Benefits Reference Guide

Your Choices Make A Difference

St. Lucie PUBLIC SCHOOLS

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ONLINE RESOURCES:

>> **Click to view important information on how to enroll, the enrollment link and plan information.**

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What's Happening at SLPS?

St. Lucie
PUBLIC SCHOOLS

STAY CONNECTED
For news and happenings across all campuses, visit **stlucie.k12.fl.us** and follow St. Lucie Public Schools (SLPS) on social media.

Schedule your individual enrollment session online at **myenrollmentschedule.com/stlucie**.

MORE INFO
For more information, you can contact the FBMC Benefits Management, Inc. Service Center at 1-855-LUCIE4U (1-855-582-4348), Monday - Friday, 7 a.m. - 7 p.m. ET.

Important Dates to Remember

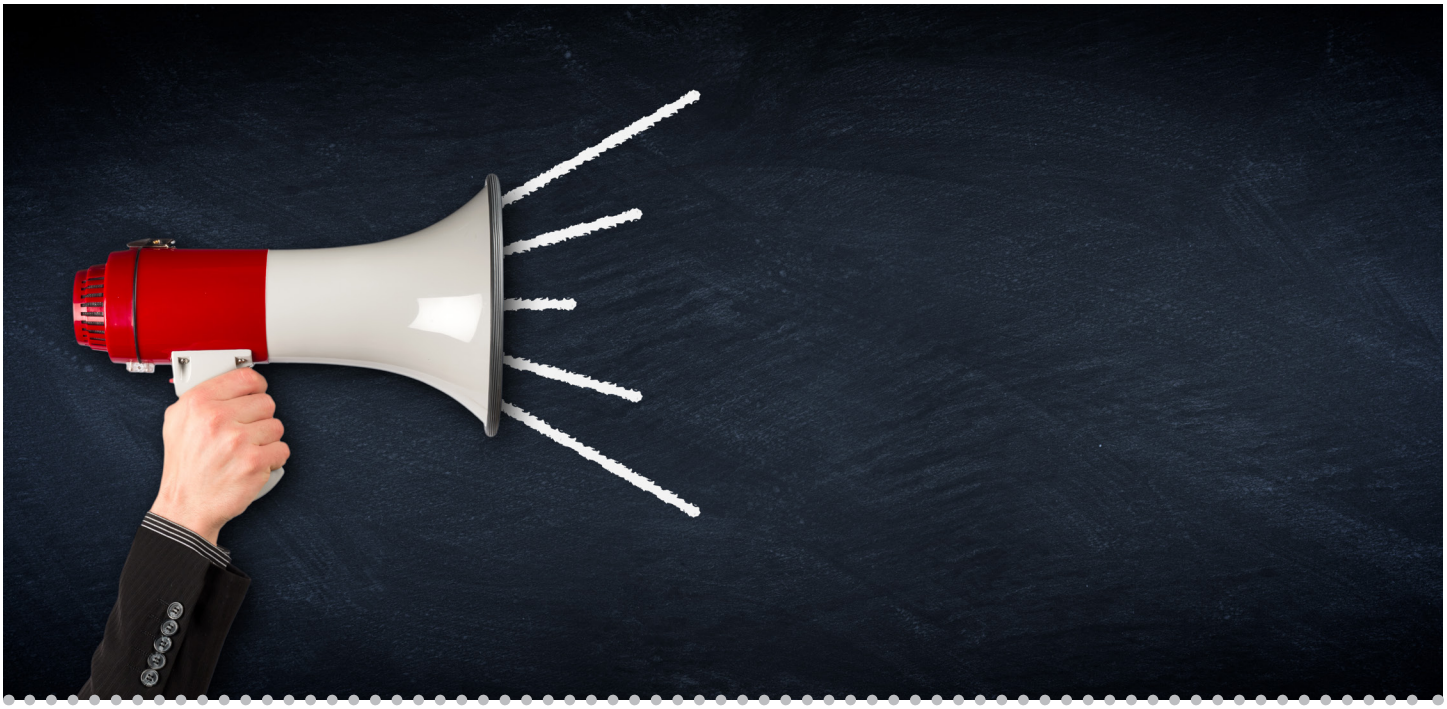
Your **changes only** open enrollment dates are:
October 8, 2018 through October 26, 2018

Your plan year dates are:
January 1, 2019 through December 31, 2019

Trustmark Voluntary Benefits period of coverage:
February 1, 2019 through January 31, 2020

Connect With Us

Key Things To Know



Welcome To Your 2019 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 you a comprehensive and affordable benefits program. Your benefits are a valuable part of your employment with SLPS, so be sure you are making the most of them!

This year, SLPS supports the new theme, "Your Choices Make a Difference," which positively encourages you to make good decisions through continuing benefits education – to make a difference for your health and wellness. Being mindful of your daily nutritional choices and increased physical activity may lead to improved health during the plan year.

Important Notes

- **CHANGES ONLY ENROLLMENT -** If you do not make changes during the open enrollment period, your current elected benefits will roll over for the 2019 Plan Year.
- **ENROLLMENT SESSION ATTENDANCE -** To enroll in or make changes to any benefits, you can complete an enrollment online or attend an enrollment session with a Benefits Counselor. Schedule your individual enrollment session online at **myenrollmentschedule.com/stlucie**.
- **GROUP LIFE -** Life plan is once again being offered on a Guaranteed issue basis.
- **2019 MEDICAL PLANS -** SLPS continues to offer you three different BlueOptions medical plans, including two, high-deductible health plans. Employees that choose one of the high-deductible health plans may also add a Health Savings Account (HSA). Employees hired January 1, 2014 or later are only eligible to enroll in the BlueOptions 05180/05181 or 05192/05193 Plan.
- **SLPS $750 HSA CONTRIBUTION -** For the 2019 plan year, SLPS will continue to make a one-time contribution of $750 to a HSA in January, 2019 to each employee enrolled as of January 1, 2019 in the BlueOptions Plan 05180/05181 or 05192/05193. For employees enrolled after January 1, 2019, SLPS will contribute $31.25 per pay period to the HSA through June 30, 2019.
- **DUAL SPOUSE - 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 Benefits Counselor. Please contact the Risk Management Office at 772-429-5521 for more information.

Key Things To Know

What benefits are available?

SLPS recognizes that your needs change from year to year. We are providing one-on-one benefits sessions. Your 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 - vision plan with in and out-of-network options.

Medical Bridge Plans - supplemental hospital confinement benefit, which helps to offset out-of-pocket expenses and deductibles associated with hospital stays. Benefit choices of $1,000 or $2,000 are payable directly to the employee so you can use the money as you desire.

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

ID Theft - is a program available to protect and monitor your personal information.

Group Term Life - Term Life is guaranteed issue up to $50,000. If you enroll in the maximum amount of group term life, you may also purchase additional term life, up to a max of $500,000. Coverage for spouse and dependents may be purchased as well.

Healthcare 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.

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

Pet Assure and PetPlus - are pet-focused benefits that offer discounts on medical services provided by in-network veterinarians and wholesale pricing on prescriptions, preventatives and other products.

Accident Insurance - helps pay for unexpected Healthcare expenses due to non-occupational covered accidents for initial care, injuries and follow-up care.

Critical Illness LifeEvents - pays benefits for early identification and 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, and optional accidental death benefit, waiver of premium, EZ Value Plan, and children's term benefit.

Employee Assistance Program (EAP) - provides a variety of short-term counseling and informational services. Up to six free and confidential counseling sessions.

Premium Conversion

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

- 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

Send enrollment appeals to:
FBMC Benefits Management, Inc.
Enrollment Appeals
PO Box 1878, Mail Slot 79
Tallahassee, FL 32302-1878
Fax: 1-850-425-6220

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

Did You Know?

SLPS will make a one-time contribution of $750 to a Health Savings Account on January 1, 2019 if you are enrolled in the BlueOptions Plan 05180/05181 or BlueOptions Plan 05192/05193.

Eligibility + Coverage

Period of Coverage

If you enroll during your annual open enrollment, your period of coverage is January 1, 2019, through December 31, 2019 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, 2019 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 for more information on qualifying events.**

About Your Medicare Rx

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, 2019) 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 due date 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, 2019) 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.

Eligibility + Coverage

Employees on an Approved Workers' Compensation and FMLA Leave

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.

Employees on an Approved Non-FMLA Leave

St. Lucie Public Schools does not contribute towards your insurance premiums while you're 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 (Pretax):

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

1. The covered employee's spouse under a legally-valid existing marriage;

2. The covered employee's natural, newborn, adopted, foster, or step child(ren) (or a child for whom the covered 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
   - **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 disabled dependent child.

   - **c)** in the case of a disabled 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 disability; and
   - **iii.** chiefly dependent upon the covered dependent for support and maintenance provided that the symptoms or causes of the child's disability 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 disabled child.

or

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

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.

Eligibility + Coverage

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:

- 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).
- Group Medical Bridge- coverage will cease at the end of the calendar year in which the child reaches age 26.
- Term Life- coverage will cease at the end of the calendar year in which the child reaches age 20 (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 disabled 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.

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.

How to Enroll

Enroll Online

Employees may choose to enroll online at **myFBMC.com.** You must be registered to access the web enrollment. If you have not already, you will need to register following the first-time user link provided.

Once registered, you may access the web enrollment instructions at the "Resources" tab.

Accessing Your Online Benefits

- Log in to **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 dependent or 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 your enrollment is complete.
- Print out your confirmation statement containing all 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 elections.

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

Enrollment changes after October 26, 2018 will not be permitted unless there has been a valid CIS event.

Enroll with a Benefits Counselor

To make an appointment with a Benefits Counselor, go to **myenrollmentschedule.com/stlucie**.

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

- Social Security numbers for your dependents
- Dates of birth for all your dependents and beneficiaries
- Addresses for all your dependents and beneficiaries

Complete your enrollment with the assistance of a Benefits Counselor by October 26, 2018.

Visit with a Benefits Counselor for your chance to enter a raffle to win some valuable prizes!

Make an Appointment

If you are interested in electing or making a change to your voluntary benefits, please make an appointment with a Benefits Counselor by going to **myenrollmentschedule.com/stlucie** and selecting "Make an Appointment."

Enrolling Online

1 How to Enroll Online

To enroll online, go to the FBMC homepage at **myFBMC.com** and log in with your username and password.

Username and Password

To access your account, you will need to register for a user name and password (if you have not already done so). You will need your name, your mailing ZIP code, a valid email address and one of the following: Your SSN, your Employee ID or your FBMC Member ID. You will use the email address and a password you select to access your enrollment and account information on **myFBMC.com.**

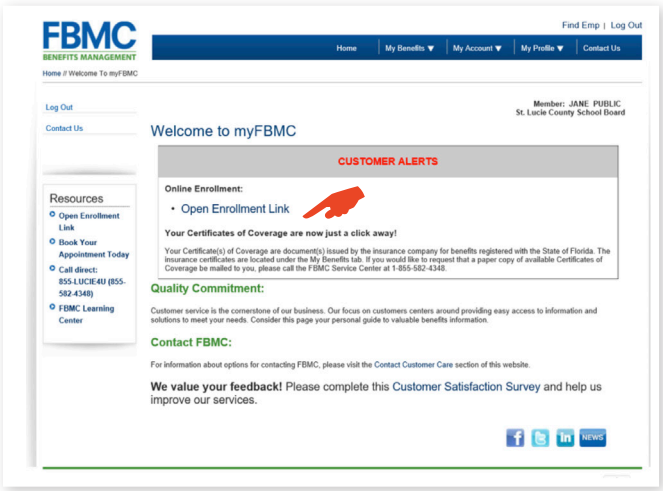
If you forget your password, click the "Forgot your password?" link for help, or you may contact a Service Center Representative at 1-855-LUCIE4U (1-855-582-4348).

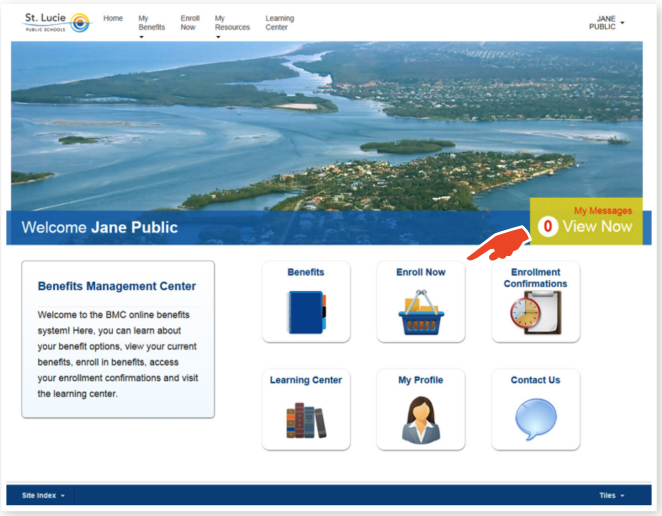
Record Your Password Here.

Remember, this will be your password for web access.

2 Access Your Web Enrollment

After entering your username and password at **myFBMC.com**, click the "Open Enrollment" link. A second "Open Enrollment 2019" link will then be provided - select this link to access your open enrollment application.

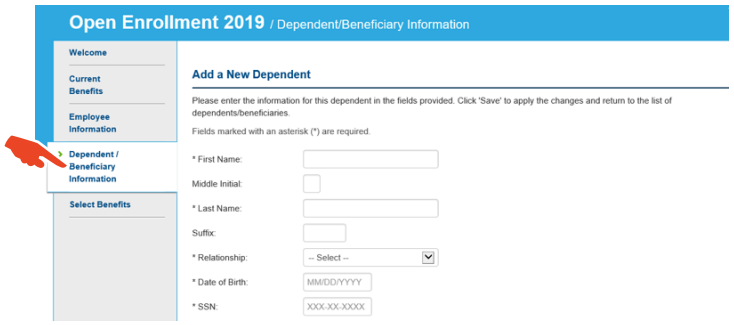


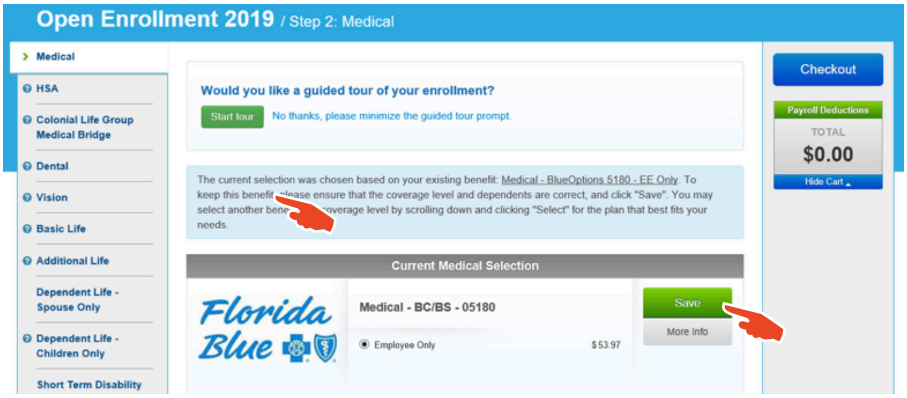


Enrolling Online

3 Verify Your Dependent and Demographic Info

You can add dependent information by clicking on the "**+**". You may update dependent information by clicking on the person's name. You may remove dependents by clicking on the "**x**" icon.





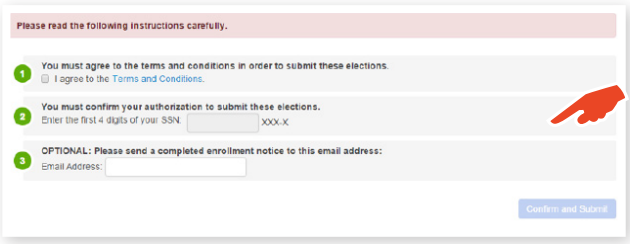
4 Begin the Enrollment Process

For each benefit, choose your coverage level or election amounts and then go to the next benefit. Continue until enrollment is complete. If you decide to waive a benefit, you must select "waive."

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

5 Agreement and Authorization

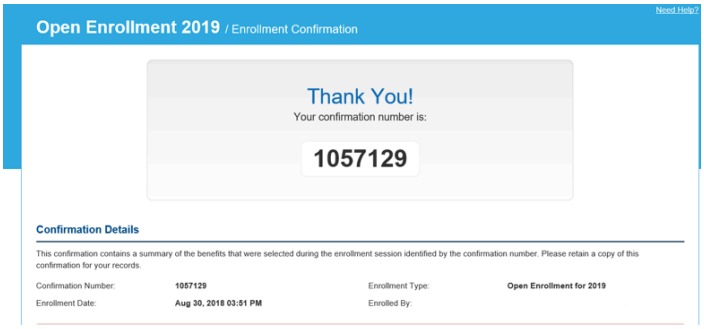
In order to complete your enrollment, you must check the box to agree to the Terms and Conditions, type in the first four digits of your SSN and you have the option to include your email address to receive an enrollment confirmation notification online.



6 Print and Keep Your Confirmation Notice

Once you have completed the enrollment process, you will receive a confirmation number and 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 Open Enrollment period to make any changes to your benefits.



Florida Blue Medical Plans

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA - Compatible 05180 (Single Coverage)	BlueOptions HSA - Compatible 05181 (Family Coverage)
DEDUCTIBLE (DED)		
In-Network (Per Person / Family Aggregate)	$1,500	$3,000
Out-of-Network (Per Person / Family Aggregate)	$3,000	$6,000
COINSURANCE (MEMBER RESPONSIBILITY)		
In-Network	10%	10%
Out-of-Network	40% OF ALLOWED AMOUNT+SUBJECT TO BALANCE BILLING CHARGES	40% OF ALLOWED AMOUNT+SUBJECT TO BALANCE BILLING CHARGES
OUT-OF-POCKET MAXIMUM (INCLUDES DED, COINS, & COPAYS)		
In-Network (Per Person / Family Aggregate)	$3,000	$6,000
Out-of-Network (Per Person / Family Aggregate)	$6,000	$12,000
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections		
In-Network Primary/Family Care Physician	DED + 10%	DED + 10%
In-Network Specialist	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
E-Office Services		
In-Network Primary/Family Care Physician	DED + 10%	DED + 10%
In-Network Specialist	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Office Services		
In-Network Primary/Family Care Physician	DED + 10%	DED + 10%
In-Network Specialist	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Provider Services at Hospital and ER		
In-Network Primary/Family Care Physician	DED + 10%	DED + 10%
In-Network Specialist	DED + 10%	DED + 10%
Out-of-Network	IN-NETWORK DED + 10%	IN-NETWORK DED + 10%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center		
In-Network Specialist	DED + 10%	DED + 10%
Out-of-Network	IN-NETWORK DED + 10%	IN-NETWORK DED + 10%
PREVENTIVE CARE		
Adult/Child Wellness Office Services		
In-Network Primary/Family Care Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	40% (NO DED)	40% (NO DED)
Colonoscopies (Routine - 1 every 10 years) Age 50+ then Frequency Schedule Applies		
In-Network Specialist	$0	$0
Out-of-Network	$0	$0

Florida Blue Medical Plans

	BlueOptions HSA - Compatible 05192 (Single Coverage)	BlueOptions HSA - Compatible 05193 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
	$2,500	$5,000	$1,500 / $4,500
	$5,000	$10,000	$4,500 / $13,500
	15%	15%	20%
	50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES	50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES	50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES
	$6,000	$7,150 / $12,000	$4,500 / $9,000
	$12,000	$24,000 / $24,000	$9,000 / $18,000
	DED + 15%	DED + 15%	$10
	DED + 15%	DED + 15%	$10
	DED + 50%	DED + 50%	DED + 50%
	DED + 15%	DED + 15%	$10
	DED + 15%	DED + 15%	$10
	DED + 50%	DED + 50%	DED + 50%
	DED + 15%	DED + 15%	$30
	DED + 15%	DED + 15%	$55
	DED + 50%	DED + 50%	DED + 50%
	DED + 15%	DED + 15%	DED + 20%
	DED + 15%	DED + 15%	DED + 20%
	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%	IN-NETWORK DED + 20%
	DED + 15%	DED + 15%	ASC: $55, HOSPITAL: DED + 20%
	IN-NETWORK DED + 15%	IN-NETWORK DED + 15	ASC: $55, HOSPITAL: IN-NETWORK DED + 20%
	$0	$0	$0
	$0	$0	$0
	50% (NO DED)	50% (NO DED)	50% (NO DED)
	$0	$0	$0
	$0	$0	$0

Florida Blue Medical Plans

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA - Compatible 05180 (Single Coverage)	BlueOptions HSA - Compatible 05181 (Family Coverage)
Mammograms (Routine)		
In-Network	$0	$0
Out-of-Network	$0	$0
EMERGENCY/URGENT CARE		
Ambulance Maximum (per day)	NO MAXIMUM	NO MAXIMUM
In-Network	DED + 10%	DED + 10%
Out-of-Network	IN-NETWORK DED + 10%	IN-NETWORK DED + 10%
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network	DED + 10%	DED + 10%
Out-of-Network	IN-NETWORK DED + 10%	IN-NETWORK DED + 10%
Urgent Care Centers (UCC)		
In-Network	DED + 10%	DED + 10%
Out-of-Network	OON DED + 10%	OON DED + 10%
FACILITY SERVICES – HOSPITAL/SURGICAL/ICL/IDTF - Unless otherwise noted, physician services are in addition to facility servic		
Ambulatory Surgical Center		
In-Network	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Independent Clinical Lab		
In-Network (Quest Diagnostics)	DED	DED
Out-of-Network	DED + 40%	DED + 40%
Independent Diagnostic Testing Facility - X-Rays and AIS (Includes Physician Services)		
In-Network - Advanced Imaging Services (AIS)	DED + 10%	DED + 10%
In-Network - Other Diagnostic Services	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Inpatient Hospital (per admit)		
In-Network	OPTION 1 - DED + 10% OPTION 2 - DED + 10%	OPTION 1 - DED + 10% OPTION 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Outpatient Hospital (per visit)		
In-Network	OPTION 1 - DED + 10% OPTION 2 - DED + 10%	OPTION 1 - DED + 10% OPTION 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Therapy at Outpatient Hospital		
In-Network	OPTION 1 - DED + 10% OPTION 2 - DED + 10%	OPTION 1 - DED + 10% OPTION 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 40%
OTHER SPECIAL SERVICES AND LOCATIONS		
Durable Medical Equipment (DME), Prosthetics, Orthotics	NO MAXIMUM	NO MAXIMUM
In-Network (CareCentrix)	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%

Florida Blue Medical Plans

	BlueOptions HSA - Compatible 05192 (Single Coverage)	BlueOptions HSA - Compatible 05193 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
	$0	$0	$0
	$0	$0	$0
	NO MAXIMUM	NO MAXIMUM	NO MAXIMUM
	DED + 15%	DED + 15%	DED + 20%
	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%	IN-NETWORK DED + 20%
	DED + 15%	DED + 15%	$250
	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%	$250
	DED + 15%	DED + 15%	$60
	OON DED + 15%	OON DED + 15%	OON DED + $60
es. See Professional Provider Services.			
	DED + 15%	DED + 15%	$200
	DED + 50%	DED + 50%	DED + 50%
	DED	DED	$0
	DED + 50%	DED + 50%	DED + 50%
	DED + 15%	DED + 15%	$250
	DED + 15%	DED + 15%	$50
	DED + 50%	DED + 50%	DED + 50%
	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 20% OPTION 2 - DED + 20%
	$500 PAD + DED + 50%	$500 PAD + DED + 50%	$500 PAD + DED + 50%
	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 20% OPTION 2 - DED + 20%
	DED + 50%	DED + 50%	DED + 50%
	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - $55 OPTION 2 - $80
	DED + 50%	DED + 50%	DED + 50%
	NO MAXIMUM	NO MAXIMUM	NO MAXIMUM
	DED + 15%	DED + 15%	DED + 20%
	DED + 50%	DED + 50%	DED + 50%

Florida Blue Medical Plans

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions HSA - Compatible 05180 (Single Coverage)	BlueOptions HSA - Compatible 05181 (Family Coverage)
Home Healthcare (BPM)	20 VISITS	20 VISITS
Home Healthcare In-Network (CareCentrix)	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Hospice	NO MAXIMUM	NO MAXIMUM
In-Network	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Skilled Nursing Facility BPM	60 DAYS	60 DAYS
In-Network	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 40%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Physician Office Visit		
In-Network Family Physician or Specialist	DED + 10%	DED + 10%
Out-of-Network Provider	DED + 40%	DED + 40%
Inpatient/Outpatient Hospitalization - Facility		
In-Network	OPTION 1 - DED + 10% OPTION 2 - DED + 10%	OPTION 1: DED + 10% OPTION 2: DED + 10%
Out-of-Network	DED + 40%	DED + 40%
Emergency Room Facility Services (per visit)		
In-Network	DED + 10%	DED + 10%
Out-of-Network	IN-NETWORK DED + 10%	IN-NETWORK DED + 10%
Provider Services at Hospital and ER		
In-Network Family Physician or Specialist	DED + 10%	DED + 10%
Out-of-Network Provider	IN-NETWORK DED + 10%	IN-NETWORK DED + 10%
PRESCRIPTION DRUGS		
Deductible	**$1,500 IN-NETWORK DEDUCTIBLE APPLIES**	**$3,000 IN-NETWORK DEDUCTIBLE APPLIES**
In-Network (Mandatory Generic Program)		
Retail (30 days) Generic/Preferred Brand/ Non-Preferred	$10 / $30 / $50	$10 / $30 / $50
Mail Order/Retail (90 days) Generic/ Preferred Brand/Non-Preferred	$20 / $60 / $100	$20 / $60 / $100
	CONDITION CARE RX PROGRAM - AVAILABLE FOR HSA PLANS ONLY 05180/05181, IN-NETWORK DEDUCTIBLE IS WAIVED/COPAY ONLY, **"CLICK HERE TO SEE COVERED MEDICATIONS"**	

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.

Florida Blue Medical Plans

	BlueOptions HSA - Compatible 05192 (Single Coverage)	BlueOptions HSA - Compatible 05193 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
	20 VISITS	20 VISITS	20 VISITS
	DED + 15%	DED + 15%	DED + 20%
	DED + 50%	DED + 50%	DED + 50%
	NO MAXIMUM	NO MAXIMUM	NO MAXIMUM
	DED + 15%	DED + 15%	DED + 20%
	DED + 50%	DED + 50%	DED + 50%
	60 DAYS	60 DAYS	60 DAYS
	DED + 15%	DED + 15%	DED + 20%
	DED + 50%	DED + 50%	DED + 50%
	DED + 15%	DED + 15%	$0
	DED + 50%	DED + 50%	50% (NO DED)
	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1: DED + 15% OPTION 2: DED + 15%	OPTION 1: $0 OPTION 2: $0
	DED + 50%	DED + 50%	50% (NO DED)
	DED + 15%	DED + 15%	$0
	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%	$0
	DED + 15%	DED + 15%	$0
	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%	$0
	$2,500 IN-NETWORK PLAN DEDUCTIBLE APPLIES	**$5,000 IN-NETWORK PLAN DEDUCTIBLE APPLIES**	**$0**
	$10 / $40 / $75	$10 / $40 / $75	$10 / $30 / $50
	$20 / $80 / $150	$20 / $80 / $150	$20 / $60 / $100
	CONDITION CARE RX PROGRAM - AVAILABLE FOR HSA PLANS ONLY 05192/05193, IN-NETWORK DEDUCTIBLE IS WAIVED/COPAY ONLY **"CLICK HERE TO SEE COVERED MEDICATIONS"**		**N/A**

Condition Care Rx Program

The **Florida Blue Condition Care Rx Program** is a wonderful addition to your health insurance benefits. It was designed to help those of you who are on the District's **High Deductible HSA Plan 05180/05181 or 05192/05193** manage the cost of some of your prescriptions.

If your medication is on the list below for **diabetes**, **cholesterol**, **respiratory issues**, **high blood pressure** and a few other health conditions, you will **NOT** have to meet your deductible first. It will be **WAIVED** and you will only pay a copay at the pharmacy instead!!

For a complete list of current medications that are included in your Condition Care Rx Program, please click the link below:

Condition Care Rx Drug List

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 on 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	$$
Tier 3	Covered **Non-Preferred** Brand Medication	$$$

Prescription Drug Program

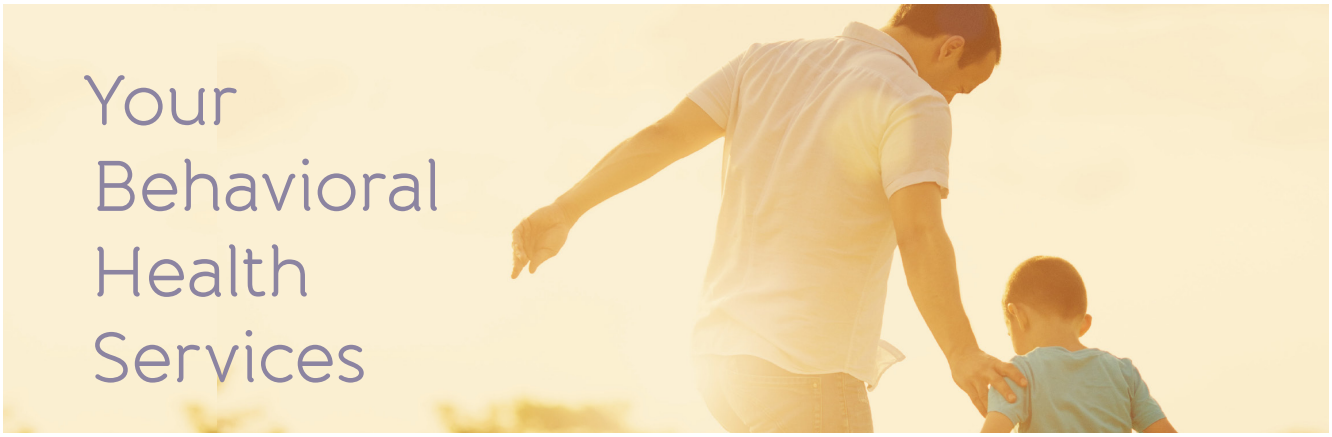
3. Coverage Requirements, Limits and Authorizations
With certain medications there are potential safety risks, such as overuse, which can be harmful to your health and costly to your wallet. These medications may be included in one or more of our Responsible Rx programs such as **Prior Authorization**, **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 Walgreens, CVS, Publix, Target, Walmart and Winn-Dixie. To find a participating pharmacy near you, please visit us at ***www.floridablue.com***.
• **Home Delivery** for up to a 90-day supply. Please call 1-877-787-3047 or click on this link to access the Alliance Rx Walgreens Prime Home Delivery Program AllianceRxWP.com
• **Specialty Pharmacy** Certain Self-Administered Specialty Drugs such as injectable, infused, oral or inhaled drugs must be purchased from one of our two participating specialty pharmacies, **CVS/CareMark or Alliance Rx Walgreens Prime**. If your medication is a Self-Administered Specialty drug, simply call **CVS/CareMark toll-free at 866-278-5108 or Alliance Rx Walgreens Prime 877-627-6337. For a current list of Specialty Medications, please click here.**

Florida Blue Resources

FAQ's	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.	**2019 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**
Can I go online and order a Health and/or Dental ID card or view my claims?	**www.floridablue.com** **Register online to:** · Review your plan benefits · View your deductible · Find an in-network doctor or hospital · View claim activity, status and history · Understand your medical costs · Order an ID card · Access our exclusive discount program (Blue365) · Enroll in Tivity Health Fitness Your Way 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).
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 after hours and on weekends or enroll a family member into their own health or dental plan?	**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 questions concerning 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 healthcare 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

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

Medical Rates

2019 Employee Payroll Contributions	BLUE OPTIONS HSA COMPATIBLE 05180/05181	BLUE OPTIONS HSA COMPATIBLE 05192/05193	BLUE OPTIONS 05771 Only available to employees hired before January 1, 2014.
	PER PAY PERIOD	PER PAY PERIOD	PER PAY PERIOD
Employee Only	$53.97	$15.99	$75.33
Employee + 1 Dependent	$446.54	$361.46	$494.39
Employee + Family	$638.41	$530.30	$699.89
Dual Employee + Family	$187.95 Each Employee Per Pay Period	$133.90 Each Employee Per Pay Period	$218.69 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

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 (pretax)
- 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).

Did You Know?

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

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

2019 maximum HSA contributions allowed by the IRS:

The Internal Revenue Service (IRS) issued Revenue Procedure 2018-30, which provides the 2019 inflation-adjusted amounts for health savings accounts (HSAs) as determined under Section 223 of the Internal Revenue Code.

For calendar year 2019, the annual limitation on deductions for an individual with self-only coverage under a high-deductible health plan is $3,500. For calendar year 2019, the annual limitation on deductions for an individual with family coverage under a high deductible health plan is $7,000. Individuals over the age of 55 may contribute up to $1,000 more to their HSA per year until they turn 65 and are enrolled in Medicare.

Health Savings Account

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 **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 percent 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 percent).

How to fund Your HSA:

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

Did You Know?

SLPS will make a one-time contribution of $750 to a Health Savings Account on January 1, 2019 if you are enrolled in the BlueOptions Plan 05180/05181 or BlueOptions Plan 05192/05193.

Health Equity. Inc. – HSA Administrator for St. Lucie Public Schools Employees

- In partnership with Florida Blue, Health Equity, Inc. 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 Healthcare FSA?

Yes, individuals may enroll in a Limited-Use Healthcare FSA to pay certain eligible expenses. The Limited-Use Healthcare 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 healthcare plan. Dependent Care Spending Account eligibility is not affected by your HSA participation. Additionally, You can save money and pay less tax by enrolling in an Limited Use Healthcare FSA, HSA, or both. These are pretax benefits that you can take advantage of either independently of each other or together.

Florida Combined Life Dental Plans

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.

The 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

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
$1,500 - $1,999	$700	$500	$1,250

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)

To see a list of the dentists in our network, visit **Florida Bluedental.com**. Don't see your dentist in our network? Send an email 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 percent 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 Plans

Financial Features	BlueDental Choice PPO Low		BlueDental Choice PPO 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 *	**You Pay**	**You Pay**	**You Pay**	**You Pay**
PREVENTIVE **	**0%**	0%	**0%**	10%
BASIC **	**20%**	20%	**10%**	20%
MAJOR **	**50%**	50%	**40%**	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 BlueDental Pays Benefit Waiting Period	 **$500** 50% NONE		 **$1,000** 50% 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	**$15.68**		**$19.11**	
Employee Plus 1	**$32.94**		**$40.20**	
Employee Plus 2 or more	**$56.73**		**$70.86**	

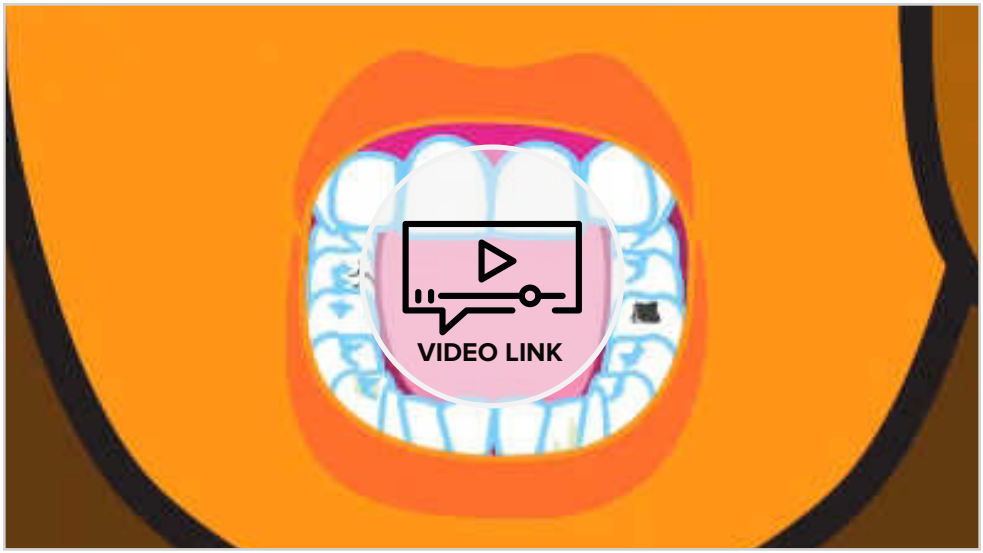
The information provided above is a summary of benefits for the group Choice certificate. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as a part of the contract. 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 Dental Plans



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

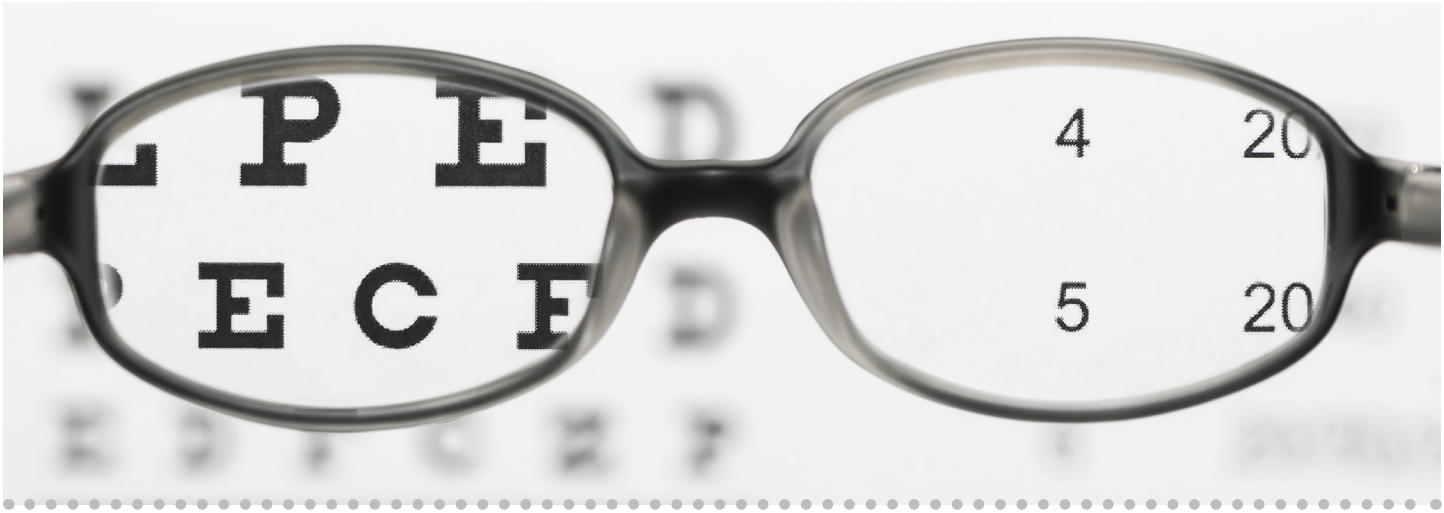
- Choose your dental insurance plan from the drop-down menu under **Insurance Plan Information** (this information is available on your BlueDental ID card.) Selecting your plan ensures that your search will only list providers who are part of your plan's network.

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 Plans



See How Davis Vision Plan Expands Your Vision Plan Features!

Davis Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

- Paid-in-full eye examinations, eyeglasses and contacts!
- Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]
- Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]
- One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

[1]Laser Vision Correction discounts of up to 25 percent off the provider's Usual & Customary fees, or five percent off advertised specials, whichever is lower.

Value for Davis Vision Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100 percent member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

Replacement contacts through Davis Vision contact lens replacement service, saving both time and money.

Tax-Free Vision Rates	24 PAY PERIODS
Employee Only	$2.98
Employee + Family	$8.40

The Exclusive Collection

The Exclusive Collection of frames is available at close to 9,000 locations across the U.S. Log in to your account to browse frames and find a Collection near you.

Free Breakage Warranty

Your glasses are covered with our FREE one-year breakage warranty. Some limitations apply.

Find A Network Provider

Just log on to the open enrollment section of our Member site at **davisvision.com/member** and click "Find a Provider" to locate a provider near you, including: Visionworks

1. Contact lens coverage varies by product selection.
2. Visually-required contacts are covered in full with prior approval.
3. Some limitations apply to additional discounts, discounts not applicable at all in-network providers. Davis Vision has done its best to accurately reflect plan coverage herein.
4. The Exclusive Collection of Contact Lenses evaluation, fitting and follow-up care is covered-in-full.

If differences exist between this document and the plan contract, the contract will prevail.

For more details about the plan, just log on to the open enrollment section of our Member site at **davisvision.com/member** or call 877-923-2847 and enter Client Code 8165.

Vision Plans

In-Network Benefits	Plan Design Options
Frequency – Once Every:	**Designer**
Eye Examination inclusive of Dilation (when professionally indicated)	12 Months
Spectacle Lenses	12 Months
Frame	12 Months
Contact Lens Evaluation, Fitting & Follow-Up Care (in lieu of eyeglasses)	12 Months
Contact Lenses (in lieu of eyeglasses)	12 Months
Copayments	
Eye Examination	$0
Spectacle Lenses	$0
Contact Lens Evaluation, Fitting & Follow-Up Care	$0[/1]
Eyeglass Benefit – Frame	
Frame Allowance (Retail):	Up to $130 Plus a 20% discount on any overage[/2]
Davis Vision Exclusive Collection[/3] **(in lieu of Allowance):**	
Fashion / Designer / Premier - member charge (if applicable)	$0 / $0 / $25
Eyeglass Benefit - Spectacle Lenses	**Member Charges**
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Covered
Tinting of Plastic Lenses	Covered
Scratch-Resistant Coating	Covered
Polycarbonate Lenses (Children[/4] / Adults)	$0 / $30
Ultraviolet Coating	$12
Anti-Reflective (AR) Coating (Standard / Premium / Ultra)	$35 / $48 / $60
Progressive Lenses (Standard / Premium / Ultra)	$50 / $90 / $140
High-Index Lenses	$55
Polarized Lenses	$75
Plastic Photochromic Lenses	$65
Scratch Protection Plan: Single Vision / Multifocal Lenses	$20 / $40
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens: Materials Allowance	Up to $130 Plus a 15% discount on any overage[/2]
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types	Covered
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types	Up to $60 allowance Plus a 15% discount on any overage[/2]
Exclusive Collection Contact Lenses[/3] **(in lieu of Allowance):** Materials: Disposable OR Planned Replacement: up to	4 OR 2 boxes
- Evaluation, Fitting & Follow-up Care	Covered
Medically Necessary Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care	Covered
Additional Savings	
Retinal Imaging – member charge	$39
Additional Pairs of Eyeglasses	30% discount[/2]

Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $35	Single Vision Lenses: $25	Trifocal Lenses: $60	Elective Contact Lenses: $85
Frame: $30	Bifocal/Progressive Lenses: $40	Lenticular Lenses: $100	Medically Necessary CL: $210

[1/] Copayment applies to Collection Contact Lenses only.

[2/] Additional discounts not applicable at Walmart, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions.

[3/] Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

[4/] Polycarbonate lenses are covered for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

Vision Plans

Options and Upgraded Lens Options	COPAYS
Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any Rx)	$0
Oversized Lenses	$0
Plastic Lenses	$0
Polycarbonate Lenses Children Adults)	 $0 $30
High-Index Lenses	$55
Polarized Lenses	$57
Progressive Lenses (Standard/Premium/Ultra)	$50/$90/$140
Anti-Reflective (AR Coating Standard/Premium/Ultra)	$35/$48/$60
Ultraviolet Coating	$12
Tinting of Plastic Lenses (Solid/Gradient)	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$65
Scratch-Resistant Coating	$0
Scratch-Protection Plan (Single-Vision/ Multifocal)	$20/$40
Additional Pairs of Eyeglasses	30% discount

Additional Savings

Retinal Imaging (Member Charge)	$39
Additional Pairs of Eyeglasses	30% discount

Out-Of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
PO Box 1525
Latham, NY 12110

Group Medical Bridge Plans

Colonial Life Group Medical Bridge Plans

If you got sick or hurt, could you cover all of your medical expenses?

Even if you have coverage that helps with most of the expenses, you may still have to deal with deductibles, co-payments and co-insurance. Not to mention all the other bills you're already paying each month—mortgage, groceries, electricity and gasoline. That money has to come from somewhere, too.

Colonial Life's Hospital Confinement Indemnity Insurance plan offers added financial protection for those out-of-pocket costs related to a covered accident or a covered sickness.

Group Medical Bridge Plans

Plan Features

This plan is available to all eligible employees regardless of what medical plan you are enrolled in.

Hospital Confinement Benefit

You will have a choice of $1,000 or $2,000 benefit. Benefit is payable once per covered person per year.

Accident Only Emergency Room Visit Benefit

Provides $150 benefit payable once per covered person per year for treatment in a hospital emergency room for a covered accident.

Benefits may be paid directly to you unless you specify otherwise. Benefits are paid regardless of any other insurance you may have with other insurance companies. Coverage is available for you, your spouse and your eligible dependent children.

What Benefit is included??

A $1,000 or $2,000 hospital confinement benefit can help pay for the costs associated with a hospital stay. Maximum of one benefit per calendar year per covered person.

How are Benefits Paid?

- Benefits are paid directly to you, unless you specify otherwise.
- Your benefits are paid regardless of any other coverage you may have.

Exclusions and Limitations

We will not provide benefits for injuries received in accidents or sicknesses which are caused by: alcoholism, drug addiction, dental procedures, elective procedures, cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide, intentional injuries, war, serving in the armed forces or giving birth within the first 9 months after the certificate effective date. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss due to a pre-existing condition as defined in the certificate unless the pre-existing limitation period stated in the certificate schedule has been satisfied.*

Provider

Visit **ColonialLife.com** to learn more about hospital confinement indemnity insurance and how it can help protect what really counts.

Colonial Life insurance products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

Coverage is subject to policy exclusions and limitations that may affect benefits payable. Products may vary by state and may not be available in all states. For cost and complete details, see your Professional Benefits Counselor.

* The pre-existing condition limitation (medical treatment, advice, or medication taken during the six-month period prior to the coverage effective date), has been waived for policies effective January 1, 2019.

Group Medical Bridge Plans

Group Medical Bridge Plans

Choice of $1,000 or $2,000 Hospital Confinement Benefit

All rates are dependent upon your age on the effective date of coverage.

Hospital Confinement Benefit Amount:
$1,000 BENEFIT AMOUNT
Emergency Room Visit:
$150 (ACCIDENT ONLY)

Rates	24 PAY PERIODS
	Ages 17-49
Employee	$5.06
EE and Spouse	$9.11
EE and Children*	$8.03
EE and Family**	$12.10
	Ages 50-59
Employee	$6.44
EE and Spouse	$12.82
EE and Children*	$9.42
EE and Family**	$15.80
	Ages 60-64
Employee	$8.92
EE and Spouse	$18.55
EE and Children*	$11.89
EE and Family**	$21.53
	Ages 65+
Employee	$12.46
EE and Spouse	$25.83
EE and Children*	$15.43
EE and Family**	$28.81

Hospital Confinement Benefit Amount:
$2,000 BENEFIT AMOUNT
Emergency Room Visit:
$150 (ACCIDENT ONLY)

Rates	24 PAY PERIODS
	Ages 17-49
Employee	$9.83
EE and Spouse	$17.66
EE and Children*	$14.83
EE and Family**	$22.65
	Ages 50-59
Employee	$12.60
EE and Spouse	$25.07
EE and Children*	$17.59
EE and Family**	$30.07
	Ages 60-64
Employee	$17.55
EE and Spouse	$36.52
EE and Children*	$22.54
EE and Family**	$41.52
	Ages 65+
Employee	$24.63
EE and Spouse	$51.09
EE and Children*	$29.62
EE and Family**	$56.09

All rates are based on your age on the effective date of coverage and will continue to be based on the original age for the life of the policy.
*Children includes eligible dependent children only.
**Family includes spouse and eligible dependent children.

Group Life/AD&D Insurance

Find Out About This New Plan And Its Benefits!

SLPS is pleased to offer expanded Group Term Life and AD&D Insurance coverage to you and your dependents through Standard Insurance Company.

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 and AD&D Insurance, which is available **guarantee issue** during open enrollment.

There are seven levels of Group Term Life and AD&D insurance available:

Group Term Life Insurance Post-Tax Rates	24 PAY PERIODS
Employee Coverage*	**Premium Per Pay Period**
$10,000	$1.38
$15,000	$2.06
$20,000	$2.75
$25,000	$3.44
$30,000	$4.13
$40,000	$5.50
$50,000	$6.88

* Benefits reduce to 65% at age 65, 50% at age 70

Additional Life and AD&D Insurance

In addition to these seven levels, you are now able to elect Additional Life/AD&D Insurance in multiples of $25,000, up to $500,000 in Life and matching AD&D insurance coverage. Additional Life/AD&D Insurance amounts up to $150,000 are available on a guaranteed issue basis (no medical questions asked). Anything over this amount requires Evidence of Insurability (EOI).

Spouse Life/AD&D Insurance

You are now able to elect Spouse Life/AD&D Insurance in multiples of $25,000 up to $250,000 in life and matching AD&D insurance coverage for your spouse. Spouse Life/AD&D Insurance amounts up to $50,000 are available on a guaranteed-issue basis (no medical questions asked). Anything over this amount requires Evidence of Insurability (EOI). The amount you can purchase for your spouse cannot exceed 100 percent of the Basic Life and the Additional Life/AD&D Insurance amounts combined.

Dependent Child(ren) Life/AD&D Insurance

You are now able to elect $10,000 in life and matching AD&D for all eligible dependent children, regardless of how many up to age 25 The amount you can purchase for your dependent cannot exceed 100 percent of the Basic Life and the Additional Life/AD&D Insurance amounts combined.

Premium Waiver

If you are currently under age 70 and become totally disabled while insured under this plan and complete a waiting period of 180 days, your Basic and Additional Life and your child/spouse's life insurance may continue without premium payment, subject to the terms of the group policy. AD&D will not continue while on waiver of premium. 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 to 65 percent at age 65 and 50 percent at age 70.

Staying Covered

Conversion Privileges at Termination

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group term life insurance coverage from The Standard.

Conversion Privileges at Termination

If your insurance reduces or ends, you may be eligible to convert your existing life insurance to an individual life insurance policy without submitting proof of good health.
For more information on Portability and Conversion please refer to your certificate of coverage or contact The Standard at 1-800-378-4688 ext. 6785.

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 31-day period before your retirement date to request a Continuation of Benefits Form.

Plan Provider

Standard Insurance Company insures this plan. The Standard has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Founded in 1906, The Standard has developed a national presence in the employee benefits industry, providing customers with group and individual disability insurance and retirement plans, and group life and dental insurance.

Group Life/AD&D Insurance

Additional Life/AD&D Rates

COVERAGE	24 PAY PERIODS								
	Under 25 Years Old	Ages 25-29	Ages 30-34	Ages 35-39	Ages 40-44	Ages 45-49	Ages 50-54	Ages 55-59	Ages 60-64
$25,000	$0.81	$0.94	$1.19	$1.31	$1.44	$2.06	$3.19	$5.69	$8.44
$50,000	$1.63	$1.88	$2.38	$2.63	$2.88	$4.13	$6.38	$11.38	$16.88
$75,000	$2.44	$2.81	$3.56	$3.94	$4.31	$6.19	$9.56	$17.06	$25.31
$100,000	$3.25	$3.75	$4.75	$5.25	$5.75	$8.25	$12.75	$22.75	$33.75
$125,000	$4.06	$4.69	$5.94	$6.56	$7.19	$10.31	$15.94	$28.44	$42.19
$150,000	$4.88	$5.63	$7.13	$7.88	$8.63	$12.38	$19.13	$34.13	$50.63
$175,000	$5.69	$6.56	$8.31	$9.19	$10.06	$14.44	$22.31	$39.81	$59.06
$200,000	$6.50	$7.50	$9.50	$10.50	$11.50	$16.50	$25.50	$45.50	$67.50
$225,000	$7.31	$8.44	$10.69	$11.81	$12.94	$18.56	$28.69	$51.19	$75.94
$250,000	$8.13	$9.38	$11.88	$13.13	$14.38	$20.63	$31.88	$56.88	$84.38
$275,000	$8.94	$10.31	$13.06	$14.44	$15.81	$22.69	$35.06	$62.56	$92.81
$300,000	$9.75	$11.25	$14.25	$15.75	$17.25	$24.75	$38.25	$68.25	$101.25
$325,000	$10.56	$12.19	$15.44	$17.06	$18.69	$26.81	$41.44	$73.94	$109.69
$350,000	$11.38	$13.13	$16.63	$18.38	$20.13	$28.88	$44.63	$79.63	$118.13
$400,000	$13.00	$15.00	$19.00	$21.00	$23.00	$33.00	$51.00	$91.00	$135.00
$425,000	$13.81	$15.94	$20.19	$22.31	$24.44	$35.06	$54.19	$96.69	$143.44
$450,000	$14.63	$16.88	$21.38	$23.63	$25.88	$37.13	$57.38	$102.38	$151.88
$475,000	$15.44	$17.81	$22.56	$24.94	$27.31	$39.19	$60.56	$108.06	$160.31
$500,000	$16.25	$18.75	$23.75	$26.25	$28.75	$41.25	$63.75	$113.75	$168.75

All rates are dependent upon your age on the effective date of coverage.
Rates are based on the employee and will increase as the employee ages. The rates for aging up are automatically increased the beginning of each plan year.

Group Life/AD&D Insurance

Additional Life/AD&D Rates

- Benefits reduce to 65% at age 65, 50% at age 70

	24 PAY PERIODS
	Ages 65-69
$16,250	$10.44
$32,500	$20.88
$48,750	$31.32
$65,000	$41.76
$81,250	$52.20
$97,500	$62.64
$113,750	$73.08
$130,000	$83.53
$146,250	$93.97
$162,500	$104.41
$178,750	$114.85
$195,000	$125.29
$211,250	$135.73
$227,500	$146.17
$260,000	$167.05
$276,250	$177.49
$292,500	$187.93
$308,750	$198.37
$325,000	$208.81

	24 PAY PERIODS	
	Ages 70-74	Ages 75+
$12,500	$15.72	$48.47
$25,000	$31.44	$96.94
$37,500	$47.16	$145.41
$50,000	$62.88	$193.88
$62,500	$78.59	$242.34
$75,000	$94.31	$290.81
$87,500	$110.03	$339.28
$100,000	$125.75	$387.75
$112,500	$141.47	$436.22
$125,000	$157.19	$484.69
$137,500	$172.91	$533.16
$150,000	$188.63	$581.63
$162,500	$204.34	$630.09
$175,000	$220.06	$678.56
$200,000	$251.50	$775.50
$212,500	$267.22	$823.97
$225,000	$282.94	$872.44
$237,500	$298.66	$920.91
$250,000	$314.38	$969.38

Dependent Child(ren) Life and AD&D Rates

	24 PAY PERIODS
$10,000	$0.58

The rates are dependent upon your age on the effective date of coverage.

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 the flexible benefits plan.

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 resume if you begin to cooperate in the rehabilitation plan within 30 days of the date benefits terminated.

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.

STD Post-Tax Rates	24 PAY PERIODS
Plan A	$13.39
Plan B	$14.91
Plan C	$17.14

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.

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: **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.

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.

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.

Plans

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.

Disability Income Protection

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

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

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.

Disability Income Protection

Mental Illness, Alcoholism and Drug Abuse Limitation

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

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

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

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

Premiums Waived

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

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.

LTD Post-Tax Rates	24 PAY PERIODS
Plan I	$6.49
Plan II	$8.34
Plan III	$12.61
Plan IV	$14.50
Plan V	$16.19

Plan Provider

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

The licensed Florida agent is Christine Carolyn Wise #E026735.

Disclaimer

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

To Submit a Claim:

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

Will Preparation Program

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

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

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

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

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

Think you can't afford to create a will?

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

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

It's easy! Go to **CignaWillCenter.com**.

Accessing Cigna's Will Center

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

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

- **Last will & testament** - specifies what is to be done with your property when you die, names the executor of your estate and allows you to name a guardian for your minor children.
- **Living will** - contains your wishes regarding the use of extraordinary life support or other life-sustaining medical treatment.

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

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

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

Did You Know?

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

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.

Flexible Spending Accounts

Flexible Spending Accounts

A Flexible Spending Account (FSA) lets you pay for eligible expenses with tax-free money. You contribute to an FSA with pretax money from your paycheck. This, in turn, may help lower your taxable income. There are two types of FSAs – Healthcare FSA and Dependent Care FSA.

Healthcare FSA

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

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses, such as before and after school care, day time baby-sitting fees, elder care services, nursery and preschool costs. Eligible dependents include your qualifying child up to age 13, spouse and/or relative.

You can request reimbursement from your Dependent Care FSA after your dependent receives day care services. Unlike the Healthcare 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 Healthcare FSA:

- Minimum Annual Contribution: $150
- Maximum Annual Contribution: $2,600

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 $2,600.
- 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.

Grace Period and Run-Out Period

You have a 120-day run-out period (ending April 30, 2020) after your 2019 plan year ends to submit reimbursement requests for all eligible FSA expenses incurred DURING your plan year. You may, however, continue using only your Healthcare FSA during the grace period, which is two months and 15 days after the end of your 2019 plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period.

Plan for Your FSA Savings

Worksheets will help you 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.

CLICK HERE TO DOWNLOAD A PRINTABLE FSA WORKSHEET>>

Flexible Spending Accounts

FSA Appeals and Managing Your FSA Online

Appeals Process

If you have an FSA reimbursement claim denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to:

PayFlex Systems USA, Inc.
Flex Department
PO Box 981158
El Paso, TX 79998-1158

or fax to 1-855-703-5305

Your appeal must include:

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

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

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

Use your PayFlex Card®, your account debit card

The PayFlex debit card is a convenient way to pay for eligible Healthcare expenses. The card knows when the expense is eligible and whether you have funds available. When you use the card, save your Explanation 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're a new Healthcare FSA member, 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.

Filing a Claim with PayFlex

If you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **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 mail it to PayFlex at PO Box 981158 El Paso, TX 79998-1158 or fax it to PayFlex at 1-855-703-5305. This form can be found in the Resource Center at **payflex.com** or you may call PayFlex at 844-PAYFLEX to request a form.

After you log in to **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. 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 **payflex.com.**
- Click on **Create Your Profile** and follow the online instructions.
- After successfully registering your account, My Dashboard will be displayed and you will be able to access your account information.
- To receive electronic account notifications, select **My Settings** at the top of the page and
  - Select the notifications link,
  - Enter your email address and then re-enter to confirm, and
  - Then select the notifications you wish to receive and click Submit.

Enroll in Direct Deposit

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to **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.

Limited-Use Healthcare FSA

For HSA Participants Only

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

What is a Limited-Use Healthcare FSA?

A Limited-Use Healthcare 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 Healthcare 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 Healthcare 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 Healthcare FSA expenses can be found on this page.

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

Minimum Annual Deposit:	$150
Maximum Annual Deposit:	$2,600

Whose expenses are eligible?

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

Registering Your Account

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

Filing A Claim Online

After you log in, click on the "Financial Center" tab and select your account from the drop-down menu. 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 **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 Healthcare 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, 2019.

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 Limited Healthcare 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.

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

Group Legal Plan

Find Out More About This Plan and Its Benefits!

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.

How legal insurance benefits you

- Receive 100 percent paid-in-full coverage for most covered legal matters when you work with a Network Attorney.
- Save an average of $2,100 per legal matter.
- Access a nationwide network of more than 13,000 attorneys who average 20 years of experience.
- Quickly address your covered legal situations with a Network Attorney for legal help and representation.
- Use DIY Docs® to create any of 350+ legally valid documents, including state-specific templates.

Group Legal Plan Premium	24 PAY PERIODS
Premium Includes Eligible Dependents	$10.87

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 **ARAGlegal.com/myinfo** 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 **ARAGlegal.com/myinfo** 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
- Email 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.

Visit ARAGlegal.com/myinfo and enter Access Code 18197slp to learn more about your legal benefit!

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®, 500 Grand Avenue, Suite 100, Des Moines, IA 50309.

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.

Covered Services:

TELEPHONE/ ONLINE BENEFITS	ULTIMATE ADVISOR®
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	•

Group Legal Plan

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	**ULTIMATE ADVISOR®**
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)	•
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	•

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 percent off the Network Attorney's normal rates. For additional details regarding your plan's specifically covered services, visit **ARAGlegal.com/myinfo** 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, where 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.

Pet-Focused Benefits

You may choose any or all of the following pet plans:

- Pet Assure Plan
- PetPlus Rx Plan

Pet Assure Plan

Pet Assure is a post-tax employee benefit program that enables members to receive discounts on all medical services provided by network veterinarians.

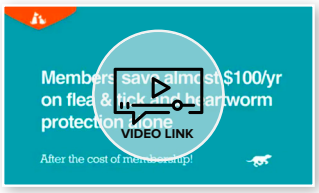
You will save hundreds on your pets' medical care for as little as $4.00 a pay period. Pet Assure is the nation's oldest and largest veterinary discount plan and has been saving pet parents money on pet expenses since 1995.

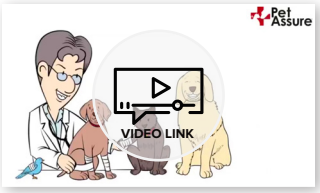
Here's what your membership includes:

- Twenty-five percent off all in-house medical services each and every time you visit a network veterinarian. With Pet Assure, you'll receive your discount right at the vet's office. This plan is not insurance so there are no hassles, no claim forms and no deductibles. Savings are instant! (See details below.)
- Any type of pet, with absolutely no exclusions, can receive the discounts. There are no exclusions based on type, breed, age, past medical history, or pre-existing conditions. Do you have one dog, five cats, a lazy iguana and a donkey? One Pet Assure membership covers them all.
- 24/7 Pet Assure Locator Service (PALS). Don't worry about your pet getting lost anymore! Every pet that joins can register in the Pet Assure's 24/7 Lost Pet Recovery Service and receive a unique identification tag.

There are dozens of network providers in Miami and the surrounding areas. For a complete list of participating veterinary practices and merchants, visit Pet Assure online at **petassure.com**.

If you have any questions, please call Pet Assure at: 800-891-2565.





Pet Assure & PetPlus Rates

	24 PAY RATE
Pet Assure Single	$4.00
Pet Assure Unlimited	$5.50
PetPlus Rx Single	$2.25
PetPlus Rx Unlimited	$4.25
Pet Assure Single + PetPlus Rx Single	$6.25
Pet Assure Single + PetPlus Rx Unlimited	$8.25
Pet Assure Unlimited + PetPlus Rx Single	$7.75
Pet Assure Unlimited + PetPlus Rx Unlimited	$9.75

*Unlimited plans covers all pets in your household.

PetPlus Rx

With PetPlus, members get wholesale pricing on prescriptions, preventatives and other products which are almost never covered by insurance. It's instant savings without any paperwork. All dogs and cats are covered!

You will get wholesale pricing on:

- Flea and Tick Preventatives
- Heartworm Preventatives
- Rx Medications

Benefits:

- Free shipping on all mail orders
- Same day Rx pickup at over 60,000 CareMark pharmacies nationwide, including CVS and Walmart
- PetPlus will get a prescription for you, no need to ask your vet
- 24/7 Pet Help Line powered by whiskerDocs - call, email or chat with a veterinary expert at any time, day or night (valued at $100/year)
- Vitamins and Supplements
- Dietary Food

SLPS Employee Pets!



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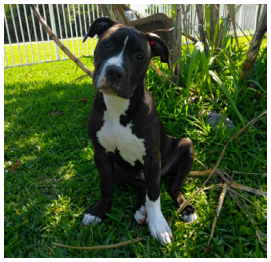

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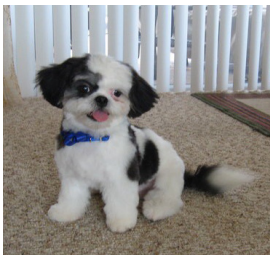
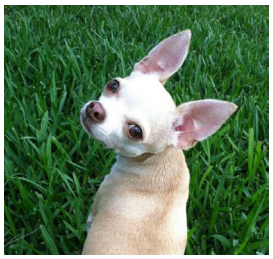
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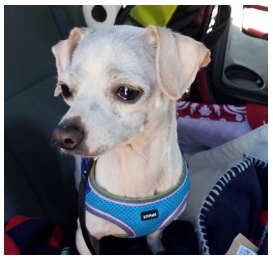
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OUR


PETS


2019

Universal LifeEvents®

* This benefit is only offered during open enrollment

Trustmark Universal LifeEvents® Insurance Plan

How does LifeEvents® work?

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

Death Benefit

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, such as funeral costs, rent or mortgage, debt, tuition, and more.

Long-Term Care Insurance Rider

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

The LifeEvents® Advantage

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

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

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

[1] Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 18 to 64.

Features You Will Appreciate

- Lifelong protection
- Family coverage
- Accelerated Death Benefit Insurance Rider for Terminal Illness
- 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.

Separately priced benefits:

- Children's term life insurance rider — Covers Accidental Death Benefit and Waiver of Premium Payments for newborns to age 22.
- EZ Value — Automatically raises your benefits to keep pace with your increasing needs, without additional underwriting.

Your Policy Contact Information

Trustmark Insurance Co.
Customer Service
Mon. - Thurs., 8 a.m. - 8 p.m. ET
Fri. 8 a.m. - 7 p.m. EST
1-800-918-8877
Trustmark Claims
1-877-201-9373, Option 2
trustmarksolutions.com

How Living Benefits Add Up

EXAMPLE: $100,000 DEATH BENEFIT	MAXIMUM BENEFIT AMOUNT
Long-Term Care Insurance Rider (LTC)[2] - Pays a monthly benefit equal to 4% 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 - Living Benefits may double the value of your life insurance.	$200,000

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

Who is Eligible?

- Employees – Ages 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 2019 open enrollment, the accident plan effective date will be February 1, 2019 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

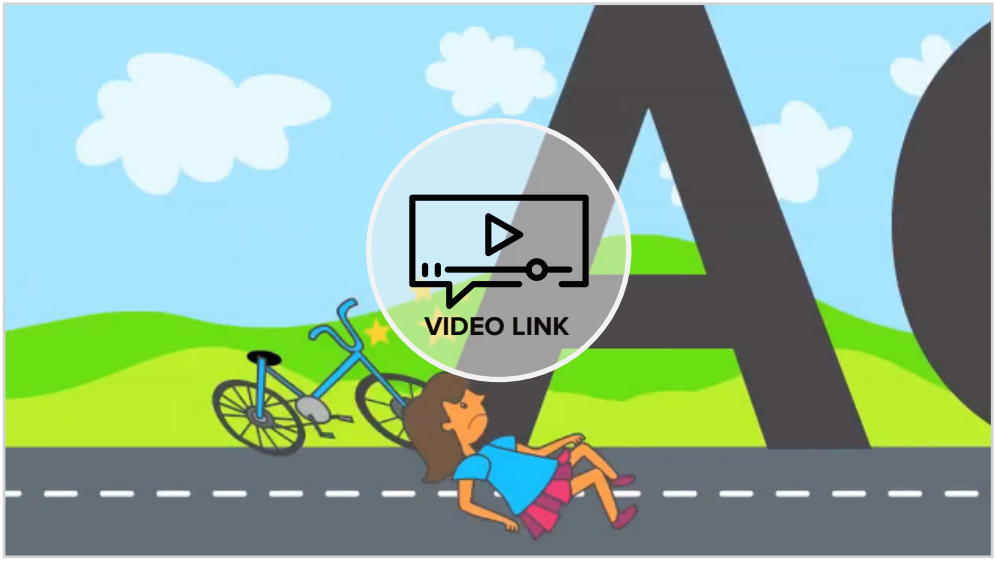
Accident Insurance Rates

	24 PAY PERIOD
	Post-Tax
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
- Hemoccult 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

Schedule of Benefits[1]

Effective 8/1/2012

Accident Insurance Provides Non-Occupational Coverage

Benefit	Amount
Initial Care	
Hospital Benefits	
Admission Benefit (per admission)	$3,200
Confinement Benefit (per day up to 365 days)	$500
ICU Benefit (per day up to 15 days)	$1,000
Emergency Room Treatment	$150
Ambulance	
Ground	$600
Air	$2,500
Initial Doctor's Office Visit	$200
Lodging (per night up to 30 days per accident)	$200
Surgery Benefit	
Open, abdominal, thoracic	$2,000
Exploratory	$200
Blood, Plasma and Platelets	$600
Emergency Dental Benefit	
Extraction	$150
Crown	$450
Follow-Up Care	
Accident Follow-Up Treatment	$200
Physical Therapy	
Up to six visits per person per accident	$100
Appliance	$250
Transportation	
100+ miles, up to three trips	$600
Prosthetic Device or Artificial Limb	
More than one	$2,000
One	$1,000
Skin Grafts	25% of burn benefit
Accidental Death	
Employee	$100,000
Spouse[4]	$50,000
Child	$25,000
Accidental Death – Common Carrier	
Employee	$200,000
Spouse[4]	$100,000
Child	$50,000

Benefit	Amount
Injuries	
Fractures	
Open reduction	up to $15,000
Closed reduction	up to $7,500
Chips	25% of closed amount
Dislocations	
Open reduction	up to $12,000
Closed reduction	up to $6,000
Laceration	$50-$1,000
Burns	
Flat amount for:	
Third-degree 35 or more sq. in.	$25,000
Third-degree 9-34 sq. in.	$4,000
Second-degree for 36% or more of body	$2,000
Concussion	$200
Eye Injury	
Requires surgery or removal of foreign body	$400
Ruptured Disc	$1,000
Loss of Finger, Toe, Hand, Foot or Sight	
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
Tendon/Ligament/Rotator Cuff Injury	
Repair of more than one	$1,500
Repair of one	$1,000
Exploratory surgery without repair	$200
Torn Knee Cartilage	$1,250
Exploratory surgery	$250
Wellness Benefit	
Two per person annually	
Routine physicals, immunizations and health screening tests. 60-day waiting period applies.	
Catastrophic Accident	
Employee	$150,000
Spouse	$75,000
Child	$75,000

[1]Benefits are payable only as the result of a covered accident. Benefits may vary by state and additional benefits may be available in some states. Most benefits are paid once per person per covered accident unless otherwise noted. [4]In some states, spouse, domestic partner or civil union partner.

Critical HealthEvents

Critical HealthEvents℠ Insurance

Trustmark's Critical HealthEvents℠ 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 HealthEvents work?

Critical HealthEvents 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 HealthEvents 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 HealthEvents 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 HealthEvents 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.

Benefits are restored each year. *Example:*

YEAR 1 *(January 1st)* 100% benefit available each and every year for any covered illness.

YEAR 1 Early identification– 10% benefit paid, 90% benefit remains

YEAR 1 Early stage diagnosis– 50% benefit paid, 40% benefit remains.

YEAR 2 *(January 1st)* Benefit well is restored. 100% benefit is again available.

Wellness Program

Wellness Program Offerings

- "The Triple W": Wednesdays Weekly Wellness Emails
- Wellness Website - access everything related to your Wellness program on the SLPS Wellness Website
- Monthly health newsletters and bulletin boards
- Health Fair at Your Worksite
- Cancer & Osteoporosis Screenings
- Full access to the Employee Assistance Program (EAP) – free and confidential counseling, legal and financial services, will preparation, etc.
- Exercise DVDs lending library
- Walking paths at your workplace
- District-wide Wellness challenges and competition
- Exercise at Work - Zumba and Yoga
- Subsidized Weight Watchers Program at ork & Better You Diabetes Program
- Staff Sports – Soccer, Kickball, Volleyball & More
- Lunch n' Learns, webinars, lectures, and cooking classes
- If you have Florida Blue medical insurance through the District, earn incentive points ($$) throughout the year for completing certain activities such as exercising, participating in a health fair, or a tobacco cessation program. These are just to name a few – don't miss the opportunity to earn money while getting healthy.

Free!

- Flu shots at work
- Tobacco Cessation Workshops
- Classes:
  - Diabetes Management
  - Stress Management, and more!

Living Better, Together.
St. Lucie Public Schools Wellness Program

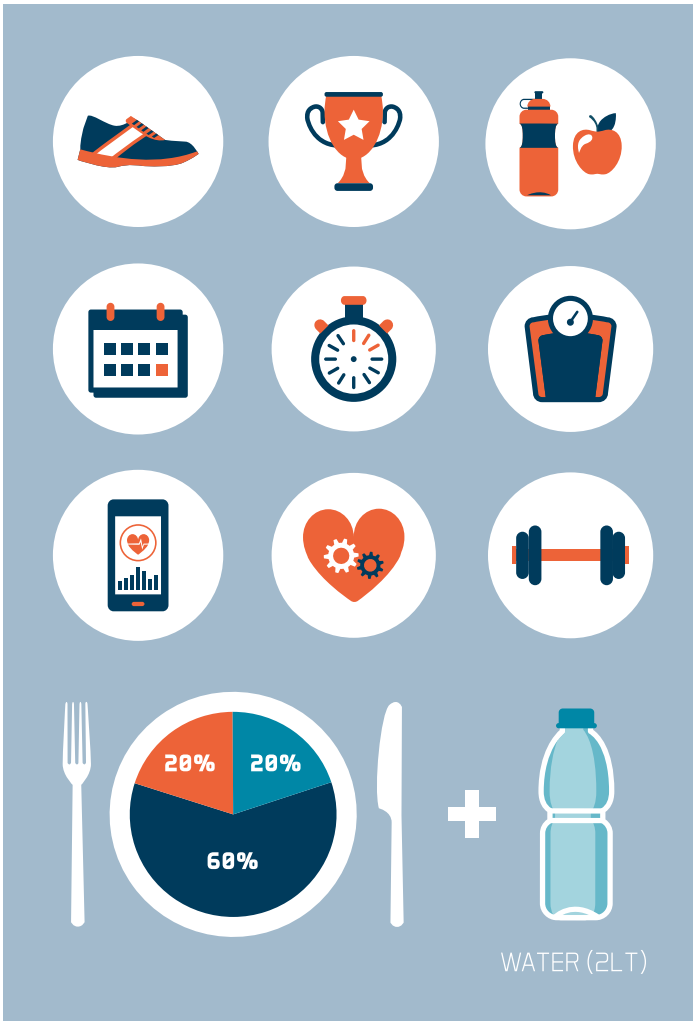
Contact

Stacy Donnelly
Wellness Manager - Risk Management
stacy.donnelly@stlucieschools.org
Phone: 772-429-3974
https://www.stlucie.k12.fl.us/health-wellness/

Wellness Program

Wellness Activities and Associated Points – 1 Point = $1

Earn up to 200 incentive points ($200) for participating in various wellness activities if you carry Florida Blue medical insurance through the District between June 1, 2018 through April 30, 2019. You will receive the money you earn on your HSA card or paycheck on June 28, 2019.



50 points:

- Attend a Health Fair- Complete a Personal Health Assessment & Biometric Screening (can also be completed at Quest Diagnostics)
- Participate in a Tobacco Cessation Program*

30 points:

- Annual Physical from your Primary Care Physician*
- Annual Physical from your Gynecologist*

20 points:

- Exercise at least 12 times per month for at least 30 minutes at a time. Must complete Exercise Tracking Log or hand in gym attendance printout*
- Florida Blue Assistance Program - Participate in the Healthy Addition Prenatal Program

15 points:

- Cancer Screening(s) - prostate, skin, breast, colon, pap smear, etc.*
- Attend a Health Lecture
- Submit a Wellness Success Story – ½ page minimum
- Participate in a Webinar from the Employee Assistance Program, Florida Blue, or from your Wellness Manager. Up to five times per year*
- Participate in a 5k/10k/Triathlon/Half Marathon - Up to four times per year

10 points:

- Dental Cleaning (Prophylaxis) - Up to two times per year*
- Vision/Glaucoma Screening - One time per year*
- Blood Donation - Up to five times per year*

5 points:

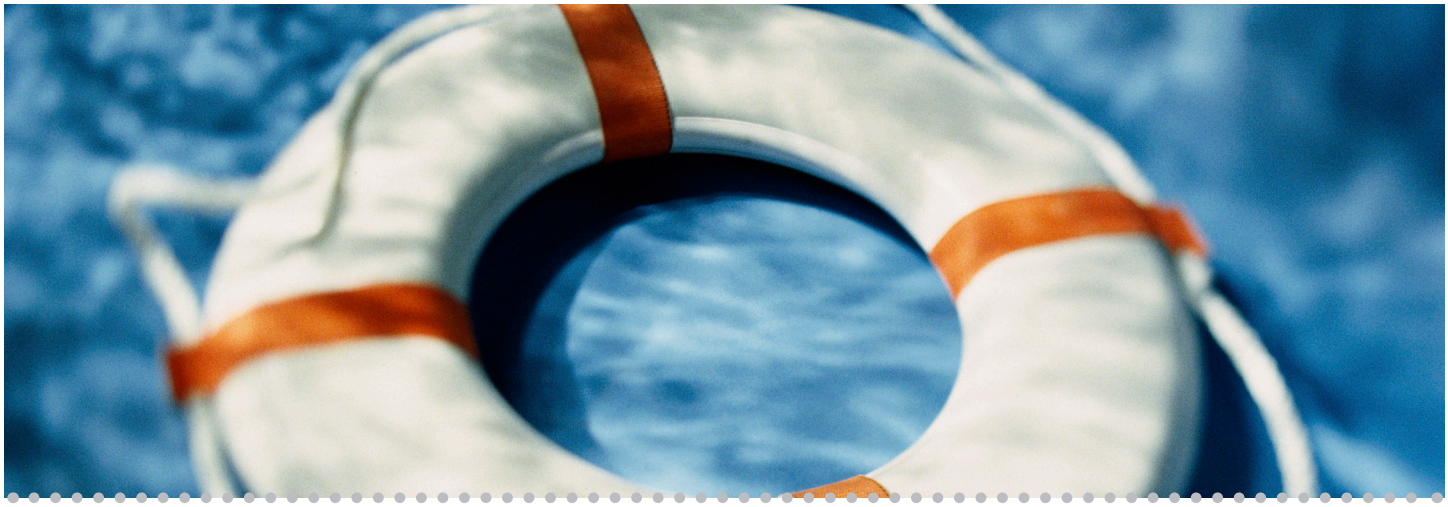
- Immunizations - Flu, pneumonia, shingles*

3 points per month:

- Enroll in and maintain active membership in the Better You Diabetes Prevention Program through the Solera Network (100% attendance required. Must submit monthly documentation in current reporting period.)

* Must provide documentation in order to receive points ($).* Check your point status with your wellness manager.

Resources for Living



Employee Assistance Program

Are you having a tough time finding your happy place? Are you caught up in life's storm? Do you feel like your world is upside down?

The Employee Assistance Program (EAP) can help! SLPS is pleased to provide the EAP program to employees, spouses, and dependents at NO COST.

The Employee Assistance Program services are aimed at helping individuals who are experiencing personal or job-related difficulties, such as financial problems, marital concerns, parenting or childcare problems, adjustment to changes like moving, problems with co-workers, substance abuse, etc. The use of this program is strictly confidential.

Resources For Living services are available to you, all members of your household and your adult children up to the age of 26, regardless of your medical insurance coverage. Services are confidential and are available 24 hours a day, 7 days a week.

Services include:

- Six face-to-face counseling services per year
- Legal & financial consultation and referrals
- Up to three telephonic Life Coaching sessions per issue
- Online services such as: child care, adoption, college planning, elder care, will preparation, pet care & much more
- Full access to the myStrength website (online wellness portal)

Counseling and Relationship Support

- Unlimited, toll-free telephonic access to EAP dedicated staff, 24 hours per day
- Telephonic and video conferencing access to licensed behavioral health professionals
- Support, consultation and resources for stress, family relationship issues, anger management, substance abuse, and helping you balance work and home life
- Direct access to a full range of Web-based tools and resources, such as easy-to-find information, self-assessments and more, on a variety of relevant topics
- Six face-to-face counseling sessions per issue per year, with licensed network professionals, at no cost to you; i.e., no copays or deductibles

Online Services

- Online information and provider search features for locating resources that families need, such as:
  - Child care
  - Parenting
  - Special needs
  - Urgent/daily living needs - Summer care
  - Convenience/personal services - Pet care
  - Elder care
  - Caregiver support
  - Care for people with disabilities
  - Adoption
  - Temporary back-up care - School/college planning
    Consumer information
- Online discounts on brand-name products and services, including categories such as computers & electronics, theme parks, movie tickets, local attractions, travel, gifts, apparel, child and elder care, flowers, jewelry, fitness centers and more

All services through MHNet are completely CONFIDENTIAL. No information can be shared with anyone including SLPS unless you provide written permission to your counselor or provider*. Call 1-800-272-3626 or visit: **mylifevalues.com**.

Username: St Lucie School Board
Password: 8002723626

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 **myFBMC.com** for information on rules governing periods of coverage and IRS Special Consistency Rules.

VALID CHANGE IN STATUS EVENTS:

TYPE OF CHANGES	DESCRIPTION	SUPPORTING DOCUMENT
Marital Status *(Marriage or Divorce)* **Plans that may be affected:** *Medical, Dental, Vision, Healthcare 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, Healthcare 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, Healthcare 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, Healthcare 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, disabled/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 disabled 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 Healthcare 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 Healthcare 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 company's 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, Healthcare 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, Healthcare 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.

Notes

Benefits Directory

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

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

Melissa Rusignuolo
Florida Blue 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
ndbh.com

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

Florida Combined Life
(Dental)
Customer Service
1-888-223-4892
Mon - Fri, 8 a.m. - 5 p.m.
FloridaBluedental.com
1-800-999-5431

Davis Vision
(Vision)
Customer Service
Mon - Fri, 8 a.m. to 11 p.m. ET
1-800-999-5431 - Client Code: 8165
davisvision.com

Life Insurance Company of North America, a Cigna Company
(Long and Short-Term Disability)
cigna.com
1-800-36-CIGNA (1-800-362-4462)
(Will Preparation)
1-800-901-7534
CignaWillCenter.com

Trustmark
(Accident Insurance, Critical Illness, LifeEvents Universal LifeEvents, Critical HealthEvents)
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
trustmarksolutions.com

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

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

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

ARAG®
(Legal Insurance)
ARAG
500 Grand Avenue
Suite 100
Des Moines, IA 50309
1-800-247-4184
Access Code 18197slp
ARAGLegalCenter.com

Pet Assure and PetPlus
(Pet Discount Plans)
415 Cedar Bridge Ave
Lakewood, NJ 08701
1-800-891-2565
petassure.com
petassure.PetPlus.com

Standard Insurance Company
(Group Life & AD&D Insurance)
Mon - Fri, 9 a.m. - 8 p.m. ET
1-800-325-5757
1-800-628-8600

Colonial Life
(Group Medical Bridge Plans)
Customer Service
Mon. - Fri., 7 a.m. - 7 p.m. CT
1-800-325-4368
ColonialLife.com

FBMC® BENEFITS MANAGEMENT

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