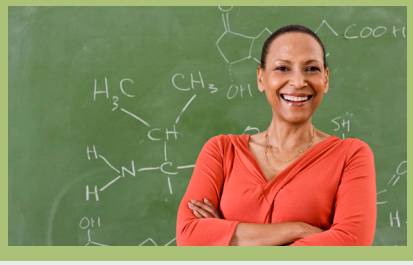
2017

BENEFITS MADE SIMPLE

St. Lucie Public Schools

Flexible Benefits Plan Reference Guide



2017 St. Lucie Public Schools

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What's New?

Welcome to your 2017 St. Lucie Public Schools (SLPS) Benefits Open Enrollment. Open Enrollment is your annual opportunity to make changes to your benefit elections. SLPS is committed to providing security for you and your family by offering a comprehensive and affordable benefits program. It is your responsibility to read the benefit plan information before making your elections. Your benefits are a valuable part of your employment with St. Lucie Public Schools. Be sure you are making the most of them.

This year, SLPS continues to support the theme, "Benefits Made Simple," to highlight easier access to your benefits information through this interactive guide, which includes: videos with valuable information, links to help you quickly access websites and directional tabs to help you easily navigate through the guide.

You are encouraged to read your Benefits Plan Reference Guide, which provides the information necessary to help you decide the benefits that are right for you. It is also a good tool to refer to throughout the year.

All benefit-eligible employees actively at work will have the opportunity to enroll online at www.myFBMC.com or schedule an appointment with a Professional Benefits Counselor.

What's New?

- **Open Enrollment for your 2017 plan year benefits will be between October 10, 2016 through October 28, 2016. Make sure you don't miss out on scheduling a personal appointment with a Benefits Counselor today!** To make an appointment, go to **www.myenrollmentschedule.com/stlucie.**
- **Visit with a Professional Benefits Counselor to enter the raffle to win a bicycle or one of several gift cards!**
- **NEW for 2017!** You may now enroll in ARAG Group Legal plan coverage. See page 44 for plan details!
- **NEW for 2017!** SLPS now offers Trustmark Critical LifeEvents voluntary benefit. See page 53 for plan details.
- Trustmark Critical Illness/Cancer Insurance will no longer be offered for 2017.
- **Fidelity Security Life will no longer offer the Group Cancer Policy, effective 1/1/2018. For the 2017 Plan Year, your existing policy can be changed from "employee and family" to "employee only" or your policy can be cancelled. No new enrollments will be permitted.**
- SLPS continues to offer you two different BlueOptions medical plans, which include a high-deductible health plan. Employees that choose the high-deductible health plan may also add a Health Savings Account (HSA).
- **For the 2017 Plan Year, SLPS will make a one-time contribution of $750 to a Health Savings Account in January, 2017 to each employee enrolled as of January 1, 2017 in the BlueOptions Plan 05180/05181. For employees enrolled after January 1, 2017, SLPS will contribute $31.25 per pay period to the Health Savings Account through June 30, 2017.**
- Employees hired January 1, 2014 or later are only eligible to enroll in the BlueOptions 05180/05181 Plan.
- **SLPS offers "dual employee family" health plan coverage.** If both you and your spouse are employed by SLPS 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.

  Note: The HSA employer contribution for each employee in the "dual employee family" will be combined and distributed into the primary spouse's account only. Health Equity does not have the ability for the secondary employee to be recognized as a member. The secondary employee can only be listed as a dependent.

  The enrollment process for "dual employee family" 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 at 772-429-5521 to schedule your special enrollment session.

About Your Benefits

Introduction

SLPS offers a wide range of benefits to our benefit-eligible employees. This reference guide will describe your available benefits, which include: medical, dental, vision, group hospital indemnity, group term life, disability, will preparation, ID theft, flexible spending accounts, limited use medical flexible spending accounts, legal and voluntary benefits, such as accident, critical illness/cancer and critical life events coverages. During Open Enrollment, all benefit eligible employees can make changes to their current elections or add new coverages. If you choose to meet with a Professional Benefits Counselor, please review the benefit materials prior to your appointment so you are prepared to make critical decisions.

What Benefits are Available?

SLPS recognizes that your needs change from year to year. We are providing one-to-one benefits sessions. Your Professional Benefits Counselor will provide you with guidance on the following valuable benefits:

Health — provides comprehensive medical and pharmacy benefits.

Dental — provides valuable dental benefits with a Low or High PPO plan.

Vision — offers two vision care options available, the In-Network Option and the Out-of-Network Option.

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

Disability Income Protection (STD/LTD) — provides a stable income source to carry you and your family through a temporary or long-term disability.

Will Preparation — This is a program available at no extra charge to individuals who have Cigna's long-term or short-term disability coverage.

ID Theft — This is a program available at no extra charge to individuals who have Cigna's long-term or short-term disability coverage.

Group Term Life — provides a maximum of $50,000 Term Life Insurance, which is available guaranteed issue during Open Enrollment.

Health care Flexible Spending Accounts — can help you save tax dollars on qualified medical expenses and certain over-the-counter drugs and medicines.

Dependent Care Flexible Spending Accounts — can help you save tax dollars on care for your dependents while you are working or actively looking for work.

Accident Insurance — helps pay for unexpected health care expenses due to non-occupational accidents and insurance provided benefits due to covered accidents for initial care, injuries and follow-up care.

Critical Illness LifeEvents — This plan pays benefits for early identification as well as for later-stage diagnosis of critical illnesses. Earlier benefits help provide funds as quickly as possible to help ensure that treatment or preventive measures may stave off late-stage illness.

Universal LifeEvents — matches your needs throughout your lifetime. Includes accelerated death benefit, built-in long-term care benefit, accidental death benefit, EZ Value Plan, children's term benefit and waiver of premium.

Employee Assistance Program (EAP) — provides a variety of short-term counseling and informational services.

Legal - provides affordable and reliable legal counsel for everyday life matters through a nationwide network of more than 10,000 credentialed attorneys.

Did you know?

SLPS will make a one-time contribution of $750 to a Health Savings Account on January 1, 2017 if you are enrolled in the BlueOptions Plan 05180/05181.

Enrollment at a Glance

Important Dates to Remember

Your Open Enrollment dates are:
October 10, 2016 through October 28, 2016

Your Period of Coverage dates are:
January 1, 2017 through December 31, 2017

Period of Coverage dates for Trustmark Voluntary Benefits:
February 1, 2017 through January 31, 2018

Things to Know About Your Open Enrollment

- Attend your consultation with your Professional Benefits Counselor to learn about your flexible benefits. You may ask any plan questions at this time. **Visit a Professional Benefits Counselor to enter the raffle to win a bicycle or one of several gift cards!**
- **Complete your enrollment online at www.myFBMC.com or with the assistance of a Professional Benefits Counselor by October 28, 2016. To make an appointment with a Professional Benefits Counselor, go to www.myenrollmentschedule.com/stlucie.**
- Remember to bring all necessary dependent and beneficiary information to your enrollment session, including your dependent(s)' Social Security number(s) and date(s) of birth.
- **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 FRS.
- 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 - 7 p.m. ET.

Pre-Enrollment Checklist

Bring the following information to your appointment when you see a Professional Benefits Counselor.

- ☐ **Social Security numbers** for your dependents
- ☐ **Dates of Birth** for all your dependents and beneficiaries
- ☐ **Addresses** for all your dependents and beneficiaries

Premium Conversion

Premium conversion lets you set aside money from your pre-tax 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 an enrollment change, request for a mid-plan year election change or a reimbursement claim denied, in full or in part, you have the right to appeal the decision by sending a written request for a review within 30 days of the initial denial.

Your appeal must include:

- The name of your employer
- Your contact information, including an email address so that you may be contacted easily and timely
- Why you believe your variance request should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal
- If your appeal is the result of a denied reimbursement request, you must also include the date of the services for which your request was denied, a copy of the denied request, and the denial letter you received

Enrollment appeals should be sent to:
FBMC Benefits Management, Inc.
Enrollment Appeals
P.O. Box 1878, Mail Slot 79
Tallahassee, FL 32302-1878
Fax to: 1-850-425-6220

For FSA claims reimbursement:
PayFlex Systems USA Inc.
P.O. Box 3039
Omaha, NE 68103-3039
Fax to: 1-855-703-5305

Change in Status

You can only make benefit changes outside of the Open Enrollment period if you have a qualified Change in Status (CIS). 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. Please contact Risk Management if you have experienced a qualifying event so they may assist you with filing your CIS. Please provide supporting documentation within **60 days** of a qualifying event. **For more information on qualifying events and changing your coverage, see page 56.**

Enrollment at a Glance

Online Enrollment

Benefit eligible employees have the ability to make benefit elections and changes online during Open Enrollment for the 2017 Plan Year. The website is accessible 24 hours a day during the Open Enrollment period, which is October 10, 2016 through October 28, 2016.

Accessing the online enrollment website:

- Log in to **www.myFBMC.com**
- Follow the instructions to set up your own username and password.
- Click the "Web Enrollment" link.
- Verify your demographic information.
- Add or update any beneficiary information.
- Begin the enrollment process.
- For each benefit, choose your coverage level or election amounts and then go to the next benefit.
- Continue until enrollment is complete.
- Print out your confirmation statement containing all your benefit elections for you and your family.

Note: You may save your enrollment session progress and return later to complete the enrollment at any point once you've started the benefit selections.

Whether you choose to individually enroll online or meet with a Professional Benefits Counselor, it is your responsibility to carefully review your confirmation statement.

Enrollment changes after October 28, 2016 will not be permitted unless there has been a valid Change in Status event. Please refer to Change in Status section in this Guide for the change in status requirements.

How to Find Information About Your Benefits

There are four ways to receive benefit information:

1. You may contact the individual providers' customer service department about the specific plan for which you are inquiring (refer to the Benefits Directory).
2. Visit **www.myFBMC.com** to view a listing of your current benefits and to submit questions via e-mail to Customer Care.
3. For personal assistance, call the Service Center 1-855-LUCIE4U (1-855-582-4348), Monday-Friday, 7 a.m - 7 p.m. ET.
4. You may also contact the SLPS Risk Management Department at 772-429-5521 for more information.

Schedule an appointment to meet with a Professional Benefits Counselor to make sure you are entered in the raffle!

To make an appointment, go to www.myenrollmentschedule.com/stlucie.

How To Enroll	
Option 1	**Option 2**
Enroll on your own via the Internet at www.myFBMC.com: You may enroll anywhere you have internet access by logging on at **www.myFBMC.com.** Please note, you are required to schedule an appointment to meet with a Professional Benefits Counselor if you wish to enroll as "Dual Spouse."	**By enrollment appointment with a Professional Benefits Counselor:** If you prefer to meet one-on-one with a Professional Benefits Counselor, you must make an appointment for an Open Enrollment session at any of the designated locations. The Professional Benefits Counselor will review your current benefits selections and assist with any changes that you wish to make.

Participation in the St. Lucie Public Schools Benefit Program

Be aware that when you participate in the District Benefit Program, you are automatically making the following affirmations:

1. You authorize the St. Lucie Public Schools (SLPS) to deduct premiums for the benefits rolled over or elected for the plan year.
2. You certify that the information you supplied on the online enrollment website is true and complete to the best of your knowledge.
3. You understand that health, dental, vision, flexible spending account(s), hospital indemnity, and cancer contributions will be deducted pre-tax to the extent possible and that your income subject to federal income tax and Social Security withholding (FICA) will be reduced, and that this may slightly affect your Social Security benefits in the future.
4. You acknowledge that you cannot stop or change benefits paid for on a pre-tax basis during the plan year unless you experience a relevant qualifying event.
5. All benefits are subject to change. All benefits are subject to the provisions and exclusions of the master contract.
6. You understand that a Section 125 Flexible Spending Account (Health care Expense and Dependent Care) can be used only to reimburse payment of eligible expenses incurred during the plan year while participating in the plan and that any amount remaining in either spending account, that is not used during the plan year, will be forfeited. Funds in one spending account cannot be used to reimburse expenses covered by another account. Expenses for which you are reimbursed cannot be claimed.
7. You understand and agree that SLPS and the Third Party Administrator (TPA) will not incur any liability resulting from failure to read all rules pertaining to benefit enrollment; to enroll online accurately or to submit elections; or in the administration of your flexible spending accounts. You also understand that elections for benefits on a pre-tax basis are irrevocable and cannot be changed after the established deadline date. Subsequent changes can only be made upon experiencing a relevant qualifying event.
8. You agree for yourself and covered members of your family and others covered under SLPS insurance plans to be bound by the benefits, deductibles, copayments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements and plan documents for the plans in which you enroll.
9. Chapter 207-251 Laws of Florida requires agencies to notify individuals of the purpose(s) that requires the collection of Social Security numbers. SLPS collects Social Security numbers (SSNs) of employee and dependents for enrollment in health insurance, life insurance, and other miscellaneous insurances. The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
10. 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 Benefit Plan is included in the compensation reported to the FRS.
11. Social Security consists of two components: FICA and Medicare. A separate maximum wage to which the tax is assessed applies to both tax components. The maximum taxable annual wage for FICA varies from year to year. There is no maximum taxable annual wage for Medicare. 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.

IMPORTANT REMINDERS:

- Open Enrollment ends **October 28, 2016**.
- It is your responsibility to verify that the benefit selections made **during** Open Enrollment are correct. You can verify this information during a scheduled enrollment session or by logging onto **www.myFBMC.com** to view your benefits prior to the close of open enrollment on **October 28, 2016**.
- **Open Enrollment changes will not be permitted after October 28, 2016 unless there has been a valid Change in Status event.**

Eligibility Requirements

Period of Coverage

If you enroll during your annual Open Enrollment, your period of coverage is January 1, 2017, through December 31, 2017 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 for more information.
- If you are a newly-hired employee, your period of coverage for:
  - the SLPS 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.
  - The Trustmark Voluntary benefits begins **February 1, 2017 through January 31, 2018** with payroll deductions taken on a post-tax basis.
- Upon certain qualifying events, a covered dependent, spouse and dependents may be eligible to continue their health plan coverage for group health plan continuation coverage under the Consolidated Omnibus Budget 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, on page 56, for more information on qualifying events.**

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. You will receive more details about prescription drug coverage and Medicare in a separate mailing.

Who is eligible to participate in the Flexible Benefits Plan?

All full-time employees actively at work on the plan effective date (January 1, 2017) 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 SLPS Group Health and Dental plans?

All full-time employees actively at work on the plan effective date (January 1, 2017) 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.

Employees on an Approved Workers' Compensation and FMLA Leave

Effective January 1, 2017, if you are approved for Workers' Compensation or FMLA (Family Medical Leave Act) leave, St. Lucie Public Schools will continue to provide employer contributions towards your benefits. You are required to continue to pay your share for your benefit elections while out on leave. Payments to continue your benefits must be paid within 30 days of your first missed deduction or within 30 days of your initial billing notification (whichever is later). For further information on how to make those payments, please contact the Risk Management Department at (772) 429-5521.

If you have not returned to active duty when your FMLA leave ends, your benefits will terminate at the end of that month. You may continue coverage for your eligible insurance benefits by paying the total premium amount under COBRA (Comprehensive Omnibus Budget Reconciliation Act). Upon expiration of benefits, a COBRA notice will be mailed to your home address on record to provide you an opportunity to elect coverage.

The Human Resources Department determines eligibility for FMLA based on Federal regulations.

Eligibility Requirements

Employees on an Approved Non-FMLA Leave

Effective January 1, 2017, St. Lucie Public Schools does not contribute towards your insurance premiums while out on non-FMLA leave. In many cases, insurance coverage ends at the end of the month your leave starts (call Risk Management to determine your status). For example, if your leave begins on September 3rd, your benefits will end on September 30th. You may continue your eligible insurance benefits by paying the total premium amount under COBRA. Upon the expiration of benefits, a COBRA notice will be mailed to your home address on record to provide an opportunity to elect coverage.

If your leave extends beyond 30 days, or into a new month, it is each employee's responsibility to re-enroll, by contacting the Risk Management Department. This must occur within 60 days of your return to work. If you do not re-enroll upon your return, you will not be eligible to enroll in coverage until the next open enrollment.

Dependent eligibility for Group Health and Dental Plans (Pre-tax):

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 dependent has been court-appointed as legal guardian or legal custodian) who:
   - **a)** has not reached the end of the calendar year in which he or she becomes 26

   or

   - **b)** 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.
   - **c)** 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 dependent 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.
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.

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 dependent 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 SLPS health plan on the first day of employment. New employees must enroll within 60 days of hire by completing an application through the Risk Management Department. The effective date for the SLPS 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.

Eligibility Requirements

Retiring Employees

A retiree is a former full-time employee of the SLPS 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 , Health care FSA and 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 Health care FSA may be used to pay for eligible expenses incurred by you, your spouse, your qualifying child or your qualifying relative. You may use your Dependent Care FSA to pay for eligible dependent care expenses for qualifying individuals. **Please visit www.payflex.com for answers to frequently asked FSA questions.**

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 enroll in a Health care 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 1-877-357-3268 or go to **http://flmedicaidtplrecovery.com/hipp/** 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.

Did you know?

If you do not want to make any changes to your current benefits selections, you do not need to enroll during this open enrollment. Your current benefits will continue into 2017.

How to Enroll

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is advantageous to thoroughly review your enrollment materials. If you are ready to enroll, but need assistance, contact FBMC Service Center at 1-855-LUCIE4U (1-855-582-4348). Once you have the answers you need, you may begin the enrollment process. **Please note that online enrollment is only available during Open Enrollment. Newly-hired employees must meet with someone in the Risk Management Department to enroll for benefits coverage.**

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

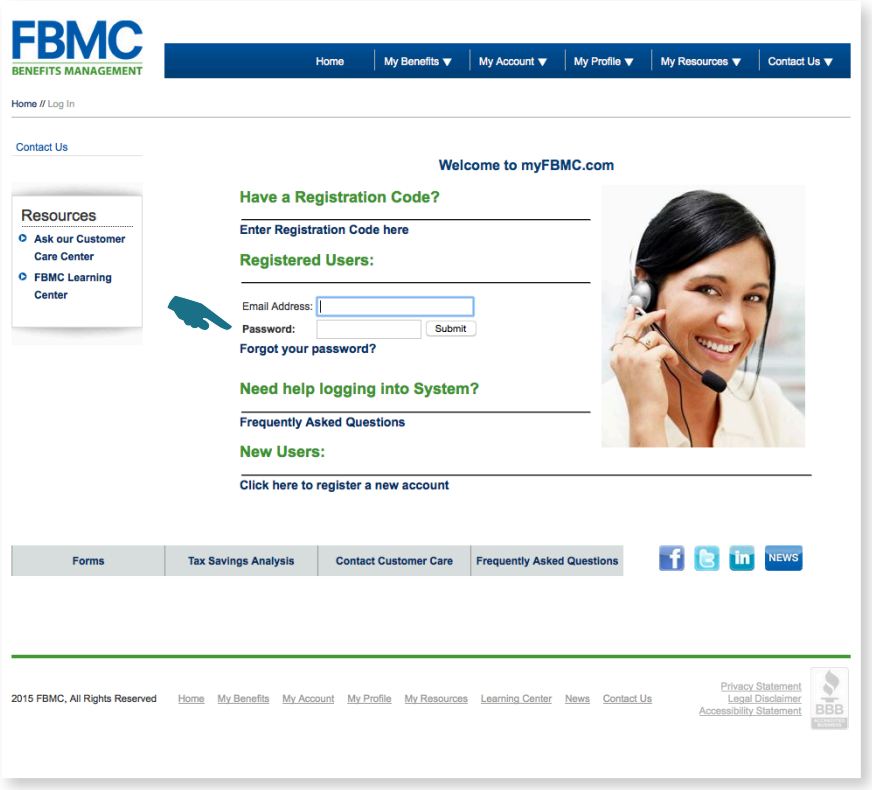
1 Log in

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 (1-855-582-4348).



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.

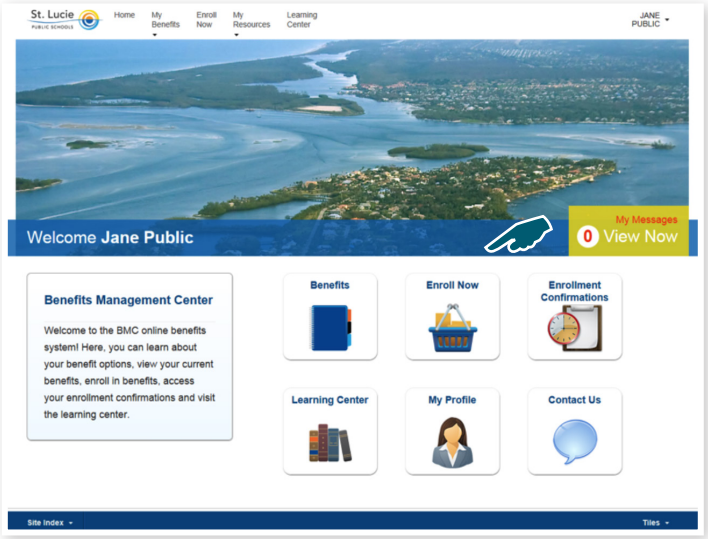
How to Enroll

2 Access your Web Enrollment

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

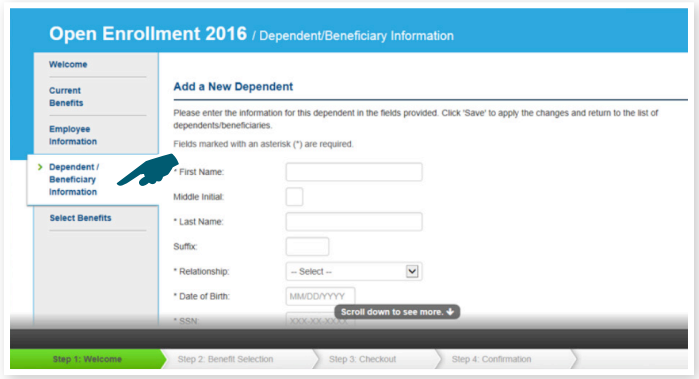
3 Enroll Now

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.



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.

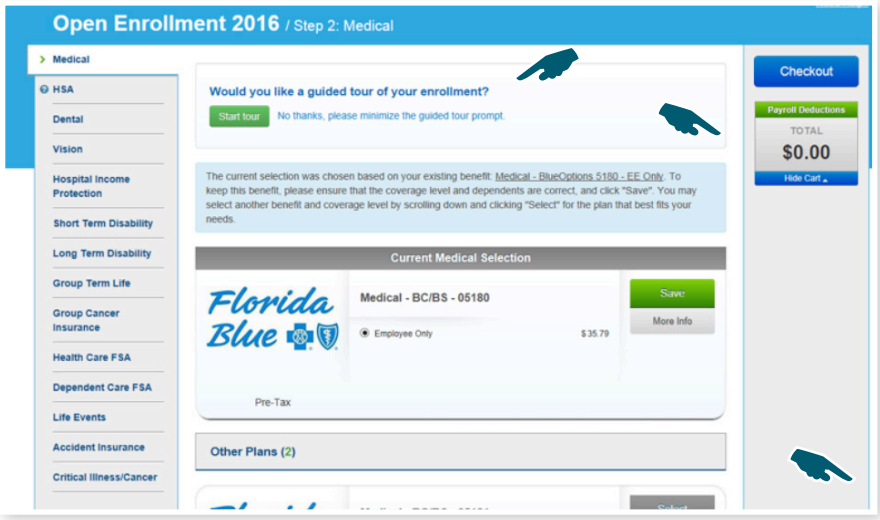


How to Enroll

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.



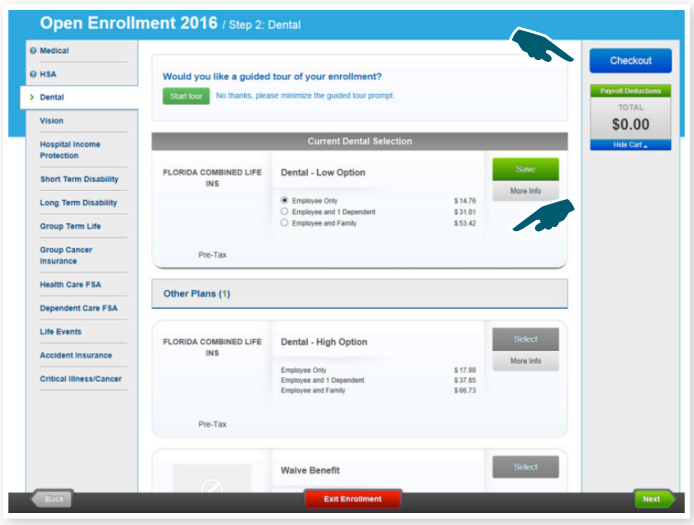
Choose Benefits

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, however it is not a completed enrollment session.

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

6 Payroll Deductions

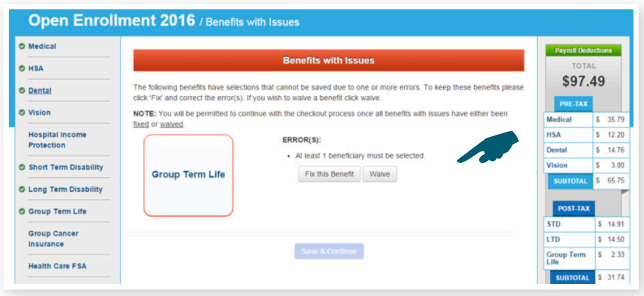
Upon selecting a benefit, be sure to click the "Save" button. Your saved benefit will appear under payroll deductions with the appropriate benefit cost. This will allow you the opportunity to view your total payroll deductions as you continue through your enrollment session. Once you have made all of your benefit selections for the 2017 Plan Year, you can checkout by clicking the "Checkout" button.

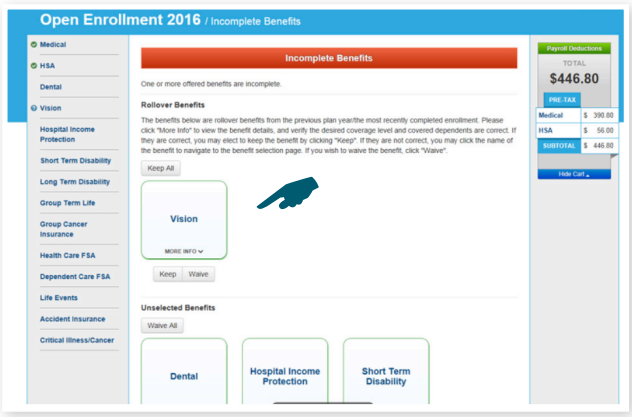


How to Enroll

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, you cannot save your enrollment 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:

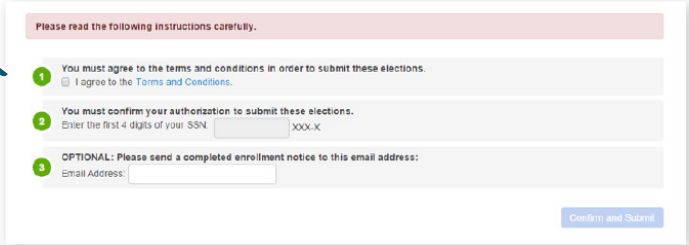
Rollover Benefits: If you have a current benefit and forgot to save it during your enrollment session, you must click the "Keep" button for the benefit to rollover to the 2017 Plan Year.

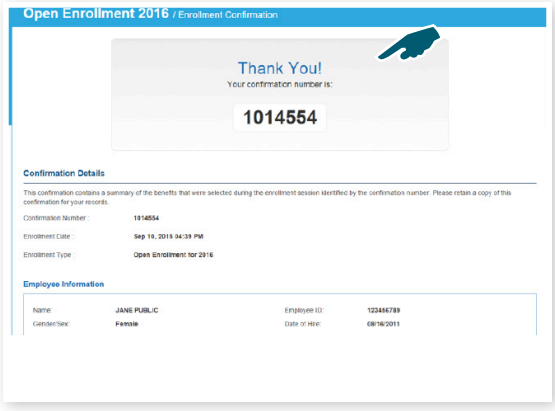
Unselected Benefits: Any other benefits you did not save during your enrollment session will appear here. You may click the benefit button to return to the corresponding benefit page and select the benefit, or click "Waive" to waive the benefit and continue to checkout.

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 first 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 October 28, 2016, to make any changes to your benefits.

FloridaBlue Health Plans

Summary of Health Benefits for
St. Lucie Pubic Schools 01-01-17 thru 12-31-17

Florida Blue
In the pursuit of health

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

FloridaBlue Health Plans

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA-Compatible 05180 (Single Coverage)	BlueOptions HSA-Compatible 05181 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
EMERGENCY / URGENT / CONVENIENT CARE			
Ambulance Maximum (per day)	No Maximum	No Maximum	No Maximum
In-Network	DED + 10%	DED + 10%	DED + 20%
Out-of-Network	In-Ntwk DED + 10%	In-Ntwk DED + 10%	In-Ntwk DED + 20%
Convenient Care Centers (CCC)			
In-Network	DED + 10%	DED + 10%	$30
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Emergency Room Facility Services (also see Professional Provider Services)			
In-Network	DED + 10%	DED + 10%	$250
Out-of-Network	In-Ntwk DED + 10%	In-Ntwk DED + 10%	$250
Urgent Care Centers (UCC)			
In-Network	DED + 10%	DED + 10%	$60
Out-of-Network	OON DED + 10%	OON DED + 10%	OON DED + $60
FACILITY SERVICES – HOSPITAL / SURGICAL / ICL / IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.			
Ambulatory Surgical Center			
In-Network	DED + 10%	DED + 10%	$200
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Independent Clinical Lab			
In-Network (Quest Diagnostics)	DED	DED	$0
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS)	DED + 10%	DED + 10%	$250
In-Network - Other Diagnostic Services	DED + 10%	DED + 10%	$50
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Inpatient Hospital (per admit)			
In-Network	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 20% Option 2 - DED + 20%
Out-of-Network	DED + 40%	DED + 40%	$500 PAD + DED + 50%
Inpatient Rehab Maximum (PBP)	30 Days	30 Days	30 Days
Outpatient Hospital (per visit)			
In-Network	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 20% Option 2 - DED + 20%
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Therapy at Outpatient Hospital			
In-Network	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - $55 Option 2 - $80
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
OTHER SPECIAL SERVICES AND LOCATIONS			
Advanced Imaging Services in Physician's Office			
In-Network Primary/Family Care Physician	DED + 10%	DED + 10%	$250
In-Network Specialist	DED + 10%	DED + 10%	$250
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Birthing Center			
In-Network	DED + 10%	DED + 10%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Durable Medical Equipment, Prosthetics, Orthotics BPM	No Maximum	No Maximum	No Maximum
In-Network (Carecentrix)	DED + 10%	DED + 10%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Home Health Care BPM	20 Visits	20 Visits	20 Visits
In-Network (Carecentrix)	DED + 10%	DED + 10%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Hospice LTM	No Maximum	No Maximum	No Maximum
In-Network	DED + 10%	DED + 10%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	DED + 50%
Skilled Nursing Facility BPM	60 Days	60 Days	60 Days
In-Network	DED + 10%	DED + 10%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	DED + 50%

FloridaBlue Health Plans

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA-Compatible 05180 (Single Coverage)	BlueOptions HSA-Compatible 05181 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Hospitalization-Facility In-Network Out-of-Network	 Option 1- DED + 10% Option 2 - DED + 10% DED + 40%	 Option 1- DED + 10% Option 2 - DED + 10% DED + 40%	 Option 1- $0 Option 2 - $0 50% (No DED)
Outpatient Hospitalization-Facility (per visit) In-Network Out-of-Network	 Option 1 - DED + 10% Option 2 - DED + 10% DED + 40%	 Option 1 - DED + 10% Option 2 - DED + 10% DED + 40%	 Option 1 - $0 Option 2 - $0 50% (No DED)
Provider Services at Hospital and ER In-Network Family Physician or Specialist Out-of-Network Provider	 DED + 10% In-Ntwk DED + 10%	 DED + 10% In-Ntwk DED + 10%	 $0 $0
Physician Office Visit In-Network Family Physician or Specialist Out-of Network Provider	 DED + 10% DED + 40%	 DED + 10% DED + 40%	 $0 50% (No DED)
Emergency Room Facility Services (per visit) In-Network Out-of-Network	 DED + 10% In-Ntwk DED + 10%	 DED + 10% In-Ntwk DED + 10%	 $0 $0
Provider Services at Locations other than Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network Provider	 DED + 10% DED + 10% DED + 40%	 DED + 10% DED + 10% DED + 40%	 $0 $0 50% (No DED)
PRESCRIPTION DRUGS			
Deductible	**$1500** **In-Network Plan** **Deductible Applies**	**$3000** **In-Network Plan** **Deductible Applies**	$0
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	$20 / $60 / $100	$20 / $60 / $100

CONDITION Rx PROGRAM FOR HSA PLANS ONLY To access the covered medications, click here: Condition Care Rx Drug List						
Deductible ****WAIVED****	**$1500** **In-Network Plan** **Deductible Applies**			**$3000** **In-Network Plan** **Deductible Applies**		
In-Network (Mandatory Generic Program) **Retail (30 days)** Generic/Preferred Brand/Non-Preferred	Generic/Preferred $10	Brand/Non-Preferred $30	 $50	Generic/Preferred $10	Brand/Non-Preferred $30	 $50
Mail Order/Retail (90 days) Generic/Preferred Brand/Non-Preferred	$20	$60	$100	$20	$60	$100

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.

Condition Care Rx Program

The **Florida Blue Condition Care Rx Program** is a wonderful new addition to your benefits for 2017. It was designed to help those of you who are on the **High Deductible HSA Plan 5180/5181**, manage the cost of some of your medications used to treat certain chronic conditions and encourage medication adherence.

What this means, is for those of you who are taking certain medications for **diabetes**, **cholesterol**, **respiratory issues** and **high blood pressure**, you will **NOT** have to meet your deductible first. Your deductible will be **WAIVED** and you will only pay your copay instead!!

A list of current medications that are a part of the Condition Care Rx Program for Health Savings Account (HSA) compatible plans may be found by clicking the link below:

Condition Care Rx Drug List

Please see the chart below for your **Generic**, **Preferred Brand** and **Non-Preferred Brand** copay amounts:

Deductible WAIVED	**$1500 In-Network Plan Deductible Applies**			**$3000 In-Network Plan Deductible Applies**		
In-Network (Mandatory Generic Program) **Retail (30 days)** Generic/Preferred Brand/Non-Preferred	Generic/Preferred $10	Brand/Non-Preferred $30	$50	Generic/Preferred $10	Brand/Non-Preferred $30	$50
Mail Order/Retail (90 days) Generic/Preferred Brand/Non-Preferred	$20	$60	$100	$20	$60	$100

Your Prescription Drug Program

Did you know that most medical conditions have several drug options? That's why we have a team of pharmacists, doctors and other experts continually working to determine which medicines are clinically effective, safe AND cost less. Ultimately, you and your doctor will decide what medicine is best for you.

To understand how your prescription benefits work, it helps to familiarize yourself with your Prescription Drug program. Log in to our member site, **www.floridablue.com**, to see your prescription benefits, compare drug prices and more. When you get a prescription, the amount you'll pay at the pharmacy will depend on four things:

1. Is the drug covered by your prescription plan?
2. What tier is the drug?
3. Are there additional requirements, limits or authorization needed first?
4. Are you using a participating retail, mail-order or specialty pharmacy?

1. Covered Drugs

The Medication Guide includes a list of covered drugs called a formulary. Our formulary may be updated up to four times a year after careful review by a team of medical experts. We evaluate how well the drugs work and how they compare to other drugs for the same condition. Clinical effectiveness, safety risks, side effects and costs are all considered during this review. Why is this review so important? Using formulary drugs that are proven to work helps you stay well and helps keep costs down for everyone.

2. Drug Tier and Your Cost

Your plan covers Tier 1, 2 and 3 drugs. With most plans, if you choose a brand name drug when a generic is available, you'll pay your benefit amount plus the difference in the cost between the two drugs. If a brand name drug is recommended, your doctor must write "medically necessary" on your prescription to avoid paying this difference. Please refer to your benefit materials for more details. Below describes each benefit tier and how it affects your cost.

DRUG TIER	PRESCRIPTION DRUG DESCRIPTION	YOUR COST
Tier 1	Covered **Generic** Medication	$
Tier 2	Covered Preferred **Brand** Medication	$$
Tier 3	Covered **Non-Preferred Brand** Medication	$$$

3. Coverage Requirements, Limits and Authorizations

With certain medications there are potential safety risks, such as over use, which can be harmful to your health and costly to your wallet. These medications may be included in one or more of our Responsible Rx programs such as Prior Authorization, Responsible Steps or Responsible Quantity. Your **Medication Guide** indicates which drugs are included in these programs. Below is a description of how each program works:

- **Prior Authorization** This means that your doctor will need to submit medical documentation and an authorization form to request approval for the drug to be covered. If it is not approved, you may purchase the drug at your own expense.
- **Responsible Quantity** Some drugs have a maximum quantity that is covered for a given time period. For example, if your doctor prescribes a medication that has a 30-day limit of 9 tablets, your plan covers 9 tablets that month. These safety limits are based on the drug manufacturer's and Food and Drug Administration's dosing guidelines.
- **Responsible Steps (Step Therapy)** Certain drugs are not covered unless you try another FDA approved drug first. There may be a lower cost drug that is clinically and cost effective to treat your condition. If an alternate drug is not recommended for you or you had other insurance when you tried the alternate drug, simply ask your doctor to submit an authorization form to request that the drug be covered. You may purchase the drug at your own expense, if not approved.

4. Which Pharmacy You Use Matters

Where you go for your prescriptions will depend on the kind of medication you need. You'll pay less and avoid filing a claim when your prescriptions are filled at a participating pharmacy: retail, mail-order or specialty.

- **Retail Pharmacy for up to a 30-day or 90-day supply**
  Fill prescriptions for non-specialty Generic and Brand Name drugs at your local participating retail pharmacy, including many national chains such as CVS/pharmacy, Publix, Target, Walgreens, Walmart and Winn-Dixie. **To find a participating pharmacy near you, please visit us at www.floridablue.com.**
- **Mail-order for up to a 90-day supply**
  Please click on this link to access FloridaBlue's Prime Mail order program MyPrime.com.
- **Specialty Pharmacy**
  Certain Self-Administered specialty drugs such as injectable, infused, oral or inhaled drugs must be purchased from our participating specialty pharmacy, CareMark. If your medication is a Self-Administered Specialty drug, simply call CareMark toll-free at 1-866-278-5108.

FloridaBlue Resources

Florida Blue
In the pursuit of health

Questions	Resources	How to Access
What health and dental plan options are available to me?	**Interactive Benefit Portal** Please click on the link to the right to watch a video highlighting many of your benefits.	**2017 Benefits Overview** **Or** Text **Blue 1213** to **258311**
I need my ID number, I have a question about my claim, I don't understand my plan…	**On-Site Customer Service** A Florida Blue Customer Service Representative is available at the District Office to assist members with benefit issues, including plan design questions, claim inquiries and ID cards.	**Melissa Rusignuolo** Located at the District Office in Risk Mgt **(772) 429-7702** **Melissa.Rusignuolo@floridablue.com**
Will I save money if I use an Urgent Care Center instead of the ER?	**Know Before You Go** Use our online Medical Cost Comparison Tool to shop around for health care services. You can save money and still get the quality care you deserve.	Go to **www.floridablue.com** log into your **Member Account** select **Tools** and **Medical Care Comparison**
I need someone to assist me with a chronic condition such as: Cancer, Diabetes, Asthma, authorizations for procedures and care after surgery…	**Care Consultants** Our team of Care Consultants is standing by to answer questions about your benefits, treatment choices and cost saving options.	Toll Free at **1-888-476-2227** Monday - Friday, 8am to 9pm
Where can I go to get help afterhours and on weekends?	**Florida Blue Center** The Florida Blue Retail Center located inside the St Lucie West Walmart store, provides great face-to-face customer service.	**772-621-8830** 1675 NW St Lucie West Blvd (Walmart) Port St Lucie, FL 34986 9am-7pm (Mon-Sat)
I have a question about my health…	**Health Dialog 24-Hour Nurse Line** Questions about your health can come up at any time, including times when doctors' offices are closed. Our 24-hour nurse line can help you make informed health care choices.	Toll Free at **1-877-789-2583**
I need help with a claim and I have other questions…	**Customer Service** · Find out what's covered and how much you'll pay · Maximize your health plan benefits to save money. · Find out if an authorization is in place prior to having a procedure or surgery.	Toll Free at **1-800-664-5295** Monday-Thursday 8am-6pm Friday 9am-6pm
Can I go online and order a Health or Dental ID card or check my claims?	**www.floridablue.com** **Register online to:** · Review your plan benefits · View your deductible · Find a participating doctor or hospital · View claim activity, status and history · Use your personalized WebMD site · Understand your upfront medical costs · Order an ID card · Access our exclusive discount program (Blue365) · Access your employee incentive program	Go to **www.floridablue.com** and click **"Member login".** All you need to register is a valid email address and your Member Number (located on your Florida Blue Member ID card).

Your Behavioral Health Services

As a member of Florida Blue, your health insurance plan includes behavioral health benefits. These include mental health services, substance use treatment and more. Since 2011 New Directions Behavioral Health® has managed behavioral health services for Florida Blue. If you have questions about your benefits or want more information simply call us or visit ndbh.com.

What You Can Expect

When you call us, we can help you in a number of ways:

- Find the right doctors and schedule appointments
- Provide referrals to doctors and treatment facilities in your health plan network
- Assist you, your doctors and your insurance company to work together toward your goals
- Inform you about topics such as depression, anxiety, substance use disorder, autism spectrum disorder and bipolar disorder
- Offer coaching and support programs
- Give you information about people and groups in your community that can help you

Help is just a phone call away. Licensed clinicians are ready to take your call 24 hours a day, 7 days a week toll-free at 1-866-287-9569. You can also view our website at www.ndbh.com for articles, videos, guidebooks and more.

We focus on finding you the right care at the right time. Our goal is to help you lead a healthier life long-term.

NEW DIRECTIONS℠

TOGETHER IS THE WAY FORWARD

1-866-287-9569 | ndbh.com

201508FL

FloridaBlue Health Rates

2017 Per Pay Employee Payroll Contributions

Coverage Level	BlueOptions HSA Compatible 05180/05181 (per pay period)	BlueOptions 05771 Only available to employees hired before January 1, 2014. (per pay period)
Employee Only	$17.18	$35.24
Employee + 1 Dependent	$349.12	$389.58
Employee + Family	$511.36	$563.34
Dual Employee + Family	$130.47 each employee per pay period	$156.46 each employee per pay period

If both you and your spouse are employed by SLPS 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 Part A and/or Part B**
- You cannot be claimed as a dependent on someone else's tax return

2017 maximum HSA contributions allowed by the IRS:

- Single coverage $3,400.00
- Family coverage $6,750.00
- "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 Account:

- 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 Public Schools Employees

- In partnership with FloridaBlue, 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

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 your health care 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.

Did you know?

Contributions remain in your account from year to year until you use them.

Florida Combined Life Dental Plan

Financial Features	BlueDental Choice Low				BlueDental Choice High			
	In-Network		Out-of-Network		In-Network		Out-of-Network	
Deductible (Basic & Major Services Only) Per Person Per Plan Year Per Family Per Plan Year *In-Network deductible credits apply to Out-of-Network deductible and Out-of-Network deductible credits apply to In-Network deductible.*	$50 $150		$50 $150		$50 $150		$50 $150	
Coinsurance *	We Pay	**You Pay**	We Pay	**You Pay**	We Pay	**You Pay**	We Pay	**You Pay**
PREVENTIVE **	100 %	0%	100%	0%	100%	0%	90%	10%
BASIC **	80%	20%	80%	20%	90%	10%	80%	20%
MAJOR **	50%	50%	50%	50%	60%	40%	50%	50%
Service Highlights								
Oral Evaluations (Exams) Bitewing X-ray Prophylaxis/Periodontal Cleanings (4) – Adult/Child Fluoride Treatment (No age limit) Office Visits X-rays – Intraoral/Complete Series/Panoramic Sealants	Preventive				Preventive			
Amalgam Restorations (Silver Fillings) Resin-Based Restorations (Anterior and Posterior) Extractions Surgical Extractions Root Canal Therapy Periodontal Treatment	Basic				Basic			
Crowns Osseous Surgery Complete Dentures Partial Dentures Fixed Partial Dentures (Bridges) Surgical Placement of Implant Body Implant Supported Porcelain Fused to Metal Crown	Major				Major			
Orthodontia Services ***(children to age 19)***								
Orthodontia Lifetime Maximum	$500				$1,000			
BlueDental Pays	50%				50%			
Benefit Waiting Period	NONE				NONE			
Waiting Period: (Major Services)	**NONE**				**NONE**			
Calendar Year Maximum Per Person	**$1,000**				**$1,500**			
Procedures Performed By Specialist	**Covered**				**Covered**			
Dental Rollover	**Yes**				**Yes**			
TYPE OF COVERAGE	**PREMIUM AMOUNT PER PAY PERIOD**							
Employee	**$14.76**				**$17.99**			
Employee Plus 1	**$31.01**				**$37.85**			
Employee Plus 2 or more	**$53.42**				**$66.73**			

The information provided above is a summary of benefits for the group Choice certificate. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as a part of the contract. Possession of this summary in no way implies coverage nor does it guarantee benefits under the plan.

* Percentage of fee schedule
** Some limitations may apply
*** Percentage of fee schedule + balance of any charges; non-par dentists may charge fees in excess of our Fee Schedule and may bill you the difference.

Florida Combined Life Insurance Company, Inc. (FCL) is an affiliate of Blue Cross Blue Shield of Florida, Inc. (BCBSF). BCBSF and FCL are Independent licensees of the Blue Cross and Blue Shield Association.

Florida Combined Life Dental Plan

BlueDental Choice

Did you know that dental health can have an influence on the development of conditions such as diabetes, coronary artery disease and low-birth-weight, premature babies? An undeniable relationship exists between a healthy mouth and overall good health. That means it is more important than ever for you to receive regular preventive dental care that will help you maintain not only your good oral health, but your good health in general.

BlueDental Choice℠ is a flexible PPO plan designed to encourage regular cleanings and preventive services that lead to good oral health and better overall health.

Our dental PPO network consists of a network of quality dentists who have agreed to provide services based on a negotiated fee. When you use a participating dentist in the BlueDental Choice network* for your plan, you'll receive maximum plan benefits and be protected against balance billing (the difference between the BlueDental Choice fee schedule and the dentist's normal charges). You also have the option of visiting a non-participating dentist although balance billing may occur.

As a BlueDental Choice member you can look forward to:
- No referrals or authorizations to see a general dentist or specialist
- Access to one of the largest dental networks in Florida
- Access to a vast national network

Maximum Rollover - Maximum Rollover is a BlueDental Choice benefit that rewards you just for visiting the dentist. Each year when you visit the dentist and use less than the yearly claim payment threshold, you'll receive Rollover dollars to help cover future unexpected visits or higher out-of-pocket costs for complex procedures.

It's that easy. Maximum Rollover is applied automatically as long as:
- You receive at least one covered service during your plan year
- You are an active member of your plan on the last day of the plan year
- You don't exceed the claim payment threshold in your plan year

Benefits

Orthodontic Discount Program** – When you choose an orthodontist in our orthodontic provider network, you'll receive 20 percent off your total case fee. This discount is only available to you when orthodontic coverage is not part of your plan.

Cosmetic Dental Discount Program** – You can experience significant savings on cosmetic dentistry procedures by visiting a dentist who participates in our cosmetic dentistry network. As a BlueDental Choice member, you'll receive a 20-percent savings on the following procedures:
- Cosmetic Contouring
- Laminate Veneer (porcelain or composite)
- Whitening (in office or at-home system)

The following example shows how your Maximum Rollover amount is determined.

If your annual benefit maximum is:	AND your total claims paid for the benefit period do not exceed:	THEN we will rollover	Accumulated totals will be capped at:
$1,000 - $1,249	$500	$350	$1,000
$1,250 - $1,499	$600	$450	$1,250
$1,500 - $1,999	$700	$500	$1,250
$2,000 - $2,499	$800	$600	$1,500

To see a list of the dentists in our network, visit www.floridabluedental.com. Don't see your dentist in our network? Send an e-mail to FCLProvidernomination@FCLife.com or fax your nomination to (904) 866-4846.

Questions? Need more information? Our Customer Service representatives can help. Just call (888) 223-4892 from 8 a.m. to 8 p.m. Monday through Friday.

*Networks are comprised of independent contracted dentists.

**Certain dentists have voluntarily agreed to offer a 20% discount off their usual charge for non-covered cosmetic or orthodontic services. These dentists are identified by an affiliation to either the Cosmetic Dental Discount Program or Orthodontic Discount Program. Because these dentists are neither contractually nor legally bound to offer these discounts, we recommend that you contact the provider to inquire about the continued availability of any discount prior to scheduling an appointment.

Florida Combined Life Dental Plan

Find the dentist that best meets your needs!

1 Go to www.floridabluedental.com

- Click **Find a Dentist**, found in the navigation bar along the top of the page.
- Go to **Dentist Information** on the second line and choose **Type of Dentist** and enter the Dentist's name.

2 Choose your dental insurance plan

- Choose your dental insurance plan from the drop-down menu under **Insurance Plan Information** (this information is available on your BlueDental ID card.) Selecting your plan ensures that your search will only list providers who are part of your plan's network.

3 Choose your location

- Narrow your search by Zip Code/Distance, Address or County and click **Search**.
- If you'd like to narrow your search even further, click **within** and enter a distance. This feature will allow you to narrow your search for a dentist based on the nearest location to you.

Need help finding a dentist in your area? We can help!
Just call 1-888-223-4892 or visit us online at www.FloridaBlueDental.com.

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 — Vision Care Plan (VCP) offers the LASIK procedure for plan members who are nearsighted or have astigmatism and wear glasses or contacts. You may also use independent Lasik provider-network doctors to receive a ten percent discount from usual and customary prices and pay no more than $1,800 per eye for conventional Lasik and $2,300 per eye for custom Lasik, due to SB632.

Did you know?

Choosing an in-network vision provider can help you save money.

Your Tax-Free Rates

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

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

For vision care questions, please contact VisionCare Plan Member Services online at **www.compbenefits.com** or call 1-800-865-3676, Mon - Fri, 8 a.m. - 5 p.m. ET.

In-Network Option and Out-of-Network Option

Copayment/Credit Schedule	IN-NETWORK EYE DOCTOR	OUT-OF-NETWORK EYE DOCTOR* (up to plan maximums)
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 (in lieu of exam, frames and lenses)	$85 reimbursement (in lieu of exam, frames and lenses)

* Please note: Amounts shown above are maximums.

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.
- 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

How to File a Claim

1. Contact the FBMC Service Center to obtain an In-Hospital Indemnity Benefit Claim Form to begin the process, or you may contact Fidelity Security Life Insurance Company (FSL) directly to obtain a form and file a claim.
2. Please complete the Statement of Insured section of the Claim Form and attach copies of itemized hospital billings, to include date(s), place of service and diagnosis.
3. Submit the Claim Form, along with the documents to FBMC Benefits Management, Inc.
4. FBMC will forward all documents 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 #M-00116

Policy No. HP-5

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

Coverage	**$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

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 policy terminates or a class terminates except for non-payment of premium), you can only convert this plan (if you have been covered for at least five years) 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 Post-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:

1. The listed beneficiary must notify FBMC Service Center of the claim to begin the process.
2. 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
3. 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.
4. 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 (FSL) 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-30

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.

SLPS is pleased to announce three coverage options, depending on your salary. This insurance plan provides three levels of short-term disability coverage:

- Plan A - This insurance plan provides up to 60 percent of your weekly salary up to a maximum of $500 per week.
- Plan B - This insurance plan provides up to 60 percent of your weekly salary up to a maximum of $600 per week.
- Plan C - This insurance plan provides up to 60 percent 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 Post-Tax Short-Term Disability Income Protection Rates

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 and substantial duties of your regular occupation or you are unable to earn 80 percent 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
- Worker's Compensation injury/sickness
- 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 SLPS 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 percent, 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 continuous 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.

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

Long-Term Disability Income Protection

- 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.

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.

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.

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.

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.

Long-Term Disability Income Protection

Premiums Waived

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

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.

Your Post-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

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 health care 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 **www.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 **www.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.

Health care 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.

Find additional 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.

Did you know?

The Identity Theft Program is available to you, if you enroll in group long or short-term disability coverage.

Group Cancer Insurance Plan

Fidelity Security Life will no longer offer the Group Cancer Policy, effective 1/1/2018. For the 2017 Plan Year, your existing policy can be changed from "employee and family" to "employee only" or your policy can be cancelled. No new enrollments will be permitted.

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) per surgery
- Up to $1,000 for surgery per 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 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 60 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.

Eligibility

If you, your spouse or your unmarried dependent children under age 26 (30 years if Florida resident or part-time or full-time student) (must be dependent upon you for support and living in your household) has not had any type of cancer, If you, your spouse or your unmarried dependent children under age 26 (30 years if Florida resident or part-time or full-time student) (must be dependent upon you for support and living in your household) has not had any type of cancer, 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. 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.

How to File a Claim:

1. Contact the FBMC Service Center to obtain a "Statement of Cancer Claim" form to begin the process; or, you may contact Fidelity Security Life Insurance Company directly to obtain a form and file a claim.
2. Please complete the "Statement of Cancer Claim" form and forward to the physician and request that the Attending Physician Statement be completed.
3. After the Attending Physician Statement is completed, submit it and the completed claim form along with a copy of the pathologist's report and any bills for covered expenses to Fidelity Security Life Insurance Company.
4. If a claim process is started through FBMC Benefits Management, letters will be sent to the insured 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 #M-7000-FL
Policy No. CA-54

This page is for informational purposes only.

Flexible Spending Accounts

Health Care FSA

A Health care 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, who can be claimed on your taxes. 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 before and after school care, day time 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 after your dependent receives day care services. Unlike the Health care FSA, your full annual contribution is not available at the beginning of the plan year. You can only get reimbursed up to the amount that is available in your account at that time.

Annual Contribution Limits

For Health Care FSA:

Minimum Annual Contribution: $150
Maximum Annual Contribution: $2,550

For Dependent Care FSA:

Minimum Annual Contribution: $150
The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual contribution is $2,500.
- If you are single and head of household, your maximum annual contribution is $5,000.
- If you are married and filing jointly, your maximum annual contribution is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual contribution 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 contribution 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. Using your FSA is easy with PayFlex.

Examples of How to Use Your FSA

Health Care 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 PayFlex. Once your claim is processed and approved, you'll receive payment by check or direct deposit.

If you don't want to pay for the office visit out of your pocket, you can use your PayFlex debit card. Only use your card after insurance has covered their portion of the expense. Be sure to save your documentation from your card purchases. You may be asked to provide documentation to verify that your expenses were eligible. Failure to submit proper documentation can result in deactivation of your card and you may have to pay back the funds at the end of the plan year.

Dependent Care FSA Example:

Paying for dependent care services

Once you have paid for (and received) a dependent care service, send a completed claim form to PayFlex, 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 & Age– Person who received the service.

If you don't have documentation to support your day care expense, you can have your provider sign a completed claim form and send to PayFlex. Once your claim is processed and approved, payment will be sent to you by check or direct deposit.

Use your PayFlex Card®, Your Account Debit Card

The PayFlex debit card is a convenient way to pay for eligible health care expenses. The card knows when the expense is eligible and whether you have funds available. When you use the card, save your Explanations of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you have a health care FSA, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA. If you need an additional debit card for your spouse or dependent, over the age of 18, you are able to request an additional card online or contacting customer service. You can order an additional card for your spouse or dependent online at no cost.

Be sure to use all of your FSA funds by the end of the 2017 Plan Year, or risk forfeiting the balance. Save all of your FSA receipts!

Flexible Spending Accounts

Filing a 2017 Claim with PayFlex

Those who participate in a Flexible Spending Account can visit www.payflex.com to access their account information. For 2017 FSA claims to PayFlex, if you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **www.payflex.com** or through the PayFlex Mobile® app to pay yourself back for your out of pocket expenses. Or you can fill out a paper claim form and fax or mail it to PayFlex. This form can be found in the Resource Center at **www.payflex.com** or you may call PayFlex at 1-800-284-4885 to request a form.

After you log in to www.payflex.com, click on the Financial Center tab and select your account from the drop down. Click on File a Spending Account Claim to get started. If you're a first time user, be sure to register first. Please see below for how to register online and for claim filing tips.

When you submit a claim, you need to include supporting documentation that shows the following:
- Merchant or service provider name
- Name of patient (if applicable)
- Date of service
- Amount you were required to pay
- Description of item or service

How to Register Online

- Go to www.payflex.com and select "CREATE YOUR PROFILE." You will be asked to enter your last name, mailing address, zip code, last four characters of your ID number and date of birth.
- Once your information is authenticated, you can create a username and password, provide your phone number and e-mail address and select security questions/answers.

Note: If you already have a username and password for www.healthhub.com, you'll use that to log in to www.payflex.com.

Claim Filing Tips

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to **www.payflex.com.** Click on the "Financial Center" tab. Select your account from the drop down menu and click on Enroll in Direct Deposit to get started.

FSA Worksheets

Use the worksheets below to determine how much you will contribute per pay period into your FSAs. 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.

Health Care FSA Worksheet

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

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or copayments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
TOTAL CONTRIBUTION (cannot exceed $2,500)	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
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	$ _____
Before & after school care	$ _____
Summer day camps	$ _____

ELDER CARE SERVICES

Day care center	$ _____
In-home care	$ _____
TOTAL CONTRIBUTION Remember, your total contribution cannot exceed IRS limits.	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
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. Once you're an FSA member, you can enroll in Direct Deposit through PayFlex's member website at **www.payflex.com**.

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.

The PayFlex Card®

Instant Access to Your Money

The PayFlex Card makes it easy for you to spend the money in your Health care FSA. When you use this debit card, it uses the money in your account to pay for eligible health care expenses.

Frequently Asked Questions

How Does the Card Work?

Your PayFlex Card may be used to pay for eligible health care products and services. When you receive your card, follow the activation instructions. To use your card, simply swipe and select either "debit" or "credit." However, some merchants may ask you to select "debit." This means you will need to enter a personal identification number (PIN) to complete the transaction. To get a PIN, call Card Services at 1-888-999-0121. A PIN can be created at any time. If you order a card for your spouse or dependent, they will use the same PIN you use. After you swipe the card, our system automatically confirms whether you have enough funds to pay for the expense. If you have funds available, your expense will be taken out of your account. You can view all of your card transactions online.

Where Can I Use the Card?

You can use your card at qualified merchants where MasterCard® is accepted. This includes doctor and dental offices, hospitals, pharmacies (including mail-order prescriptions), and hearing and vision care centers. You may also use your card at some discount and grocery stores. These stores must have a system that can process health care cards.

What Can I Pay for with my Card?

You can use the card to pay for eligible expenses allowed under your plan. These generally include copays, prescriptions, vision and hearing products, and much more. To view a list of common eligible expenses, visit www.payflex.com. Click on Individuals and select explore expenses. The list of eligible expense items is found via the resource center.

What if I Don't Use my Card to Pay for an Expense?

If you pay for an eligible expense with cash, check or a personal credit card, you can submit a claim for reimbursement online or through the PayFlex Mobile® app. You can also fill out a paper claim form and fax or mail it to PayFlex®. Note: You must include supporting documentation when you submit your claim.

Can I Use My Card for Prescription and Over-the-Counter (OTC) Expenses?

You may use your PayFlex Card at most retail or online locations to pay for prescriptions and certain OTC items. Such OTC items include bandages, contact lens solution, first aid kits, hot and cold packs, and thermometers. You cannot use the card to pay for OTC drugs and medicine such as pain relievers, cold and flu remedies, or allergy and sinus products. To get reimbursed for OTC drugs and medicine, you'll need a written prescription from your doctor. After you get the prescription, you must pay for the OTC drug or medicine with cash, check or personal credit card. Then submit a claim for reimbursement. Be sure to include the receipt and written prescription when you submit your claim.

Quick Tips

- Spending made simple for the family — If you are a new member, you will automatically receive one card. You can order a card online for your spouse or dependent at no cost.
- Save your receipts — If you receive a Request for Documentation letter or see an alert message on your account, this means we need documentation for a card purchase.
- Access your account balance — Log in to your account through **www.payflex.com**. You can view your available balance on "My Dashboard".
- Check your card's expiration date — Your card is valid for five years, as long as you are an active member. Before your card expires, you will receive a new card in the mail.
- Replace lost or stolen cards — Please call us right away at 1-800-284-4885 to report a lost or stolen card. Do not order another card online.

IMPORTANT: Request for Documentation Alerts and Letters

There may be times that PayFlex needs documentation from you for your card transactions. If documentation is needed, PayFlex will post an alert message online or send you a Request for Documentation letter. This is done when PayFlex needs to verify that you used your card to pay for an eligible item or service. If you do not respond to the request, your card will be suspended.

To stay up to date on your card transactions, we encourage you to sign up to receive debit card notifications through e-mail, web alert or both. Log in to **www.payflex.com** and click on My Settings. Click on the notifications link and enter your e-mail address. Then select the notifications you wish to receive. Be sure to sign up for the Debit Card Substantiation Notification. This e-mail notification will let you know when we need documentation from you.

The PayFlex Card® and PayFlex Mobile® App

How to Respond to a Request for Documentation Alert or Letter

If PayFlex needs more information on a debit card purchase, you have three options.

1. **Send us the Explanation of Benefits (EOB) or detailed receipt for the card payment.** You can upload to **www.payflex.com** as a PDF file, send through the PayFlex Mobile app, or fax or mail it to PayFlex.
2. **Substitute another expense for the one in question.** Upload, fax or mail* the EOB or detailed receipt for another eligible item or service. You must have incurred this expense in the same plan year. (Note: This option is only available if you have not been reimbursed for the item or service. And if you haven't already paid for it with your PayFlex Card®.)
3. **Pay back your account for the amount in question.** Send a personal check or money order directly to PayFlex.

Note: If you do not respond to the request, your card will be suspended until you either send in the requested documentation or pay back the account. If your card is suspended, you can still pay for eligible expenses with another form of payment. You will then need to submit a claim for reimbursement. Once we receive and process your documentation or repayment, your card will be active again.

**If you choose to fax or mail documentation, include a copy of your Request for Documentation letter.*

PayFlex Mobile®

Helping You Stay Connected to Your FSA

Get access to your FSA with our free** PayFlex Mobile application. This app makes it easy for you to manage your account virtually 24/7. It's available for iPhone® and iPad® mobile digital devices, as well as Android™ and BlackBerry® smartphones.

The PayFlex Mobile app lets you:

- View your account balance and manage your account funds.
- Request reimbursement and view transaction history.
- View PayFlex Card®, your account debit card, purchases and submit documentation (if applicable).
- View your benefits plan information (if applicable).
- View a list of common eligible expense items.

Security is our Priority

PayFlex Mobile is a secure and safe way to view your account information. PayFlex uses the same security for the app as the PayFlex member website.

Account Alerts at Your Fingertips

Receive important account alerts about the status of your account. You can also find out when you need to take action.

Note: Not all of the PayFlex Mobile functionality is available for BlackBerry smartphones. Menu layouts, designs and screen displays may vary on your device.

Learn More About How to Use the App

After you enroll in an FSA, be sure to check out our PayFlex Mobile Quick Reference Guide to help you get started. You can find this guide on **www.payflex.com** via the resource center.

Questions?

Visit **www.payflex.com** or call us at 1-800-284-4885. Customer service representatives are available Monday - Friday, 8 a.m. - 8 p.m. ET and Saturday, 10 a.m. - 3 p.m. ET.

***Standard text messaging and other rates from your wireless carrier still apply.*

Limited-Use Medical Flexible Spending Account

For HSA Participants Only

Minimum Annual Deposit:	**$150**
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 Health care 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 Health care 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 Health care 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 Health care FSA expenses can be found on this page.

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

Whose expenses are eligible?

Your Limited-Use Health care Flexible Spending Account may be used to reimburse eligible expenses incurred by you, your spouse, your qualifying child or your qualifying relative. Please visit **www.payflex.com** for more information.

Registering Your Account

Go to payflex.com and click on CREATE YOUR PROFILE to get started.

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 Health care 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.

Filing A Claim Online

After you log in, click on the "Financial Center" tab and select your account from the drop down. Click on File a Spending Account Claim to get started.

When you submit a claim, you need to include supporting documentation that shows the following:
- Merchant or service provider name
- Name of patient (if applicable)
- Date of service
- Amount you were required to pay
- Description of item or service

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to www.payflex.com. Click on the "Financial Center" tab. Select your account from the drop down menu and click on Enroll in Direct Deposit to get started.

When are my funds available?

Once you sign up for a Limited-Use Health care 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, 2017.

There is no administrative charge for a Limited-Use Health care FSA.

Group Legal Plan

GROUP LEGAL PLAN
UltimateAdvisor®

You never know when legal issues can create serious problems in your life; even threaten everything you've worked so hard for…your home, your income, your assets and more. As a legal plan member, you have the professional legal help you need to protect yourself and your loved ones from legal difficulties.

Here are the kinds of situations where you could use the help of an attorney:

- You realize you need to create or update a will.
- There's a charge that's not yours on your credit card bill.
- You're thinking of adopting a child.
- You want to sell your house and build or buy another one.
- You have a legal dispute with a neighbor.
- Your child is in trouble with the law.

These situations happen every day…to people just like you. But now, with a legal plan, you can protect yourself when faced with legal issues. You'll have peace of mind that comes from having an attorney on your side.

UltimateAdvisor covers almost all of the legal situations you're likely to face. And given that attorneys charge an average of $312* per hour, the plan can protect you from huge legal expenses. Even if you use it only once a year, the plan will likely pay for itself.

*Average attorney rates in the United States of $312 per hour for attorneys with 11 to 15 years of experience, Survey of Law Firm Economics, The National Law Journal and ALM Legal Intelligence, July 2011.

What the Plan Pays

Under the plan, you may choose to receive services from any attorney. However, In-Office Legal Services benefits are paid differently depending on whether you see a Network Attorney (an attorney who is a member of the plan) or you see a Non-Network Attorney:

- If you see a Network Attorney, the plan pays attorney hourly fees in full for most covered legal matters. In addition, you do not need to file a claim for reimbursement; the Network Attorney does it for you. A complete list of Network Attorneys for your state, the areas of law they practice, their phone number and if they speak a foreign language will be provided to you after you enroll by calling 800-247-4184 or you can visit ARAG's site at www.ARAGLegalCenter.com and type in your Access Code: 18197slp

- Network Attorney Guarantee- If there is not a Network Attorney located within 30 miles of your home, ARAG guarantees you will receive in-network benefits. ARAG will work with you to arrange for you to receive covered legal services through an attorney in your area.

- If you receive services from a Non-Network Attorney, you pay the cost of legal services and then file a claim form along with your attorney's billing statement to ARAG. You will be reimbursed for covered expenses up to the lesser of actual costs or a scheduled amount outlined in the corresponding tables. If you see a Non-Network Attorney, you must notify ARAG within 60 days of consulting a Non-Network Attorney. In addition, your claim for reimbursement must be received by ARAG within 120 days after you incur a legal expense.

Enrollment in this plan is for the entire calendar year. If you enroll, your per pay period cost of coverage will be paid on an after-tax basis.

For more information on UltimateAdvisor:

- Visit www.ARAGLegalCenter.com and type in your Access Code: 18197slp for detailed information on plan benefits, how to use the plan and FAQs
- Talk to an ARAG Customer Care Counselor toll-free from 7 a.m. to 7 p.m. Central Time, Monday through Friday at 800-247-4184
- E-mail an ARAG Customer Care Counselor at service@ARAGlegal.com

Group Legal Plan

Services Not Covered

The plan does not cover:

- Matters against us, the policyholder or a member against the interests of the named plan member under the same Certificate.
- Legal services arising out of a business interest, investment interests, employment matters, your role as an officer or director of an organization, and patents or copyrights.
- Legal services in class actions, post judgments, punitive damages, malpractice, appeals, small claims court or equivalent court in your state.
- Legal services deemed by us to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute, or in our reasonable belief you are not actively and reasonably pursuing resolution in your case.

Telephone Legal Access Services include the Exclusions above and:

- Matters which in the opinion of the Telephone Legal Access law Firm, may not ethically or appropriately be handled over the telephone.
- Matters which require in your and/or the Telephone Legal Access Law Firm's opinion, your personal presence in an attorney's office or your direct and personal representation by another attorney.
- Matters for which you have already received advice from another attorney.
- Matters outside the jurisdiction of the United States of America.

Pre-existing Conditions

Any legal matter which occurs or is initiated prior to your effective date will be considered excluded and no benefits will apply. ARAG defines initiated at the date when the infraction occurs or a document is filed with the court or when an attorney is hired.

Waiver of Premium

Death Benefit - This waiver of premium will cover the surviving spouse or domestic partner and insured dependents for one year from the date the named insured passed away. After that year, the spouse, domestic partner or insured dependent can roll their membership to the conversion plan.

Military Leave - Should a named insured be called to active duty for a period of more than thirty (30) consecutive days for the purposes of military service or of responding to a declared national emergency, coverage for the spouse and the insured dependents will continue, without the payment of premium, for the length of the named insured's absence and for so long as the named insured remains eligible for benefits through the policyholder.

Conversion

You may continue this insurance when you no longer qualify as an employee or as a member of the group to which this policy is issued. You must notify ARAG within 90 days of this disqualifying event to make arrangements for premium payment. Any questions regarding the ARAG conversion plan, please contact ARAG at 800-247-4184.

Disclaimer Language

This information is for illustrative purposes only and is not a contract. This information is intended to provide a general review of the plan described. Please remember that only the insurance policy can give actual terms, coverages, amounts, conditions and exclusions.

Plan Administrator

If you have any questions or concerns, please contact the plan administrator at ARAG®, 400 Locust Street, Suite 480, Des Moines, IA, 50309 or at 1-800-247-4184.

Underwriter Information

Insurance products are underwritten by ARAG® Insurance Company of Des Moines, Iowa or GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance of West Des Moines Iowa. Additional services may be provided by ARAG LLC or ARAG Services LLC. Some products are only available through membership in the ARAG Association LC.

Group Legal Plan

Covered Services:

TELEPHONE / ONLINE BENEFITS	ULTIMATEADVISOR®
DIY Docs	•
Education Center	•
ID Theft Legal Advice & Representation	•
ID Theft Prevention/ Recovery Tools & Resources	•
ID Theft Restoration (Case Management)	•
Legal Hotline	•
Standard Immigration Assistance	•
Reduced Fees	•
Caregiving Services	
Advice	•
Annual Checkup	•
CareScout Services	•
Financial Wellness Hotline including Debt Management	•
Financial Tools and Resources Online	•
Expanded ID Theft Protection	
ID Theft Restoration (Full Service)	•
ID Theft - Child Monitoring	•
ID Theft- Lost Wallet	•
ID Theft Insurance ($1,000,000)	•
ID Theft- Credit Monitoring	•
ID Theft - Internet Surveillance of Personal Information	•
IN-OFFICE BENEFITS	**ULTIMATEADVISOR®**
Adoption	•
Building Codes	•
Consumer Protection	•
Defense of Debt Collection	•
Defense of Civil Damage Claims	•
Dissolution of Marriage Contested (15 hours)	•
Dissolution of Marriage Uncontested	•
Document Preparation and Review	•
Driving Privilege Protection w/o DWI	•
Driving Privilege Restoration w/o DWI	•
Easements	•
Eminent Domain	•
Estate Administration and Closing (9 hours)	•

Group Legal Plan

IN-OFFICE BENEFITS	ULTIMATEADVISOR®
Foreclosure Defense	•
Garnishment Defense	•
Guardianship / Conservatorship	•
Habeas Corpus	•
Insanity	•
IRS Audit Protection	•
IRS Collection Defense	•
Juvenile Court Proceedings	•
Minor Traffic Offenses (excluding DWI-related offenses)	•
Name Change	•
Neighbor Disputes (Primary and Secondary Residence)	•
Parental Responsibilities	•
Personal Bankruptcy (Chapter 7 & 13)	•
Prenuptial Agreement	•
Protection from Domestic Violence	•
Purchase/Sale of Home (Primary and Secondary Residence)	•
Real Estate Disputes (Primary and Secondary Residence)	•
Refinancing of Primary Residence- advice/document review	•
School Administrative Hearings	•
Small Claims Assistance	•
Social Security / Veterans / Medicare	•
Tenant Matters (Tenant only)	•
Personal Property Disputes	•
Wills (Standard/Complex, Power of Attorney, Living Will, Codicil)	•
Zoning and Variances	•
Criminal Misdemeanor	•
Child Support Enforcement (8 hours)	•
General Office Work (4 hours per family per year)	•
Irrevocable Trusts	•
Post Decree Defense (8 hours)	•
Post Decree Enforcement (8 Hours)	•
Revocable Trusts	•

Group Legal Program

PREMIUM	ULTIMATEADVISOR®
Premium includes eligible dependents	$10.87 per 24 pay deductions

Pre-existing and personal legal matters not listed above.

For any legal matters not covered and not excluded, you can still receive at least 25% off the Network Attorney's normal rates. For additional details regarding your plan's specifically-covered services, visit ARAGLegalCenter.com and enter Access Code 18197slp or call 800-247-4184.

If you have any questions or want to learn more about how your legal coverage protects you and your family, call ARAG's Customer Care Center at 800-247-4184, with representatives who can help you navigate your legal issues.

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa, GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call 800-247-4184.

*Average attorney rates in the United States of $323 per hour for attorneys with 11 to 15 years of experience, The Survey of Law Firm Economics: 2014 Edition, The National Law Journal and ALM Legal Intelligence, July 23, 2014.

Universal 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 health care, 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.

Your policy/group certificate and applicable riders will contain specific covered conditions and exact terms and provisions. Plan Form IUL.205 is underwritten by Trustmark Insurance Company, Lake Forest, Illinois.

Let's see LifeEvents in action (Sample)

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

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

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

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.

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] 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.	$100,000
Benefit Restoration Insurance Rider 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.	$100,000
Total Maximum Benefit	**$200,000**

Living Benefits may double the value of your life insurance.

[2]The 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.

LTC EE BRFL 0808

Accident Insurance

Accident insurance helps pay for unexpected health care 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 18 to 80, actively working full-time
- Spouses – Ages 18 to 80, who are not disabled
- Children – Birth through age 25, who are unmarried and dependent

For the 2017 Open Enrollment, the accident plan effective date will be February 1, 2017 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

Your Post-Tax Accident Insurance Rates*

	24 pay periods
Employee only	$9.44
Employee & spouse	$16.17
Employee & children	$24.01
Employee & family	$30.74

*Actual payroll deduction amount may vary based on rounding calculations.

Did you know?

Promote your good health through the Wellness Benefit offered through your Accident Insurance.

Your policy/group certificate and applicable riders will contain specific covered conditions and exact terms and provisions.

Accident Insurance

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. File a wellness claim directly through Trustmark.

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

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.

Your policy/group certificate and applicable riders will contain specific covered conditions and exact terms and provisions.

Plan Form A-607 is underwritten by Trustmark Insurance Company, Lake Forest, Illinois.

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 (per admission)	$3,200
Hospital Confinement (per day up to 365 days)	$500
Hospital ICU (per day up to 15 days)	$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	$40,000
Loss of one hand, foot or sight of one eye	$20,000
Loss of two or more fingers, toes or any combination of two or more losses	$4,000
Loss of one finger or one toe	$2,000
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 LifeEvents

Critical LifeEvents℠ Insurance

Trustmark's Critical LifeEvents℠ was designed to focus on the many ways critical illness touches your life. Benefits are payable for early identification as well as for later-stage diagnosis. Earlier benefits help provide funds as quickly as possible to help ensure that treatment or preventive measures may stave off late-stage illness. A replenishing annual benefit helps you deal with a new or recurring covered condition. You can use the benefit any way you wish, whether it's for treatment, changes to your home or someone to watch your kids.

How does Critical LifeEvents work?

Critical LifeEvents is designed to help manage critical illness the way it is experienced by those closest to it. Early diagnosis of a major illness can be a lifesaver, yet successful treatment may be expensive, and a critical illness can sometimes come back again. Critical LifeEvents protection provides continual assistance when covered critical illnesses come into your life:

- Your benefit replenishes each calendar year to help you deal with a new or recurring covered condition.
- Benefits are payable for early identification of a condition as well as for later-stage diagnosis. These can help with early treatment that may stave off serious late-stage illness.
- The policy focuses on the conditions that are most likely to occur. This helps keep coverage affordable.
- Events that trigger a benefit are simple and easy to understand.
- Benefits can be used to pay for whatever you and/or your family need most.
- Choose a personalized benefit amount at time of enrollment: your maximum available for benefit payouts each calendar year.

How are benefits paid?

Critical LifeEvents pays a benefit when there's a new diagnosis of a covered critical illness. Depending on the diagnosis you receive, your benefit payment may be 100%, 50% or 10% of your selected benefit amount.

The following conditions are covered with no lifetime maximum on the number of payouts:

- Cancer
- Coronary Artery Disease/Heart Attack
- Cerebral Vascular Disease/Stroke

You are not alone when you have Trustmark protection. Life goes on. And so does your Trustmark Critical LifeEvents Insurance.

Features that work for you

- Healthy Living Rider – Provides coverage annually for one $50 routine service for early detection and prevention. Also pays for certain follow-up diagnostic tests; your policy will contain complete details.
- Specified Illness Rider – Provides a benefit at 10%, 50%, or 100%, once per lifetime per condition, for additional covered conditions, including: permanent blindness, occupational HIV, paralysis due to sickness, renal or other organ failure, stem cell/bone marrow transplant, central nervous conditions, or complications of diabetes.

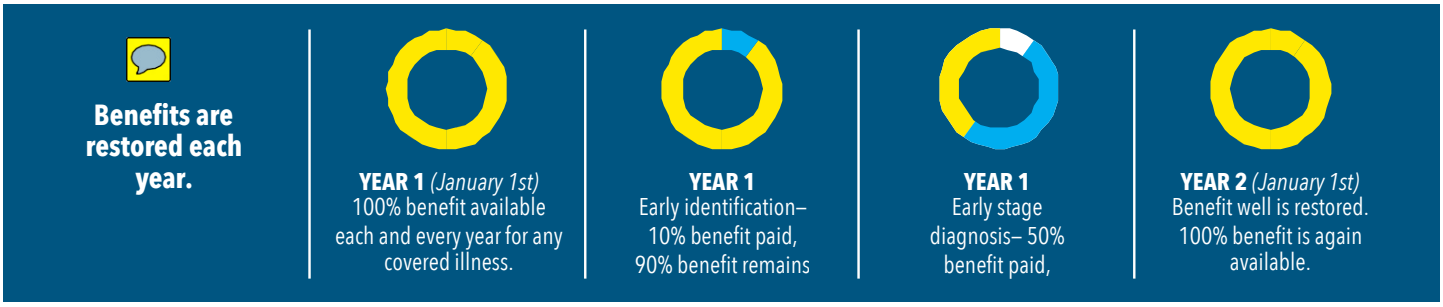
A 30-day waiting period may apply before benefits are payable. Please consult your policy/ group certificate for specific covered illnesses and details.

Benefits you'll appreciate

- Access to medical experts – Receive one-on-one support through Best Doctors®, a leader in connecting you to medical information you may need for a wide range of medical conditions.
- Guaranteed renewable – Guaranteed active coverage for life, as long as premiums are paid. Your premium may change if the premium for all policies in your class changes.
- Level premiums & coverage – Rates will not increase and benefits will not decrease due to age.
- Family coverage – Apply for your spouse, children, and dependent grandchildren.
- Portability – Take your coverage with you and pay the same premium even if you change jobs or retire.
- Convenient payroll deduction – No checks to write.

A direct bill option is available if you change jobs or retire.

Pre-Existing Condition Limitation: No benefit will be paid for any condition caused by or resulting from a pre-existing condition.



Wellness Program

GET AFTER IT!

Did you know you can earn up to 200 incentive points ($200) for participating in health & wellness activities if you carry Florida Blue insurance through the District?

GET IT DONE – Get Healthy and Earn Money:

- The wellness incentive program will run from July 1, 2016 – April 28, 2017.
- 1 point = $1
- Earning your reward?
- If you have the HSA High Deductible Plan (5180/5181) – You will notice a deposit into your HSA account at the end of June 2017.
- If you have the Co-Pay Plan (5771) – You will notice a credit on your paycheck at the end of June 2017.
- Learn more ~ http://www.stlucie.k12.fl.us/health-wellness/

Wellness Activities & Associated Points Points = Money! (July 1, 2016 - April 28, 2017)

This will be automatically uploaded:

- Personal Health Assessment – Attend a Health Fair (50 points)
- National Diabetes Prevention Program- 100% attendance required (50 points)
- Annual Physical from your Gynecologist (25 points)
- Annual Physical from your Primary Care Physician (25 points)
- Florida Blue Assistance Program- Participate in the Healthy Addition Program or Next Steps Program (20 points)
- Health Lecture (15 points)
- Blood Donation –Up to 5 times per year (must allow 56 days in between) (10 points)

Must provide Explanation of Benefits (EOB) or statement from your Doctor – send to Wellness Manager:

- Cancer Screening- Receive cancer screening(s) - prostate, skin, breast, colon, pap smear, etc. (10 points)
- Counseling Sessions- Up to two times per year through Employee Assistance Program (10 points)
- Dental Cleaning- Up to two times per year (10 points)
- Vision/Glaucoma Screening- One time per year (10 points)

Must email or pony the Wellness Manager:

- Florida Blue Assistance Program – Participate in a Condition Management or Care Coordination Program (20 points)
- Exercise at least 12 times per month for at least 30 minutes at a time. Must complete a monthly activity log or hand in gym attendance (15 points)
- Participate in a 5k/10k/Triathlon/Half Marathon/Marathon – Must provide a copy of your registration to Stacy Donnelly (Up to 4 times per year) (15 points)

You must self-report this by clicking the "I did this" box on the Florida Blue website or phone app:

- Access the Florida Blue website or Florida Blue App (10 points)
- Immunizations- Receive vaccinations(s) - flu, pneumonia, shingles (5 points)

Your Employee Assistance Program

SLPS 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

Did you know?

The Employee Assistance Program allows up to six face-to-face visits per year for employee and eligible members.

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 copay.

In-Network Benefits include:

- Up to six 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 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

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 Public 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.mylifevalues.com

Log in 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 1-800-272-3626.

Changing Your Coverage

Qualifying Events for Changing Your Coverage

Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, such as adding or dropping dependents, depending on whether or not you experience an "eligible" qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125.

Within **60 days** of a qualifying event, please contact Risk Management if you have experienced a qualifying event so they may assist you with filing your CIS. Upon the approval of your election change request, your existing elections may be stopped or modified (as appropriate). However, if your election change request is denied, you will have **60 days** from the date you receive the denial to file an appeal with SLPS. For more information, refer to the "Appeal Process" section of this Benefits Reference Guide. Visit **www.myFBMC.com** for information on rules governing periods of coverage and IRS Special Consistency Rules.

ALL CHANGES MUST BE MADE WITHIN 60 DAYS OF THE QUALIFYING EVENT

Valid Change in Status Events:

TYPE OF CHANGES	Description	Supporting Document
Marital Status *(Marriage or Divorce)* **Plans that may be affected:** *Medical, Dental, Vision, Health care FSA, DEP FSA, Group Life Insurance , Short Term Disability, Long Term Disability, HIP*	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in Florida).	• Marriage Certificate and Recent IRS 1040 Tax Return (Tax Return required if married prior to current calendar year); OR • Divorce Decree; OR • Death Certificate.
Change in Number of Employee's Dependents *(Birth, Adoption or Legal Custody)* **Plans that may be affected:** *Medical, Dental, Vision, Health care FSA, DEP FSA, Group Life Insurance, Short Term Disability, Long Term Disability and HIP*	A change in number of dependents includes the following: birth, adoption and placement for adoption. **Note:** You can add your other eligible dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.	• Birth Certificate or Hospital Certificate with Foot Prints; OR • Adoption papers or placement for adoption papers; OR • Legal Custody papers
Change in Employment Status **Plans that may be affected:** **Gain of Employment** *Medical, Dental, Vision, DEP FSA, Group Life Insurance, Short Term Disability and Long Term Disability and HIP* **Loss of Employment** *Medical, Dental, Vision, Health care FSA, DEP FSA, Group Life Insurance, Short Term Disability and Long Term Disability, HIP* **Note:** Change can only be made for individual involved	Change in employment status of the employee, employee's spouse or employee's dependent that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.	• Letter from employer showing employment and insurance termination date; OR • Letter from employer showing employment and insurance effective date. **Note:** Letter must be on the company's letterhead
Gain or Loss of Dependents' Eligibility Status (Death, Dependent no longer meets eligibility requirements) **Plans that may be affected:** *Medical, Dental, Vision, Health care FSA, DEP FSA, Group Life Insurance, Short Term Disability and Long Term Disability, HIP* **Note:** Change can only be made for individual involved	An event that causes an employee's dependent to satisfy or cease to satisfy dependent eligibility coverage requirements which may include change in age, student status, death, marriage, handicapped/ disabled, employment or tax dependent status.	• Death certificate of dependent child; OR • Letter from employee indicating child is dependent/non-dependent on them for support; OR • Letter from employer indicating the child no longer meets their eligibility requirements with the effective date. **Note:** Physician certification is required for disabled or handicapped dependent children who are over the maximum age of 26.

Changing Your Coverage

Coverage and Cost Changes **Plans affected:** *Dependent FSA* **Note**: Does not apply to Health care FSA	Change is permitted when you switch dependent care providers. **Note:** However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.	• A letter from the daycare which outlines the type of change and effective date. This change can be an increase in cost, decrease in costs or provider no longer provides services. • Letter from employee indicating the child has reached the maximum age limit of 13.
Open Enrollment Under Other Employer's Plan **Plans affected:** *Medical, Dental, Vision, Dependent FSA, Group Life Insurance, Short Term Disability, Long Term Disability, HIP* **Note**: Does not apply to Health care Expense FSA	Employee may make an election change when their spouse or dependent makes an Open Enrollment change in coverage under their employer's plan if they participate in their employer's plan and 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.	Open Enrollment election form with the companies name on it or a letter on letterhead from the employer indicating the Open Enrollment Period and effective date of coverage.
Judgment/Decree/Order **Plans affected:** *Medical, Dental, Vision, Health care FSA, HIP* **Note**: Does not apply to a Dependent Care FSA	If a judgment, decree or order from a divorce, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual) including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.	Legal Court documentation that outlines the judges orders: • Divorce papers • Court orders
Medicare/Medicaid **Plans affected:** *Medical, Dental, Vision, Health Care FSA and HIP* **Note**: Does not apply to a Dependent Care FSA	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.	• Medicaid approval or disapproval letter; OR • Medicaid ID card with effective date; OR • Medicare approval or disapproval letter; OR • Medicare ID card with effective date
Family and Medical Leave Act (FMLA) Leave of Absence **Plans that may be affected:** All plans	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave.	Must be placed on approved FMLA leave by HR Department.
Revoking Election of Coverage **Plans affected:** *Medical*	Your plan permits a mid-year election change in employer-sponsored health coverage in order to purchase other coverage. You may prospectively revoke an election of coverage under a group health plan that is not a health FSA under the following circumstances. 1. You have a reduction in average weekly hours of service to less than 30 hr. per week and you and your spouse and dependents you currently cover enroll in another plan that provides minimum essential coverage that becomes effective no later than the first day of the second month following the date of termination of your employer's plan. 2. You are eligible to enroll in a State Exchange during Open Enrollment of the Exchange; or through a Special Enrollment Right and you and your spouse and dependents you currently cover enroll in a State Exchange that is effective no later than the day immediately following the last day of coverage of your employer's plan.	Your employer will let you know of any requirements needed to demonstrate proof that you have enrolled in or will enroll in other Qualified Health Plan coverage.

COBRA Q&A

COBRA Administrator

FBMC Benefits Management Inc., benefits manager for SLPS, has contracted with PayFlex Systems USA, Inc. to administer COBRA services as required by law.

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 and Health 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 and Health FSAs, 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 and Health FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical and Health FSA for the remainder of the plan year or until such time that you receive the maximum Medical and Health FSA benefit of $1,000.

If your employer funds all or any portion of your Medical and Health FSA, you may be eligible to continue your Medical and Health 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 and Health FSAs. If you have questions about your employer-funded Medical or Health FSA, call FBMC Benefits Management (FBMC) at 1-855-5MY-SLPS or 1-855-569-3277 between the hours of 7:00 a.m. and 8:00 p.m..

How can you extend the length of continuation coverage?

For Group Health Plans (Except Medical Expense FSAs):

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify PayFlex Systems USA, Inc. of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify PayFlex of that fact within 60 days of the later of 1) the SSA's determination of disability (the date of the SSA award letter); 2) the date of your qualifying event; 3) the date of your loss of coverage; or 4) the date you were notified of the requirement (the date of your qualifying event letter). The notification must also be provided before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify PayFlex of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan and FBMC within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

COBRA Q&A

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Premium Payments should be mailed to:
PayFlex Systems USA, Inc.
BENEFITS BILLING DEPARTMENT
P.O. BOX 14394
LEXINGTON, KY 40512-4394

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. For Medical Expense FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact PayFlex to confirm the correct amount of your first payment.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

COBRA Q&A

Can you elect other health coverage besides continuation coverage?

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You must contact your employer if you wish to elect alternative coverage. If your group health plan offers conversion privileges, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum COBRA continuation coverage available to you.

How do I continue coverage on voluntary benefits?

Contact SLPS Employee Benefits Department at 772-429-5520 if you would like to continue your voluntary 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 in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact FBMC Service Center toll free at 1-855-5MY-SLPS or 1-855-569-3277 between the hours of 7:00 a.m. and 8:00 p.m. ET.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the COBRA Administrator.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

Notes

Notes

Benefits Directory

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

Melissa Rusignuolo
FloridaBlue On-Site
Group Service Rep. Health/Dental
1-772-429-7702
1-772-343-1193 (fax)
melissa.rusignuolo@floridablue.com

New Directions
(Mental Health Benefits)
1-866-287-9569
www.ndbh.com

Health Equity
(Health Savings Account/Bank)
1-866-346-5800
www.healthequity.com

Florida Combined Life
(Dental)
Customer Service
1-888-223-4892
Mon – Fri, 8 a.m. – 5 p.m.
www.floridabluedental.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 - 7 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
www.CignaWillCenter.com

Trustmark
(Accident Insurance, Critical Illness, LifeEvents Universal LifeEvents, Critical LifeEvents)
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

Transamerica
(Existing Universal Life and Long-Term Care Policies)
Universal Life - 1-800-322-0426
Long-Term Care - 1-800-227-3740

St. Lucie Public Schools
Risk Management Dept.
1-772-429-5521

PayFlex
(Flexible Spending Accounts)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
Sat, 10 a.m. - 3 p.m. ET
1-800-284-4885

Toll-Free Claims Fax
1-855-703-5305
www.payflex.com

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

Legal Insurance
ARAG®
Legal Insurance
400 Locust Street
Suite 480
Des Moines, IA 50309
800-247-4184
Access Code 18197slp
www.ARAGLegalCenter.com

FBMC
BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Service Center: 1-855-LUCIE4U (1-855-582-4348)
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.

FBMC/SLPS/0916