better choices better health

Monroe County School District

2018 BENEFITS
REFERENCE GUIDE

Superintendent's Message

Dear District Employees,

We are fortunate to work in a district where the safety and health of students and employees is of utmost importance. You perform your best when you feel your best. We want all of our employees to have the opportunity to reach their full potential, professionally and in their personal lives. Investing in your health now can provide priceless, long-term benefits in the future.

The Monroe County School District and I encourage you to research the right benefit plan to meet your family needs. To help you choose the plan that best fits your health care needs, we encourage you to take time to assess your own wellness, as well as your family's health needs. An easy way to do so is by scheduling a physical so you will know your numbers and establish a baseline for the year. Knowledge is your greatest ally in the fight against illness, and is a great preventative measure as well. We're committed to making sure you feel fully informed and prepared when choosing your 2018 benefit plan.

Our district offers a wide range of detailed benefit plans that were crafted to ensure you and your family members receive the coverage you need if illness or an injury occurs. The School Board has put forth substantial funding and time to provide the best programs possible for the employees of Monroe County School District. With the well-being of our students and staff in mind, we know our investment in offering you great health care options will reap invaluable benefits for our district as a whole. Please take the time to carefully review the options available to you. Having peace of mind is the greatest gift you can give yourself and your family.

Sincerely,

Mark T. Porter, Superintendent

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Important Enrollment Information

- **Open enrollment is October 30, through November 17, 2017.**
- **The plan year is January 1, 2018, through December 31, 2018.**
- **This is a mandatory enrollment. In order to complete your enrollment, you must log in to the online system at www.myFBMC.com and confirm or waive every benefit you wish to continue, add or change. In addition, please verify your current benefits elections and update your dependent and beneficiary information.**
- The Standard Insurance Company is your new Life Insurance and Long-Term Disability Provider. Be sure to review and consider enrollment in these important benefits.
- PayFlex is your new Flexible Spending Account administrator. Please note that your Medical Expense FSA allows a maximum carryover of $500. If you do not exhaust your 2018 FSA balance and elect a Medical Expense FSA in 2019, up to $500 may be used to pay for 2019 medical claims. This does not apply for Dependent Care FSA.
- If you do not have school board medical coverage and do not wish to receive your $21.08 per pay period employer contribution, check the waiver box on your enrollment form.
- You will be assessed a $50.00 per pay surcharge if you enroll your spouse in the Monroe County School District medical plan and your spouse has access to medical coverage through an outside employer.
- You may visit **www.myFBMC.com** for more information. You may also contact the FBMC Service Center at 833-MCSD-4US (833-627-3487).

The Monroe County School District provides all employees with:

- $10,000 Life and AD&D Insurance
- Partially paid medical coverage for employees who choose medical insurance and
- If you do not have medical insurance through the school board, a contribution amount of $21.08 per pay period may be used to purchase pre-tax voluntary benefits, excluding 401(k). Any unused balances will revert back to the school board.
- Dual Spouse Provision: The Dual Spouse Enrollment Option is available for both instructional and non-instructional employees. Employees should call the Employee Benefits and Risk Management Department at (305) 293-1400, ext. 53342, or see Wanda Menendez during enrollment for details.

FBMC Benefits Management – Your New Benefits Administrator

Monroe County School District is happy to once again partner with FBMC Benefits Management, Inc. as your benefits contract administrator!

The SMART Choices Plan Advantage

How Does the SMART Choices Plan Work?

1. An employer contribution is applied to your School Board medical coverage. If you do not have medical insurance through the School Board, a share of the contribution amounting to $21.08 per pay period may be used to purchase pretax voluntary benefits, excluding 401(k) and dependent care FSAs. Any unused balances will revert back to the school board.
2. You choose any pretax voluntary benefits you and your family need and the premium costs are deducted tax free from your gross pay before income and Social Security taxes are calculated.
3. Taxes are calculated on the amount of your salary remaining after all premiums have been deducted. Then, any other after-tax payroll deductions you may have are taken out of your paycheck.
4. The amount remaining in your paycheck is your take-home pay for each pay period. Since you have paid less tax, you have more income to spend.

Making Your Benefits Work for You

- Once you review the FSA guidelines and become familiar with how the program works, you'll determine how the program can save you and your family a significant amount of tax money — if you're clear on the governing IRS rules.
- Submit your supporting documentation and completed reimbursement request form (for paper claims) for reimbursement processing. Once the plan year ends, you have a 90-day run-out period to submit your supporting documentation.

Direct Deposit

Enroll in direct deposit to ensure that your FSA reimbursement checks are automatically deposited into your checking or savings account. There is no fee for this service, and you don't have to wait for postal service delivery of your reimbursement. To apply, complete the application form available from our website at **www.myFBMC.com**, or call FBMC Benefits Management, Inc. Customer Care at 833-MCSD-4US (833-627-3487), any time during the plan year.

Premium Conversion

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

You can use Premium Conversion for:

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

Important Dates to Remember

Your Open Enrollment dates are:
October 30, 2017 through November 17, 2017

Your Period of Coverage dates are:
January 1, 2018 through December 31, 2018

Appeals Process

If you have a request for a mid-plan year election change, you have the right to appeal the decision by sending a written request within 30 days of the denial to **FBMC Benefits Management, Inc. (Attn: Appeals Committee)**.

Your appeal must include the name of your employer and:

- the date of the services for which your request was denied
- a copy of the denied request and the denial letter you received
- why you think your request should not have been denied
- any information you think may have a bearing on your appeal

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

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

If you have an FSA reimbursement claim denied in whole or in part, you may submit a written appeal to Payflex within 180 days of the initial notice of adverse benefit determination. The appeal should state the reasons you feel the claim should not have been denied and should include any additional facts and/or documents that support your claim.

When Does My Period of Coverage Begin?

Current Employees: Your period of coverage is January 1, 2018 through December 31, 2018. See page 39 for information about changing your coverage.

New Employees: If you are a new full-time employee, you are eligible for the SMART Choices Plan on the first day of the month following 15 calendar days of active employment. If you do not enroll before your period of coverage begins, you will not be able to do so until the next plan year or until you experience a valid change in status.

If you enroll during open enrollment, your period of coverage is the same as the plan year (January 1, 2018 through December 31, 2018).

Who Is Eligible to Enroll in the Flexible Benefits Plan?

If you are a full-time instructional or non-instructional employee of the school board who works at least 51 percent of the average time required for your position, you are eligible to enroll in the SMART Choices Plan.

Upon certain triggering events, spouses, ex-spouses, children and employees going from full-time to part-time status may be eligible for coverage under the Consolidated Omnibus Budget

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Eligibility Requirements

Reconciliation Act (COBRA). Please contact your Employee Benefits and Risk Management Department for additional information.

Who Are Eligible Dependents?

Eligible dependents are:

- your legal spouse
- your own unmarried children
- children for whom you have been appointed legal guardian; and
- stepchildren and legally adopted children (provided they reside in your household and primarily depend on you for support).

In the State of Florida anyone up to the age of 30 may be considered a dependent for the purposes of health insurance eligibility and access. For all health coverage offered under your employer's plan, you may continue to cover your dependent child until the end of the calendar year in which the child reaches the age of 30 if the child:

- is unmarried and does not have a dependent of his or her own
- is a resident of Florida or a full-time or part-time student and
- is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

Note: The premium rates for covering dependents are applicable through the end of the plan year in which the dependent(s) turn(s) age 26. In the following plan years through the end of the plan year in which the dependent(s) turn(s) age 30, additional premiums will apply.

Note: The extension of coverage up to age 30 does not apply to accident only, specified disease, disability income, Medicare supplement, or long-term care insurance policies. The premiums for such continued coverage must be on a post-tax basis. Your employer is responsible for ensuring the proper tax treatment for any dependent coverage elected under these provisions.

Special Dependent Eligibility*

In the State of Florida anyone up to the age of 30 may be considered a dependent for the purposes of "health" insurance eligibility and access. For medical coverage offered under your employer's plan, you may continue to cover your dependent child through the end of the calendar year in which the child reaches the age of 30 if the child:

- Is age 26 - 30, unmarried and does not have a dependent child(ren) of his or her own;
- Is a resident of Florida or a full-time or part-time student;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act; and
- Has not had a gap in "creditable coverage" of more than 63 days

The premiums for such continued coverage will be on a post-tax basis, unless covering a disabled child. Your employer is responsible for ensuring the proper tax treatment for any dependent coverage elected under these provisions.

***Note:** If you reside outside of the State of Florida and have a dependent who meets the above criteria, they are eligible for coverage. For any dependents covered, regardless of the above until the end of the calendar year the dependent reaches age 26, deductions are eligible to be taken on a pre-tax basis.

The Internal Revenue Service allows employees to receive health insurance subsidies for themselves and their eligible dependents "tax free" as defined under IRS guidelines, excluding amounts attributable to coverage of an adult child(ren) (AC). Therefore Jackson Health System must include the fair market value of AC benefits in the employee's income, referred to as "imputed income" and this imputed income will be taxed accordingly. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

What Benefits Am I Eligible for If I Terminate Employment?

During the plan year, except as otherwise provided by law and in accordance with your employer's plan(s), terminating employees are covered until the last day of the month following 31 days after termination, provided you make necessary contributions. If termination occurs in the month of December, then coverage will cease no later than December 31, 2018. You can continue certain benefits by contacting the following within 30 days of your termination of employment*:

- Employee Benefits and Risk Management Department for benefits continuation and to obtain information on the Family Medical Leave Act (FMLA).
- Customer Care Center at 833-MCSD-4US (833-627-3487), to apply for continuation, on an after-tax basis, of your Dental, Vision and Medical Expense FSA coverage.

How Will Retiring Affect my Eligibility?

During the plan year, except as otherwise provided by law and in accordance with your employer's plan(s), an employee who retires is covered until the last day of the month following 31 days of retirement. 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. During the

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Eligibility Requirements

90 days preceding your scheduled retirement, it's important that you contact customer care for continuation of flexible benefits. You may not continue disability income protection or a dependent care FSA upon retirement.

A retiree is a former full-time employee of the school board who is currently receiving income under the Florida Retirement System (FRS).

Does Employee Leave Affect My Eligibility?

Employees on leave of absence are eligible for certain types of coverage depending on the type of leave (A or B).

A. **Board-Approved Paid Medical Leave, and Board-Approved Nonpaid Medical Leave** – The School Board continues to pay the the employer contributions toward benefits for up to one year if you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications). Your premium deductions will continue through the SMART Choices Plan as long as you receive a salary. The Family Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Consult with your Employee Benefits and Risk Management Department for further information.

B. **Board-Approved Nonpaid Personal Leave** – The school board does not pay for your benefits. You can continue to receive coverage under your benefits for up to one year if you pay the school board contribution and your premiums directly to the school board. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Consult with your Employee Benefits and Risk Management Department for further information.

If you go on board-approved leave for any reason, you may pay your premiums to the school board to maintain your benefits except for VISTA 401(k). If you have not maintained a current premium status while on leave, you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law.

How Does the Flexible Benefits Plan Affect Other Benefits?

Your contributions to the flexible benefits plan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS. Any salary directed to your flexible benefits plan is included in the compensation reported to the Florida Retirement System.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if the Monroe County School District offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the District-offered coverage. Also, this employer contribution– as well as your employee contribution to employer-offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Employee Benefits and Risk Management Department at (305) 293-1400, ext. 53342, or see Wanda Menendez.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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How to Enroll Online

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is advantageous to thoroughly review your enrollment materials. If you are ready to enroll, but need assistance, contact FBMC Service Center at 1-833-MCSD-4US (833-627-3487). Once you have the answers you need, you may begin the enrollment process. **Please note that online enrollment is only available during open enrollment. Newly-hired employees must meet with someone in the Risk Management Department to enroll for benefits coverage.**

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

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

How to Enroll Online

1 Log in

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

Username and Password

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

If you forget your password, click the "Forgot your password?" link for help or you may contact FBMC Service Center at 1-833-MCSD-4US (833-627-3487).

Record your password here.
Remember, this will be your password for Web access.

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

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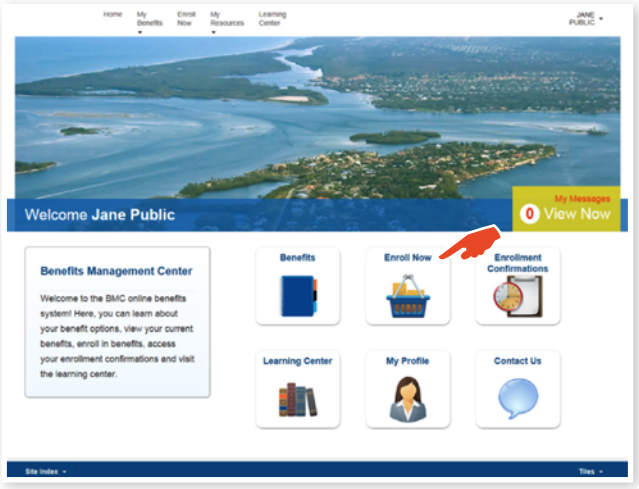
2 Access your Web Enrollment

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

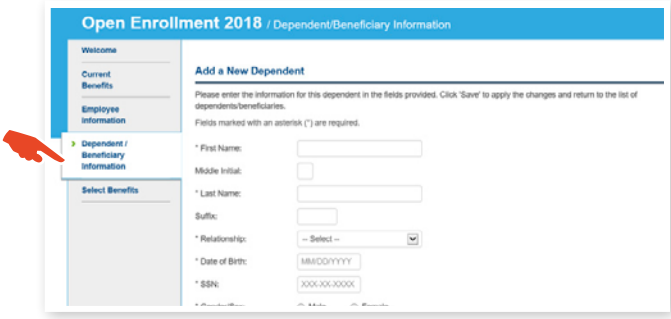


3 Enroll Now

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

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

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

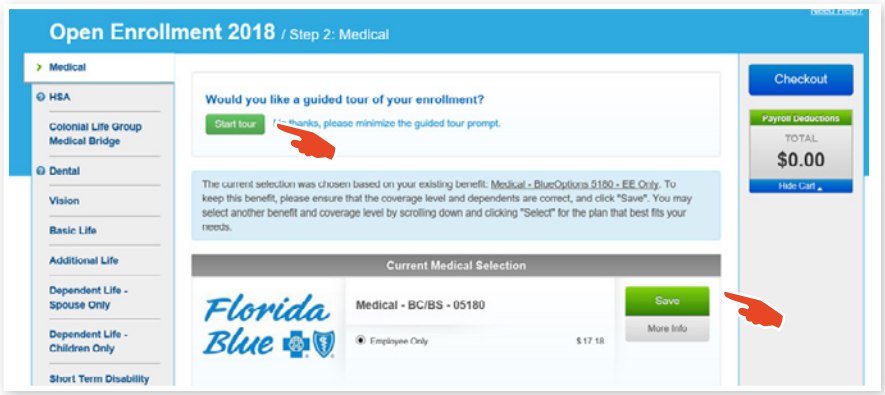


How to Enroll Online

5 Begin the Enrollment Process

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

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

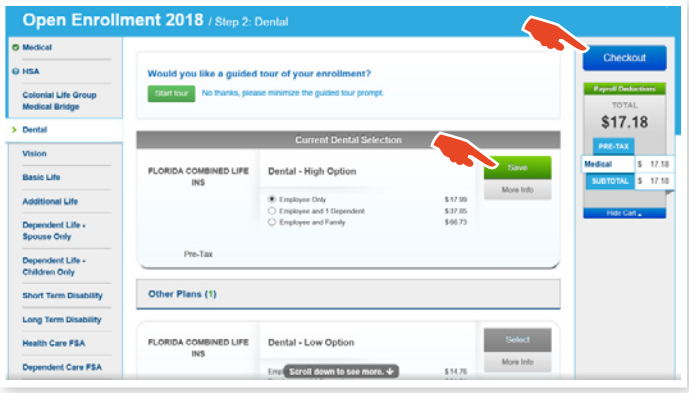


Choose Benefits

For each benefit, choose your coverage level or election amounts by clicking "Select" in the benefit box of your choice. The selected benefit will move to the top of the page. Be sure to click the "Save" button to save each benefit selection before continuing to the next benefit page. To continue to the next benefit page, click "Next" at the bottom right of the screen. You may save your enrollment session progress and return later to complete the enrollment at any point, once you have started the benefit selections by clicking the "Save" button and then click "Exit Enrollment" at the bottom of the screen. Exiting your enrollment early will record your previously saved benefit selections, however it is not a completed enrollment session.

6 Payroll Deductions

Upon selecting a benefit, be sure to click the "Save" button. Your saved benefit will appear under payroll deductions with the appropriate benefit cost. This will allow you the opportunity to view your total payroll deductions as you continue through your enrollment session. Once you have made all of your benefit selections for the 2018 Plan year, you can checkout by clicking the "Checkout" button.



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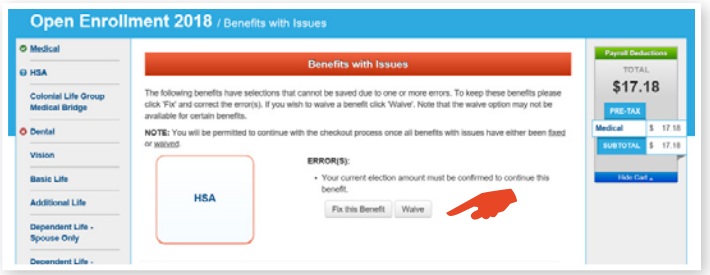

7 Benefit Issues

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

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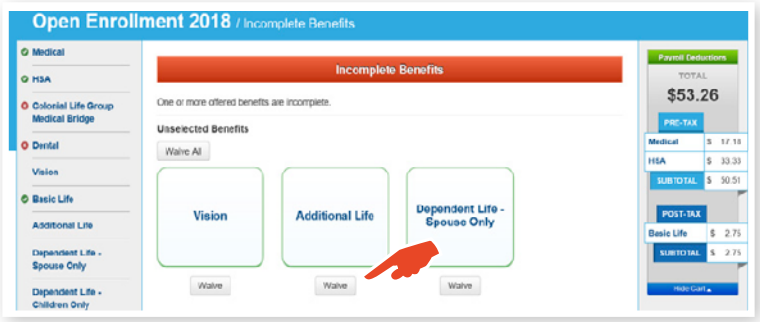
8 Incomplete Benefits

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

Rollover Benefits: If you have a current benefit and forgot to save it during your enrollment session, you must click the "Keep" button for the benefit to rollover to the 2018 Plan year.

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

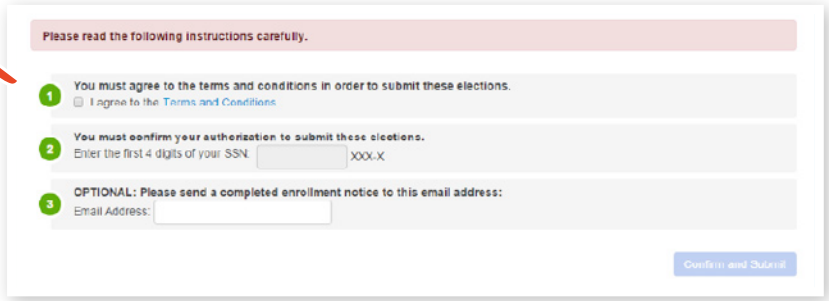
Remember, you must save or waive each benefit to proceed to checkout.



How to Enroll Online

9 Agreement and Authorization

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



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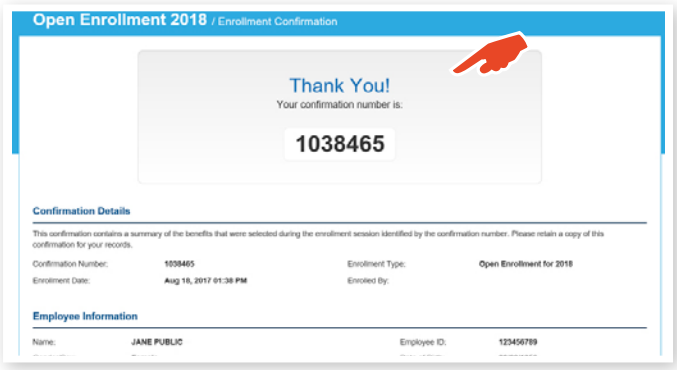

10 Print and Keep Your Confirmation Notice

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

You may access the web enrollment 24 hours a day, 7 days a week to make changes to your benefit elections. You have until the end of the open enrollment period, which ends on November 17, 2017, to make any changes to your benefits.

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions Predictable Cost 03768 BUY UP PLAN	BlueOptions Predictable Cost 03559 CORE PLAN	BlueOptions Plan 05360 HIGH DEDUCTIBLE
Deductible (DED) (Per Person/Family Agg)			
In-Network	$1,000 / $2,000	$1,500 / $3,000	$2,000 / $4,000
Out-of-Network	Combined with In-Network	Combined with In-Network	Combined with In-Network
Coinsurance (Member Responsibility)			
In-Network	25%	25%	25%
Out-of-Network	40%	40%	40%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins and all Copays (Excludes Rx)	Includes DED, Coins and all Copays (Excludes Rx)	Includes DED, Coins, & Copays(Excludes Rx)
In-Network	$5,850 / $10,960	$5,850 / $10,960	$5,850 / $10,960
Out-of-Network	Combined with In-Network	Combined with In-Network	Combined with In-Network
Lifetime Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections			
In-Network Family Physician	$10	$10	$10
In-Network Specialist	$10	$10	$10
Out-of-Network	$10	$10	$10
E-Office Visit Services			
In-Network Family Physician	$10	$10	$10
In-Network Specialist	$10	$10	$10
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Office Services			
In-Network Family Physician	$30	$40	$50
In-Network Specialist	$30	$50	DED + 25%
Out-of-Network Family Physician	$40	$50	$60
Out-of-Network Specialist	$40	$70	DED + 40%
Provider Services at Hospital			
In-Network Family Physician	$50	$50	DED + 25%
In-Network Specialist	$50	$50	DED + 25%
Out-of-Network Family Physician	$50	$50	DED + 40%
Out-of-Network Specialist	$50	$50	DED + 40%
Provider Services at ER			
In-Network Family Physician	$50	$50	DED + 25%
In-Network Specialist	$50	$50	DED + 25%
Out-of-Network Family Physician	$50	$50	In-Ntwk DED + 25%
Out-of-Network Specialist	$50	$50	In-Ntwk DED + 25%
Provider Services at Other Locations			
In-Network Family Physician	$30	$40	DED + 25%
In-Network Specialist	$30	$50	DED + 25%
Out-of-Network Family Physician	DED + 40%	DED + 40%	DED + 40%
Out-of-Network Specialist	DED + 40%	DED + 40%	DED + 40%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center			
In-Network Specialist	$45	$75	DED + 25%
Out-of-Network	$45	$75	DED + 40%

COST SHARING MAXIMUMS SHOWN ARE PER BENEFIT PERIOD (BPM) UNLESS NOTED	BlueOptions Predictable Cost 03768 BUY UP PLAN	BlueOptions Predictable Cost 03559 CORE PLAN	BlueOptions Plan 05360 HIGH DEDUCTIBLE
PREVENTIVE CARE			
Adult Wellness Office Services			
In-Network Family Physician / Specialist	$0 / $0	$0 / $0	$0 / $0
Out-of-Network Family Physician	$40	$50	DED + 40%
Out-of-Network Specialist	$40	$70	DED + 40%
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0
Mammograms (Routine)			
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0
Well Child Office Visits (No BPM)			
In-Network Family Physician / Specialist	$0 / $0	$0 / $0	$0 / $0
Out-of-Network Family Physician	$40	$50	DED + 40%
Out-of-Network Specialist	$40	$70	DED + 40%
EMERGENCY / URGENT / CONVENIENT CARE			
Ambulance Maximum (per day)	**No per Day Maximum**	**No per Day Maximum**	**No per Day Maximum**
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	In-Ntwk DED + 25%	In-Ntwk DED + 25%	In-Ntwk DED + 25%
Convenient Care Centers (CCC)			
In-Network	$20	$20	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Emergency Room Facility Services			
In-Network	$250	$350	DED + 25%
Out-of-Network	$250	$350	In-Ntwk DED + 25%
Urgent Care Centers (UCC)			
In-Network	$50	$50	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
FACILITY SERVICES – HOSPITAL / SURGICAL / LAB / INDEPENDENT DIAGNOSTIC TESTING FACILITY			
Ambulatory Surgical Center			
In-Network	$200	$250	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Independent Clinical Lab			
In-Network	$0	$0	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS)	$200	$200	DED + 25%
In-Network - Other Diagnostic Services	$50	$50	DED + 25%
Out-of-Network-Advanced Imaging (AIS)	$200	$200	DED + 40%
Out-of-Network-Other Diagnostic Services	DED + 40%	DED + 40%	DED + 40%

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Cost Sharing Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions Predictable Cost 03768 BUY UP PLAN	BlueOptions Predictable Cost 03559 CORE PLAN	BlueOptions Plan 05360 HIGH DEDUCTIBLE
Inpatient Hospital (per admit)			
In-Network	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Inpatient Rehab Maximum	30 Days	30 Days	30 Days
Outpatient Hospital (per visit)			
In-Network	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Therapy at Outpatient Hospital			
In-Network	Option 1 – $45 Option 2 -- $60	Option 1 – $50 Option 2 -- $70	Option 1 - DED + 25% Option 2 - DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Hospitalization			
In-Network	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Outpatient Hospitalization (per visit)			
In-Network	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 – DED + 25% Option 2 – DED + 25%	Option 1 - DED + 25% Option 2 - DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Provider Services at Hospital			
In-Network Family Physician	$30	$40	DED + 25%
In-Network-Specialist	$30	$50	DED + 25%
Out-of-Network Family Physician	$40	$50	DED + 40%
Out-of-Network-Specialist	$40	$70	DED + 40%
Provider Services at ER			
In-Network Family Physician	$30	$40	DED + 25%
In-Network-Specialist	$30	$50	DED + 25%
Out-of-Network Family Physician	$40	$50	In-Ntwk DED + 25%
Out-of-Network-Specialist	$40	$70	In-Ntwk DED + 25%
Physician Office Visit			
In-Network Family Physician	$30	$40	$50
In-Network-Specialist	$30	$50	DED + 25%
Out-of-Network Family Physician	$40	$50	$60
Out-of-Network Specialist	$40	$70	DED + 40%
Emergency Room Facility Services (per visit)			
In-Network	$250	$350	DED + 25%
Out-of-Network	$250	$350	In-Ntwk DED + 25%
Provider Services at Locations other than Hospital and ER			
In-Network Family Physician / Specialist	$30 / $30	$40/ $50	DED + 25%/DED + 25%
Out-of-Network Family Physician	$40	$50	DED + 40%
Out-of-Network Specialist	$40	$70	DED + 40%

Cost Sharing Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions Predictable Cost 03768 BUY UP PLAN	BlueOptions Predictable Cost 03559 CORE PLAN	BlueOptions Plan 05360 HIGH DEDUCTIBLE
OTHER SPECIAL SERVICES AND LOCATIONS			
Advanced Imaging Services in Physician's Office			
In-Network Family Physician	$200	$200	DED + 25%
In-Network Specialist	$200	$200	DED + 25%
Out-of-Network	$200	$200	DED + 40%
Birthing Center			
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics BPM	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Enteral Formulas	**$2,500 Maximum**	**$2,500 Maximum**	**$2,500 Maximum**
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Home Health Care BPM	**30 visits**	**30 visits**	**30 Visits**
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Hospice (In-Patient, Out-Patient & Home)	**No Maximum**	**No Maximum**	**No Maximum**
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Outpatient Therapy (PT, OT, ST, Cardiac and Spinal Manipulations)	**122 Visits (Includes up to 26 Spinal Manipulations)**	**122 Visits (Includes up to 26 Spinal Manipulations)**	**122 Visits (Includes up to 26 Spinal Manipulations)**
In-Network Free Standing Rehabs	$30	$50	DED + 25%
In-Network Family Physician / Specialist	$30 / $30	$40/ $50	DED + 25%
Out-of-Network Family Physician / Specialist	$40 / $40	$50 / $70	DED + 40%
Out-of-Network-All Other Locations	DED + 40%	DED + 40%	DED + 40%
Skilled Nursing Facility BPM	**60days**	**60 days**	**60 Days**
In-Network	DED + 25%	DED + 25%	DED + 25%
Out-of-Network	DED + 40%	DED + 40%	DED + 40%
Acupuncture (Cover up to 28 visits per CYM)			
In-Network	$30	$50	DED + 25%
Out-of-Network	$40	$70	DED + 40%
Bariatric Surgery	Covered	Covered	Covered
Removal of Impacted Wisdom Teeth	Covered	Covered	Covered

Diabetic Supplies (lancets, strips, etc.) are available through DME. Diabetic Equipment (insulin pumps, tubing) are covered under the medical benefits.

The information contained in this Summary of Benefits includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. Additionally, Interim rules released by the Federal Government February 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE).

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2018 Per Pay Employee Payroll Contributions (20 pay)

Coverage Level	Buy-Up Plan #3768 (per pay period)	Core Plan #3559 (per pay period)	CDHP #5360 (per pay period)
Employee Only	$146.88	$88.58	$35.68
Employee + Spouse*	$279.61	$204.40	$129.09
Employee + Children	$244.26	$177.80	$114.08
Employee + Family*	$346.56	$264.94	$181.13

*Spousal Surcharge

The spousal surcharge is a premium added if your spouse has access to medical coverage through an outside employer but is enrolled in the Monroe County School District medical plan. The amount of the surcharge that will be assessed is $50.00 deducted on a per-pay-period basis.

The spousal surcharge will be waived if:

- You do not enroll your spouse in the District's medical plan.
- Your spouse is not employed.
- You and your spouse both work for the Monroe County School District.
- Your spouse is employed, but is not eligible for medical coverage through her/his employer.
- Your spouse is eligible for and/or enrolled in Medicare/Medicaid, causing the District's medical plan to be listed as secondary insurance.

If you enroll your spouse as a dependent on your medical plan, you must sign and turn in an affidavit attesting to one of the above criteria applying in order to have this fee waived. If you are enrolling online during open enrollment, this affidavit will be offered on the enrollment site during the enrollment process.

Your Prescription Drug Program

Co-payment	Generic	Preferred Brands	Non-Preferred Brand
Buy-up Plan - Deductible: $100/individual, $200/family			
Retail:	**$10**	**$45**	**$60**
Mail order:	**$20**	**$90**	**$120**
Core Plan - Deductible: $100/individual, $200/family			
Retail:	**$15**	**$55**	**$75**
Mail order:	**$30**	**$110**	**$150**
High Deductible Plan - Deductible: $100/individual, $200/family			
Retail:	**$15**	**$60**	**$85**
Mail order:	**$30**	**$120**	**$170**

The School Board's health insurance plan's prescription program is administered by Medimpact with the Mail Order portion administered by Medimpact Direct.

Should you have any further questions, please do not hesitate to contact the Employee Benefits Department, Monroe County School District at 305-293-1400, ext. 53340, or visit **http://benefits.keysschools.schoolfusion.us**.

Important Notice from Monroe County District School Board's Health Care Plan About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Monroe County School Board Health Care Plan coverage will be affected. For those individuals who elect Part D coverage, coverage under the entity's plan will end for the individual and all covered dependents, etc. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage/**), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. If you do decide to join a Medicare drug plan and drop your current Monroe County District School Board's Health Care Plan coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the Employee Benefits & Risk Management Department at Monroe County District School Board at 305-293-1400. Ext. 53340 for further information .

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Monroe County District School Board Health Care Plan changes. You also may request a copy of this notice at any time.

For More Information About Options Under Medicare Prescription Drug Coverage

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

For More Information About Medicare Prescription Drug Coverage

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

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

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

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Humana Dental

How the Dental Care Plan Works for You

If you are planning some major dental work for you and/or your dependents during the upcoming plan year, the dental care plan could dramatically reduce your out-of-pocket expenses.

You know that professional dental care is important. Unfortunately, fitting this expense into your budget isn't always easy. That's why the school board gives you a choice of two plans, the Managed Care (C-150) Plan and the PPO/Indemnity (Custom PPO Plan), to make dental care more affordable.

What tax-free rates will I pay for my dental plan?

	Managed Care (DHMO) Plan C150	Custom PPO Dental Plan
Coverage	20 pay periods	20 pay periods
Employee	$11.58	$12.67
Employee + 1	$22.01	$25.19
Employee & family	$30.00	$37.48

Plan Provider

The dental plans are underwritten by Humana.

For the most up-to-date listing of providers in your area, go to **www.HumanDental.com**. Call 1-800-342-5209, Monday through Friday, 8 a.m. to 6 p.m.

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OPTION I - Humana Managed Care (DHMO) Plan C150

Humana DHMO C150 plan is a network-based plan that emphasizes prevention and cost containment. There is no deductible and no lifetime maximum. In order to receive services, you must select a primary dentist who participates in the Humana DHMO network. Your primary dentist will provide all of your routine dental care. When you visit your primary care dentist, you may be required to pay a co-payment for some services provided by your primary care dentist. If the dental services provided are not listed as covered procedures under the plans, the primary care dentist will bill you at a 25 percent discount off normal fees. The plan provides the highest standards of quality care and allows members to seek care from in-network specialists at a 25 percent discount off normal fees.

The plan does not cover services (except emergency care) received from out-of-network dentists.

Plan Features

- Preventive services are 100 percent covered after a $5 office visit co-payment.
- Most other common dental procedures are covered for a fixed co-payment, so there are no hidden costs.
- Specialist services are discounted at 25 percent off normal fees.
- For any procedure not specifically listed, you will receive a 25 percent discount off the dentist's normal fees.
- There are no deductibles.
- There are no claims to file.
- There are no waiting periods.
- There are no benefit maximums.

Managed Care (C-150)

Preventive Care	You Pay
Routine exams	No charge
Prophylaxis (general cleaning) (one per 6 months)	No charge
Fluoride treatment (one per 12 months)	No charge
Office Visits	$5
Basic Services:	
Emergency treatment	$20 (during office hrs.)
X-ray (bitewings)	No charge
Simple extraction (single tooth)	No charge
Restorative services (fillings)	
Amalgam "silver":	
(primary, three surface)	No charge
(permanent, three surface)	No charge
Composite Resin "white":	
(anterior, one surface)	$35
(anterior, three surfaces)	$50
Root canal:	
One canal per tooth	$100
Two canals per tooth	$200
Three or more canals per tooth	$250
Periodontics:	
Scaling and root planning (per quadrant)	$50 (limit 4 per year)
Periodontal maintenance	$50
Major procedures:	
Crowns (porcelain fused to base metal)	$280
Crowns (porcelain fused to noble metal)	$280*
Bridges (per unit-porcelain fused to noble metal)	$280*
Prosthetics:	
Complete Dentures (standard upper or lower)	$300 + lab
Orthodontia (braces):	
Consultation	25% discount
Treatment plan, records	25% discount
Routine 24-month (fully banded case)	25% discount
Calendar year maximum	None
Calendar year deductible	None
Claim forms	Not required

* Additional cost applies for high noble and noble metal.

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Humana Dental

OPTION II - Humana Humana Custom PPO Dental Plan

Humana PPO plan is similar to traditional dental insurance plans. Under this plan you do not have to pre-select a primary dentist. When you want dental services, simply make your appointment with any licensed dentist. For maximum benefits, select a dentist from Humana's extensive PPO network. Our PPO dentists have agreed to accept a discounted fee for each procedure. These discounts can be as much as 30 percent off the usual fees. When you receive treatment from a Humana PPO dentist, your share of the cost will be reduced. Once services are performed, you or your dentist must file a claim form in order to receive reimbursement. Your claim will be paid based on your group's schedule of benefits. The plan will pay a percentage of the eligible charges, up to the plan's annual limit for benefits.

Plan Features

- You have the freedom to select any licensed dentist.
- You pay lower out-of-pocket costs when you select an in-network dentist.
- Our state-of-the-art claims center provides fast handling of customer claims and reimbursements.

Maximum Benefits

Lifetime	In-Network	Out-of-Network
Type I, II, III	Unlimited	Unlimited
Type IV	$1,000	$1,000
Calendar Year		
Type I, II, III	$1,500	$1,500
Type IV	$500	$500
Deductible†		
Type I	None	None
Type II, III, IV	$50	$50

† Maximum of 3 per family

Humana's Extended Annual Maximum

With Humana's Extended annual maximum, employees won't have to put off important dental care procedures for themselves or their covered dependents. Extended annual maximum is available immediately after the annual maximum for a plan is reached, and there's no cap on the dollars paid in a year. That's an attractive advantage over traditional rollover options. Extended annual maximum helps employees save money by ensuring they have access to network discounts and 30 percent coinsurance, even after they have reached their annual maximum. Employees can achieve and maintain their best health by getting dental care when it's needed, before oral health issues may affect their overall health and well-being.

Humana Custom PPO

*Partial List of Covered Services**	*In-Network Reimbursements*	*Out-of-Network Reimbursements*
Type I		
Diagnostic & Preventive	100%*	75%
• Oral examination (once per 6 months)		
• Prophylaxis (cleaning, once per 6 months)		
• Topical fluoride (children under 16, once per 12 months)		
• X-rays (limitations may apply)		
• Sealants (once per 3 years for children under 16, for non carious molars only)		
Type II		
Basic Services	75%*	50%
• Simple restorative (amalgam, synthetic or composite filings)		
• Space maintainers (for children under 16)		
• Non-surgical tooth extractions		
• Non-surgical periodonics		
Type III		
Major Services	50%*	25%
—12 month waiting period—		
• Major restorative (crowns/inlays/onlays)		
• Bridge, denture repair		
• Prosthetics (bridges and dentures)		
• Emergency palliative treatment		
• Endodontics (root canals)		
• Surgical tooth extractions		
• Surgical periodontics		
Type IV		
Orthodontics	50%*	50%
—12 month waiting period—		
• Dependent children (18 years of age or younger)		

* Reimbursement based on percentage of negotiated PPO network fees

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Humana Vision

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Your Monthly Vision Rates

Coverage	20 pay periods
Employee Only	$3.07
Employee + 1	$6.13
Employee + Family	$11.29

		If you use an IN-NETWORK provider (Member Cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Routine eye exam	Exam with dilation, as necessary	$10	Up to $30
	Retinal imaging[1]	Up to $39	Not covered
Contact lens[2] exam options	Standard contact lens fit and follow-up	Up to $55	Not covered
	Premium contact lens fit and follow-up	10% off retail	Not covered
Frames*		Up to $100, 20% off balance over $100	Up to $50
Standard plastic lenses[3]	Single vision	$15	Up to $25
	Bifocal	$15	Up to $40
	Trifocal	$15	Up to $60
	Lenticular	$15	Up to $100
Lens options[3]	UV coating	$15	Not covered
	Tint (solid and gradient)	$15	Not covered
	Standard scratch-resistance	$15	Not covered
	Standard polycarbonate		
	• Adults	$40	Not covered
	• Children <19	$40	Not covered
	Standard anti-reflective coating	$45	Not covered
	Premium anti-reflective coating		
	• Tier 1	$57	Not covered
	• Tier 2	$68	Not covered
	• Tier 3	80% of charge	Not covered

Humana Vision

		If you use an IN-NETWORK provider (Member Cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
	• Tier 3	80% of charge	Not covered
	Standard progressive (add-on to bifocal)	$25	Up to $40
	Premium progressive		
	• Tier 1	$110	Not covered
	• Tier 2	$120	Not covered
	• Tier 3	$135	Not covered
	• Tier 4	$90, 80% of charge, then up to $120	Not covered
	Photochromatic / plastic transitions	$75	Not covered
	Polarized	20% off retail	Not covered
*Discounts available on all frames except when prohibited by the manufacturer			
Contact lenses (Applies to materials only)	Conventional	Up to $100, 15% off balance over $100	Up to $80
	Disposable	Up to $100	Up to $80
	Medically necessary	$0	Up to $200
Frequency	Examination	Once every 12 months	Once every 12 months
	Lenses or contact lenses	Once every 12 months	Once every 12 months
	Frames	Once every 24 months	Once every 24 months
Diabetic Eye Care (Care and testing for diabetic members)	Exam	$0	Up to $77
	Retinal imaging	$0	Up to $50
	Extended ophthalmoscopy	$0	Up to $15
	Gonioscopy	$0	Up to $15
	Scanning laser	$0	Up to $33
	(Up to 2 services per benefit year for each listed service)		

OPTIONAL BENEFITS

Polycarbonate Lenses for Children <19	Provides for standard polycarbonate lens

ADDITIONAL PLAN DISCOUNTS

Member may receive a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.

Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location.

1 Member costs may exceed $39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.

2 Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.

3 Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.

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Humana Vision

Limitations and Exclusions:
Plan limitations and exclusions may vary based on benefits selected. Please see your certificate of coverage for a complete listing of your limitations and exclusions.

1 Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2 Services:
- That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
- Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
- Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.

3 Any loss caused or contributed by:
- War or any act of war, whether declared or not;
- Any act of international armed conflict; or
- Any conflict involving armed forces of any international authority.

4 Any expense arising from the completion of forms.
5 Your failure to keep an appointment.
6 Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7 Prescription drugs or pre-medications, whether dispensed or prescribed.
8 Any service not specifically listed in the Schedule of Benefits.
9 Any service that we determine:
- Is not a visual necessity;
- Does not offer a favorable prognosis;
- Does not have uniform professional endorsement; or
- Is deemed to be experimental or investigational in nature.

10 Orthoptic or vision training
11 Subnormal vision aids and associated testing
12 Aniseikonic lenses
13 Any service we consider cosmetic.
14 Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15 Services provided by someone who ordinarily lives in your home or who is a family member.
16 Charges exceeding the reimbursement limit for the service.
17 Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18 Plano lenses
19 Medical or surgical treatment of eye, eyes, or supporting structures
20 Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21 Any vision examination, vision materials.
22 Any examination or material required by an Employer as a condition of employment or safety eyewear, unless covered under this policy.
23 Non-prescription sunglasses except for 20% discount
24 Two pair of glasses in lieu of bifocals
25 Services or materials provided by any other group benefit plans providing vision care.
26 Certain name brands when manufacturer imposes no discount.
27 Corrective vision treatment of an experimental nature
28 Solutions and/or cleaning products for glasses or contact lenses
29 Contact lenses
30 Pathological treatment
31 Non-prescription items
32 Costs associated with securing materials
33 Pre- and Post-operative services
34 Orthokeratology
35 Routine maintenance of materials
36 Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
37 Artistically painted lenses

Vision products insured by Humana Insurance Company of Humana Insurance Company of Kentucky of Humana Health Benefit Plan of Louisiana, Inc.

This is not a complete disclosure of plan qualifications and limitations. Check with your local Humana sales office to verify product availability.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.

Humana Vision

Know what your plan covers

Attached is a summary of HumanaVision benefits that are described in detail in your certificate. You can find your certificate on **Humana.com** or call 1-866-537-0229. Here's what you can expect:

- Quality routine eye health care from independent eye care professionals and national retail locations.
- Services and materials provided on a prepaid basis, and the plan pays in-network providers directly, you also have the freedom to use out-of-network providers if you prefer
- Life without claim forms! With HumanaVision, you pay your eye care professional directly for copayments and any extra cosmetic options selected at the time of service
- Select a vision provider from our network simply by visiting **Humana.com**, if you prefer, call us at 1-866-537-0229

Know what your plan doesn't cover

Some items and services not included in HumanaVision are:

- Orthoptics or vision training, subnormal vision aids or Plano (non-prescription) lenses
- Replacement of lost or broken lenses, except at the regularly-scheduled plan intervals
- Medical or surgical treatment of eyes
- Care provided through or required by any government agency or program, including Workers' Compensation or a similar law

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.[1]

[1] Thompson Media Inc.

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This is not a complete disclosure of plan qualifications and limitations.

Check with your local Humana or HumanaDental sales office to verify product availability.

Insured by Humana Insurance Company or CompBenefits Insurance Company or CompBenefits Company

Group Term Life Insurance

Group Term Life Insurance

Monroe County Schools is pleased to offer a new 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. All employees receive a minimum of $10,000 Basic Term Life & AD&D (Employer paid). See your certificate for details.

Additional Life/AD&D Insurance

All employees are also able to elect up to $300,000 in Additional Life/AD&D in increments of $10,000 and matching AD&D insurance coverage.

Existing employees can purchase or increase their Additional Life/AD&D up to $300,000 on a guaranteed issue basis (no medical questions asked) during this open enrollment only or within the first 31 days following a family status change.

New hires are eligible to purchase up to $300,000 on a guaranteed issue basis (no medical questions asked) during their initial enrollment eligibility period.

Spouse Life/AD&D Insurance

You are able to elect Spouse Life/AD&D Insurance in multiples of $5,000 up to $150,000 in life and matching AD&D insurance coverage. Spouse Life/AD&D Insurance amounts up to $50,000 are available on a guaranteed issue basis (no medical questions asked) for new hires and for existing employees during this open enrollment only or within the first 31 days following a family status change. Anything over this amount requires Evidence of Insurability (EOI).

You must be enrolled in Additional Life to enroll in the Spouse Life plan. The amount you can purchase for your spouse cannot exceed 100 percent of the Additional Life/AD&D Insurance amounts you select.

Dependent Child(ren) Life/AD&D Insurance

You are able to elect $10,000 in life and matching AD&D for all eligible dependent children, regardless of how many up to age 20 (or 24 if the child attends school full time). You must be enrolled in Additional Life to enroll in the Child Life plan.

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 833-MCSD-4US (833-627-3487) for a waiver of premium application.

Coverage Level At Ages 65, 70, and 75

Your benefits decrease to 65 percent at age 65, to 40 percent at age 70 and to 25 percent at age 75.

Staying Covered 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 Privilege 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 x6785.

Additional Life/AD&D Rates

Payroll deductions are based on 20 pays. Rates are dependent upon your age on the effective date of coverage. Please note that if you move up to the next age bracket, your payroll deduction will change in January following your birthday.

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.

Do you need Life insurance?

Ask yourself: Would someone suffer an economic hardship if you died? If the answer is yes, the next step is to determine the right amount of Life insurance to help protect your loved ones. Just use our handy calculator to estimate your needs at https://www.standard.com/individual/insurance/group-life/estimate-life-insurance-needs. Every family has unique circumstances that can make it difficult to estimate needs. Take a few minutes to use this simple form and we can help you find the right amount to protect your loved ones.

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Group Term Life Insurance

Employee Life/AD&D rates (based on 20 payroll deductions):

Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*	70-74*	75+*
Coverage Amount*												
$10,000	0.54	0.54	0.66	0.66	1.02	1.62	2.82	4.62	5.10	6.44	7.18	4.49
$20,000	1.08	1.08	1.32	1.32	2.04	3.24	5.64	9.24	10.20	12.87	14.35	8.97
$30,000	1.62	1.62	1.98	1.98	3.06	4.86	8.46	13.86	15.30	19.31	21.53	13.46
$40,000	2.16	2.16	2.64	2.64	4.08	6.48	11.28	18.48	20.40	25.74	28.70	17.94
$50,000	2.70	2.70	3.30	3.30	5.10	8.10	14.10	23.10	25.50	32.18	35.88	22.43
$60,000	3.24	3.24	3.96	3.96	6.12	9.72	16.92	27.72	30.60	38.61	43.06	26.91
$70,000	3.78	3.78	4.62	4.62	7.14	11.34	19.74	32.34	35.70	45.05	50.23	31.40
$80,000	4.32	4.32	5.28	5.28	8.16	12.96	22.56	36.96	40.80	51.48	57.41	35.88
$90,000	4.86	4.86	5.94	5.94	9.18	14.58	25.38	41.58	45.90	57.92	64.58	40.37
$100,000	5.40	5.40	6.60	6.60	10.20	16.20	28.20	46.20	51.00	64.35	71.76	44.85
$110,000	5.94	5.94	7.26	7.26	11.22	17.82	31.02	50.82	56.10	70.79	78.94	49.34
$120,000	6.48	6.48	7.92	7.92	12.24	19.44	33.84	55.44	61.20	77.22	86.11	53.82
$130,000	7.02	7.02	8.58	8.58	13.26	21.06	36.66	60.06	66.30	83.66	93.29	58.31
$140,000	7.56	7.56	9.24	9.24	14.28	22.68	39.48	64.68	71.40	90.09	100.46	62.79
$150,000	8.10	8.10	9.90	9.90	15.30	24.30	42.30	69.30	76.50	96.53	107.64	67.28
$160,000	8.64	8.64	10.56	10.56	16.32	25.92	45.12	73.92	81.60	102.96	114.82	71.76
$170,000	9.18	9.18	11.22	11.22	17.34	27.54	47.94	78.54	86.70	109.40	121.99	76.25
$180,000	9.72	9.72	11.88	11.88	18.36	29.16	50.76	83.16	91.80	115.83	129.17	80.73
$190,000	10.26	10.26	12.54	12.54	19.38	30.78	53.58	87.78	96.90	122.27	136.34	85.22
$200,000	10.80	10.80	13.20	13.20	20.40	32.40	56.40	92.40	102.00	128.70	143.52	89.70
$210,000	11.34	11.34	13.86	13.86	21.42	34.02	59.22	97.02	107.10	135.14	150.70	94.19
$220,000	11.88	11.88	14.52	14.52	22.44	35.64	62.04	101.64	112.20	141.57	157.87	98.67
$230,000	12.42	12.42	15.18	15.18	23.46	37.26	64.86	106.26	117.30	148.01	165.05	103.16
$240,000	12.96	12.96	15.84	15.84	24.48	38.88	67.68	110.88	122.40	154.44	172.22	107.64
$250,000	13.50	13.50	16.50	16.50	25.50	40.50	70.50	115.50	127.50	160.88	179.40	112.13
$260,000	14.04	14.04	17.16	17.16	26.52	42.12	73.32	120.12	132.60	167.31	186.58	116.61
$270,000	14.58	14.58	17.82	17.82	27.54	43.74	76.14	124.74	137.70	173.75	193.75	121.10
$280,000	15.12	15.12	18.48	18.48	28.56	45.36	78.96	129.36	142.80	180.18	200.93	125.58
$290,000	15.66	15.66	19.14	19.14	29.58	46.98	81.78	133.98	147.90	186.62	208.10	130.07
$300,000	16.20	16.20	19.80	19.80	30.60	48.60	84.60	138.60	153.00	193.05	215.28	134.55

* Your coverage amount decreases to 65% at age 65, to 40% at age 70 and to 25% at age 75. Premiums are also based on the reduced benefit amount. Example: $10,000 coverage amount decreases to $6,500 at age 65, to $4,000 at age 70 and to $2,500 at age 75.

Dependent Child(ren) Life - based on 20 payroll deductions:

$0.78 for $10,000 of insurance on each eligible child, regardless of the number of children.

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Group Term Life Insurance

Spouse Life/AD&D rates (based on 20 payroll deductions):

Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Coverage Amount*												
$5,000	0.27	0.27	0.33	0.33	0.51	0.81	1.41	2.31	2.55	3.22	3.59	2.24
$10,000	0.54	0.54	0.66	0.66	1.02	1.62	2.82	4.62	5.10	6.44	7.18	4.49
$15,000	0.81	0.81	0.99	0.99	1.53	2.43	4.23	6.93	7.65	9.65	10.76	6.73
$20,000	1.08	1.08	1.32	1.32	2.04	3.24	5.64	9.24	10.20	12.87	14.35	8.97
$25,000	1.35	1.35	1.65	1.65	2.55	4.05	7.05	11.55	12.75	16.09	17.94	11.21
$30,000	1.62	1.62	1.98	1.98	3.06	4.86	8.46	13.86	15.30	19.31	21.53	13.46
$35,000	1.89	1.89	2.31	2.31	3.57	5.67	9.87	16.17	17.85	22.52	25.12	15.70
$40,000	2.16	2.16	2.64	2.64	4.08	6.48	11.28	18.48	20.40	25.74	28.70	17.94
$45,000	2.43	2.43	2.97	2.97	4.59	7.29	12.69	20.79	22.95	28.96	32.29	20.18
$50,000	2.70	2.70	3.30	3.30	5.10	8.10	14.10	23.10	25.50	32.18	35.88	22.43
$55,000	2.97	2.97	3.63	3.63	5.61	8.91	15.51	25.41	28.05	35.39	39.47	24.67
$60,000	3.24	3.24	3.96	3.96	6.12	9.72	16.92	27.72	30.60	38.61	43.06	26.91
$65,000	3.51	3.51	4.29	4.29	6.63	10.53	18.33	30.03	33.15	41.83	46.64	29.15
$70,000	3.78	3.78	4.62	4.62	7.14	11.34	19.74	32.34	35.70	45.05	50.23	31.40
$75,000	4.05	4.05	4.95	4.95	7.65	12.15	21.15	34.65	38.25	48.26	53.82	33.64
$80,000	4.32	4.32	5.28	5.28	8.16	12.96	22.56	36.96	40.80	51.48	57.41	35.88
$85,000	4.59	4.59	5.61	5.61	8.67	13.77	23.97	39.27	43.35	54.70	61.00	38.12
$90,000	4.86	4.86	5.94	5.94	9.18	14.58	25.38	41.58	45.90	57.92	64.58	40.37
$95,000	5.13	5.13	6.27	6.27	9.69	15.39	26.79	43.89	48.45	61.13	68.17	42.61
$100,000	5.40	5.40	6.60	6.60	10.20	16.20	28.20	46.20	51.00	64.35	71.76	44.85
$105,000	5.67	5.67	6.93	6.93	10.71	17.01	29.61	48.51	53.55	67.57	75.35	47.09
$110,000	5.94	5.94	7.26	7.26	11.22	17.82	31.02	50.82	56.10	70.79	78.94	49.34
$115,000	6.21	6.21	7.59	7.59	11.73	18.63	32.43	53.13	58.65	74.00	82.52	51.58
$120,000	6.48	6.48	7.92	7.92	12.24	19.44	33.84	55.44	61.20	77.22	86.11	53.82
$125,000	6.75	6.75	8.25	8.25	12.75	20.25	35.25	57.75	63.75	80.44	89.70	56.06
$130,000	7.02	7.02	8.58	8.58	13.26	21.06	36.66	60.06	66.30	83.66	93.29	58.31
$135,000	7.29	7.29	8.91	8.91	13.77	21.87	38.07	62.37	68.85	86.87	96.88	60.55
$140,000	7.56	7.56	9.24	9.24	14.28	22.68	39.48	64.68	71.40	90.09	100.46	62.79
$145,000	7.83	7.83	9.57	9.57	14.79	23.49	40.89	66.99	73.95	93.31	104.05	65.03
$150,000	8.10	8.10	9.90	9.90	15.30	24.30	42.30	69.30	76.50	96.53	107.64	67.28

* Your coverage amount decreases to 65% at age 65, to 40% at age 70 and to 25% at age 75. Premiums are also based on the reduced benefit amount. Example: $10,000 coverage amount decreases to $6,500 at age 65, to $4,000 at age 70 and to $2,500 at age 75.

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Disability Income Protection

A disability can put a lot of things in your life on hold. Unfortunately, expenses aren't one of those things. They keep right on coming. If you become disabled, this insurance plan can help you keep up by providing a stable monthly income, up to a maximum of $1,500 a month, or 60 percent of your monthly salary, whichever is less.

Plan Features

- Benefits start after you are disabled for 90 days.
- For employees working 30 or more hours per week, benefits are payable monthly up to age 65, if you are disabled before age 63. If you become disabled between the ages of 63 and 69, benefits are payable on a decreasing scale, with a maximum one year benefit period for disabilities that commence at age 69 or older.
- For employees working less than 30 hours per week, benefits are payable monthly for a maximum period of 5 years if disabled before age 63. If disability occurs between ages 63 and 69, benefits are payable on a decreasing scale with a maximum one year benefit at age 69 or older.
- Benefits coordinate with "other income benefits" as described on the following page.
- The minimum monthly benefit for employees working 30 or more hours per week is $300 per month. The minimum monthly benefit for employees working less than 30 hours per week is $100 per month. The minimum monthly benefit is the minimum amount payable, once all other income benefits have been applied.
- Premiums are waived while you receive payments under this plan.

Mental Illness, Alcoholism, Drug Abuse Limitation

You can receive payments for a covered disability which does not require hospitalization that 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 hospital confined.

Return to Work Incentive Benefit

This benefit offers an effective incentive for employees who are ready to return to work, but not full time. If you are covered for work incentive benefits, you may return to work while disabled and your disability benefits will continue.

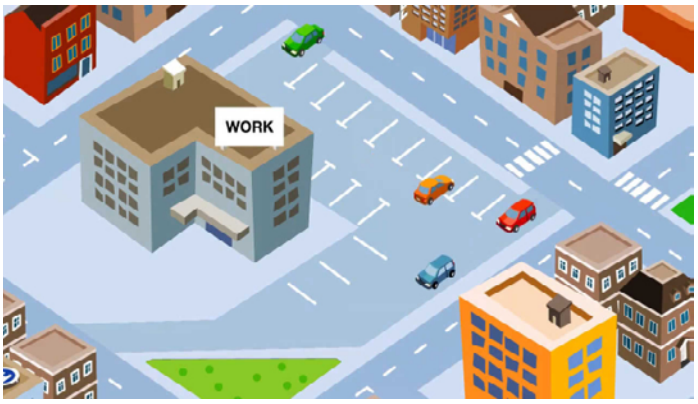
For the first 12 months you return to work, if, for any month during that period, the sum of your disability benefit, your income from the rehabilitative work and any additional other income benefits exceed 100 percent of your indexed covered earnings, your disability benefit will be reduced by the excess amount.

After 12 months, your disability benefit will be reduced by 50 percent of your income received during any month of rehabilitative work.

Disability Income Rates

Coverage	20 pay periods
Employee Only	$8.40

Click to play the LTD Disability Video:



Reasonable Accommodation Expense Benefit

This coverage includes a $25,000 Reasonable Accommodation Expense Benefit, which reimburses employers for workplace modifications that enable employees to return to or remain at work. The Reasonable Accommodation Expense Benefit is separate from the LTD claim payment.

Rehabilitation Plan Benefit

This benefit increases the LTD benefit amount by 10% of predisability earnings, not to exceed the maximum benefit, when member is participating in an approved rehabilitation plan. This benefit will also assist in paying for approved expenses incurred by a disabled member a part of an approved rehabilitation plan.

Eligibility Waiting Period

For employees hired on or before the policy effective date:
No waiting period.

For employees hired after the policy effective date:
The first of the month following 15 calendar days of active employment.

Termination of Insurance

The insurance on an employee will end on the earliest date below:

- the date the employee is eligible for coverage under a plan intended to replace this coverage
- the date the policy is terminated
- the date the employee is no longer in an eligible class
- the day after the period for which premiums are paid
- the date the employee is no longer in active service.

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Disability Income Protection

Rehabilitation During Period of Disability

A Rehabilitation Plan is a written agreement between you and the insurance company in which the insurance company agrees to provide, arrange or authorize vocational and physical rehabilitation services.
The Rehabilitation Plan may, at the insurance company's discretion, allow for payment of your medical expenses, education expenses, moving expenses, accommodation expenses or family care expenses while you participate in the program.
If, while you are disabled, the insurance company determines that you are a suitable candidate for rehabilitation, you may participate in a Rehabilitation Plan. You and the insurance company must mutually agree upon the terms and conditions of the Rehabilitation Plan. The insurance company may require that you participate in a rehabilitation assessment with you, your employer, your physician and others, as appropriate, to develop a rehabilitation plan. If you refuse to participate in the rehabilitation efforts disability benefits will not be payable.

Survivor Benefit

If death occurs after the employee has been receiving the monthly benefits for at least six months, his or her eligible survivor will receive a lump sum eqal to 3 times the non-integrated LTD benefits.

Definition of "Disability"

The plan considers you disabled if you:

- cannot perform all the material and substantial duties of your regular occupation, and
- are unable to earn more than 80 percent of your indexed covered earnings, solely due to injury or sickness.

After monthly benefits have been payable for 24 months, the plan considers you disabled if you cannot perform the material and substantial duties of any occupation or employment for which you may reasonably become qualified based on your education, training or experience and are unable to earn more than 80 percent of your indexed covered earnings, solely due to injury or sickness.

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 which begins more than 12 months after the most recent effective date of your insurance.

Conversion Privilege

If you terminate employment or if your coverage ends for any reason except non-payment of premium, you can convert this plan to an individual policy by applying for conversion within 63 days of termination. To be eligible for conversion, you must have been insured for disability benefits and actively at work for at least 12 months.

Other Income Benefits

When an employee is disabled, he or she may be eligible for benefits from other income sources. If so, the insurance company may reduce the disability benefits payable by the amount of such other income benefits. The extent to which other income benefits will reduce any disability benefits payable under the policy is shown in the schedule of benefits.

Other income benefits include:

1. any amounts that the employee or any dependents, if applicable, receive (or are assumed to receive) under:
   - the Canada and Quebec Pension Plans
   - the Railroad Retirement Act
   - any local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer
   - any sick leave plan of the employer;
   - any work loss provision in mandatory "no-fault" auto insurance
   - any workers' compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted.
2. any Social Security disability benefits the employee or any third party receives (or is assumed to receive) on the employee's behalf or for his or her dependents, or that his or her dependents receive (or are assumed to receive) because of the employee's entitlement to such benefits.
3. any retirement plan benefits funded by the Employer. "Retirement plan" means any defined benefit or defined contribution plan sponsored or funded by an employer. It does not include an individual deferred compensation agreement, a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan.
4. any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same claim for disability and contains the same or similar provision for reduction because of other insurance, the insurance company will pay its pro rata share of the total claim. "Pro rata share" means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies.
5. 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.
6. any wage or salary for work performed. If an employee is covered for work incentive benefits, the insurance company will only reduce disability benefits to the extent provided under the work incentive benefit in the schedule of benefits.

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Disability Income Protection

What's Not Covered?

The plan will not pay disability benefits for a disability that results, directly or indirectly, from:

- suicide, attempted suicide or whenever an employee injures himself or herself on purpose
- war or any act of war, whether or not declared
- serving on full-time active duty in any armed forces*
- active participation in a riot
- commission of a felony or
- revocation, restriction or non-renewal of an employee's license, permit or certification necessary to perform the duties of his or her occupation, unless due solely to injury or sickness otherwise covered by the policy.

* If the Employee sends proof of military service, the insurance company will refund the portion of the premium paid to cover the employee during a period of such service.

The plan will not pay disability benefits for any period of disability during which the employee:

- is incarcerated in a penal or corrections institution
- is not receiving appropriate care
- fails to cooperate with the insurance company in the administration of the claim including, but not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due
- refuses to participate in rehabilitation efforts required by the insurance company or
- refuses to participate in a work transition arrangement or other modified work arrangement.

Important Notice

This information is a brief description of the important features of this plan. It is not a contract. Terms & conditions of the coverage are set forth in group policy #163696 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

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.

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Flexible Spending Accounts

Health Care FSA

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

Dependent Care FSA

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

You can request reimbursement from your Dependent Care FSA after your dependent receives day care services. Unlike the Health care FSA, your full annual contribution is not available at the beginning of the plan year. You can only get reimbursed up to the amount that is available in your account at that time.

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Annual Contribution Limits

For Health Care FSA:

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

For Dependent Care FSA:

Minimum Annual Contribution: $250
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.

Using Your FSA Dollars

When you pay for an eligible health care or dependent care expense, you want to put your account to work right away. Using your FSA is easy with PayFlex.

Examples of How to Use Your FSA

Health Care FSA Example:

Paying an office visit

After paying for your care at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with a claim form to PayFlex. Once your claim is processed and approved, you'll receive payment by check or direct deposit.

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

Dependent Care FSA Example:

Paying for dependent care services

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

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

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

Use your PayFlex Card®, Your Account Debit Card

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

Be sure to use all of your FSA funds by the end of the 2018 Plan Year, or risk forfeiting the balance. Save all of your FSA receipts!

Flexible Spending Accounts

Filing a 2018 Claim with PayFlex

Those who participate in a Flexible Spending Account can visit **www.payflex.com** to access their account information. For 2018 FSA claims to PayFlex, if you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **www.payflex.com** or through the PayFlex Mobile® app to pay yourself back for your out-of-pocket expenses. Or you can fill out a paper claim form and fax or mail it to PayFlex at PayFlex Systems USA, Inc. P.O. Box 981158 El Paso, TX 79998-1158. This form can be found in the Resource Center at **www.payflex.com** or you may call PayFlex at 1-800-284-4885 to request a form.

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

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

How to Register Online

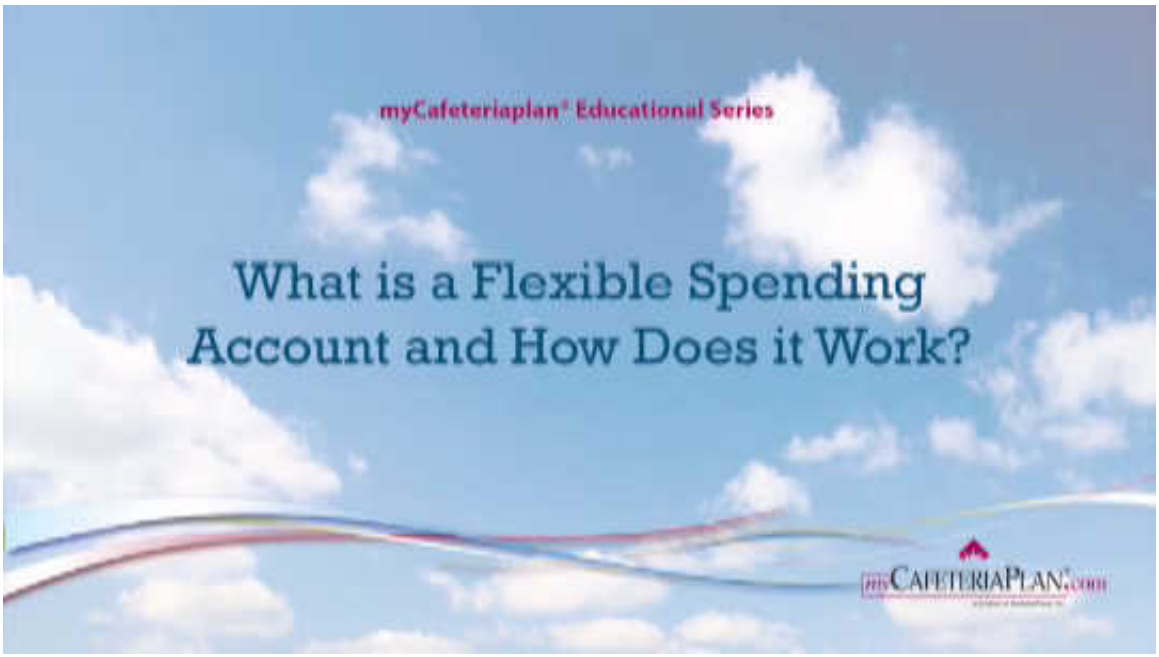
- Go to **www.payflex.com** and select "CREATE YOUR PROFILE." You will be asked to enter your last name, mailing address, ZIP code, last four characters of your ID number and date of birth.
- Once your information is authenticated, you can create a username and password, provide your phone number and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

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

Claim Filing Tips

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

Click to view the video:



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FSA Worksheets

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

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

Health Care FSA Worksheet

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

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or copayments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
TOTAL ANNUAL CONTRIBUTION **(cannot exceed $2,600)**	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.	$ _____

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

Dependent Care FSA Worksheet

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

CHILD CARE EXPENSES

Day care services	$ _____
In-home care/au pair services	$ _____
Nursery and preschool	$ _____
Before & after school care	$ _____
Summer day camps	$ _____

ELDER CARE SERVICES

Day care center	$ _____
In-home care	$ _____
TOTAL ANNUAL CONTRIBUTION Remember, your total contribution cannot exceed IRS limits.	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.	$ _____

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

Direct Deposit delivers your money to you faster, and unlike with a check, the funds are in your account automatically – no waiting in bank or ATM lines, no waiting for it to clear. Once you're an FSA member, you can enroll in Direct Deposit through PayFlex's member website at **www.payflex.com**.

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

The PayFlex Card®

Instant Access to Your Money

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

Frequently Asked Questions

How Does the Card Work?

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

Where Can I Use the Card?

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

What Can I Pay for with my Card?

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

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

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

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

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

Quick Tips

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

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The PayFlex Card® and PayFlex Mobile® App

IMPORTANT: Request for Documentation Alerts and Letters

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

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

How to Respond to a Request for Documentation Alert or Letter

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

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

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

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

PayFlex Mobile®

Helping You Stay Connected to Your FSA

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

The PayFlex Mobile app lets you:

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

Security is our Priority

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

Account Alerts at Your Fingertips

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

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

Learn More About How to Use the App

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

Questions?

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

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

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Vista 401(k) Supplemental Retirement Plan

Plan Features

Who Can Join?

All full-time employees are eligible to participate in the Vista 401(k) Supplemental Retirement Plan.

How Does the Plan Work?

The basic processes are simple:

- Contributions to the plan are made through regular payroll deductions.
- Selections from over 25 mutual funds are available.
- No taxes are paid on any contributions or earnings until they are withdrawn.

How to Enroll

To enroll in your Vista 401(k) Plan simply visit our website at **www.vista401k.com** or complete an enrollment form indicating:

- The per pay period amount you want to contribute.
- How you want your money invested (you may defer that decision until after you have enrolled but before the first payroll deductions are received). If no decision is made, your contributions will be made to the target retirement fund closest to your retirement (age 62).
- The beneficiary who will receive your account in the event of your death.

Mail your completed form to Vista 401(k) at P.O. Box 1878, Tallahassee, FL 32302-1878.

How to Change Your Investments

You can change your investments by going to the Vista 401(k) website at **www.vista401k.com** or contact FBMC's Retirement Services Team at 1-866-325-1278 and request a change of investment form. Either system enables you to:

- Change how your future contributions will be invested.
- Transfer your existing account balance among the fund choices.

There is no minimum time period before transfers or exchanges are allowed.

Participant Statement

You will receive personal account statements on a quarterly basis.

Your statement will show activity in your account including contributions, shares purchased, gains/losses, fund transfers and distributions. You may also create a statement for any time period by visiting our website at **www.vista401k.com**.

You can also obtain information from our website or through the IVR at 1-800-213-2310.

401(k) enrollment forms can be downloaded from www.vista401k.com or contact FBMC Retirement Services at 1-866-325-1278.

Contributions

Contribution Limits

The minimum contribution is $25 per payroll. The IRS regulates the maximum contribution. Please visit **www.vista401k.com** for current annual amount.

Tax Savings

Each contribution defers your federal income taxes. Additionally, no taxes are paid on any earnings in the plan until they are withdrawn. Your contributions are, however, subject to FICA taxes. Visit our website at **www.vista401k.com** and perform an investment analysis.

Contribution Changes

You can change or stop your contributions at any time.

Fees and Expenses

Vista 401(k) plan expenses are as follows:

- Overall Management - A "wrap" fee of 0.50% is assessed from your asset balances and paid to FBMC.
- Administration - $1.00 per month is assessed to participants no longer actively contributing to their 401(k) account
- Mutual Fund - There are investment fees that are different for each fund as described in their prospectus. A detailed summary is available at **www.vista401k.com**
- $20 fee for distributions and loans.
- Front-end or loading charge - none.
- Surrender charge - none.
- Fees and/or restrictions on transferring plan assets between funds - none.
- Other charges - none.
- Loan fee - $65.

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Vista 401(k) Supplemental Retirement Plan

Restrictions on Plan Distributions

Your 401(k) account is a long-term investment, designed specifically for your retirement needs. Because of this, the IRS restricts when you can withdraw your money. You are able to withdraw your money when you reach age 59½, retire, terminate employment, become totally and permanently disabled, or have a financial hardship (see hardship withdrawal provisions). Federal law imposes these limitations.

Taxes on Distributions

You pay taxes on your Vista 401(k) plan contributions and your earnings when you withdraw them. If a check is written to you, your distribution will have 20% federal income tax withheld. If you want to avoid paying taxes on your withdrawal, you may do a direct rollover to an IRA or your new employer's 401(k) plan.

An additional 10% penalty tax will be imposed for distributions made before the age of 59½ except for the following circumstances:

- distributions if you have reached age 55 and retired early
- hardship distributions
- distributions to an alternate payee under a qualified domestic relations order, issued by the court in the divorce or dissolution of marriage proceeding
- distributions made due to an employee's death or disability
- a direct rollover to another qualified plan
- purchase of service credits for a defined benefit plan.

Loans

Your 401(k) plan has a loan provision to give you access to your money The following rules apply:

- You must have a minimum of $2,000 in your account.
- You can borrow up to 50% of your account balance, with a maximum of $50,000. Employer contributions and any earnings are not eligible for a loan.
- The minimum loan amount is $1,000.
- You have a choice of paying your loan back, with interest, in 1, 2, 3 or 4 years.
- You pay back your loan through equal payroll deductions.
- There are no penalties if you prepay your loan, but if you want to pay it off early, you must pay it off in one lump sum.
- You can only have one loan at a time; there is a 30-day waiting period between loans.
- The interest rate will be 2% over the prime rate.
- Your total payment (principal and interest) will be deposited back into your account.
- There is a $65 fee for loan processing, which includes State of Florida Documentary Stamp payment.

Hardship Withdrawal Provisions

The IRS considers your 401(k) account to be a ***last resort*** for money. You must meet specific criteria to qualify for a financial hardship. The IRS allows the following six reasons for hardship withdrawal of your 401(k) funds. The withdrawal cannot exceed the cost of your hardship.

- Purchase of a primary residence (excluding mortgage payments).
- Tuition expenses and related educational fees for you or your dependent's next 12 months of post-secondary education.
- Expenses incurred by you or your dependents to obtain medical services.
- Payments to prevent eviction or foreclosure on your primary residence.
- Payments for burial or funeral expenses for the employee's deceased parent, spouse, children or dependents.
- Expenses for the repair of damage to the employee's principal residence that qualifies for the casualty deduction under code section 165.

You must complete a hardship withdrawal application that details your financial situation and provide written documentation for all eligible expenses.

Your contributions to the Vista 401(k) plan and any other retirement plan, such as a 403(b) tax-deferred annuity, must be suspended for six months after the withdrawal.

Rollovers

You may roll over, on a tax-free exchange basis, funds from a previous employer's 401(a), 401(k), 403(b), 457 or IRA plans into your Vista 401(k) plan.

Call Vista 401(k) toll-free at 1-866-325-1278 for information.

All investments involve risks. You should carefully consider all of your options before investing.

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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 a qualifying event as determined by the Treasury regulations promulgated under 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 election change. 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 **30 days** from the date you receive the denial to file an appeal with FBMC Benefits Management, Inc. For more information, refer to the "Appeal Process" section of this Benefits Reference Guide.

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

Valid Election Change Events

TYPE OF CHANGES
• **Marital Status**
• **Change in Number of Employee's Dependents**
• **Change in Employment Status**
• **Gain or Loss of Dependents' Eligibility Status**
• **Coverage and Cost Changes**
• **Open Enrollment Under Other Employer's Plan**
• **Judgment/Decree/Order**
• **Medicare/Medicaid**
• **Family and Medical Leave Act (FMLA) Leave of Absence**
• **Revoking Election of Coverage**
• **Special Enrollment Rights**

Review the Monroe County School District's Plan document for more information and a complete listing of permitted election change events.

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COBRA Q&A

Which benefits are COBRA eligible?

Dental and Vision are COBRA eligible, along with the Medical and Medical Flexible Spending Accounts (FSA).

What is Continuation Coverage?

Federal law requires that most group health plans, including medical flexible spending accounts (medical expense FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan.

How Long Will Continuation Coverage Last?

For Medical Expense FSAs:

If you fund your medical expense FSA entirely, you may continue your medical expense FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already received, as reimbursement, the maximum benefit available under the medical expense FSA for the year. For example, if you elected a medical expense FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your medical expense FSA for the remainder of the plan year or until such time that you receive the maximum medical expense FSA benefit of $1,000.

If your employer funds all or any portion of your medical expense FSA, you may be eligible to continue your medical expense FSA beyond the plan year in which your qualifying event occurs and you may have Open Enrollment rights at the next Open Enrollment period. There are special continuation rules for employer-funded medical expense FSAs. If you have questions about your employer-funded medical expense FSA, you should call FBMC Benefits Management (FBMC) at 1-855-569-3262.

PayFlex – FBMC's Outsource Partner

COBRA benefits communication is being supported by FBMC Benefits Management's outsource provider, PayFlex Systems USA, Inc. Please note that all PayFlex correspondence you receive is approved for distribution by the Monroe County School District and FBMC Benefits Management, Inc.

Appeals

To appeal a claim, you may submit documentation showing that your claim was denied and include updated documentation. Instructions for submitting the appeal are included on the denied claim notification.

For More Information

This *COBRA Q&A* section does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available from your employer.

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at **www.dol.gov/ebsa**.

Keep Your Address Updated

In order to protect your family's rights, you should keep FBMC informed of any changes in the addresses of family members. Call FBMC Service Center at (833) 627-3487. You should also keep a copy, for your records, of any notices you send to your employer and FBMC.

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Taxable Benefits and the IRS

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

Notice of Administrator's Capacity

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

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

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

Social Security

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

However, the tax savings realized through the flexible benefits plan generally outweigh the Social Security reduction. Call the service center at 1-855-569-3262 for an approximation.

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

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

FBMC Privacy Statement

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal, and sometimes sensitive, information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect.

Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.

FBMC's privacy statement is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services.

FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

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

II. Under federal law you have certain rights with respect to your protected health information.

You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information.

We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.

IV. We limit how, and with whom, we share customer information.

We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information as we otherwise would. The words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator for more information.

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Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.

Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

FLORIDA – Medicaid
Website: flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within "30 days" or any longer period that applies under the plan after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within "30 days" or any longer period that applies under the plan after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:
Risk Management Department
241 Trumbo Road
Key West, FL 33040
833-MCSD-4US (833-627-3487)

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Notes

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Benefits Directory

Monroe County School District
School Board Office
Mon - Fri, 8 a.m. - 5 p.m. ET
305-293-1400

Florida Blue
Medical Benefits
1-888-387-4962
www.BCBSFL.com

Humana Services
Dental Insurance
Mon-Fri, 8 a.m. - 5 p.m. ET
1-800-432-3376
www.compbenefits.com

Humana
Vision Care Plan
1-866-537-0229
www.HumanaVisionCare.com

MedImpact
Prescription Plan
1-844-348-8505
www.medimpact.com

FBMC Benefits Management, Inc.
(Contract Administrator)
Mon - Fri, 7 a.m. - 10 p.m. ET
833-MCSD-4US (833-627-3487)
www.fbmc.com

PayFlex
(Flexible Spending Accounts and COBRA Administrator)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
Sat, 10 a.m. - 3 p.m. ET
844-PAYFLEX (844-729-3539)

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

Vista 401(k) Plan
FBMC Retirement Services
Mon - Fri, 8 AM - 5 PM
1-866-325-1278
Automated Services
1-800-213-2310
www.vista401k.com

Trustmark Insurance Company
(Existing Policy holders only)
(Universal Life, Critical Illness, Cancer Protector)
Customer Service
Mon - Thur, 8 a.m. - 7 p.m. ET
1-800-918-8877
Fri, 9 a.m. - 7 p.m. ET

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

Standard Insurance Company
(Group Long Term Disability Insurance)
Mon – Fri, 9 a.m. – 8 p.m. ET
1-800-325-5757
1-800-628-8600

FBMC BENEFITS MANAGEMENT™

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Service Center: 833-MCSD-4US (833-627-3487)
www.myFBMC.com

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