orthoptics or vision training, subnormal vision aids, aniseikonic lenses or plan (non-prescription) lenses
- Medical or surgical treatment of the eyes
- Two pairs of glasses in lieu of bifocals
- Broken or lost frames or lens replacement, except at specified times
- Workers' Compensation-provided services and materials; any employer-required exam; other group plan-provided services or materials and
- Services or materials not obtained in the prescribed procedure

In-Network Option and Out-of-Network Option

Co-payment/Credit Schedule

	IN-NETWORK EYE DOCTOR (up to plan maximums)	OUT-OF-NETWORK EYE DOCTOR*
Vision Examination Materials	Covered in full	\$35 reimbursement
Single Vision Lenses	Covered in full	\$25 reimbursement
Bifocal Lenses	Covered in full	\$40 reimbursement
Trifocal Lenses	Covered in full	\$60 reimbursement
Lenticular Lenses	Covered in full	\$100 reimbursement
Frames	\$30 retail allowance	\$30 reimbursement
Contact Lenses		
Medically Necessary	Covered in full	\$210 reimbursement
Elective	\$85 allowance	\$85 reimbursement
	(in lieu of exam, frames and lenses)	(in lieu of exam, frames and lenses)

* Please note: Amounts shown above are maximums.

Vision Care

Vision Care In-Network

Fort Pierce

Center for Eyecare & Surgery — (772) 466-5146
Jesse Gibson — (772) 466-2385
St. Lucie Eye Associates — (772) 461-5660
CR Lait Optical — (772) 465-0544
Paul B Moll — (772) 466-2070
William A. Olivos — (772) 460-8487

Port St. Lucie

VisionPlus — (772)-770-2020
Envision Eye Care — (772) 621-8777
St. Lucie Eye Associates — (772) 340-2929, (772) 335-3939
Stuart Eye Institute — (772) 335-1766
Clayton L. Olesen — (772) 878-6334
South Florida Vision — (772) 398-3244
Family Eye Care — (772) 337-5332
LC Erbe — (772) 873-0037
Alan Siegel — (772) 335-5006

Vero Beach

LensCrafters — (772) 567-5954
JCPenney Optical — (772) 778-805
Sears Optical — (772) 567-8755
Vision Plus — (772) 770-2020
Treasure Coast Opticians — (772) 569-4822
Treasure Coast Eye Associates — (772) 978-0845
Daniel M. Fleming — (772) 569-2214
Tropical Eye Associates (772) 567-5102
World of Vision — (772) 562-2020
Eye Clinic of Vero — (772) 567-6513

Your Tax-Free Rates

Coverage	24 pay periods
Employee Only	\$3.00
Employee & Family	\$8.47

Plan Provider

Humana underwrites the Vision plan. Call VisionCare Plan at 1-800-865-3676 to obtain your claim forms prior to going to the eye doctor. For questions regarding your vision benefit, visit the VisionCare Plan website at www.compbenefits.com, call VisionCare Plan at 1-800-865-3676 or FBMC's Service Center at 1-855-LUCIE4U (1-855-582-4348).

Group Hospital Indemnity Insurance

Group Hospital Indemnity Insurance provides daily benefits if you or your covered dependents are hospitalized for a covered sickness or injury.

The 19 levels of daily coverage are:

\$10 \$15 \$20 \$25 \$30 \$35 \$40
 \$45 \$50 \$55 \$60 \$65 \$70 \$75
 \$80 \$85 \$90 \$95 \$100

Plan Features

- Benefits start on the first day of hospitalization.
- Benefits continue up to 365 days or until you are discharged, whichever occurs first for each injury or sickness.
- You may continue this benefit if you retire from School Board employment by submitting an Employee Change In Status Form to FBMC Benefits Management, Inc., within the 60-day period preceding your retirement to convert your group policy to an individual policy.
- Your coverage will continue as long as the Group Master Policy remains in effect, you pay your premiums and you remain eligible for coverage under the plan.

What's Not Covered

- Suicide attempts or intentionally self-inflicted injuries
- Injuries or sickness resulting from declared or undeclared war or any act thereof, or sustained while serving in the armed forces of any country
- Treatment for injuries or sicknesses covered by Workers' Compensation
- Treatment for the prevention or cure of narcotic addiction or alcoholism
- Injuries sustained in the commission of a felony or while in jail

Plan Provider

Fidelity Security Life Insurance Company underwrites this plan. Fidelity Security Life Insurance Company has been rated "A-", Excellent, based on an analysis of financial position and operating performance by A.M. Best Company, an independent analyst of the insurance industry. For the latest rating, visit www.ambest.com.

Policy Form #M-00116

Policy No. HP-5A/B

Your Pre-tax Group Hospital Indemnity Insurance Rates

24 PAY PERIODS

Daily Benefit Amount

Coverage	\$10	\$15	\$20	\$25	\$30	\$35	\$40	\$45	\$50	
Employee Only	\$.80	\$1.20	\$1.60	\$2.00	\$2.40	\$2.80	\$3.20	\$3.60	\$4.00	
Employee & Family	1.80	2.70	3.60	4.50	5.40	6.30	7.20	8.10	9.00	
	\$55	\$60	\$65	\$70	\$75	\$80	\$85	\$90	\$95	\$100
Employee Only	\$4.40	\$4.80	\$5.20	\$5.60	\$6.00	\$6.40	\$6.80	\$7.20	\$7.60	\$8.00
Employee & Family	9.90	10.80	11.70	12.60	13.50	14.40	15.30	16.20	17.10	18.00

Short-Term Disability Income Protection

A short-term disability doesn't have to put your life or your income on hold. Short-Term Disability insurance can provide a stable income source to carry you and your family through a temporary disability.

The St. Lucie County Schools is pleased to announce additional levels of coverage, depending on your salary. This insurance plan provides three levels of short-term disability coverage:

- Plan A - This insurance plan provides up to 60% of your weekly salary up to a maximum of \$500 per week.
- Plan B - This insurance plan provides up to 60% of your weekly salary up to a maximum of \$600 per week.
- Plan C - This insurance plan provides up to 60% of your weekly salary up to a maximum of \$750 per week.

The Weekly Benefit payable to the Employee for any week the Employee is disabled is the Gross Disability Benefit minus Other Income Benefits and the Calculation for Optimum Ability.

The Calculation for Optimum Ability is the earnings the Employee could earn if working at Optimum Ability, minus Disability Earnings.

"Other Income Benefits" means any benefits listed in the Other Income Benefits provision that an Employee receives on his or her own behalf or for dependents, or which the Employee's dependents receive because of the Employee's entitlement to Other Income Benefits.

Eligibility for Coverage

To receive coverage under this plan, you must be an active, full time employee of the Board who is eligible for fringe benefits.

When do I Enroll?

You may enroll as a new hire during your initial eligibility period or annually during Open Enrollment.

How long are my benefits payable?

Once you qualify for benefits under this plan, you will continue to receive them until the end of the 11-week benefit period, or until you no longer qualify for benefits, whichever occurs first.

Benefits payable under this plan will terminate on the earliest of any date indicated below:

- the date we determine you are no longer disabled.
- the date you earn from any occupation more than the percentage of your covered earnings as defined in your definition of disability.
- the date the maximum benefit period ends.
- the date you cease to get appropriate care.
- the date you die.
- the date you refuse to participate without good cause in all required phases of the rehabilitation plan.
- the date you fail to cooperate with us in the administration of the claim.

Benefits may be resumed if you begin to cooperate in the rehabilitation plan within 30 days of the date benefits terminated.

Your Pre-tax Short-Term Disability Income Protection Rate

Coverage	24 pay periods
Plan A	\$13.39
Plan B	\$14.91
Plan C	\$17.14

What is my Benefit Waiting Period?

Before collecting benefits, you must satisfy an elimination period following your date of disability. For your plan, this period is the later of any accumulated sick leave or 14 consecutive days of continuous disability from either accident or sickness.

How will I determine if I am disabled?

Disabled means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation or you are unable to earn 80% or more of your covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.

Important Facts About Short-Term Disability

Work Incentive Benefits – are designed to allow a disabled employee to return to work while considered disabled, and to continue to receive weekly benefits (benefit will be offset if the sum of disability benefit, current earnings and any other income benefits exceeds 100 percent of weekly covered earnings).

Rehabilitation During Disability – If you are offered a rehabilitative assistance program, we will work with you during the course of your elimination period or while benefits are payable. You will be expected to cooperate with the implementation of that assistance program. If you refuse such assistance without good cause (e.g., a medically substantiated reason), disability benefits will not be payable and coverage under this plan will end. Coverage may be reinstated, and benefits resumed, if within 30 days of the termination date, you agree to participate in the rehabilitation efforts.

Note that there is a minimum benefit of \$25.

What if I have a Pre-Existing Condition?

If your disability results directly or indirectly from a pre-existing sickness or injury for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or consulted a Physician within 12 months before the most recent effective date of your insurance, you will receive no weekly benefit for that condition. However, this limitation does not apply to a period of disability that begins more than 12 months after the most recent effective date of your insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits.

Short-Term Disability Income Protection

What's not Covered?

Benefits are not payable for disability resulting from:

- Suicide, attempted suicide, or whenever you injure yourself on purpose
- War or any act of war, whether or not declared
- Active participation in a riot
- Commission of a felony
- The revocation, restriction or non-renewal of your license, permit or certification necessary for you to perform the duties of your occupation, unless solely due to injury or sickness otherwise covered by the policy
- Cosmetic surgery or medically unnecessary surgical procedures (Medically necessary means prescribed by a licensed physician as required treatment for a sickness or injury and appropriate according to conventional medical practice in the locality where it is performed. Benefits are payable if the disability is caused by your donation of an organ in a non-experimental organ transplant procedure.)

In addition, we will not pay disability benefits for any period of disability during which you are incarcerated in a penal or corrections institution for any reason.

How do I know which level of coverage to select?

Consider your annual salary when selecting a level of coverage to provide you and your family the most protection.

- If your annual salary is less than \$43,333, Plan A offers the best coverage for your salary.
- If your annual salary is \$43,333 to \$52,000, Plan B offers the best coverage for your salary.
- If your annual salary is greater than \$52,000, Plan C offers the best coverage for your salary.

How do I file a short-term disability claim?

- Call the number below, as soon as possible. 1-800-36-CIGNA or 1-800-362-4462 or
- Access the website at: <https://dmswebintake.group.cigna.com>. Please provide the following information when filing a short-term disability claim:
 - Your name, address, phone number, birth date, date of hire, Social Security Number and employer's name, address, and phone number.
 - The date and cause of your disability, as well as your anticipated return-to-work date. If your disability is due to pregnancy, provide the actual or expected date of delivery.
 - The name, address, phone number of each doctor you are seeing or have seen for the disability causing your illness or injury.

When Coverage Takes Effect

If you meet these eligibility requirements, your coverage takes effect on the later of the program's effective date, the date you become eligible, the date your completed enrollment form is received, or the date you authorize any necessary payroll deductions. If you have to submit

evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you. If you're not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

Effects of Other Income Benefits

- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf; or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits.
- Benefits payable by a Canadian and/or Quebec provincial pension plan.
- Amounts payable under the Railroad Retirement Act.
- Amounts payable under any local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer.
- Employer-paid portion of company retirement plan benefits.
- Amounts payable by company-sponsored sick leave or salary continuation plan.
- Amounts payable by any individual, franchise or group insurance or similar plan.
- Benefits payable under work-loss provisions of any mandatory "no fault" auto insurance.
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration, or otherwise, where a third party may be liable, regardless of whether liability is determined.

Income sources that **will not** reduce your benefits under this plan are:

- Benefits paid by personal, individual disability income policies.
- Individual deferred compensation agreements.
- Employee savings plans, including thrift plans, stock options, or stock bonuses.
- Individual retirement funds, such as IRA or 401(k) plans.
- Profit-sharing, investment or other retirement or savings plans maintained in addition to an employer-sponsored pension plan.

This information is a brief description of the important features of this plan. It is not a contract. Terms and conditions of the short-term disability coverage are set forth in Group Policy No. LK 750339, on policy form TL-004700, issued in Florida and subject to its laws. The availability of this offer may change. Please keep this material as a reference, and file it with your certificate, should you become insured.

Plan Provider

Coverage is underwritten by Life Insurance Company of North America (LINA), 1601 Chestnut Street, Philadelphia, PA 19192.

The licensed Florida agent is Christine Carolyn Wise #E026735

To Submit a Claim:

Call CIGNA's toll-free number at 1-800-36-CIGNA or 1-800-362-4462 and a representative will walk you through the process. CIGNA will take all of the information over the phone.

Long-Term Disability Income Protection

Who is Eligible for Coverage?

All active, full-time employees of the Board who are eligible for fringe benefits.

When Coverage Takes Effect

If you meet these eligibility requirements, your coverage takes effect on the latter of the program's effective date, the date you become eligible, the date we receive your completed enrollment form or the date you authorize any necessary payroll deductions.

If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you. If you're not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

What's Considered a "Disability"?

You are considered disabled if:

- An injury or sickness leaves you unable to perform all the material duties of your regular occupation and
- After 24 months of receiving monthly benefits, you are unable to perform all the material duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience.

Plan I

The monthly maximum benefit is \$1,200 or 60 percent of your monthly covered earnings, whichever is less.

Plan II

The monthly maximum benefit is \$1,800 or 60 percent of your monthly covered earnings, whichever is less.

Plan III

The monthly maximum benefit is \$2,500 or 60 percent of your monthly covered earnings, whichever is less.

Plan IV

The monthly maximum benefit is \$3,750 or 60 percent of your monthly covered earnings, whichever is less.

Plan V

The monthly maximum benefit is \$5,000 or 60 percent of your monthly covered earnings, whichever is less.

Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

The minimum monthly benefit for all five levels of coverage is \$200 or 30 percent of your monthly benefit, whichever is less, regardless of other income you or your dependents receive during your disability.

The Plan also pays an additional 15%, up to the lesser of the plan maximum benefit, or \$5,000 per month for catastrophic disabilities.

How do I know which level of coverage to select?

Consider your annual salary when selecting a level of coverage to provide you and your family the most protection.

- If your annual salary is less than \$24,000, Plan I offers the best coverage for your salary.
- If your annual salary is \$24,000 to \$36,000, Plan II offers the best coverage for your salary.
- If your annual salary is greater than \$36,000 to \$50,000, Plan III offers the best coverage for your salary.
- If your annual salary is greater than \$50,000 to \$75,000, Plan IV offers the best coverage for your salary.
- If your annual salary is greater than \$75,000 Plan V offers the best coverage for your salary.

Plan Features

- Benefits start after 90 days of disability. A period of disability will be considered even if you return to full time work in your regular job for up to a total of 15 days during the Benefit Waiting Period. The Benefit Waiting Period will be extended by the number of days you temporarily return to work.
- Benefits are payable monthly up to age 65, if disabled before age 63. If you become disabled between the ages of 63 and 69, benefits are payable on a decreasing scale. A maximum one year benefit is paid for disabilities that begin at age 69 or older.
- Benefits under this plan will be coordinated with Workers' Compensation, Social Security Disability Benefits or any other group benefits to ensure you receive up to 60 percent of your monthly income.

Long-Term Disability Income Protection

Effects of Other Income Benefits

Disability insurance is designed to help you meet your financial obligations, if you cannot work as a result of a covered injury or sickness. The disability benefit provided by this plan is a total benefit; this is, it will be reduced by any disability benefits payable on behalf of you or your dependents, whether or not you are actually receiving them. Your disability benefits will not be reduced by Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you receive them

Other income sources that may reduce your benefits under this plan include:

- Employer-paid portion of company retirement plan benefits
- Amounts payable under local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer
- Amounts payable under any workers' compensation (including temporary or permanent disability benefits), occupational disease, and unemployment compensation. This includes damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted
- Amounts payable by any franchise or group insurance or similar plan
- Benefits payable by a Canadian and/or Quebec provincial pension plan
- Amounts payable under the Railroad Retirement Act
- Amounts payable by company sponsored sick leave or salary continuation plan
- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf; or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits.
- Benefits payable under work-loss provisions of any mandatory "no fault" auto insurance
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgement, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.

Age When Disability Began	Date Monthly Benefits Cease
Age 62 or under	The latter of: (a) your 65th birthday; or (b) the date the 42nd Monthly Benefit is payable;
Age 63	The date the 36th Monthly Benefit is payable;
Age 64	The date the 30th Monthly Benefit is payable;
Age 65	The date the 24th Monthly Benefit is payable;
Age 66	The date the 21st Monthly Benefit is payable;
Age 67	The date the 18th Monthly Benefit is payable;
Age 68	The date the 15th Monthly Benefit is payable;
Age 69 or over	The date the 12th Monthly Benefit is payable.

Income sources that **WILL NOT** reduce your benefits under this plan are:

- Benefits paid by personal, individual disability income policies
- Individual deferred compensation agreements
- Employee savings plans, including thrift plans, stock options or stock bonuses
- Individual retirement funds, such as IRA or 401(k) plans
- Profit sharing, investment or other retirement or savings plans maintained in addition to an employer-sponsored pension plan

This information is a brief description of the important features of this plan. It is not a contract. Terms and conditions of the long-term disability coverage are set forth in Group Policy No. LK8046, on policy form LM-6N05, issued in Florida and subject to its laws. The availability of this offer may change please keep this material as a reference, and file it with your certificate, should you become insured.

How long are my benefits payable?

If you are disabled at or before age 62, your benefits are payable monthly up to age 65, or the date of the 42nd monthly benefit, whichever is later. For disabilities that commence between age 63 and age 69, benefits are payable on a decreasing scale, with a maximum one-year benefit period for disabilities that commence at age 69 or older.

Pre-existing Conditions

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you incurred expenses, received medical treatment, took prescribed drugs or consulted a physician in the three months before the most recent effective date of your insurance, you will receive no monthly benefits for that condition. However, this limitation does not apply to a total disability that begins more than 12 months after the most recent effective date of your insurance.

Family Survivor Benefit

The plan also includes a Family Survivor Benefit feature. With this feature, if you die after collecting disability benefits for six or more consecutive months, we pay an amount equal to 100 percent of the total of your last month's benefit plus any other earnings by which this benefit had been reduced. We continue this benefit for a period of six months.

We pay this benefit directly to your lawful spouse, or to your children (in equal shares), if there is no lawful spouse.

Long-Term Disability Income Protection

What's Not Covered

No Monthly Benefits will be paid if your Disability results, directly or indirectly, from:

- intentionally self-inflicted injuries while sane or insane
- any act or hazard of a declared or undeclared war and
- illnesses or injuries if you are not under the care and supervision of a licensed physician.

Mental Illness, Alcoholism and Drug Abuse Limitation

You can receive payments for a covered disability which does not require hospitalization but results from mental illness, alcoholism or drug abuse for a maximum of 24 months. After 24 months, the benefit will continue only while the disabled employee is confined for at least 14 consecutive days in a hospital licensed to provide care and treatment for the condition causing the disability.

Monthly benefits will be payable for no more than 24 months during your lifetime for Disability or Residual Disability caused or contributed to by one or more of the following conditions:

- Alcoholism
- Drug addiction or abuse
- Bipolar affective disorder (manic depressive syndrome)
- Schizophrenia
- Delusional (paranoid) disorders
- Psychotic disorders
- Depressive disorders
- Anxiety disorders
- Somatoform disorders (psychosomatic illness)
- Eating disorders
- Mental Illness

This limitation does not apply to any period of time during which you are confined for more than 14 consecutive days in a hospital licensed to provide care and treatment for the condition causing the Disability.

Premiums Waived

If your disability entitles you to receive benefits from this plan, your premiums will be waived while you receive benefits.

Your Pre-tax Long-Term Disability Income Protection Rates

Coverage	24 pay periods
Plan I	\$6.49
Plan II	\$8.34
Plan III	\$12.61
Plan IV	\$14.50
Plan V	\$16.19

Conversion Privilege

If you terminate employment or if coverage ends for any reason except non-payment of premium, you can convert this plan to an individual policy by applying for conversion within 31 days of termination. You do not have to submit evidence of good health if you apply within the 31 days. Contact FBMC's Service Center at 1-855-LUCIE4U (1-855-582-4348) to request a LINA Conversion Application.

- the date the plan is terminated by the insurer or the employer
- the day after the last date for which premium has been paid by you or the employer
- the date you become eligible for a plan of benefits intended to replace this coverage.

If you are disabled and receiving benefits under this plan, your benefits and coverage will continue until the expiration of your benefit period, or until you no longer qualify for benefits under the plan, whichever occurs first.

This information is a brief description of the important features of this plan. It is not a contract. Policy No. LK-8046. Written on form # LM-6NO5.

Plan Provider

Coverage is underwritten by Life Insurance Company of North America (LINA). 1601 Chestnut Street, Philadelphia, PA 19192.

The licensed Florida agent is Christine Carolyn Wise #E026735

Disclaimer

As used in this brochure, the term CIGNA and CIGNA Group Insurance are registered service marks of Life Insurance Company of North America, a CIGNA company, which is the insurer of the Group Policy. Insurance products and services are provided by the individual CIGNA companies and not by the Corporation itself.

To Submit a Claim:

Call CIGNA's toll free number at 1-800-36-CIGNA or 1-800-362-4462 and a representative will walk you through the process. CIGNA will take all of the information over the phone.

Will Preparation Program

CIGNA makes it easy for you to take charge of those difficult life and health legal decisions. There are no more reasons to hesitate planning for the future with our online will preparation services. **This program is available at no extra charge to individuals who have CIGNA's long-term or short-term disability coverage.**

Think you don't need a will or living will?

If you're like most people, you don't like thinking about planning for your death. However, there are many good reasons why it's very important to have a will no matter what your personal circumstances might be. For example, you will want to have a say in your healthcare treatment if you're not able to speak for yourself, to assign guardianship for minor children, and to secure your assets.

Think you don't have enough assets to need a will?

Nearly one in four (24 percent) of American adults say their biggest reason for not having a will is a lack of sufficient assets*. Not having a will puts your family in the position of having to guess about how to manage your personal and financial assets after your death.

Think you can't afford to create a will?

Now you can. CIGNA's Will Center allows you to easily complete essential life and health legal documents online at no cost to you. Not sure how to develop your will? Don't worry. CIGNA's Will Center is secure, easy to use, and available to you and your covered spouse seven days a week, 365 days a year. And, if you have any questions, phone representatives are available to assist you toll-free at (800) 901-7534 (no legal advice is provided). Once registered on the site, you will have direct access to a Personal Estate Planning Web page, where you can:

- create and maintain your personalized legal documents
- follow an intuitive, interactive question and answer process to create state-specific legal documents tailored to your situation
- preview, edit, download and print your legal documents for execution

It's easy! Go to CIGNAWillCenter.com

Accessing Cigna's Will Center

To access your personal Estate Planning Web page, simply complete the online form and register as a new user. When prompted for a registration code, provide your date of birth plus the last four digits of your Social Security Number. Once this is completed you can immediately start building your will and other legal documents.

Now is the time to get started. Visit CIGNAWillCenter.com to create your own personalized:

Last Will & Testament – specifies what is to be done with your property when you die, names the executor of your estate and allows you to name a guardian for your minor children.

Living Will – contains your wishes regarding the use of extraordinary life support or other life-sustaining medical treatment.

Healthcare Power of Attorney – allows you to grant someone permission to make medical decisions on your behalf if you are unable to make them yourself.

Financial Power of Attorney – allows you to grant someone permission to make financial decisions on your behalf if you are unable to make them yourself.

Plus find information on:

- Estate Planning
- Identity Theft Information Kit
- CIGNA's Life and Disability Planning Kits – Access insurance calculators to determine whether you and your family have sufficient coverage for the future.

Products and services are provided by underwriting subsidiaries of CIGNA Corporation, including Life Insurance Company of North America and CIGNA Life Insurance Company of New York and not CIGNA Corporation. CIGNA's Will Preparation Services are provided under an arrangement with ARAG. CIGNA's Will Preparation Services are independently administered by ARAG. CIGNA does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG Web site, the services of ARAG or any attorney in the ARAG network.

* - National Association of Estate Planners and Councils. "Wills 101: Everything You Know But Don't Want to Think About." June 2006.

Identity Theft Program

You've heard about it in the news — you may even know someone who's been a victim. Identity theft is America's fastest growing crime, victimizing almost 11 million people a year. It's a serious crime that occurs when an unauthorized person uses your personal information — your name, Social Security Number, bank or credit account number(s), or driver's license number — for fraudulent activity. It's also a silent crime, often taking a year or more to be discovered, leaving victims with a cumbersome, time-intensive process to restore their credit records and good name. **CIGNA's Identity Theft Program is available to individuals who have CIGNA's group long or short-term disability coverage.** This program provides resolution services to help you work through critical identity theft issues you may encounter.

Valuable help when you need it most

- A review of credit information to determine if an identity theft has occurred
- An identity theft resolution kit and an identity theft affidavit for credit bureaus and creditors
- Help with reporting an identity theft to credit reporting agencies
- Assistance with placing a fraud alert on credit reports, and cancellation and replacement of lost or stolen credit cards
- Assistance with replacement of lost or stolen documents
- Access to free credit reports
- Education on how to identify and avoid identity theft
- \$1,000 cash advance to cover financial shortages if needed
- Emergency message relay
- Help with emergency travel arrangements and translation services

Services for every situation

No matter where or when you come under the attack of identity theft, CIGNA's services are there for you.

- We assist with credit card fraud, and financial or medical identity theft;
- We provide real-time, one-on-one assistance—24 hours a day, 365 days a year—in every country in the world;
- You'll have unlimited access to our personal case managers until your problem is resolved;
- Our website offers helpful information to reduce your risk of identity theft before it happens.

If you need help

If you suspect you might be a victim of identity theft, call us now at 1-888-226-4567. Our personal case managers are standing by to help you. Please indicate that you are a member of CIGNA's Identity Theft Program, Group #57.

Group Term Life Insurance

If you're like most people, you want to make sure that your loved ones are adequately provided for if something happens to you. You are eligible for a maximum of \$50,000 Term Life Insurance, which is available guarantee-issue during Open Enrollment.

There are seven levels of group term life insurance available:

\$10,000	\$15,000	\$20,000
\$25,000	\$30,000	\$40,000
\$50,000		

Premium Waiver

You may apply for a waiver of premiums if you have been totally disabled for nine consecutive months while insured under this plan. Call FBMC's Service Center at 1-855-LUCIE4U (1-855-582-4348) for a waiver of premium application.

Coverage Level At Ages 65 and 70

Your benefits decrease by 35 percent at age 65. All benefit amounts in excess of \$3,000 will reduce to \$3,000 at age 70.

Staying Covered

Conversion Privilege at Termination

- If you terminate employment or if your coverage ends for any reason (except non-payment of premium), you have the right to convert this plan to an individual policy by applying for conversion and paying the first premium within 31 days of termination. You do not have to submit evidence of good health if you apply within the 31 days. Contact Fidelity Security Life Insurance Company at 1-800-648-8624, ext. 1100, to request an application for conversion.

Retirement

- If you retire, you may continue your term life coverage. Call FBMC's Service Center at 1-855-LUCIE4U (1-855-582-4348) within the 60-day period before your retirement date to request a Continuation of Benefits Form.

Your Pre-tax Group Term Life Insurance Rates

Employee Coverage	Premium per pay period (24 pay periods)
\$10,000	\$1.55
\$15,000	\$2.33
\$20,000	\$3.10
\$25,000	\$3.88
\$30,000	\$4.65
\$40,000	\$6.20
\$50,000	\$7.75

How to File a Claim:

- The listed beneficiary must notify FBMC Service Center of the claim to begin the process or the beneficiary/family member may directly contact Fidelity Security Life (FSL) to file a claim.
- The listed beneficiary must provide the following
 - The date of death
 - Caller's name and relationship to insured
 - The name, address and phone number of the caller
- The following forms and proofs will be required for submission, including:
 - A completed claim form by beneficiary (if more than one, each beneficiary must complete a form)
 - Certified copy of death certificate
 - If an accidental death, an autopsy report and the police accident or investigation report will be required.
- If a claim process is started through FBMC Benefits Management, letters will be sent to the beneficiary requesting all the forms needed to process the claim. FBMC will forward the claim to FSL for final processing.

Plan Provider

Fidelity Security Life Insurance Company underwrites this plan. Fidelity Security Life Insurance Company has been rated "A-" (Excellent), based on an analysis of financial position and operating performance by A.M. Best Company, an independent analyst of the insurance industry. For the latest rating, visit www.ambest.com.

Policy Form #ML-00072

Policy No. TL-30A/B

Group Cancer Insurance Plan

With improved medical technologies, your chances of surviving cancer are better today than ever before. This plan helps offset the cost of procedures and treatments for you and your covered dependents and pays benefits in addition to any other medical coverage you have.

Plan Features:*

- Benefits are paid directly to you
- Pays regardless of other insurance
- \$100 per day during the first 90 cumulative days that you are hospitalized for cancer. After 91 cumulative days, hospital expenses are fully covered up to \$5,000 per month, in lieu of all other benefits
- Up to \$1,500 for radiation treatment, chemotherapy and X-rays (does not include diagnostic procedures)
- Up to \$120 for anesthesiologist services (\$40 for skin cancer)
- Up to \$1,000 for surgery (per the Policy's surgery schedule)
- Up to \$1,200 for blood and plasma (no maximum for leukemia)
- Up to \$30 per day for a private duty nurse (\$900 maximum), and
- Up to \$50 per ambulance service per confinement (\$500 maximum).
- Cancer Screening Benefit for the insured/insured spouse that pays 50 percent up to \$50 according to the baseline schedule (shown below) per benefit period for a screening by low-dose mammography** for the presence of occult breast cancer. A diagnosis of cancer is not necessary for this benefit to be payable.

Mammography Baseline Schedule

1 baseline - age 35 to 40

1 every two years - age 40 to 50

1 every year - age 50+

* **Note:** All benefits are maximums per illness period. An illness period begins when expenses are first incurred. Following a period of at least 45 days during which no eligible expense is incurred, any eligible expenses incurred thereafter will begin a new illness period. All benefits reduce by 50 percent at age 65.

** Low-dose mammography means X-ray examinations of the breast using equipment dedicated specifically for mammography.

Your Pre-tax Group Cancer Insurance Rates

Coverage	24 pay periods
Employee	\$3.45
Employee & Family	\$5.43

Eligibility

If you, your spouse or your unmarried dependent children under age 25 (must be dependent upon you for support and living in your household or a full time student) have received no medical treatment for any type of cancer within 10 years of your plan's effective date, you are eligible for the Cancer Insurance plan. Your coverage will continue for as long as the Group Master Policy remains in effect, you pay your premiums, and you remain eligible for coverage under the plan.

Exclusions

Benefits will not be paid under the Policy for any of the following: Injury or sickness other than Cancer; expenses the Insured Person is not legally obligated to pay or those charged only because the Insured Person has insurance; treatment or services performed outside of the U.S.; treatment or care not recommended or prescribed by a Physician; treatment or care not listed as a covered benefit by name or specific description; charges incurred while on active duty with any military, naval or air force of any country or international organization; cancer for which compensation is paid under any Worker's Compensation Law, Occupational Disease Law, the 4800 Time Benefit Plan or similar legislation; confinement or treatment in a government Hospital; or any surgical procedure, treatment or drug considered experimental by either the American Medical Association or the Health Care Finance Administration, unless specifically added by option or Rider. This exclusion does not apply to bone marrow transplant procedures recommended by the referring and treating Physician, and also does not apply to any prescription drug that has not been approved by the FDA.

Plan Provider

Fidelity Security Life Insurance Company underwrites this plan. Fidelity Security Life Insurance Company has been rated "A-" (Excellent), based on an analysis of financial position and operating performance by A.M. Best Company, an independent analyst of the insurance industry. For the latest rating, visit www.ambest.com.

Policy Form #M-7000-FL

Policy No. CA-54

Flexible Spending Accounts

Medical Expense FSA

A Medical Expense FSA is used to pay for eligible medical expenses which aren't covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as after school care, baby-sitting fees, elder care services, nursery and preschool. Eligible dependents include your qualifying child, spouse and/or relative.

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Annual Contribution Limits

For Medical Expense FSA:

Minimum Annual Deposit: \$150
Maximum Annual Deposit: \$2,500

For Dependent Care FSA:

Minimum Annual Deposit: \$150

The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

Using Your FSA Dollars

When you pay for an eligible health care or dependent care expense, you want to put your account to work right away. WageWorks gives you several convenient reimbursement options.

Filing a claim

You can file a claim online to request reimbursement for your eligible expenses. To submit a paper claim by fax or mail, log into your account, download a Pay Me Back claim form and follow the instructions for submission. You may also contact WageWorks Customer Service at 1-855-428-0446 to obtain a claim form.

- Go to www.myfbmc.com, log into your account and click the Health Care or Dependent Care tab.
- Select the online claim form.
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
 - Date of service or purchase
 - Detailed description
 - Provider or merchant name

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

Examples of how to use your FSA

Medical Expense FSA Example:

Paying an office visit

After paying for your care at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with a claim form to WageWorks. Within five business days, WageWorks will process your request and mail your reimbursement check to you or direct deposit your funds into the account of your choice.

Dependent Care FSA Example:

Paying for dependent care services

Once you have paid for (and received) dependent care service, send a completed claim form to WageWorks, along with documentation showing the following:

- Provider Name – Facility name or person who provided the service.
- Dates of Service – Start and end dates for services provided.
- Service Description – Detailed description for services provided.
- Amount – The amount incurred for the services.
- Dependent Name – Person who received the service.

Your request will be processed within five business days and either mailed to you or deposited into the account you have chosen.

FSA Worksheets

Use the worksheets below to determine how much to deposit in your FSA. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount (including the administrative fees) cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

Medical Expense FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles \$ _____

Coinsurance or co-payments \$ _____

Vision care \$ _____

Dental care \$ _____

Prescription drugs \$ _____

Travel costs for medical care \$ _____

Other eligible expenses \$ _____

TOTAL (cannot exceed \$2,500) \$ _____

DIVIDE by the number of paychecks you will receive during the plan year.* \div _____

This is your pay period contribution. \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services \$ _____

In-home care/au pair services \$ _____

Nursery and preschool \$ _____

After school care \$ _____

Summer day camps \$ _____

ELDER CARE SERVICES

Day care center \$ _____

In-home care \$ _____

TOTAL Remember, your total contribution cannot exceed IRS limits. \$ _____

DIVIDE by the number of paychecks you will receive during the plan year.* \div _____

This is your pay period contribution. \$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Direct Deposit delivers your money to you faster, and unlike with a check, the funds are in your account automatically – no waiting in bank or ATM lines, no waiting for it to clear.

You will have the opportunity to elect Direct Deposit reimbursements when setting up your profile.

Please note the bank information entered will be sent to the bank to confirm the account number. Any reimbursements issued during this prenote process will be issued as a check until this process has been completed. If you do not want your reimbursements sent via direct deposit, you may have your reimbursements sent via a check to your home address.

Limited-Use Medical FSA

For HSA Participants Only

Minimum Annual Deposit: \$250
Maximum Annual Deposit: \$2,500

Participants enrolled in a Health Savings Account will not be eligible to enroll in a standard Medical Flexible Spending Account.

What is a Limited-Use Medical Reimbursement Account?

A Limited-Use Medical Expense FSA is designed specifically for employees who wish to take advantage of a Health Savings Account (HSA), while continuing to enjoy the tax savings expected from an FSA. Much like a Medical Expense FSA, funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. **However, the funds in a Limited-Use Medical Expense FSA can only be used for dental, vision and preventive care expenses not covered by your high deductible health plan.** Your HSA is designed to be used for all other medical-related expenses. A partial list of eligible Limited-Use Medical Expense FSA expenses can be found on this page.

Aside from these minor differences, a Limited-Use Medical Expense FSA follows the same procedures for reimbursement as a Medical Expense FSA.

Whose expenses are eligible?

Your Limited-Use Medical Expense Flexible Spending Account may be used to reimburse eligible expenses incurred by yourself, your spouse, your qualifying child or your qualifying relative. You may use your Dependent Care Flexible Spending Account to receive reimbursement for eligible dependent care expenses for qualifying individuals. Please see the Flexible Spending Account FAQs at www.myFBMC.com.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Medical Expense FSA. Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

Filing a claim

You can file a claim online to request reimbursement for your eligible expenses. To submit a paper claim by fax or mail, log into your account, download a Pay Me Back claim form and follow the instructions for submission. You may also contact WageWorks Customer Service at 1-855-428-0446 to obtain a claim form.

Partial List of Medically Necessary Eligible Expenses*

Birth control pills and devices for dependent children
Contact lenses (corrective)
Dental fees
Eyeglasses
Guide dogs
LASIK
Optometrist fees
Orthodontic treatment

Note: Budget conservatively. No reimbursement or refund of a Limited Medical Expense FSA funds is available for services that do not occur within your plan year.

* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year.

- Go to www.myfbmc.com, log into your account and click the Health Care or Dependent Care tab.
- Select the online claim form.
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
 - Date of service or purchase
 - Detailed description
 - Provider or merchant name

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

When are my funds available?

Once you sign up for a Limited-Use Medical Expense FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible expenses at the start of your plan year, which is January 1, 2014.

There is no administrative charge for a Limited-Use Medical Expense FSA.

Trustmark LifeEvents

* This benefit is only offered during Open Enrollment

How does LifeEvents work?

LifeEvents combines two important benefits – permanent life insurance and long-term care – into one affordable product. With LifeEvents, your benefits may be paid under the Accelerated Death Benefit Insurance Rider, under the Long-Term Care Insurance Rider, or as a combination of both. Let's take a closer look.

Accelerated Death Benefit Insurance Rider

Most people buy life insurance for the financial security of the death benefit. And it's easy to see why. A death benefit puts money in your family's hands quickly when they need it most. It's money they may use any way they want to help cover short- and long-term expenses like these:

- Funeral costs
- Rent or mortgage payments
- College tuition for children or grandchildren
- Debt
- Retirement and more

Long-Term Care Insurance Rider

This benefit makes it easy to accelerate the death benefit to help pay for home healthcare, assisted living, nursing care and adult day care services when you are chronically ill, should you or your covered spouse ever need them.

The LifeEvents Advantage

LifeEvents is unique. It's designed to match your needs throughout your lifetime, so you have the benefits you need, when you need them most. See for yourself:

Working years

LifeEvents pays a higher death benefit during working years when expenses are high and your family needs maximum protection. Then at age 70, when expenses typically reduce, LifeEvents reduces the death benefit amount to better fit your needs; however, your benefits for the Long-Term Care Insurance Rider never reduce.¹

Throughout retirement

LifeEvents pays a consistent level of benefits during retirement, which is when you may be susceptible to becoming chronically ill and may need long-term care services.

Features you'll appreciate

Lifelong protection – Provides coverage that will last your lifetime.

Family coverage – Apply for your spouse even if you choose not to participate. Dependent children and grandchildren may be covered under a Universal Life certificate.

Accelerated Death Benefit Insurance Rider – Accelerates up to 75 percent of your death benefit if your doctor determines your life expectancy is 24 months or less.

Guaranteed renewable – Guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all certificates in your class changes.

Let's see LifeEvents in action

Example: 35-year old, \$8/week premium, \$75,000 benefit

	Before Age 70	Age 70+
Death Benefit: \$75,000	\$75,000	\$75,000 ¹
LTC Benefit	\$75,000	\$25,000

¹Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 64 and under.

Why buy LifeEvents at work?

1. **Portability** – Take your coverage with you and pay the same premium if you change jobs or retire.
2. **Payroll deduction** – No bills to watch for. No checks to mail. A direct bill option is available when you change jobs or retire.
3. **One-on-one guidance** – You'll get personalized benefit advice and assistance with the application process from a Florida-licensed agent.

Let's see how Living Benefits add up

Example: \$100,000 Death Benefit	Maximum Benefit
Long-Term Care Insurance Rider (LTC)²	\$100,000
Pays a monthly benefit equal to 4 percent of your death benefit for up to 25 months. The Long-Term Care Insurance Rider accelerates the death benefit and proportionately reduces it.	
Benefit Restoration Insurance Rider	\$100,000
Restores the death benefit ² that is reduced by the Long-Term Care Insurance Rider, so your family receives the full death benefit amount when they need it most.	
Total Maximum Benefit	\$200,000
Living Benefits may double the value of your life insurance.	

²The Long-Term Care (LTC) Insurance Accelerated Death Benefit Rider is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services, and to qualify for benefits you must be chronically ill. Pre-existing condition limitation may apply. Please consult your certificate for complete details.

Accident Insurance

Accident insurance helps pay for unexpected healthcare expenses due to non-occupational accidents that occur every day – from the soccer field to the beach and the highway in-between. Accident insurance provides benefits due to covered accidents for initial care, injuries and follow-up care. Benefits are paid directly to the employee, in addition to any other coverage they have.

Who is Eligible?

- Employees – Ages 17 to 80, actively working full-time
- Spouses – Ages 17 to 80, who are not disabled
- Children – Birth to age 26, who are unmarried and dependent

For the 2014 Open Enrollment, the accident plan effective date will be February 1, 2014 as long as you are an active employee.

Plan Features

- Coverage for non-occupational injuries
- Guaranteed issue – No medical questions
- Level premiums – Rates do not increase with age
- No limitations for pre-existing conditions
- Guaranteed renewable – Coverage remains in force for life, as long as premiums are paid
- Portable coverage – Employees can continue coverage if they leave or retire

Wellness Benefit

Promotes good health among employees and their families by providing them a \$100 benefit to offset the cost of going to the doctor for routine physicals, immunizations and health screening tests, regardless of other coverage. The benefit provides a maximum of two visits per person, annually.

Eligible tests include:

- Low-dose mammography
- Pap smear for women over age 18
- Flexible sigmoidoscopy
- Hemocult stool specimen
- Colonoscopy
- Prostate-specific antigen (PSA) test for prostate cancer
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Bone marrow testing
- Serum cholesterol test to determine HDL and LDL levels
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Serum protein electrophoresis (blood test for myeloma)
- Immunizations
- Themograph

Your Post-Tax Accident Insurance Rates

	24 pay periods
Employee only	\$8.41
Employee & spouse	\$12.85
Employee & children	\$20.69
Employee & family	\$25.13

Accidental Death Benefit

- Provides an additional lump-sum benefit for an accidental death that occurs within 90 days of a covered accident:
 - Pays \$100,000 for the insured, \$50,000 for spouse and \$25,000 for a child.
 - The benefit doubles if the accidental death is due to a common carrier.

Catastrophic Accident Benefit

- Provides an additional lump-sum benefit for catastrophic loss after fulfilling a 90-day elimination period:
 - Pays \$150,000 for the insured, \$75,000 for the spouse and \$75,000 for a child.
 - A catastrophic loss is the loss of use of sight, hearing, speech, both arms or legs.

Definitions

Covered Accident

An accident causing injury, which:

- Occurs after the effective date;
- Occurs while the certificate is in force; and
- Is not excluded by name or specific description in the certificate.

Elimination Period

The period of time after the date of a covered accident for which catastrophic accident benefits are not payable.

Injury or Injuries

An accidental bodily injury that resulted from a covered accident. It does not include sickness, disease or bodily infirmity. Overuses syndromes, typically due to repetitive or recurrent activities, such as osteoarthritis, carpal tunnel syndrome or tendonitis, are considered to be a sickness and not an injury.

Maximum Benefit Period

The longest period of time for which hospital benefits will be paid.

Non-occupational Injury

An injury that did not result from a person's work or occupation; applicable to non-occupational coverage only.

Waiting Period

The period of time following the effective date of the certificate during which wellness benefits are not payable.

Accident Insurance

Benefits for Non-Occupational Coverage, Plan 3

Accident/Injury	Benefit Amount Florida
Accident Follow-Up Treatment	\$200
Accidental Death Benefit Rider	Employee \$100,000 Spouse \$50,000 Children \$25,000
Accidental Death Benefit Rider Common Carrier	Employee \$200,000 Spouse \$100,000 Children \$50,000
Ambulance	\$600
Air	\$2,500
Appliance	\$250
Blood, Plasma and Platelets	\$600
Burns – Flat Amount for:	
Third-degree 35 or more sq. in	\$25,000
Third-degree 9 to 34 sq. in.	\$4,000
Second-degree for 36% or more of body	\$2,000
Catastrophic Accident Benefit	Employee \$150,000 Spouse \$75,000 Children \$75,000
Concussion	\$200
Dislocations	
Open reduction	Up to \$12,000
Closed reduction	Up to \$6,000
Doctor's Office Visit	\$200
Emergency Dental Benefit	
Extraction	\$150
Crown	\$450
Emergency Room Treatment	\$150
Eye Injury	\$400
Fractures	
Open reduction	Up to \$15,000
Closed reduction	Up to \$7,500
Chips	25% of closed amount
Herniated Disc	\$1,000
Hospital Admission	\$3,200
Hospital Confinement	\$500
Hospital ICU	\$1,000
Laceration	\$50 - \$1,000
Lodging	\$200 per night up to 30 days
Loss of finger, toe, hand, foot or sight of an eye	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	\$30,000
Loss of one hand, foot or sight of one eye	\$15,000
Loss of two or more fingers, toes or any combination of two or more losses	\$3,000
Loss of one finger or one toe	\$1,500
Physical Therapy	\$100 per visit, up to six visits
Prosthetic Device or Artificial Limb	
More than one	\$2,000
One	\$1,000
Skin Grafts	25% of burn benefit
Surgery	
Open, abdominal, thoracic	\$2,000
Exploratory	\$200
Tendon/Ligament/Rotator Cuff	
Repair of more than one	\$1,500
Repair of one	\$1,000
Exploratory without repair	\$200
Torn Knee Cartilage	\$1,250
Exploratory	\$200
Transportation	\$600 (100 miles up to three trips)
Wellness Benefit	\$100

Critical Illness/Cancer Insurance

Eligibility

The Critical Illness Plan can provide a benefit ranging from \$5,000 - \$100,000. This plan gives you the flexibility of using the money at your own discretion.

The plan provides an immediate pre-selected lump sum cash benefit upon first diagnosis of a covered critical illness or cancer after the plan's effective date. Your benefit is paid in full regardless of whether you have started treatment and allows you to decide how to use your benefit money.

For the 2014 Open Enrollment, Critical Illness coverage will be effective February 1, 2014 as long as you are an active employee.

Plan Features

- The Critical Illness Plan includes cancer coverage. However, the plan can be separated for "cancer-only" or "critical illness-only" coverage. See your Professional Benefits Counselor for further details.
- Waiver of Premium Rider available.
- You may add the EZ Value Plan Option, which automatically increases your coverage annually on each of the first five policy anniversaries. The increase is equal to the amount of protection an additional \$1 per week of deduction would purchase.*

* Maximum issue age is 60.

Health Screening Benefit

Pays the cost of one screening test per calendar year (up to \$100 benefit maximum). Eligible tests include:

- Low Dose Mammography
- Pap Smear (women over age 18)
- Hemocult Stool Specimen
- Prostate Specific Antigen
- Colonoscopy
- Flexible Sigmoidoscopy
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine levels of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Serum Protein Electrophoresis
- Thermography

Your Post-Tax Critical Illness Rates

Rates vary based on sex, age and if you are a smoker or non-smoker. Please check with your enroller for more information. To make an appointment, go to myenrollmentschedule.com/stlucie

Issue Ages

- Employees — 18 through 70
- Spouse — 18 through 70
- Children — 15 days through 26

What payroll deduction premiums will I pay for this plan?

You select the coverage and premium that best fits your budget and family needs. As a St. Lucie County Schools employee, your group purchasing power ensures you receive a high insurance value at an affordable cost. Speak with your Professional Benefits Counselor for more information.

Can I continue my coverage if I terminate employment or retire?

Yes. This plan is portable after the first payroll deduction. You can continue with the full amount of insurance coverage and arrange for premiums to be billed directly to you. This will automatically occur when your payroll deductions stop or you can call Trustmark's Customer Service at 1-800-918-8877.

How do I make changes to my election?

You may elect to change your policy after it goes into effect by calling the Trustmark Service Center at 1-800-918-8877. Changes are forwarded to your employer and should be reflected in your paycheck within two to four weeks.

What if I have questions about my certificate?

After you enroll, you can get answers about your certificate by calling Trustmark Customer Service at 1-800-918-8877.

Plan Provider

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" (Excellent). This information is being provided to employees in advance of more complete information from the insurer.

Policy Form CACI-82001

Your Employee Assistance Program

St. Lucie County Schools is pleased to provide an Employee Assistance Program (EAP) benefit at no cost to eligible employees, spouses, and dependents. You're automatically enrolled. No ID is required!

MHNet's EAP Program provides a variety of short-term counseling and informational services; available for problems not normally covered under the mental health provisions in your healthplan. EAP provides individuals with the resources and tools to live a balanced and healthy life at home and work.

What happens when you call MHNet?

When you contact MHNet, a telephonic assessment is conducted with you to determine what services will best assist you. If a referral to a network provider is necessary, the assessment will include gathering your specific provider criteria such as location, day and time availability, and specialty. The network provider will conduct a formal, face-to-face assessment at your first session.

Services Your EAP Offers:

Face-to-face Counseling for, but not limited to:

- Marital and Family Relationships
- Stress Management
- Alcohol and Drug Issues
- Work-related Concerns
- Depression and Anxiety
- Bereavement
- Life Coaching Services
- Online Services and Access
- Webinars
- Online Mental Wellness Services
- Legal Services
- Consultation
- Referrals
- Financial Services
- Consultation
- Referrals
- Webinars

How do EAP benefits work?

If you or a member of your family receives a mental health diagnosis and you are enrolled in the health plan, you will be referred to the Mental Health and Substance Abuse benefit and will be subject to a co-pay.

In-Network Benefits include:

- Up to six [6] face-to-face visits per year for employee and eligible family members to an approved EAP provider
- Legal and financial consultation and referrals
- Up to three [3] telephonic Life Coaching sessions per issue
- No cost to employee

Out-of-Network Benefits include:

- Must be pre-authorized by MHNet
- Providers paid at in-network rates
- Member may be responsible for additional charges

How does the Mental Health/Substance Abuse Program benefits work?

The first outpatient visit in the Mental Health/Substance Abuse Program does not require authorization. After the first visit, your provider will be required to send in a treatment report requesting further visits and authorization for continued service.

Is it confidential?

Seeking help from MHNet is between you and the counselor or provider. No information may be shared with anyone else unless you give the counselor or provider written permission to do so. St. Lucie County Schools supports the MHNet policy of confidentiality.

How do I access EAP benefits?

Services are available online at MHNet's web site. To access, please go to:

www.mhneteap.com

Login using:

USERNAME: St Lucie School Board

PASSWORD: 8002723626

Your Online Services Menu will appear. Choose the menu item of interest and enjoy!

You can also inquire about EAP Benefits by contacting MHNet Customer Service at 800-272-3626.

Changing Your Coverage

Changing your benefits during the Plan Year

Within **60 days** of a qualifying event, you must submit a Change in Status (CIS)/Election Form and supporting documentation to FBMC. Upon the approval of your request, your existing elections will be stopped or modified (as appropriate). Visit www.myFBMC.com for information on rules governing periods of coverage and IRS Special Consistency Rules.

Changes in Status:	
Marital Status	Includes changes in marriage by death of a spouse, divorce or annulment. Legal separation may not be recognized in all states.
Change in Number of Tax Dependents	Includes birth, death, adoption and placement for adoption. Existing dependents, not previously enrolled, may be added based on a valid CIS event.
Change in Status of Employment Affecting Coverage Eligibility	Includes changes in commencement or termination of your employment or your spouse or dependent's employment status that affects coverage eligibility.
Gain or Loss of Dependent Eligibility Status	Whereby your dependent satisfies or ceases to satisfy insurance coverage requirements, based on changes in their age, student, marital, employment or tax dependent status.
Change in Residence*	Includes whether you, your spouse or dependents move out of an HMO service area.
Some Other Permitted Changes:	
Coverage and Cost Changes*	Includes changes to Dependent Care FSA contribution by switching dependent care providers, due to coverage and cost changes. Custodial care for your eligible dependent by a provider related by blood or marriage does not qualify as a valid CIS event.
Open Enrollment Under Other Employer's Plan*	Valid when your spouse or dependent makes an Open Enrollment change in coverage under their employer's plan if they participate in their employer's plan and: <ul style="list-style-type: none"> • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	Includes changes to dependent child/foster child coverage based on a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody. Based on the judgement/decree/order, you may also revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pretax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 60 days of one of the following CIS events: birth, adoption, placement for adoption or if employee experiences a Medicaid or CHIP event. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Medical Expense FSA plan.

† Does not apply to a Dependent Care FSA plan.

COBRA and Retiree Q&A

What is continuation coverage?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. This right extends to your plan's Medical Expense FSA.

How long will continuation coverage last?

COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

For Medical Expense FSA, continuation coverage is generally limited to the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the account for the year. For example, if you elected a Medical Expense FSA benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your Medical Expense FSA for the remainder of the plan year or until such time that you receive the maximum Medical Expense FSA benefit of \$1,000.

If your employer funds all or any portion of your Medical Expense FSA, you may be eligible to continue your Medical Expense FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Medical Expense FSAs.

If you have questions about your employer-funded Medical Expense FSA, call FBMC Service Center at 1-8555-LUCIE4U (1-855-582-4348).

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and FBMC.

Until FRS deductions begin, payment by personal check or money order is required. Full premium payment(s) for health, life or optional insurance(s) must be paid by the due date specified.

Can I receive COBRA benefits while on FMLA leave?

The Family and Medical Leave Act (FMLA), requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions coverage would have been provided if the employee had continued working. Therefore coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. However, a COBRA qualifying event may occur when your employer's obligation to maintain health benefits under FMLA ceases, such as when you notify your employer of your intent not to return to work.

What should I do when I retire?

During the 90 days prior to your anticipated retirement date, contact your School Board payroll office and schedule an appointment to discuss retirement and continuation of group health/life plans and flexible benefits.

For More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from your employer. You can get a copy of your summary plan description from **St. Lucie County Schools**.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, U.S. Department of Labor.



Important Notice from St. Lucie County School Board About Your Prescription Drug Coverage and Medicare

Please note that this notice only pertains to you if:

- You are Medicare eligible (over age 65 or considered disabled by the Social Security Administration) and currently covered or eligible for coverage under the health plan sponsored by St. Lucie County School Board for retired employees, or
- You have a dependent spouse/domestic partner or child who is covered by Medicare or Medicaid and who is currently covered or eligible for coverage under the health plan sponsored by St. Lucie County School Board for employees and retired employees.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with St. Lucie County School Board and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. St. Lucie County School Board has determined that the prescription drug coverage offered by the St. Lucie County School Board Prescription Drug Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

While you have Creditable Coverage, you can decline coverage under Medicare Part D and if you decide to enroll in Medicare Part D in the future, you will not be assessed a late payment charge by the Center for Medicare and Medicaid Services (CMS). This letter serves as your “Notice of Creditable Coverage.” If you are covered under the St. Lucie County School Board Prescription Drug Plan, you have Creditable Coverage.

- Enrollment for Medicare Part D for the 2014 calendar year begins October 15, 2013 and runs through December 7, 2013. If you elect the St. Lucie County School Board Prescription Drug Plan for 2014, you will have Creditable Coverage and you can choose to delay enrollment in Medicare Part D without paying a Medicare Part D late enrollment penalty. As long as you maintain Creditable Coverage, you will not be assessed a late enrollment penalty if you choose to enroll in Medicare Part D at a later date. Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare. If you leave employment during the year, you may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.
- If you enroll or your dependent enrolls in Medicare Part D for the 2014 calendar year, you or your dependent cannot maintain coverage in the St. Lucie County School Board Prescription Drug Plan. If you or one of your dependents enrolls in Medicare Part D, you must disenroll them from the St. Lucie County School Board Prescription Drug Plan. To disenroll yourself or your dependent from prescription coverage, please call Risk Management. You will be able to re-enroll in the St. Lucie County School Board Prescription Drug Plan in the future during each annual open enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with St. Lucie County School Board and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be

at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Risk Management Department for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through St. Lucie County School Board changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov , or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	09/05/13
Name of Entity/Sender:	St. Lucie County School Board
Contact--Position/Office:	Risk Management
Address:	4204 Okeechobee Road, Fort Pierce, FL 34947
Phone Number:	(772) 429-5520

Beyond Your Benefits

Deferred Compensation (457 Plan)

Participating in the Flexible Benefits Plan may affect your maximum annual contribution to the 457 plan. That is, Flexible Benefits Plan contributions reduce includible compensation* from which the maximum deferrable amount is computed. You should contact the Deferred Compensation vendor or the Tax Deferred Annuity (TDA) provider about the specific effect of the Flexible Benefits Plan.

* Includible compensation is the gross income shown on your W-2 form.

Taxable Benefits and the IRS

Disability Income Protection — Disability benefits may be taxed when an employee becomes disabled depending on how the premiums were paid during the year of the disabling event. For example, if you purchased disability coverage with pretax premiums and/or nontaxable employer credits, any disability payments received under the plan will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and after-tax dollars, then any disability payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis and a disability entitles you to receive payments, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance — If the premiums for these plans are paid with pretax dollars and/or nontaxable employer credits, you will be required by the IRS to pay FICA, Medicare and federal income taxes on your benefit payments that exceed the actual medical expenses you incur. If you have questions, consult your personal tax adviser.

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums tax-free on your first \$50,000 of life insurance. You must pay tax on premiums for coverage exceeding \$50,000.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s) and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies and procedures from time to time adopted.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC's Service Center at 1-855-LUCIE4U (1-855-582-4348) for an approximation.

FBMC Privacy Statement

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC 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 FBMC. This Privacy Statement explains how FBMC 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. Note this Privacy Statement

is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally vary 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, such as 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 Federal Law 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 your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

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

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 will share personal information of VISTA 401(k) participants with the plan's recordkeeper. We also may 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. If you no longer have a customer relationship with us, we will still treat your information under 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 FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

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

1. **Contract Administrator.** FBMC Benefits Management (FBMC) has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.
2. **Policyholder.** This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. **Insurer.** The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC 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 FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Benefits Directory

Florida Blue

Customer Service
Mon - Fri, 8 a.m. - 6 p.m. ET
1-800-664-5295
www.floridablue.com

Melissa Rusignuolo
Florida Blue On-Site
Group Service Rep. Health
772-429-7702
772-343-1193 (fax)
melissa.rusignuolo@floridablue.com
www.floridablue.com

Health Equity

(Health Savings Account/Bank)
1-866-346-5800

Delta Dental Insurance Company

Customer Service
Mon - Thurs, 7:15 a.m. - 7:30 p.m. ET
1-800-521-2651
www.deltadentalins.com

VisionCare Plan (VCP),

a Humana Company (Vision)
Member Services
Mon - Fri, 8 a.m. - 5 p.m. ET
1-800-865-3676
www.compbenefits.com

Fidelity Security Life Insurance Company

(Group Hospital Indemnity Insurance,
Group Term Life and Group Cancer Insurance)
Service Center
Mon - Fri, 7 a.m. - 10 p.m. ET
1-855-LUCIE4U (1-855-582-4348)

Life Insurance Company of North America,

a CIGNA Company
(Long and Short Term Disability)
www.cigna.com
1-800-36-CIGNA (1-800-362-4462)
(Will Preparation)
1-800-901-7534
CIGNAWillCenter.com

Trustmark

(Accident Insurance, Critical Illness, LifeEvents
Universal Life)
Customer Service
Mon - Thurs, 8 a.m. - 8 p.m. ET
Fri, 8 a.m. - 7 p.m. ET
1-800-918-8877
Wellness Fax Claim#
1-508-853-2867
www.trustmarksolutions.com

WageWorks

(Flexible Spending Accounts)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-855-428-0446
Toll-Free Claims Fax
1-855-291-0625

Transamerica Life Insurance Company

(Long Term Care Insurance Division for
existing policies only)
Customer Service
Mon - Fri, 9 a.m. - 6 p.m. ET
1-800-227-3740

Transamerica Life Insurance Company

(Universal Life Insurance for existing
policies only)
Customer Service
Mon - Fri, 9 a.m. - 6 p.m. ET
1-800-322-0426

MHNet (EAP)

(Employee Assistance Program)
Customer Service
24 hours a day
1-800-272-3626



Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Service Center 1-855-LUCIE4U (1-855-582-4348) • 1-800-955-8771 (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.