Okeechobee County School Board

Employee

Benefits Guide

2021 Plan Year

OKEECHOBEE COUNTY SCHOOLS • ACHIEVING EXCELLENCE •

What's Inside

Welcome to your 2021 Employee Benefits!

Okeechobee County School Board offers a comprehensive selection of benefits to promote health and financial security for you and your family. These company sponsored benefits are an important part of a total compensation package. They represent both a valuable asset to our employees and to their families, and demonstrate an investment by Okeechobee County School Board in our employees. We are proud of our benefits program and are committed to continuously improving the plans that make up our benefits offerings.

This guide was created to answer some of the questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive.

Available Fringe Benefits

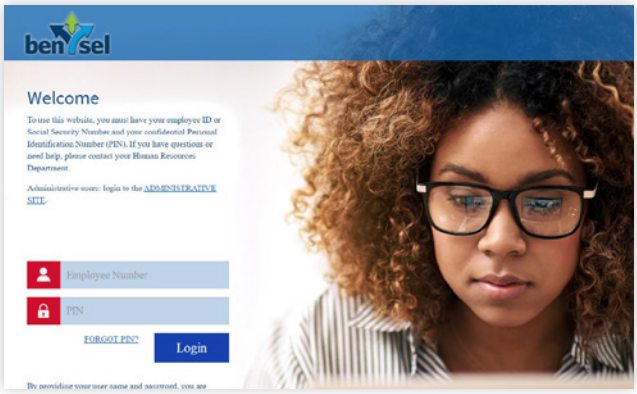
Dental Insurance	The District contributes up to **$12.50** per pay check, to each employee,to help offset the cost of any combination of these Fringe Benefits.
Vision Insurance	
Life and AD&D Insurance	
Short Term Disability Insurance	
Long Term Disability Insurance	
Accident Insurance	
Critical Illness Insurance	
Flexible Spending Account - Health Care	
Flexible Spending Account - Dependent Care	
Employee Assistance Program	Free to Employees

How to Enroll

1 Register for the portal by logging on to:
allstate.benselect.com/okeechobee

Employee ID or SSN: Your employee ID number

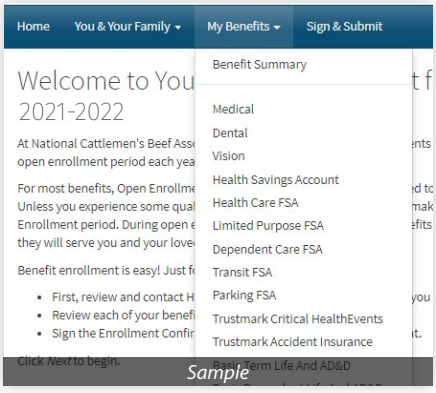
PIN:Last 4 digits of your SSN and the last 2 digits of your birth year



2 Follow the prompts to complete the registration process. Please review the personal demographic data and update as needed. Then ***click next*** to advance through each screen.

3 Next, you will be asked to enter Dependent / Beneficiary information. To add a dependent, please ***click the + sign*** and enter the dependent's information. To edit an existing dependent***, click the pencil icon*** on the right side of the dependent. After making any changes, ***click save*** on the bottom of the page. Once you are finished with this section, ***click next***.

4 Once you are at the medical screen, verify your medical plan election or waive the coverage. When you ***click next***, you will advance to any coverage that you have ***not previously enrolled in***.



5 If you would like to make changes to existing coverage, you may click on the individual coverage options listed under **"My Benefits"** or by choosing the coverage under the **"My Benefits" menu** at the top of the screen.

6 Once you select the coverage you would like to change, click on **"Unlock"** to access the options. Once you make a decision, please ***click next*** to go to the review page.

7 Once on the **"Sign and Submit"** page, you will be able to review your elections. If you need to make changes, please click on the link for that coverage. You will then unlock, make your change, and ***click next***. This returns you to the **"Sign and Submit"** page. If everything is correct, please ***click next***.

8 On the **"Confirmation"** page, enter your PIN / Password used to log in. ***This will finalize your enrollment***. You can print the confirmation form, save it as a downloadable PDF, and e-mail a confirmation summary to the e-mail address on file.

If you have any questions regarding your benefits, please call:

Benefits Service Center
(855) 858-8308
Monday - Friday: 9:00 am - 8:00 pm (EST)
Saturday: 10:00 am - 4:00 pm (EST)

Eligibility

Regular, full-time employees working four or more hours per day and at least 20 hours per week are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Medical benefits for **new hires** are effective the first day of the month following 31 days from the date of hire.

Eligible Dependents

Your dependents are eligible to participate in Okeechobee County School Board's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married;
- A dependent child under age 26. Coverage will terminate at the end of the calendar year of their 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, stepchildren and other children for whom you are the legal guardian.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

For all benefits you must enroll within 31 days from your date of hire.

Pre-Tax Benefits: Section 125

The Company's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Required Documentation

The following items are required for enrollment. All information is confidential and for Benefits purposes only.

- Birth Dates
- Dependent Birth Certificates
- Marriage Licenses
- Social Security Numbers

Benefit Election Changes

Qualifying Life Events:

- Change in status such as birth, marriage, employment, adoption, divorce or death
- Entitlement to Medicare or Medicaid
- FMLA special requirements; HIPAA special enrollment rights
- Change due to a judgement, decree or court order
- Gain or loss of other qualifying coverage

You must notify the Payroll Department at 863-462-5000 Ext. 1031 within 31 days of the life event in order to make a change in your benefit selections.

Medical Coverage

Okeechobee County School Board offers **three** medical plans contracted with Florida Blue. Choose the plan that meets your needs and those of your family. Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs. The cost of each plan is shared by OCSB and the employee.

Employee Health Center*

Located at Urgent Care of Okeechobee
305 NE Park Street
Okeechobee, FL 34972

863-484-8154

The District provides the Employee Health Center to employees and covered dependents that enroll in one of the OCSB sponsored Medical Plans. A doctor is on site five days a week and open seven days a week for routine care. Other locations in Sebring and Stuart are available. This provides covered employees and dependents with routine care seven days a week.

**Only routine care services will be fully covered by Urgent Care of Okeechobee. A copay will be incurred for the following, but not limited to; a controlled substance RX, X-Ray, EKG, etc. If unsure, verify with Urgent Care of Okeechobee before services are provided.*

Medical Plan Summary

Florida Blue	BLUE OPTIONS 3768		BLUE OPTIONS 3769		BLUE OPTIONS 5302	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible						
Individual	$500	$1,000	$500	$1,500	$2,500	$5,000
Family (aggregate)	$1,500	$3,000	$1,500	$4,500	$7,500	$15,000
Coinsurance	**10%**	**50%**	**20%**	**50%**	**30%**	**50%**
Out-Of-Pocket Maximum - includes deductible, coinsurance, copay, Rx						
Individual	$4,000	$6,000	$3,000	$6,000	$6,350	$13,000
Family (aggregate)	$8,000	$12,000	$6,000	$12,000	$12,700	$26,000
Preventive Care - provided as specified by the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. If a diagnosis is made, any services provided as part of that diagnosis may require a copay, coinsurance or deductible.						
Routine Adult /Well Woman Exam	Covered 100%	50%	Covered 100%	50%	Covered 100%	50%
Routine Mammograms	Covered 100%		Covered 100%		Covered 100%	
Routine Well Child Exams	Covered 100%	50%	Covered 100%	50%	Covered 100%	50%
Independent Clinical Lab	Covered 100%	50%*	Covered 100%	50%*	Covered 100%	50%*
Office Visits						
Family Physician	$50 copay	50%*	$40 copay	50%*	$40 copay	50%*
Specialist	$100 copay	50%*	$80 copay	50%*	$80 copay	50%*
Teladoc	$10 copay	50%*	$10 copay	50%*	$10 copay	50%*
Emergency Care						
Emergency Room (waived if admitted)	$500 copay		$500 copay		$500 copay	
Emergency Medical Transportation	10%*	10% after in-network deductible	20%*	20% after in-network deductible	30%*	30% after in-network deductible
Urgent Care	$100 copay		$100 copay		$100 copay	
Outpatient Surgery						
Facility Fee (e.g., Ambulatory Surgery Center)	$350 copay	50%*	20%*	50%*	30%*	50%*
Physician / Surgeon Fees Ambulatory Surgical Center: Hospital:	$100 copay $50 copay	50%* $50 copay	$80 copay $100 copay	50%* $100 copay	$80 copay 30%*	50%* 30%*
Inpatient Hospital Stay						
Facility Fee (e.g., Hospital Room)	$1,000 copay	50%*	20%*	50%*	30%*	50%*
Physician / Surgeon Fees	$50 copay	$50 copay	$100 copay	$100 copay	30%*	30%*
Mental Health/Substance Abuse						
Inpatient	$1,000 copay	50%	20%*	50%	30%*	50%
Outpatient	$0	50%	$0	50%	$0	50%
Physician Visit	$0	50%	$0	50%	$0	50%
Prescription Drugs - *Retail: up to 30-day supply; Mail Order: up to 90-day supply*					**($800 Brand Deductible)**	
Generic - Retail / Mail Order	$10.00 / $25.00	50%	$10.00 / $25.00	50%	$10.00 / $25.00	50%
Preferred Brand - Retail / Mail Order	$50.00 / $125.00	50%	$50.00 / $125.00	50%	$800 Rx Deductible, then: $60.00 / $150.00	$800 Rx Deductible, then: 50%
Non-Preferred Brand - Retail / Mail Order	$80.00 / $200.00	50%	$80.00 / $200.00	50%	$800 Rx Deductible, then: $100.00 / $250.00	$800 Rx Deductible, then: 50%

**After you pay the deductible.*

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

You must enroll each year

Flexible Spending Accounts (FSA)

Health Care Flexible Spending Accounts

Eligible health care expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. These include deductibles and coinsurance expenses not covered by your medical plan, expenses for glasses or contact lenses, and more.

Contribution Limits: The 2021 HCFSA annual contribution limit is $2,750.

Note: You may not participate in both the Health Care FSA and an HSA/HDHP even if through a separate entity.

Dependent Care Flexible Spending Accounts

You may use pre-tax dollars from your Dependent Care FSA (DCFSA) to pay expenses for care when the services enable you and your spouse to work outside of the home. These include expenses for the care of a dependent child, spouse or elderly parent inside your home. Also included are baby-sitters, nursery schools, and day care centers.

Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.

Eligible Dependents

In regards to your Dependent Care FSA, the IRS defines an eligible dependent as:

- A child under the age of 13 and may be claimed as a deduction for personal exemption under Code Section 151(c).
- A spouse who is physically or mentally incapable of self care.
- A disabled person who is physically or mentally incapable of self-care for whom you provide more than 50% support, and who qualifies as your dependent under Code Section 152.

Contribution Limits: The DCFSA annual contribution limit is $5,000 or $2,500 if you are married and file separate tax returns; minimum contribution is $250.

Because FSAs have tax benefits, the IRS places guidelines on them. As a general rule, any funds left in your account at the end of the plan year will be forfeited. However, **our Health Care FSA allows you to carry over up to $500 in unused funds to the next plan year**. So plan carefully when determining how much you want to contribute. **Your FSA elections are effective from September 1 through August 31.**

FSA made easy with the CPI Debit Card!

How does the Debit Card Work? It's as easy as 1, 2, 3!

1. Use your debit card at the point of purchase touse your plan dollars toward qualified purchases.
2. Save your receipts.
3. Submit your claim if you receive a substantiation letter.

How do I file claims?

Submit claims online at **www.mycpiteam.com** and log into the FSA/HRA employee portal OR using the mobile app: **myCPI Mobile.** You can also submit claims via email, fax, or regular mail to 6421 Perkins Road, Bldg A, Suite 2A; Baton Rouge, LA 70808.

Note: Even if you enrolled last year, you must enroll again this year.

Tax Savings Example

Possible savings if you use an FSA to pay for eligible health care or dependent care expenses:

	Annual Amount		Pay Periods		Per Pay Period
Health Care Spending (Example)	$2,750	÷	24	=	$114.58
Health Care Spending	$_____	÷	24	=	
Dependent Care Spending	$_____	÷	24	=	$_____

Example:	With FSA	Without FSA
Your Taxable Income	$35,000	$35,000
Pretax contribution to FSA	$2,000	$0
Your Taxable Income	$33,000	$35,000
After-tax dollars spent on eligible expenses	$0	$2,000
Estimated Tax Withholding*	$6,353	$6,766
Net Pay	$26,647	$26,234
Estimated Tax Savings	$413	$0

**This example assumes a 25% Federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will also save on any state and local taxes.*

Dental Coverage

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

Taking care of your teeth is as important as taking care of the rest of your body. That is why the District offers three Dental Plans that cover routine check-ups and additional services needed for your dental health. All Dental Plans offer choices that cover four types of expenses: Preventive and diagnostic care, basic and major procedures, and orthodontia for children.

Dental High and Low Option Plans

With these two options members can visit any licensed dentist. If you choose an in-network dentist, the rates charged for services will be lower and there are no claim forms to be completed. **Employees may continue to use the dentist of your choice.** Remember deductible, coinsurance, and annual maximums may apply.

Prepaid Option Plans

This dental plan requires the member to select a network dentist and the services listed in the schedule will only be covered when provided by a network dentist. You can find a dentist in the network at www.floridabluedental.com/members, click on the "Find a Dentist" button. When you enroll for benefits, treatments that you receive from your selected plan dentist will be provided at reduced fees as outlined in the schedule of benefits. (The schedule of benefits is available through the allstate.benselect.com/Okeechobee enrollment site.) With this plan employees have no deductible, no waiting periods, coverage for pre-existing conditions, no claim forms to file for plan dentist, no referral required for specialist services, and no annual maximum for plan dentist and plan specialist services.

Florida Blue Dental	HIGH OPTION*	LOW OPTION*	PREPAID OPTION
Annual Deductible *(Deductible does not apply to Preventive Services)*			
Individual	$50	$50	See Schedule for further details
Family per person	$50	$50	
Yearly Maximum	**$1,000**	**$1,000**	**None**
Preventive/Diagnostic	**Plan Pays:**	**Plan Pays:**	
Oral Exams	100%	50%	See Schedule for further details
Routine Cleanings, adult/child	100%	50%	
X-rays, bitewings - 2 films	100%	50%	
X-ray/Complete Series	100%	50%	
Fluoride Treatment	100%	50%	
Sealant, per Molar	100%	50%	
Basic Procedures	**Plan Pays:**	**Plan Pays:**	
Simple Extractions	80%	30%	See Schedule for further details
Fillings, one surface	80%	30%	
Endodontics - root canal, molar	50%	30%	
Periodontics scaling/root planing	50%	30%	
Major Procedures	**Plan Pays:**	**Plan Pays:**	
Major Restorations - Crowns	50%	25%	See Schedule for further details
Pontics	50%	25%	
Partials	50%	25%	
Complete Dentures	50%	25%	
Implants	50%	25%	
Orthodontia (Child only)	**Plan Pays:**	**Plan Pays:**	
Orthodontic Treatment Coinsurance	50%	50%	Not Covered
Lifetime Maximum	$1,000	$1,000	

* *You'll automatically receive the maximum rollover benefit that rewards you just for visiting the dentist whenever you use less than the yearly threshold amount and meet certain criteria. Please consult your certificate of insurance or group policy for a complete description.*

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Vision Coverage

Vision care for life

Properly caring for your eyesight is of the utmost importance. As part of keeping up with maintaining your overall health, routine eye exams should be scheduled on a regular basis. Without coverage, an exam and prescription glasses can cost $300 or more. **With VSP coverage, you'll save!**

As always, In-Network providers have the best prices and offer discount incentives. If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim to VSP for partial reimbursement.

Plan Highlights	In-Network	Out-of-Network	Frequency
Examination Copayment	$10	Up to $45	N/A
Materials Copay	$25	Varies, see below	every 12 months
Plan Provisions			
Single Vision Bifocal Trifocal	Covered in full	Up to $30 Up to $50 Up to $60	every 12 months
Frames	$150 Allowance	Up to $70	every 24 months
Contacts (in lieu of lens and frame benefits)			
Medically Necessary Contact Lenses Elective Contact Lenses Contact Exam and Fitting	Covered in full minus copay $120 allowance Not to exceed $60 copay	Up to $210 Up to $105 Not covered	every 12 months

This Summary is for informational purposes only. For specific benefit information, please refer to the applicable Insurance Contract.

Using Your VSP Benefit is Easy

- Create an account at **www.vsp.com**. Once your plan is effective, review your benefit information.
- Find an eye care provider who's right for you. To find a VSP provider, visit **www.vsp.com** or call **(800) 877-7195**.
- At your appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on **www.vsp.com**.

Voluntary Life and AD&D Insurance

THE HARTFORD

You may purchase life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by The Hartford. Accidental Death & Dismemberment (AD&D) insurance is designed to provide an additional benefit in the event of accidental death or dismemberment.

Employee coverage must be purchased to be eligible to purchase coverage for a spouse and/or dependent child.

Employee

Benefit Amount: increments of $10,000

Maximum Benefit: Lesser of 5 times your annual earnings or $250,000. Newly hired employees are guaranteed. Voluntary Life Insurance when first eligible at $150,000 or five times your annual salary (whichever is less).

Coverage above this amount or late enrollments may require EOI.

Age reductions will apply at age 65 and 70.

Spousal

Benefit Amount: increments of $5,000

Maximum Benefit: $100,000 but not to exceed 50% of employee's amount. Newly eligible spouses/new hires are guaranteed. Above this amount or late enrollments may require EOI.

Dependent Child

Benefit Amount: $10,000 per child

Age limitations apply. This rate will cover all eligible children for which you elect coverage.

	Life Monthly Rate
Age	**Rate per $1,000 of coverage**
< 25	$0.048
25-29	$0.048
30-34	$0.056
35-39	$0.091
40-44	$0.127
45-49	$0.155
50-54	$0.269
55-59	$0.390
60-64	$0.567
65-69	$0.994
70-74	$1.719
75+	$2.850
Dependent Children	**Rate per $10,000 of coverage**
	$2.00 (covers all children)

Voluntary Short-Term Disability

Disability can be expensive - especially if you are unable to work. Having an income can help you cover bills, pay for your home and provide for your family. But if you got sick or injured and couldn't work, how long could you afford life without a paycheck? Would your finances become disabled if you lost your paycheck? Voluntary Short Term Disability coverage from Allstate Benefits pays a monthly cash benefit to employees only for disabilities due to non-occupational sickness or injury. The monthly cash benefit can range from $400 up to **60% of the employee's monthly income**, at the time of enrollment. This benefit election is a fixed-rate. To increase the benefit to stay in line with salary increases, employees must apply for the additional coverage at the next open enrollment. Coverage is available for total and partial disability and more. The Allstate Benefits disability coverage helps offer peace of mind when an unexpected sickness or injury leads to a covered Partial or Total Disability, and includes provisions for Concurrent and Recurrent Disability, Pregnancy and more!

You have the option of a 7 or 14 day elimination period option.

Plan rates and summaries are available on the benefit enrollment site at **allstate.benselect.com/Okeechobee**.

Voluntary Long-Term Disability

Voluntary Long Term Disability coverage through The Hartford provides a monthly benefit up to **60% of your monthly salary** to a $6,000 maximum in the event you cannot work because of a long-term illness or injury. There is a 90-day elimination period before benefits begin. Pre-existing condition limitations apply.

	Long Term Disability Monthly Rate
Age	**Rate per $100 of coverage**
< 25	$0.13
25 - 29	$0.18
30 - 34	$0.24
35 - 39	$0.33
40 - 44	$0.44
45 - 49	$0.58
50 - 54	$0.74
55 - 59	$0.80
60 - 64	$0.85
65 +	$0.89

Evidence of Insurability: May be required for Life and Disability Benefits

If you make changes to your life or disability coverage for yourself or your spouse, you may need to complete an **Evidence of Insurability (EOI) form**. The web-based EOI form will be provided for you and asks a series of health-related questions. The form must be completed and approved by The Hartford before coverage is effective.

Voluntary Group Accident Insurance

Allstate. You're in good hands.

Group Voluntary Accident Insurance pays benefits for **on and off-the-job accidents**, plus some benefits that correspond with medical care. Because accident insurance is supplemental, it pays in addition to other coverage the insured may already have in place. This coverage pays a benefit up to a specified amount for accidental death, dismemberment, dislocation/fracture, initial hospitalization confinement, hospitalization confinement, intensive care, ambulance service, medical expenses and outpatient physician's treatment. Benefits can also help with hospitalization deductibles and copays; doctor visit copays; visits to the emergency department; physical therapy; transportation and lodging; and much more! The chart below is a partial list of the benefits included. Please refer to the product brochure for full details.

Incident	Payable
Initial Accidental Hospital Confinement	$2,000
Accidental Hospital Confinement	$800 per day
ICU Confinement	$1,600 per day
Dislocation & Fracture Benefits	Up to $8,000 Employee; Up to $4,000 Spouse; Up to $2,000 Children
Medical Expense Benefit	Up to $600
Ambulance Benefit	$800 Regular; $2,400 Air
Common Carrier Accidental Death	Up to $500,000 Employee; Up to$250,000 Spouse; Up to $125,000 Child
Accidental Death	Up to $100,000 Employee; Up to$50,000 Spouse; Up to $25,000 Child
Dismemberment	Up to $200,000 Employee; Up to$100,000 Spouse; Up to $50,000 Child

Wellness Benefit

The Allstate Benefits Accident Plan includes an Out-Patient Physician's Benefit that covers wellness, sickness or accident related visits to a doctor so that the plan can be used each and every year - regardless of injury: $50 per visit; 2 visits per individual / 4 visits per family; includes wellness visits or any doctor's office visit; and no waiting period. Covers Employee and Spouse over the age of 18. Employee must be actively at work for a minimum of 20 hours per week to be eligible. **Children up to 26 years are eligible.**

Voluntary Group Critical Illness Insurance

If you suffer a critical illness like a heart attack, chances are you'll recover. However, your bank account might not spring back as quickly. It's true that your medical insurance can help cover the cost of care and treatment. But there are other expenses you may face beyond those resulting from a loss of income. These costs may include deductibles, copays or prescriptions; rehabilitation, alternative treatments; and/or transportation to health facilities, and family travel for visits.

Group Voluntary Critical Illness Insurance pays you a lump sum benefit at first diagnosis of a covered critical illness, and can be used however you choose. So you can focus on getting better – not on your bills!

Maximum Benefit by Category

After 100% of the Basic Benefit Amount has been paid within a category, no more benefits for any illness associated with that category are payable. Once a covered person has received 100% of the Basic Benefit Amount in a category, coverage ends for that person in that category.

Employee

- All eligible employees age 18+ who are actively at work for a minimum of 20 hours per week are eligible to apply
- You can select a benefit amount of $10,000 or $20,000

Dependents

- Covered dependents receive 50% of your basic benefit amount
- Available to children, stepchildren and legally adopted children to age 26

Wellness Benefit

Allstate Benefits pays $50 when you have one of the following preventive tests performed while not hospital confined. This benefit is limited to 1 test per calendar year, per person.

- Bone Marrow Testing
- CA15-3 / CA125 and CEA Tests
- Chest X-ray; Colonoscopy
- Flexible sigmoidoscopy
- Hemoccult stool analysis
- Mammography/Breast Ultrasound
- Pap Smear/ThinPrep Pap Test
- PSA Test
- Serum Protein Electrophoresis
- Stress test on bike or treadmill
- Electrocardiogram (EKG)
- Carotid Doppler
- Echocardiogram
- Lipid panel (total cholesterol count)
- Blood test for triglycerides

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **FOR CLAIMS ASSISTANCE** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- **DO YOU NEED AN ID CARD?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Web
Medical Florida Blue	www.floridablue.com
Dental Florida Combined Life	www.floridabluedental.com
Vision VSP	www.vsp.com
Life and LTD The Hartford	www.theHartford.com
Group STD, Accident and Critical Illness Allstate Benefits	www.allstatebenefits.com
Ability Assist Counseling Services The Hartford	www.guidanceresources.com
Flexible Spending Accounts CPI	www.mycpiteam.com

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families**.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See **https://www.healthcare.gov/have-job-based-coverage/**).

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: **healthcare.gov**).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit **healthcare.gov** or call **800-318-2596**.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices continued

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be cancelled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Notes

Ability Assist Counseling Services

The employee assistance program administered through The Hartford's Ability Assist Counseling Services Program is a confidential resource that can help you deal with family problems, stress-related issues, depression, eating disorders, problems at work, and financial crises. You can also contact EAP for guidance about other situations in your life, such as moving, retirement planning, adopting a child, finding childcare or eldercare, legal questions, training a new pet, and much more as detailed below. No issue is too large or too small.

First Time User

If you are a first-time user , you will be asked to provide the following information when creating your personal username:

1. In the Company/Organization field, use: **HLF902**
2. Then, create your own confidential user name and password.
3. Finally, in the Company Name field at the bottom of personalization page, use: **abili**

Plan Cost: 100% Employer Paid

Counselors can assist you with the following and more:

- Marital/Relationship conflicts
- Family/Parenting problems
- Stress, anxiety and depression
- Substance abuse
- Work/school disagreements
- Financial Resources
- Managing a budget
- Saving for college
- Retirement
- Tax questions
- Legal Assistance
- Buying a home
- Guardianship
- Debt/Bankruptcy
- Divorce

Call or visit them online - 24 hours a day, seven days a week!

800-96-HELPS or 800-964-3577

www.GuidanceResources.com

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