WELLNESS made Simple

2016 BENEFITS REFERENCE GUIDE

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Benefits Directory

HUMAN RESOURCES CAPITAL MANAGEMENT
C/O HR Service Center
1801 NW 9th Avenue
Suite #150A Room 101
Miami, FL 33136
305-585-6771

ON-SITE FBMC SERVICE CENTER
1611 N.W. 12th Avenue
Park Plaza West L-109B
Miami, FL 33136-1096
305-585-6512

MEDICAL PROVIDER
AvMed
844-439-5378
www.avmed.org/jhs

SmartShoppers
1-800-824-9127
AvMed.VitalsSmartShopper.com

DENTAL PROVIDERS
Guardian DHMO
P.O. Box 2452
Spokane, WA 99210
Member Service: 888-618-2016

Guardian Dental PPO
Guardian Dental Claims
P.O. Box 2859
Spokane, WA 99210
Member Service:
800-541-7846

Guardian Dental Pre-Enrollment Support
Hot Line
1-888-600-1600
Group Number 00516547
www.GuardianAnytime.com

VISION PROVIDER
Guardian/Davis Vision
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110
Member Service: 877-393-7363
www.davisvision.com

Pre-enrollment Support Hot Line:
1-888-600-1600
Group Number 00516547

CONTACT ADMINISTRATOR
FBMC Benefits Management, Inc.
Service Center
Mon - Fri, 7 a.m. - 7 p.m. ET
855-56JHS4U (855-565-4748)
www.myfbmc.com

FLEXIBLE SPENDING ACCOUNTS
PayFlex
Mon - Fri, 8 a.m. - 8 p.m. ET
Saturday, 10 a.m. - 3 p.m. ET
800-284-4885
Toll-Free Claims Fax
855-703-5305
General Account Info - Voice Response
24 hours a day
800-284-4885
payflex.com

WORK & FAMILY BENEFITS
55 Lane Road
Fairfield, NJ 07004
24/7 Access for Jackson Health System employees:
786-466-8377

ACCIDENT PROVIDER
Provident Life & Accident Insurance Company (Unum)
Accident Insurance
Customer Service
800-635-5597
www.unum.com

DISABILITY PROVIDER
Reliance Standard Life Insurance Company
(Short-Term Disability)
Matrix Absence Management, Inc.
866-533-3438
24/7 for Telephonic Claims Filing or file online at www.matrixeservices.com

Reliance Standard Life Insurance Company
(Long-Term Disability)
Matrix Absence Management, Inc.
P.O. Box 13498
Philadelphia, PA 19101
800-866-2301
Fax 602-866-9707
Long Term Disability Claim forms available at HR Shared Service Center.

LIFE INSURANCE PROVIDERS
Reliance Standard Life Insurance Company
800-351-7500
www.reliancestandard.com

Allstate Benefits
American Heritage Life Insurance Company
(Critical Illness)
800-521-3535
www.allstatebenefits.com

ReliaStar Life Insurance Company
A Member of the Voya® Family of Companies
Customer Service
P.O. Box 122
Minneapolis, MN 55440-0122
800-537-5024
www.voya.com

Transamerica Life Insurance Company
888-763-7474
www.transamerica.com

Unum Life Insurance Company of America
(Long-Term Care)
800-331-1538
www.unum.com

Unum Whole Life Insurance with Long Term Care
(Whole Life Insurance)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
800-635-5597
www.unum.com

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TAX SHELTER ANNUITY PROVIDERS

403(b) and 457

Nationwide Retirement Solutions 457
P.O. Box 182797
Columbus, OH 43218-2797
877-677-3678
www.nrsforu.com

Voya Retirement Insurance and Annuity Company
403(b) and 457
3201 West Commercial Blvd.
Suite 212
Ft. Lauderdale, FL 33309
954-486-2236
305-234-3246
www.voya.com

Fidelity Investments Tax Exempt Services Co.
403(b)
P.O. Box 770002
Cincinnati, OH 45277-0089
800-343-0860
www.fidelity.com/workplace

Lincoln National Life Insurance Co.
403(b) and 457
P.O. Box 2340
Fort Wayne, IN 46801
800-254-6265 (403(b))
800-341-0441 (457)
www.lincolnlife.com

AIG/VALIC
(Variable Annuity Life Insurance Company)
403(b) and 457
8000 Governor's Square Blvd.
Suite 300
Miami Lakes, FL 33016
305-817-2250

Local
250 Bird Road, Suite 202
Coral Gables, FL 33146

Regional Service Center
10008 N. Dale Mabry Hwy., Suite 113
Tampa, FL 33618
800-448-2542 Extension 88573
www.valic.com

OTHER PROVIDERS

Veterinary Discount Plan for your Pets
Pet Assure
415 Cedar Bridge Avenue
Lakewood, NJ 08701
888-789-PETS (7387)
www.petassure.com

Legal Insurance
ARAG®
400 Locust Street
Suite 480
Des Moines, IA 50309
800-247-4184
Access Code 17845jhs
www.ARAGLegalCenter.com

Group Voluntary Hospital Indemnity Insurance
Allstate Benefits
AHL American Heritage Life Insurance Co.
Group Voluntary Hospital Indemnity Insurance
(Hospital Indemnity Insurance)
Mon - Fri, 8 a.m. - 8 p.m. ET
800-348-4489
www.allstatebenefits.com

ID Commander
Membership Services
1-855-592-7941
Mon - Fri, 9 a.m. - 6 p.m. ET.
www.idcommander.com

ConstantCredit
Membership Services
1-888-384-7935
Mon – Fri, 9 a.m. - 6 p.m. ET.
www.constantcredit.com

Open Enrollment News

Important Dates to Remember
Your Open Enrollment dates are:
November 12, 2015 through December 2, 2015.

Your Period of Coverage dates are:
January 1, 2016 through December 31, 2016.

Important Enrollment Information

Welcome to your 2016 Jackson Health System (JHS) Benefits Open Enrollment!

Open Enrollment is your annual opportunity to make changes to your benefit elections. Jackson Health System is committed to providing security for you and your family by offering a comprehensive and affordable benefits program. It is your responsibility to read the benefit plan information before making your elections. Your benefits are a valuable part of your employment with Jackson Health System. Be sure you are making the most of them.

- **This is a mandatory enrollment.** If you do not enroll during the open enrollment period, your current medical coverage and those of your dependents will be auto-assigned to Jackson First HMO. Dental and Vision will roll over to the new Guardian plan. All other benefits and those of your dependents will roll over for the 2016 Plan Year with the exception of Flexible Spending Account (FSA). If you are currently enrolled in a FSA and wish to continue, you must re-enroll.
- **Enroll online (24/7)** following the steps in the *How to Enroll* portion of this Reference Guide.
- To enroll in or make changes to any voluntary benefits you must attend an Enrollment Session. Schedule your individual enrollment session online at **www.JacksonBenefits.org.** To cancel existing individual voluntary benefits coverage please contact the benefits provider company directly. They will provide instructions for canceling your benefit coverage.
- Employees enrolling with new health insurance dependent coverage must provide dependent eligibility verification for each dependent. You must provide the required documentation during Open Enrollment (November 12, 2015 through December 2, 2015). Failure to do so will result in the inability to enroll dependents in coverage. Refer to page 16 for a detailed list of documents required to validate each of your dependents.
- You are encouraged to read your Benefits Reference Guide, which provides the information necessary to help you decide the benefits that are right for you. It is also a good tool to refer to throughout the year.

IMPORTANT: The Affordable Care Act requires Jackson Health System to provide information to the federal government that proves you and all covered dependents have medical insurance. Employees enrolling with health insurance dependent coverage are required to provide a valid social security and date of birth for each dependent.

Prepare for Enrollment

Have the following information on hand to help you successfully complete your online enrollment session. Use the checklist below as your guide.

- User name and Password to log on to the FBMC home page at **www.JacksonBenefits.org.**
- Dependents' Name, Date of Birth, Valid Social Security Number and Relationship for Medical, Dental and/or Vision coverage must be provided.
- Preferred Dental Provider (PDP) for you and your dependents if selecting one of the DHMO Dental Plans

Optional Life Insurance enrollment and changing beneficiaries

- Enrollment for the Optional Life Insurance is handled together with your Core and Voluntary Benefits during Open Enrollment.
- Life Insurance Beneficiaries may be changed at any time during the year via the online Employee Self Service (ESS).
- Go to **www.reliancestandard.com/documents/Jackson_Health/JHS** to obtain the necessary EOI form.

Make your benefits work for you – it's easy!

The Work & Family Benefits (WFB) helps create solutions for your needs. Learn more about WFB and how it can help you make your day-to-day easy and more enjoyable by reducing your concerns and struggles with knowledgeable experts and resources. Please see page 42 for more information about this no cost benefit.

For more information, you can contact FBMC Benefits Management (FBMC) Service Center at **855-56JHS4U** (855-565-4748), Monday - Friday, 7 a.m. - 7 p.m. ET. or visit **www.myFBMC.com**. You can also contact the On-site FBMC Service Center at 305-585-6512 or visit the office at: 1611 N.W. 12th Avenue, Park Plaza West L-109B, Miami, FL 33136-1096.

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What's New

This is a MANDATORY enrollment: If you do not enroll during the open enrollment period, your current medical coverage and those of your dependents will be auto assigned to the Jackson First HMO Plan. Dental and vision plans will roll over to the new Guardian corresponding plan. All other benefits and those of your dependents will roll over for the 2016 Plan Year with the exception of any flexible spending accounts (FSA). If you are currently enrolled in a FSA and wish to continue, you must re-enroll annually.

- **Medical:** Jackson Health System will continue offering the same medical plans at the same bi-weekly employee premiums for the 2016 Plan Year
- **Bariatric Surgery:** Effective January 1, 2016, bariatric services will be covered under the Jackson-offered HMO plans. This added coverage will be limited to Jackson facilities/providers only. Previously, bariatric services were only covered under the POS plan.
- **SmartShopper:** This is an incentive and engagement program that helps guide employees to the highest quality, lowest cost option for different medical services. Employees enrolling in the JHS Select HMO, Standard HMO or POS will be automatically enrolled in this program. See page 22 of this reference guide or an enrollment representative for additional information.
- **Dental and Vision Provider Change:** Effective January 1, 2016, Jackson will offer one dental provider with four different plan options. The plan designs will mirror the plans from previous years; however, will all fall under Guardian. The vision provider will also transition to Guardian/Davis Vision. This change in provider will enhance the benefit plans with added benefits, such as maximum roll over and college tuition rewards. Employees will only need one ID card for both dental PPO and vision insurance, and will have one integrated employee portal. There will also be access to approximately 20 percent more dentists.
- **Dependent Age Limit for Dental:** Effective January 1, 2016, the dependent age limit for dental will be extended from end of the calendar year dependent reaches age 25 to end of the calendar year dependent reaches age 26.
- **ConstantCredit:** This plan offers constant credit bureau activities and alerts employees of any reported changes on their credit report. This plan is available to employees and spouses/domestic partners. See page 70 of this reference guide or an enrollment representative for plan and rates information.
- **ID Commander:** With ID Commander's 360-degree approach to Identity Theft Protection – protection, detection, restoration – you can have the most complete identity protection coverage available, including $1 Million in Insurance Coverage. ID Commander, a leader in proactive identity theft protection, uses a variety of industry leading tools to help protect you from the growing crime of identity theft.
- **Dependent Eligibility Audit:** Employees enrolling with new health insurance dependent coverage must provide dependent eligibility verification for each dependent. You must provide the required documentation during open enrollment (November 12 through December 2, 2015). Failure to do so will result in the inability to enroll dependents in coverage. See pages 15 - 17 of this reference guide for a detailed list of documents required to validate each of your dependents.
- **Healthcare FSA:** Effective January 1, 2016 the Healthcare FSA allowable annual maximum contribution will increase from $2,500 to $2,550.

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How to Enroll during Open Enrollment

www.JacksonBenefits.org

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is to your advantage to thoroughly review your enrollment materials. If you are ready to enroll, but need assistance, contact FBMC Service Center at 855-56JHS4U (855-565-4748).

Once you have the answers you need, you may begin the enrollment process.

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

- **Social Security numbers (SSN)** for all your dependents.
- **Dates of birth** for all your dependents.
- **Proof of eligibility** for all your dependents.
- **Preferred Dental Provider (PDP)** if electing a DHMO dental plan.

How to Enroll Online

1. Go to the Jackson Open Enrollment website at **www.JacksonBenefits.org** and select "Enroll Online."

2. **Log on**
You will be directed to the FBMC homepage (**www.MyFBMC.com**). Enter your username and password.

User name and Password

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

If you forget your password, click the "Forgot your password?" link for help, or you may contact a Service Center Representative at 855-56JHS4U (855-565-4748).

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

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

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How to Enroll during Open Enrollment

www.JacksonBenefits.org

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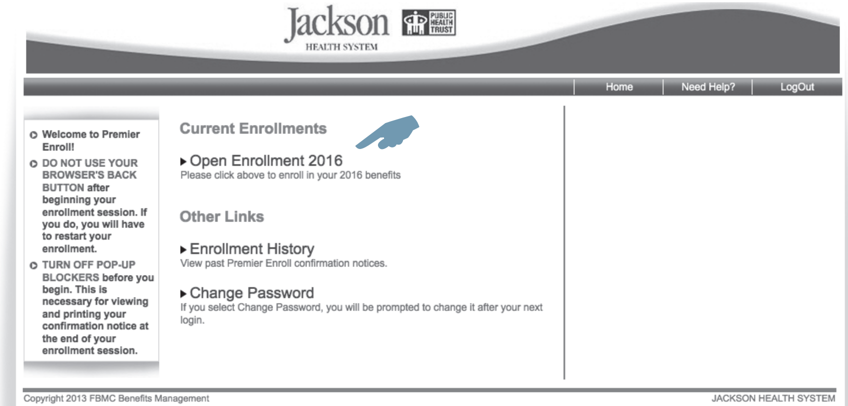
3 Access your Web Enrollment

After entering your User name and Password at **www.myFBMC.com**, click the "Open Enrollment" link. A second "Open Enrollment 2016" link will then be provided, select this link to access your open enrollment application.



4 Verify your Dependent and Demographic Info

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

How to Enroll during Open Enrollment

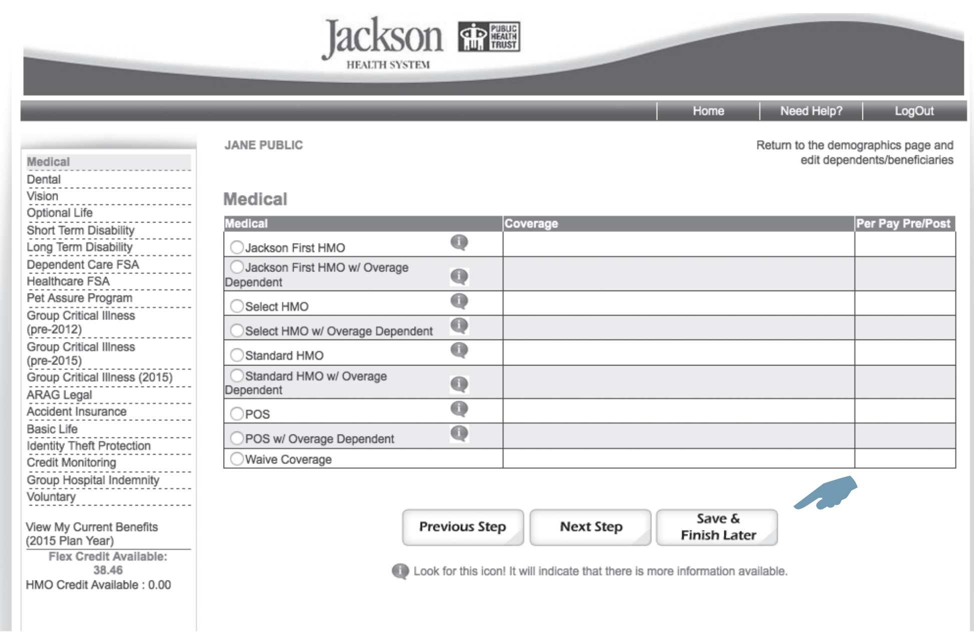
www.JacksonBenefits.org

5 Begin the Enrollment Process

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

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 & Finish Later" tab at the bottom of the screen.

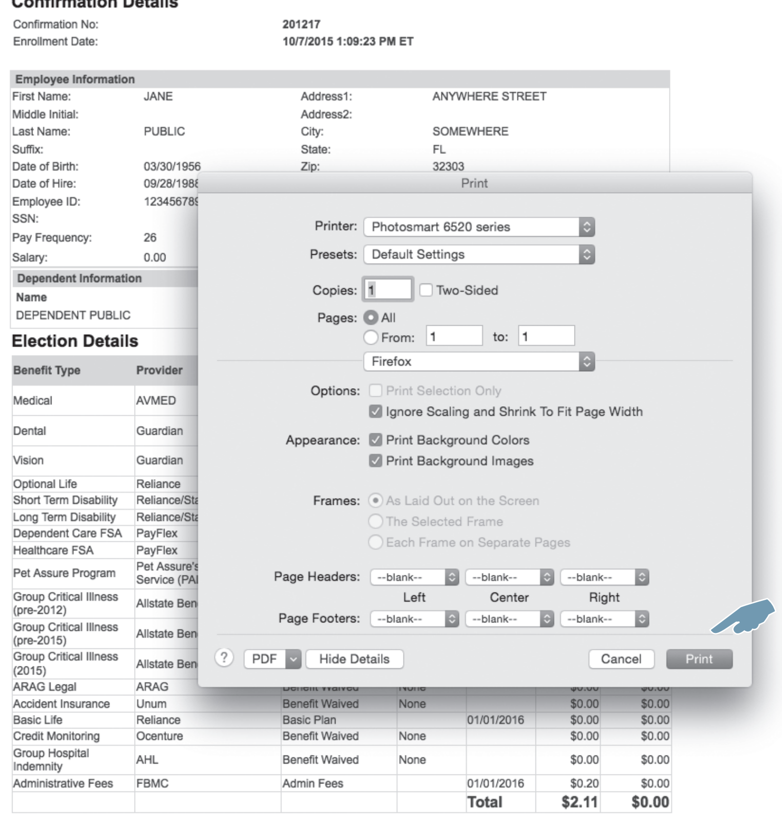
If you are interested in electing or making a change to your voluntary benefits, please make an appointment with an Enrollment Counselor by going to **www.JacksonBenefits.org** and selecting "Make an Appointment."



6 Print and Keep Your Confirmation Notice

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

You may access the Web enrollment 24 hours a day, 7 days a week, to make changes to your benefit selections. You have until the end of Open Enrollment period to make any changes to your benefits.



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How to Enroll - New Hire

ESS Lawson Portal

Before You Start Your Web Enrollment

Prior to enrolling in your benefits online, it is to your advantage to thoroughly review your enrollment materials. If you are ready to enroll, but need assistance or have questions regarding your benefits, contact On-site FBMC Service Center at 305-585-6512. For assistance with your ESS log in, contact Jackson Health System IT Customer Service Center at 305-585-6789.

Once you have the answers you need, you may begin the enrollment process.

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

- **Social Security numbers (SSN)** for all your dependents.
- **Dates of birth** for all your dependents.
- **Proof of eligibility** for all your dependents.

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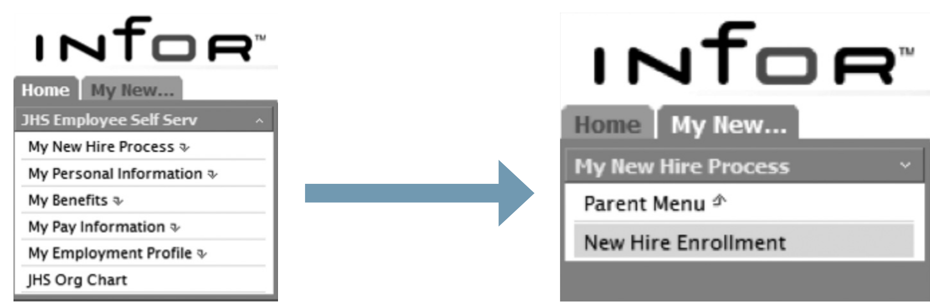
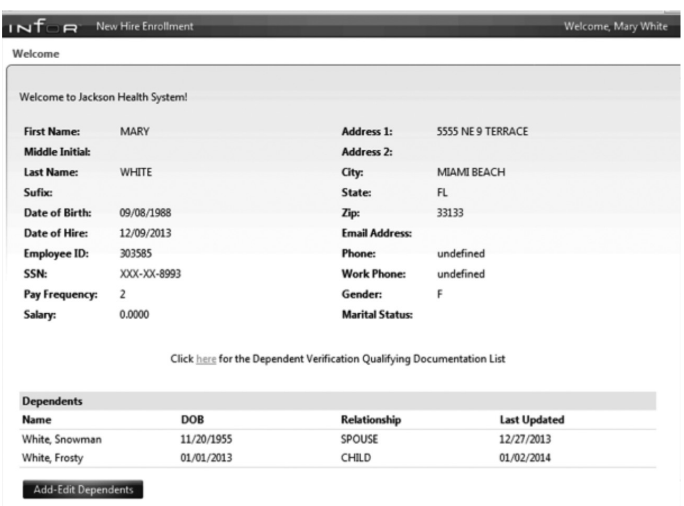
1 **Log on**

- Click "Employee Resources" tab in the Net Portal Website. Then click "Lawson Application Employee Self Service" tab.
- Type in your User name and Password to login. User name is usually your network ID that you use to log in to windows.
- Select "My New Hire Process", and then select "New Hire Enrollment."



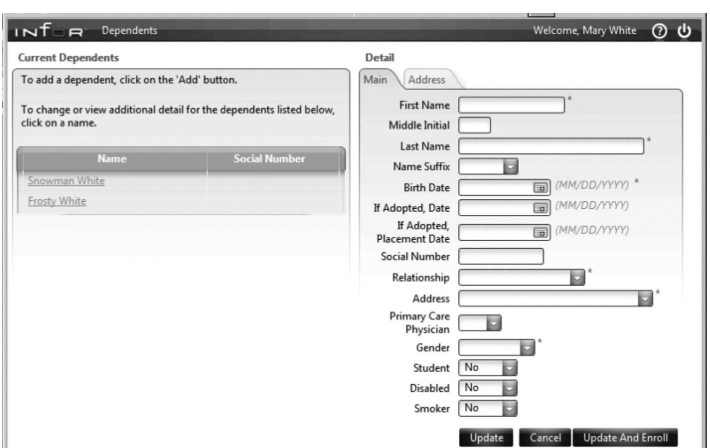
2 **Demographic & Dependents**

Verify your Demographic information and Add dependents & beneficiaries, if applicable.



How to Enroll - New Hire

ESS Lawson Portal



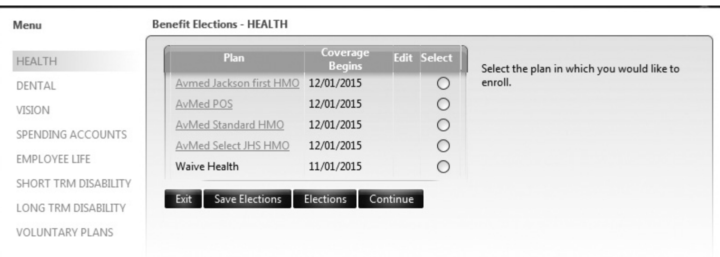
3 Dependents

Click "Update and Enroll" and then "Continue" once you finish adding dependent's profile.

4 Coverage

Choose your coverage level or election amounts for each benefit (e.g., Medical, Dental, Vision, etc.). Click "Continue" and "Add to Elections" until the enrollment is complete.

*Note: You may save your enrollment session progress and return later to complete the enrollment at any point by clicking on the "Save Elections."



5 Review Elections

Click "Review/Submit Your Election" once you complete your benefits election. You will be given a description of your benefit selection

6 Submit

Click "Submit Elections" to confirm your enrollment. Please print your Benefits Election page for your records. You will receive a confirmation email prior to your plan effective date

You may access the web enrollment 24 hours a day, 7 days a week, to make any changes to your benefits election during your new hire enrollment period (45 days). For questions, please contact On-site FBMC Service Center at 305-585-6512.

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Benefit Eligibility Information

Who is Eligible for Coverage?

JACKSON HEALTH SYSTEM EMPLOYEES: Any full-time regular employee, or a part-time employee with benefits status.

NEW HIRES: Newly-eligible employees' benefits become effective the first of the month following a 60-day waiting period from the date of hire.

NOTE: New Hires have 45 days from date of hire to complete their 2016 BeneFits Selection through Lawson Employee Self Service (ESS). If you do not enroll within the allotted time, you will be auto-assigned to Jackson First HMO, employee only coverage.

SPOUSE: Your spouse is considered your eligible dependent for as long as you are lawfully married, unless also a Jackson Health System benefits-eligible employee. If you are both employed by Jackson Health System and eligible for benefits, separate coverage must be maintained by each employee.

DOMESTIC PARTNER*: Your Domestic Partner is eligible for coverage as long as he/she:

- Is of the same or opposite sex
- Shares your permanent residence
- Has resided with you for no less than one year
- Is no less than 18 years of age and is not related to you by blood in a manner that would bar marriage under applicable state laws
- Is financially interdependent with you and has proven such interdependence by providing at least two verifying documents such as:
  - Joint mortgage or lease for a residence
  - Joint ownership of a motor vehicle
  - Joint bank or investment account, joint credit card or other evidence of joint financial responsibility
  - A will and/or life insurance policies which designates the other as primary beneficiary, beneficiary for retirement benefits, assignment of durable power of attorney or healthcare proxy.

To add a Domestic Partner, employees must register, under applicable state or municipal laws and/or provide a Certificate of Domestic Partnership (available from the Miami-Dade County Department of Regulatory and Economic Resources at **http://www.miamidade.gov/licenses/domestic-partnership.asp**) confirming the eligibility above. In addition the definition of Domestic Partner will be met as long as neither partner:

- Has signed a domestic partner affidavit or declaration with any other person within 12 months before designating each other as domestic partner.
- Is not legally married to another person, or
- Does not have any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

*NOTE: Domestic Partners or their child(ren) who do not meet the eligibility criteria will not have coverage, and any claims incurred will not be paid. All other selected paid flexible benefits will continue for the remainder of the plan year.

For mid-year family status changes, the date the partnership is registered or terminated with the MDC Department of Regulatory and Economic Resources will be the start of the 30-day eligibility period. Any resulting premium change will be effective the 1st of the month following receipt of the signed Change in Status form by the On-site FBMC Service Center, PPW L-109B.

CHILDREN: Children can include natural born children, stepchildren, adopted children, children of a domestic partner and children for whom you have been appointed legal guardian.

Your child(ren) is not considered an eligible dependent for coverage if employed by Jackson Health System and eligible for benefits.

Your dependent child(ren) is eligible for medical, dental and vision coverage through the end of the calendar year the dependent reaches age 26. Coverage applies whether your dependent is/is not married or is/is not a student.

IMPORTANT NOTE: Any parent of an employee is not eligible as a dependent for Group Insurance.

NEWBORN CHILDREN: A natural born child, adopted child, the child of your Domestic Partner, or a child for whom you have been appointed legal guardian who is born or becomes eligible while a policy is in effect will be covered from date of birth/event. However, coverage is not automatic. You must request a Change in Status form within 30 days of the event to add them to your benefits.

DISABLED CHILDREN: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. However, if coverage is terminated, it cannot be reinstated even during Open Enrollment. Proof of disability (Social Security documentation) must be provided to the On-site FBMC Service Center, PPW L-109B.

GRANDCHILDREN: Coverage of a newborn child of a covered dependent of the covered employee (other than the spouse of a covered employee) shall terminate 18 months after the birth of a newborn child. However, if the parent becomes ineligible during the grandchild's 18 months eligibility period, coverage for both the parent and the child will terminate.

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 up 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.

NOTE: The extension of coverage from age 26 up through 30 does not apply to any other benefits. 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.

Benefit Eligibility Information

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.

Employees on Leave

Jackson Health System's policy is that you automatically use any accrued vacation/personal and sick/extended illness leave. However, if you purchase either of the Disability Plans and you wish to file an insurance claim you must be disabled for more than 14 calendar days (Short-Term) or 180 calendar days (Long-Term) to make a claim on either Disability Plan.

If you go on unpaid leave, you must contact the On-site FBMC Service Center at 305-585-6512 regarding your benefits. Your rights concerning your health benefits while on unpaid leave may be affected by the Family and Medical Leave Act.

FSA Eligibility

Your Health Care Flexible Spending Account (FSA) may be used to pay for eligible expenses incurred by you, your spouse, your qualifying child or your qualifying relative. You may use your Dependent Care Flexible Spending Account (FSA) to pay for eligible dependent child(ren) under the age of 13 or adult day care expenses for qualifying individuals.

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

How does termination or leave affect my benefits?

During the plan year, except as otherwise provided by law and in accordance with your employer's plan(s), terminated employees are covered through the last day of the pay period in which employment ends, unless you decide to extend coverage under COBRA or until coverage for the plan year expires (December 31, 2016). You can continue certain benefits within 60 days of your termination of employment by contacting:

PayFlex at 800-284-4885 to apply for continuation, on an after-tax basis, of your Health Care FSA. Specific guidelines about your employer's termination and leave policies can be obtained from your employer. In addition, the Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact the health office for further information.

Short-Term Disability Income Protection and the Dependent Care FSA are not convertible. Please see pages 42-43 for further information about your disability plan.

NOTE: Your employer's Health Care FSA Plan is not subject to COBRA continuation beyond the end of the plan year in which a COBRA qualifying event occurs.

You are eligible to continue coverage under the Retiree Group if you retire from Jackson Health System/Public Health Trust provided you transition as an active employee into retirement. You will have 30 days from your separation date to make or change your election.

How does retirement affect my benefits?

Coverage continuation is not automatic. Your employee group coverage is cancelled the last day of the pay period in which the separation date falls and for which the employee experiences a regular insurance premium deduction or made direct payments to Jackson Health System (if on an unpaid leave of absence).

To continue your medical, dental and basic life insurance coverage, complete the correct retiree enrollment form (either Over or Under 65, based on eligibility) and submit it within 30 days of your separation date. Coverage for your eligible dependent(s) may be continued under the Retiree Group, but only if the dependent was enrolled immediately prior to your retirement date. To assure a smooth transition, especially if you have scheduled ongoing treatment or need prescriptions filled, submit the enrollment form and initial premium within 10 days of your separation date. Once the initial retiree premium is received, medical, dental, and/or life insurance (if elected) become effective retroactive to the date your coverage as an active employee expired (without a gap), assuming premiums were paid through that date. Your enrollment form must be received by the On-site FBMC Service Center no later than 30 days following your separation date, otherwise you forfeit Retiree Group coverage. If the Retiree Group election period lapses, you may still exercise your rights under COBRA; please refer to the COBRA section in this handbook.

Coverage under the Retiree Group will not be activated until the first retiree premium is received. **The insurance carriers will be notified to reinstate your coverage under the Retiree Group upon receipt of your initial premium payment**.

If you do not take a distribution and decide to defer your retirement, you will not be considered retired and may not be entitled to continue your Jackson Health System-sponsored health insurance coverage.

Benefit Eligibility Information

Domestic Partner Eligibility Documentation Requirements

Domestic Partners (DP)

Jackson Health System extends health insurance eligibility and other benefits to domestic partners (DP) of Jackson Health System employees. This applies to both same sex and common law relationships. Benefit plans for an employee's spouse and dependent children (medical, dental, vision, and voluntary benefits plan are extended to include domestic partners and their dependent children. Eligibility does not extend to include expense reimbursement for healthcare or dependent care spending accounts for DP's and their children.

Imputed Income

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 adult children, a DP and/or dependents of a DP that do not otherwise meet the definition of dependent under IRS regulations. Where such coverage is paid by pre-tax contribution, Jackson Health System must include the fair market value of the coverage in the employee's income, referred to as "imputed income" and this imputed income will be taxed accordingly.

SPECIAL NOTE: Under the Affordable Care Act: an employee's child may be covered through the end of the calendar year the child reaches age 26 on a tax-free basis; thereafter coverage becomes taxable if continued by the plan. Please consult with a financial planner or tax consultant to see how that impacts your particular situation.

Premiums

According to current IRS regulations, insurance premiums for domestic partners and/or DP's child(ren) must be deducted on a post-tax basis and subject to imputed income tax.

The IRS rules prohibit changing premiums mid-year from pre-tax to post-tax (or vice-versa). For example: An employee is enrolled in "Employee + Child(ren)" to cover his/her own child(ren), then acquires the child of DP during the year. The dependent child premium now becomes post-tax, by addition of the DP's child. Since IRS rules prohibit changing premiums mid-year from pre-tax to post-tax (and post-tax to pre-tax), the employee must wait until the next open enrollment to add the DP's child.

Dissolution of Domestic Partnership

Domestic partners and their dependents must be removed from Jackson Health System insurance plans upon termination of the domestic partnership. Group benefits terminate effective the date of the domestic partnership termination certificate is issued. The certificate issued by the MDC Department of Regulatory & Economic Resources declaring the termination of the domestic partnership must be presented to the FBMC Service Center Office within 30 days of issuance, along with the Change in Status form canceling the DP and dependents. Premium changes, if any, will be effective the 1st day of the pay period following receipt of the Change in Status form by the On-site FBMC Service Center Office.

NOTE: Under the domestic partnership benefits ordinance, any employee who obtains or attempts to obtain benefits fraudulently under this provision (including continuing insurance coverage for ineligible individuals after the dissolution of a domestic partnership) shall be subject to discipline, up to and including termination.

Domestic Partner Continuation of Coverage Notification

Domestic partners and their dependents are not eligible for coverage continuation under COBRA law. However, if the insured DP's dependents experience a qualifying event due to the employee's termination of employment or reduction of hours, continuation of group health, dental and/or vision coverage for up to a period of 18 months will be allowed, providing that premiums are paid on a timely basis. Events such as death of the employee, the employee's entitlement to Medicare, dissolution of the domestic partnership registered with Miami-Dade County, will qualify for continuation of group medical, dental and vision coverage for up to a period of 36 months, providing that timely premiums are paid.

It is the responsibility of the employee or DP to notify the On-site FBMC Service Center Office in writing within 30 days of the loss of eligibility and to apply for continuation of benefits. Supporting documentation is required.

Special Enrollment Rights Pertaining to Medical Benefits

You may decline medical insurance coverage for yourself and your dependents (including your spouse) because of other health insurance coverage. You may in the future be able to enroll yourself and your dependent(s) in your employer's plan provided that you follow directions outlined in the Changing Your Coverage Section on page 19.

Dependent Eligibility Verification

2016 Dependent Eligibility Verification

In an effort to continue providing optimal benefits at the lowest possible cost to you, we are conducting a Dependent Eligibility Verification for newly added dependents for the 2016 Plan Year. Confirming that only eligible dependents are covered under our health plan will help ensure you receive the lowest possible premium.

FBMC Benefits Management has been authorized to obtain documentation regarding your enrolled dependents. Please provide the required documentation for all dependents you would like to cover, through any Jackson Health System-sponsored health insurance benefit plan. **Failure to provide verification documentation for your dependents will result in the inability to enroll them in coverage.**

All documents MUST be submitted no later than **the last day of open enrollment** (December 2, 2015) in order to begin coverage for your dependents. Refer to page 16 for a detailed list of documents required to validate each of your dependents.

You may provide your documents during open enrollment at the On-site FBMC Service Center on the main campus in Park Plaza West room L-109B or fax it to 305-355-2324.

Proof of eligibility/verification and Social Security Numbers must be provided. Official documents of birth and/or marriage from anywhere in the United States may be obtained through **www.vitalchek.com** or by calling **800-255-2414** (some fees may apply).

Protecting you and your dependent's personal information is a priority to Jackson Health System and FBMC. All documents provided during the dependent verification audit are securely stored and protected through physical, electronic and procedural safeguards.

ALL DOCUMENTATION MUST BE SUBMITTED NO LATER THAN DECEMBER 2, 2015, IN ORDER TO BEGIN COVERAGE FOR YOUR DEPENDENTS.

Please Note: Any employee found to be submitting false documentation for his her dependent(s) will have the dependent deemed ineligible retroactively and will be subject to disciplinary action, up to and including termination of employment.

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Dependent Eligibility Verification

Qualifying Documentation

Dependent Relationship	Documentation Required
Spouse (Married Prior to Current Calendar Year)	• Marriage License (issued by county, state, federal, country); or • 2014 IRS Tax Return
Domestic Partner	• Certificate of Domestic Partnership
Birth Child (Up to end of calendar year reaches age 26) (Unmarried Age 26 – 30)	• Birth Certificate (issued by county, state, federal, country) or 2014 IRS Tax Return • All of the above plus: Current Student (Current Course Schedule) or Proof of Residency in the employee's home (Driver's License) AND Notarized Adult Child Affidavit
Domestic Partner's Dependent Child(ren) – Domestic Partner must be enrolled (Up to end of calendar year reaches age 26) (Unmarried Age 26 – 30)	• Birth Certificate (issued by county, state, federal, country) • Same as above plus: Current Student (Current Course Schedule) or Proof of Residency in the employee's home (Driver's License) AND Notarized Adult Child Affidavit
Stepchild(ren) (Up to end of calendar year reaches age 26) (Unmarried Age 26 – 30)	• Birth Certificate (issued by county, state, federal, country) AND Marriage License (issued by county, state, federal, country) • All of the above plus: Current Student (Current Course Schedule) or Proof of Residency in the employee's home (Driver's License) AND Notarized Adult Child Affidavit
Adopted Child(ren) (Up to end of calendar year reaches age 26) (Unmarried Age 26 – 30)	• Court Documents naming employee as parent • All of the above plus: Current Student (Current Course Schedule) or Proof of Residency in the employee's home (Driver's License) AND Notarized Adult Child Affidavit
Disabled Adult Child	• Birth Certificate (issued by county, state, federal, country) AND Social Security Disability documents determining disability. ***Please Note:** Medical Company (AvMed) may request additional documentation.
Grandchild(ren) (Birth up to 18 months) (Over 18 months old)	• Birth Certificate of grandchild AND Birth Certificate of dependent birth parent who is an eligible covered dependent residing with the employee • Legal Custody or Guardianship
Legal Guardianship/Custody (Up to end of calendar year reaches age 26) (Unmarried age 26 – 30)	• Court Order naming employee as legal guardian/custodian (Affidavit is not acceptable) If spouse (not employee) is guardian/custodian, verify marriage license AND Birth Certificate • All of the above plus: Current Student (Current Course Schedule) or Proof of Residency in the employee's home (Driver's License) AND Notarized Adult Child Affidavit

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Dependent Eligibility Verification

Dependent Information

Dependent Eligibility Documentation

RETURN IN PERSON TO:
On-site FBMC Service Center
Jackson Main Campus
1611 NW 12th Ave.
Park Plaza West L-109B
or
Fax to: 305-355-2324

Important Information

You will need:

- Proof of eligibility for all listed dependents.
- Required documentation must be provided prior to December 2, 2015. Failure to do so will result in loss of coverage for your dependents or inability to enroll them in coverage.
- **Print, complete and include this form with the required documentation.**
- If you are going to add an Adult Child, you must present the required documentation along with a completed Adult Child Affidavit.
- If the dependent eligibility/verification data presented is not valid, the dependent will be marked through and you will need to resubmit valid documentation. Please initial these that are marked through to verify that you understand that additional documentation is required.

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SOCIAL SECURITY NUMBER ____________________ EMPLOYEE NAME ____________________

DEPENDENT NAME (print clearly) Last Name First Name MI	**BIRTH DATE**	**SOCIAL SECURITY #**	**RELATIONSHIP**	**GENDER**	**DOCUMENT PROOF INCLUDED** (birth certificate, marriage certificate, etc.)

Employee Signature____________________ Date____________________

Please Note: Any employee found to be submitting false documentation for his/her dependent(s) will have the dependent deemed ineligible retroactively and will be subject to disciplinary action, up to and including termination of employment.

FBMC/JHS_DEPENDENTVERIFY/1015

Adult Child Eligibility Affidavit

AFFIDAVIT OF EXTENDED DEPENDENT ELIGIBILITY
JHS (AGE 26– 30)
Florida Statute 627.6562

EMPLOYEE INFORMATION

Name: ______________________________________ AvMed Member ID #:__________________________

Address: _____________________________________City:____________________State/Zip: __________

Phone: ______________________ Email: _____________________________ Date of Birth: ____________

DEPENDENT INFORMATION

____

Dependent's Last Name First Name Date of Birth Sex AvMed Member ID #

By checking each item below, I hereby certify that the dependent identified above:

- ☐ Is my child; and
- ☐ is unmarried; and
- ☐ has no dependents (children) of his or her own; and
- ☐ is a resident of the State of Florida or a full-time or part-time student; and
- ☐ does not have other insurance coverage and is not entitled to Medicare; and
- ☐ since the end of the calendar year my child turned 25, he/she has been continuously covered by my plan, or other creditable coverage without a gap of more than 63 days

Statement of Non-Eligible Dependent:

- ☐ I certify that the dependent identified above is NOT an eligible dependent under the requirements of the Florida Statute (FSS 627.6562). (Your dependent will be cancelled retroactive to January 1, and no further documentation is required.)

I recognize that this affidavit is a legally binding document and accept full responsibility for notifying **JHS** and/or **AvMed** immediately if there are any changes pertaining to this child's status as my dependent during the plan year. I have attached supporting documentation in the form of one of the following: ***proof of FL residency or school registration** and agree to provide the documents listed or any other documents, when requested by **JHS** or its insurers at any time as long as the child is enrolled as my dependent. I have provided this information for use by AvMed for the purpose of determining eligibility and participation in **JHS** Group Health Plan, and retroactive denial of claims previously processed. I hereby certify, under penalty of perjury, that the information provided by me is true and correct to the best of my knowledge. **ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

The documents can be faxed to the On Site Representatives at 305-372-6097 or 305-372-6083, contact phone 305-375-5306.

Employee Signature: ____**Date**______________

SWORN TO and subscribed before me this ________________day of ______________________________, 20__________,
By ____
Who is personally known to me ______ who produced a current driver's license ________ who produced ______________________ as identification.

Notary Public Signature________________________________ Notary Public Name: ________________________________
My commission expires____________________

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Changing Your Coverage

Changing your Benefits during the Plan Year

Within **30 days** of a qualifying event, you must submit a Change in Status (CIS)/Election Form and supporting documentation (must be original or government certified) to On-site FBMC Service Center, PPW L-109B. Upon the approval of your election change request, your existing benefit elections will 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. For more information, refer to the Annual Enrollment Appeals paragraph on Page 20. Visit **www.myFBMC.com** for information on rules governing periods of coverage and IRS Special Consistency Rules.

Changes in Status:	
Marital Status[1]	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in Florida).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event. Payroll changes to add a newborn are processed in accordance with Florida Statute 641.31(9). If the CIS form is received by On-site FBMC Service Center within the 31 days from birth, the premium is waived for the first 31 days. If the CIS form is received after the first 31 day, but within 60 days of the qualifying event. The new premium will be charged retroactive to the qualifying event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan which includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, student, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan which includes moving out of an HMO service area.
Some Other Permitted Changes:	
Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • The other employer's plan has a different period of coverage (usually a plan year) or • Other employer's plan permits mid-plan year election changes under this event.
Judgment/Decree/Order†	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid†	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change. Eligibility for Florida KidCare is not considered an eligible changes in status event. However, loss of Florida KidCare coverage is considered a valid change in status event.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Healthcare FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

* Does not apply to a Health Care FSA plan.
† Does not apply to a Dependent Care FSA plan.
1 Domestic Partners.

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Flexible Benefits Plan

Jackson Health System has implemented the Flexible Benefits Plan to help you reduce your taxes and increase your spendable income. You reduce your benefit costs when you pay certain benefits and expenses through the Plan.

How does the Flexible Benefits Plan work?

1. You select the benefits you and your family need — Group Medical, Group Dental and Group Vision, Health Care and/or Dependent Care Flexible Spending Account (FSA) and Short-Term and Long-Term Disability Income Protection. Each pay period, all tax-free premium deductions for benefits you have chosen are taken from your pay **before** federal income and Social Security taxes are calculated. This reduces your tax liability so **you pay less tax**.
2. After all tax-free premiums have been deducted, Federal Income and Social Security taxes are calculated on the remainder of your salary.
3. The amount remaining in your paycheck is your take-home pay for that pay period. Since you have paid less tax, you have more spendable income.

How much does it cost?

The administrative fee for your Flexible Benefits Plan is 75¢ per pay period for your medical, and/or dental plan premiums (if your premiums total $10 or more), Vision $0.20, and $1.66 per pay period for each Flexible Spending Account. Your overall administrative fees for the Flexible Benefits Plan will not exceed $3.35 per pay period. The tax savings you receive from participation in the Flexible Benefits Plan far outweigh the administrative fees, which are also tax free.

Annual Enrollment Appeals

Appeals are approved only in the extenuating circumstances and supporting documentation are within the Jackson Health System, insurance provider and IRS regulations governing the plan. If you have a request for a mid-plan year election change or post annual enrollment change request, you have the right to appeal the decision by sending a written request for review within 30 days of your receipt of denial to:

On-site FBMC Service Center
Jackson Memorial Hospital
1611 NW 12th Ave
Park Plaza West L-109B
Miami, FL 33136
Fax: 305-355-2324

Changes During the Year

The IRS requires your participation in the Flexible Benefits Plan to continue for the entire plan year, which is January 1 through December 31, 2016. You can change your pre-tax benefit election during the plan year ONLY if you experience a qualifying Change in Status event as defined by the IRS and in accordance with your employer's plan. The requested change must be consistent with the event. The request must be submitted to the On-site FBMC Service Center with the appropriate documentation within 30 days of the event.

If your covered dependent(s) become ineligible during the plan year, you must notify the FBMC Service Center within 30 days. Your notification must include the appropriate documentation of the ineligibility to allow for any reduction in premiums. Failure to notify the FBMC Service Center may result in excess premiums being deducted from your pay, which cannot be refunded, and no coverage will be available to your dependent(s).

How may FSA contributions affect my Federal Earned Income Tax Credit (EITC)?

Payroll contributions made through an FSA will lower your taxable income and taxes. Payroll reductions (including contributions to one or both FSAs) will reduce earned income for purposes of the Federal Earned Income Tax Credit (EITC). Depending on your income level, your EITC may either increase or decrease if you make payroll deductions through an FSA. This means that for some of you, participation in either FSA or both may provide to you an additional advantage by increasing your EITC (based on 2015 tax tables).

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Group Medical Plans

What AvMed medical plans are offered?

- Jackson First HMO
- JHS Select HMO
- Standard HMO
- Point of Service (POS)

Jackson First HMO

Plan offers no referral access to the Jackson-only network. Employee and covered dependents must reside in Miami-Dade, Broward and Palm Beach Counties. The plan provides 100% benefits for services performed at Jackson Health System facilities (except emergency care) or by any AvMed physician with admitting privileges at Jackson Health System. Members are encouraged but not required to select a primary care physician.

JHS Select HMO

Plan offers no referral access to the Select HMO Network of providers. Employee and covered dependents must reside in Miami-Dade, Broward and Palm Beach Counties. The plan provides 100% benefits for covered charges after applicable copays. Members are encouraged but not required to select a primary care physician.

Standard HMO

Plan offers no referral access to an expanded network of providers. The plan provides 100% benefits for covered charges after the applicable copayments. Members are encouraged but not required, to select a primary care physician.

Point of Service (POS)

- **In-network**
  Plan offers no referral access to an expanded network of providers. The plan provides 100% benefits for covered charges after the applicable copayments. Members are encouraged but not required, to select a primary care physician.
- **Out-of-network**
  A fee for service program that provides you the freedom to use any physician or accredited hospital of your choice outside of the network. Payments are based on Maximum Allowable Payment (MAP) charges. Providers who do not participate in the network may balance bill you for the amount which exceeds MAP. Coverage is subject to deductibles and coinsurance.

Is my group medical coverage guaranteed?

Yes. Enrollment in any of the group medical plans is guaranteed for those eligible.

How do I pay for these medical plans?

Medical plans are paid through automatic biweekly payroll deductions. Premiums are deducted from your salary on a pre-tax* basis to pay for any medical insurance premiums before Federal Income and Social Security taxes are calculated. This reduces your taxable income and increases your spendable income.

How much do the plans cost?

Premiums vary according to the plan you select. Jackson Health System will pay the cost of your personal coverage in the Jackson First and JHS Select HMO medical plans. Dependent premiums are your responsibility and will be deducted from your biweekly check.

Eligible employees will be required to pay a portion of the employee's premium for the Standard HMO and Point of Service (POS) Plans.

For more information on the medical plan premiums, please refer to page 28 of this Reference Guide.

* NOTE: Premiums are deducted from your salary on a post-tax basis for Domestic Partners and Adult Children.

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KNOW BEFORE YOU GO AND
EARN CASH REWARDS

Introducing AvMed SmartShopper; a Rewarding Path to Better Health

Prices for the exact same quality medical services, such as MRIs, CT Scans and lab tests, can vary from hundreds to thousands of dollars depending on location and often aren't published, you can use this to your advantage.

How AvMed SmartShopper works

Your doctor recommends a qualifying procedure.

Call SmartShopper and a Health Cost Adviser will provide information on cost-effective locations in your area for the service your doctor has recommended. You will need to have your member ID for verification. You can also shop online at **AvMed.VitalsSmartShopper.com**

Then, contact your doctor to schedule the service where you choose.

Please note: In order to qualify for incentives, you must contact AvMed SmartShopper AT LEAST 24 hours before the procedure.

If you choose to use a cost-effective location, as identified by AvMed SmartShopper, you will receive an incentive reward check in the mail within 60 days after your claim has been paid.

AvMed SmartShopper adds Cash Rewards to 2016 JHS Select, Standard and POS Health Plans

In 2016, Jackson Health System is offering SmartShopper, giving you a chance to earn cash rewards while saving the company on healthcare costs.

- Medical procedures or diagnostic tests can qualify you or your dependents for a $25 - $500 CASH REWARD when you shop with SmartShopper!
- We Speak Spanish.
- To access SmartShopper, go to **AvMed.VitalsSmartShopper.com** or call **1.800.824.9127** to quickly and easily shop healthcare services in your area.
- Earn CASH REWARDS when you choose a cost-effective location!

Incentive Reward Services	Reward Option 1	Reward Option 2	Reward Option 3
Bone Density Scans	$50	$25	N/A
Carpal Tunnel	$150	$75	$50
Colonoscopy	$150	$75	$50
ENT	$150	$75	$50
Hernia repair	$150	$75	$50
Knee Surgery (arthroscopic)	$150	$75	$50
Mammograms	$50	$25	N/A
MRIs	$150	$75	$50
Shoulder Surgery (arthroscopic)	$150	$75	$50
Ultrasound	$50	$25	N/A
Upper GI Endoscopy	$150	$75	$50

Visit us anytime at **AvMed.VitalsSmartShopper.com** or call **1-800-824-9127**
Monday-Thursday from 8:30 am-8 pm, Friday from 8:30 am-5 pm

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Jackson First (HMO) Chart

Visit our website at www.avmed.org/jhs

	Jackson First (HMO)
COVERAGE PLAN DESCRIPTION	HMO plan offered to Jackson Health System employees, covered dependents and retirees under age 65 who reside in Miami-Dade, Broward and Palm Beach counties. Members who enroll in the Jackson First HMO plan must receive all medical care except for emergency and urgent care services through a contracted Jackson First network provider.
DEDUCTIBLES/COPAYMENTS	COPAYMENTS No copayments and/or deductibles for primary care physician or specialist services in the network. For services performed out-of-network, the member will be responsible 100%; $25 copayment Emergency Room (waived if admitted). $25/$50 copayment Urgent Care. $15/$25/$35 prescription for 30-day supply based on formulary. $0 copayment for Generics drugs at Jackson Pharmacy. $30/$50/$70 Mail order prescriptions available for 90-day supply based on formulary.
PHYSICIANS	Access any primary care physician or specialist from the Jackson First HMO Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician.
A. IN-HOSPITAL PHYSICIAN SERVICES Surgery/Visits and Consultations Anesthesiologist	Benefits covered at 100% when received at participating hospitals (Jackson Health System) and rendered by participating physicians.
B. OUTPATIENT PHYSICIAN SERVICES PCP Office Visits Specialist Office Visitsy Preventive Services, Pediatrician Routine Physical Obstetrical/Gynecological Maternity Preventive Services Mammogram/Pap Smears	 No charge No charge No charge No charge No charge No charge No charge No charge
HOSPITALIZATION	Benefits covered at 100% at Jackson Health System.
HOSPITAL/SURGICAL REQUIREMENTS **Pre-certification of hospital confinements**	Handled by admitting physician.
DRUG & ALCOHOL TREATMENT **Inpatient** **Outpatient**	 No charge No charge
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	 No charge No charge
OTHER SERVICES Ambulance Vision	 No charge when pre-authorized or in case of emergency. Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.
PRESCRIPTION DRUGS	$15 Generic/$25 Brand/$35 Non-Preferred for 30-day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand copayment. See plan literature for other participating pharmacies. Mail order: 2x copay for 90-day supply. Generic contraceptives will be no charge. No charge for generic medications under the Jackson First Plan for employee using the Jackson Pharmacy.
DURABLE MEDICAL EQUIPMENT (DME)	$50 copayment per episode of illness. Please refer to brochure for limitations and restrictions.
OUT-OF-AREA 1) Emergency 2) Non-Emergency	 $25 copayment, waived if admitted, $25 participating urgent care, $50 non-participating urgent care, 100% thereafter. Not covered if provider is out-of-network.

Note: This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary of Benefits & Coverage (SBC). Maximum lifetime benefits is unlimited in-network.

JHS Select (HMO) Chart

Visit our website at www.avmed.org/jhs

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	JHS Select (HMO)
COVERAGE PLAN DESCRIPTION	HMO plan offered to Jackson Health System employees, covered dependents and retirees under 65 who reside in Miami-Dade, Broward and Palm Beach counties. Members who enroll in the Select Network plan must receive all medical care except for emergency and urgent care services through an AvMed contracted Jackson Health System Select Provider Network.
DEDUCTIBLES/COPAYMENTS	COPAYMENTS $15 Primary Care Physician/$30 Specialty office visit/services. 100% Hospital admission coverage - no copayment. $25 copayment Emergency Room (waived if admitted). $25/$50 copayment Urgent Care. $15/ $25/ $35 prescription for 30-day supply based on formulary. $30/$50/$70 Mail order prescription available for 90-day supply based on formulary.
PHYSICIANS	Access any primary care physician or specialist from the Select Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician.
A. IN-HOSPITAL PHYSICIAN SERVICES Surgery/Visits and Consultations Anesthesiologist	Benefits payable at 100% when received at participating AvMEd Select Jackson Health System hospitals and rendered by participating physicians.
B. OUTPATIENT PHYSICIAN SERVICES PCP Office Visits Specialist Office Visits Preventive Services Pediatrician Routine Physical Obstetrical/Gynecological Maternity Preventive Services Mammogram/Pap Smears	 $15 copayment/visit $30 copayment/visit No charge $15 copayment/visit No charge $30 copayment/visit $30 copayment/visit; subsequent visits no charge No charge
HOSPITALIZATION	Benefits payable at 100%. *Please confirm provider has hospital privileges at a Select Jackson Health System participating hospital.
HOSPITAL/SURGICAL REQUIREMENTS Pre-certification of hospital confinements	Handled by admitting physician.
DRUG & ALCOHOL TREATMENT Inpatient Outpatient	 No charge $15 per visit
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	 No charge $15 per visit
OTHER SERVICES Ambulance Vision	 No charge when pre-authorized or in case of emergency. Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after $15 copayment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.
PRESCRIPTION DRUGS	$15 Generic/$25 Brand/$35 Non-Preferred for 30-day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand copayment. See plan literature for other participating pharmacies. Mail order: 2x copay for 90-day supply. Generic contraceptives will be no charge.
DURABLE MEDICAL EQUIPMENT (DME)	$50 copayment per episode of illness. Please refer to brochure for limitations and restrictions.
OUT-OF-AREA 1) Emergency 2) Non-Emergency	 $25 copayment, waived if admitted, $25 participating urgent care, $50 non-participating urgent care, 100% thereafter. Not covered if provider is out-of-network.

Note: This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary of Benefits & Coverage (SBC). Maximum lifetime benefits is unlimited in-network.

Standard (HMO) Chart

Visit our website at www.avmed.org/jhs

	Standard (HMO)
COVERAGE PLAN DESCRIPTION	AvMed offers Jackson Health System employees, covered dependents and retirees under age 65 "no referral" access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges, after applicable copayments. Members are encouraged, but not required, to select a primary care physician. AvMed offers Member Service, Nurse on Call hot lines, discounted health and wellness programs, discounted Mail Order Prescriptions and more.
DEDUCTIBLES/COPAYMENTS	COPAYMENTS $15 Primary Care Physician/$30 Specialty office visit/services. 100% Hospital admission coverage - no copayment. $25 copayment Emergency Room (waived if admitted). $25/$50 copayment Urgent Care. $15/ $25/ $35 prescription for 30-day supply based on formulary. $30/$50/$70 Mail order prescription available for 90-day supply based on formulary
PHYSICIANS	Access any primary care physician or specialist from the Elite Access Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician.
A. IN-HOSPITAL PHYSICIAN SERVICES Surgery/Visits and Consultations Anesthesiologist	Benefits payable at 100% when received at participating hospitals and rendered by participating physicians.
B. OUTPATIENT PHYSICIAN SERVICES PCP Office Visits Specialist Office Visits Preventive Services Pediatrician Routine Physical Obstetrical/Gynecological Maternity Preventive Services Mammogram/Pap Smears	 $15 copayment/visit $30 copayment/visit No charge $15 copayment/visit No charge $30 copayment/visit $30 copayment/visit; subsequent visits no charge No charge
HOSPITALIZATION	Benefits payable at 100%.
HOSPITAL/SURGICAL REQUIREMENTS Pre-certification of hospital confinements	Handled by admitting physician.
DRUG & ALCOHOL TREATMENT Inpatient Outpatient	 No charge $15 per visit
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	 No charge $15 per visit
OTHER SERVICES Ambulance Vision	 No charge when pre-authorized or in case of emergency. Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after $15 copayment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.
PRESCRIPTION DRUGS	$15 Generic/$25 Brand/$35 Non-Preferred for 30 day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand copayment. See plan literature for other participating pharmacies. Mail order: 2x copay for 90-day supply. Generic contraceptives will be no charge.
DURABLE MEDICAL EQUIPMENT (DME)	$50 copayment per episode of illness. Please refer to brochure for limitations and restrictions.
OUT-OF-AREA 1) Emergency 2) Non-Emergency	 $25 copayment, waived if admitted, $25 participating urgent care, $50 non-participating urgent care, 100% thereafter. Not covered if provider is out-of-network.

* This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary of Benefits & Coverage (SBC). Maximum lifetime benefits is unlimited in-network.

Point of Service (POS) Chart

Visit our website at www.avmed.org/jhs

This plan allows you to use both in and out of network providers. For purposes of this summary, the two will be discussed separately.

	In-Network
COVERAGE PLAN DESCRIPTION	AvMed offers Jackson Health System employees, covered dependents and retirees under age 65 "no referral" access to an expanded network of providers in the state of Florida. In addition, AvMed offers a nationwide network for those residing outside of the service area. The plan provides 100% benefits for covered charges, after applicable copayments. Members are encouraged, but not required, to select a primary care physician. AvMed offers Member Service, Nurse on Call hot lines, discounted health and wellness programs, discounted Mail Order Prescriptions and more.
DEDUCTIBLES/COPAYMENTS	COPAYMENTS $15 Primary Care Physician/$30 Specialty office visit/services. 100% Hospital admission coverage - no copayment. $50 copayment Emergency Room (waived if admitted). $25/$50 copayment Urgent Care. $15/ $25/ $35 prescription for 30-day supply based on formulary. $30/$50/$70 Mail order prescription available for 90-day supply based on formulary.
PHYSICIANS	Access any primary care physician or specialist from the Elite Access Network. Members are encouraged but not required to select a primary care physician. Covered family members may choose their own primary care physician.
A. IN-HOSPITAL PHYSICIAN SERVICES Surgery/Visits and Consultations Anesthesiologist	Benefits payable at 100% when received at participating hospitals and rendered by participating physicians.
B. OUTPATIENT PHYSICIAN SERVICES PCP Office Visits Specialist Office Visitsy Preventive Services, Pediatrician Routine Physical Obstetrical/Gynecological Maternity Preventive Services Mammogram/Pap Smears	 $15 copayment /visit $30 copayment /visit No charge $15 copayment /visit No charge $30 copayment /visit $30 copayment /visit; subsequent visits no charge No charge.
HOSPITALIZATION	Benefits payable at 100% at affiliated hospitals when admitted with PCP authorization.
HOSPITAL/SURGICAL REQUIREMENTS Pre-certification of hospital confinements	Handled by admitting physician.
DRUG & ALCOHOL TREATMENT Inpatient Outpatient	No charge $15 per visit
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	No charge $15 per visit
OTHER SERVICES Ambulance Vision	No charge when pre-authorized or in case of emergency. Coverage provided for diseases of the eye and/or injuries to the eye. Eye exams for children under age 18 covered 100%, after $15 copayment. AvMed offers adult vision discounts through a preferred network of providers listed in the Provider Directory. Eye exams, glasses, contact lenses not covered.
PRESCRIPTION DRUGS	$15 Generic/$25 Brand/$35 Non-Preferred for 30 day supply, including prescription contraceptives, at participating pharmacies nationwide. If member/physician select Brand when Generic is available, member pays difference in cost plus Brand copayment. See plan literature for other participating pharmacies. Mail order: 2x copay for 90-day supply. Generic contraceptives will be no charge.
DURABLE MEDICAL EQUIPMENT (DME)	DME and Orthotic covered at 100%. External prosthetic appliance - No charge after $200 deductible per contract year.
OUT-OF-AREA 1) Emergency 2) Non-Emergency	 $50 copayment, waived if admitted/100% thereafter. Out-of-network applies: 70% of maximum allowable payment (MAP) after deductible is met.

Note: This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary of Benefits & Coverage (SBC). Maximum lifetime benefits is unlimited in-network.

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Point of Service (POS) Chart

Visit our website at www.avmed.org/jhs

This plan allows you to use both in and out of network providers. For purposes of this summary, the two will be discussed separately.

	Out-Of-Network
COVERAGE PLAN DESCRIPTION	A fee for service program that provides you the freedom to use any physician or accredited hospital of your choice outside of the network. Payments are based on maximum allowable payment (MAP) charges. Providers who do not participate in the network may balance bill you for the amount which exceeds MAP. Coverage is subject to deductibles and coinsurance.
DEDUCTIBLES/COPAYMENTS	$200 per individual; $500 per family, $50 Emergency Room copayment (waived if admitted) Same in-network prescription benefits apply if participating, pharmacy is used. Benefits payable at 70% of coinsurance after deductible is met.
PHYSICIANS	Choose any licensed physician; covered charges payable at MAP after deductible is met.
A. IN-HOSPITAL PHYSICIAN SERVICES Surgery/Visits and Consultations Anesthesiologist	30% coinsurance after deductible.
B. OUTPATIENT PHYSICIAN SERVICES Office Visits for Illness Office Visits for Injury Diagnostic X-Rays, Lab Tests, X-Ray Treatments Pediatrician 1) Medically Necessary 2) Preventive Care Birth through age 15 (Well-Baby) Routine Preventive Care for children and adults Obstetrical/Gynecological	 Plan pays 70% coinsurance, after deductible is met. Plan pays 70% coinsurance, after deductible is met. Plan pays 70% coinsurance, after deductible is met. 1) 70% of MAP, after deductible is met. 2) Plan pays 70% of MAP, after deductible is met. Plan pays 70% coinsurance, after deductible is met. Plan pays 70% coinsurance, after deductible is met.
HOSPITALIZATION	Plan pays 70% coinsurance, after deductible is met. Plan must be notified within 24 hours after date of admission.
HOSPITAL/SURGICAL REQUIREMENTS Pre-certification of hospital confinements	Pre-certification is required.
DRUG & ALCOHOL TREATMENT Inpatient Outpatient	 Plan pays 70% coinsurance, after deductible is met.* Plan pays 70% coinsurance, after deductible is met.*
MENTAL & NERVOUS DISORDERS Inpatient Outpatient	 Plan pays 70% coinsurance, after deductible is met..* Plan pays 70% coinsurance, after deductible is met.*
OTHER SERVICES Ambulance Vision	 Plan pays 70% coinsurance, after deductible is met. Coverage provided for diseases and/or injuries of the eye subject to deductible/coinsurance.
PRESCRIPTION DRUGS	$15 Generic Drug/$25 Preferred Brand/$35 Non-Preferred Brand up to a 30-day supply at any participating network pharmacy. 90 day supply at Mail Order available fro 2x copayment. Generic contraceptives no charge. See plan literature or visit website for more information.
DURABLE MEDICAL EQUIPMENT (DME)	Plan pays 70% of MAP after deductible for DME and orthotics. External prosthetic appliance not covered out of network.
OUT-OF-AREA 1) Emergency 2) Non-Emergency	 100% after $50 copayment, waived if admitted (worldwide). Plan pays 70% coinsurance, after deductible is met.

*This comparison is not a contract. For specific information on benefits, exclusions and limitations, please see the Summary of Benefits & Coverage (SBC). Maximum lifetime benefits is unlimited in-network and out-of-network. Non-participating out-of-network providers have not agreed to accept AvMed's MAP as payment in full for covered services. Therefore, if a nonparticipating provider is used the member is also responsible for the difference between MAP and the non-participating provider's actual charges.

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Medical Biweekly Rates

The previous Medical Chart pages are intended to highlight the plans available and do not constitute a contract. Precise benefits will be governed by the contracts and not by these charts. Please review details of any modification in benefits in the plan literature, or seek clarification through the health plan.

AvMed is on an ongoing basis renegotiating contracts with affiliated providers (doctors, hospitals etc.). As a result, providers may be added to or deleted from the participating provider listing of the various plans during the plan year. We highly recommend verifying the provider of your preference still participates in the program prior to seeking use of their services.

AVMED Employee, Spouse, Domestic Partner & Child(ren)

Jackson First HMO PLAN	EMPLOYEE CONTRIBUTION
Employee	$0.00
Employee + Child(ren)†	$105.00
Employee + Spouse/DP	$120.00
Family†	$160.00
JHS Select HMO PLAN	**EMPLOYEE CONTRIBUTION**
Employee	$0.00
Employee + Child(ren)†	$140.93
Employee + Spouse/DP	$165.99
Family†	$236.11
Standard HMO PLAN	**EMPLOYEE CONTRIBUTION**
Employee	$50.00
Employee + Child(ren)†	$180.17
Employee + Spouse/DP	$208.35
Family†	$287.77
POS PLAN	**EMPLOYEE CONTRIBUTION**
Employee	$75.00
Employee + Child(ren)†	$285.86
Employee + Spouse/DP	$344.54
Family†	$595.59

† Option also applies to Adult Children (AC) between 26 through 30 years of age, children of Domestic Partners and/or eligible dependents.

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Group Dental Plans

You may choose from the following dental plans:

- Guardian DentalGuard PPO Preferred
- Guardian DHMO

Employees can select coverage in a PPO or a prepaid dental program. Choices include standard or enriched dental PPO plans offered by Guardian Dental, and standard or enriched prepaid dental plans offered by Guardian. Employees with dental coverage may also choose a dentist not participating in their program and will receive applicable benefits.

Prepaid dental plans provide preventive, diagnostic, and many other services free of charge to members. Other services, including major procedures such as crowns, have fixed copayments established by the plan. Claim forms are not required. Members must use one of the plan's participating dentists to receive benefits. There is no annual dollar maximum under the prepaid dental programs.

With Guardian PPO Plan you can select between two plan options: the Standard or Enriched dental plans.

When you're covered under either of the Guardian plans, you and your family members:

- Can visit any licensed dentist, including the dental specialist of your choice.
- Can visit different dentists.
- May change dentists any time without notifying guardian Dental.
- Can receive dental care anywhere in the world (out-of-network benefits apply outside the U.S.).
- Will never have to pay more than the patient's share at the time of treatment or file claims forms when you visit a Guardian Dental PPO or DentalGuard Preferred network dentist.

Under either of the Guardian **Dental Plans (Standard or Enriched), you have access to the** Guardian **DentalGuard Preferred network.**

The Guardian network provides access to the largest network of its kind nationwide. Guardian Dental PPO network dentists agree to accept the Guardian Dental PPO contracted fees as full payment when treating PPO patients. This means your out-of-pocket costs are usually lower than when you visit a non-Guardian Dental dentist.

Benefits are payable at various coinsurance levels, depending on the type of services being performed. A dental deductible is applied for services other than preventive and diagnostic. The standard plan has an annual dollar maximum of $1,000. The enriched plan includes an orthodontia benefit not provided under the standard plan. The annual dollar maximum is $1,500 under the enriched plan, and $1,000 lifetime max for orthodontia.

Note: Non-Guardian Dental dentists will be reimbursed based on the PPO Fee Schedule instead of the program allowance. As a result members visiting a non-Guardian Dental dentist may see a change in out-of-pocket costs.

When you enroll in the Guardian Managed DentalGuard DHMO, you and your covered family members can access the dental care you need through Guardian's network of quality dentists.

Each covered family member can choose their own general dentist from the network. You will need a referral from your general dentist to see any specialist, such as an endodontist, oral surgeon, pediatric dentist or orthodontist.

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Group Dental Plans

DHMO Features and Benefits

- No deductible. No dollar maximums. No claim forms to file. No waiting periods for coverage.
- Reduced rates on all covered services.
- Coverage for most preventive services at no charge.
- The first two cleanings are in any 12 month period are at no charge. Each additional cleaning will incur a charge.
- Discounts on complex procedures.
- Specialty care provided at the same fee as general care with an approved referral.
- Orthodontic benefits for adults and children.
- Teeth whitening covered.

Is coverage guaranteed?

Yes. Enrollment in any of the group dental plans is guaranteed for eligible employees and their dependents.

How much do the plans cost?

Premiums vary according to the plan you select. Jackson Health System will pay the cost of your personal coverage under any of these standard dental plans, while you pay the difference for participation in all of the enriched plans. Premiums for dependent coverage are your responsibility and will be deducted from your biweekly check.

For more information on your benefits, please refer to the Dental Charts on the following pages.

May I cover dependents for dental only?

The member must be enrolled in the Dental plan in order to enroll any dependents. If dependents are enrolled, they must be enrolled in the same plan as the member.

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Guardian DentalGuard PPO Dental Plan

CHOICE OF DENTIST	You'll likely save most with a dentist who participates in the Guardian DentalGuard PPO network, and you'll likely save least with a non-participating dentist. Services provided by out-of-network providers will be reimbursed at the 90th percentile of usual and customary charges. Percentages below are based on Guardian's applicable allowances and not necessarily the dentist's actual charge.	
MAXIMUM BENEFIT/DEDUCTIBLE	$1,000 per year per person $50 deductible per year per person; $150 family maximum	$1,500 per year per person $50 deductible per year per person; $150 family maximum
TYPE I	**STANDARD**	**ENRICHED**
0150 Comprehensive Oral Evaluation - New or Established	Plan Pays (No deductible) 100%	Plan Pays (No deductible) 100%
0120 Periodic Oral Exam	100%	100%
X-Rays	100%	100%
1110/20 Prophylaxis	100% (Twice per calendar year)	100% (Twice per calendar year)
1203 Fluoride Treatment (children up to the age 19)	100%, 2x per year	100%, 2x per year
1351 Sealant- per tooth	100% to age 16	100% to age 16
1510 Space Maintainers	100% to age 19	100% to age 19
TYPE II	**STANDARD**	**ENRICHED**
Fillings: (silver and white)		
2330 one surface	100% (In PPO Network) / 75% (Out of PPO Network	100% (In PPO Network) / 75% (Out of PPO Network
2331 two surfaces	100% (In PPO Network) / 75% (Out of PPO Network	100% (In PPO Network) / 75% (Out of PPO Network
2332 three surfaces	100% (In PPO Network) / 75% (Out of PPO Network	100% (In PPO Network) / 75% (Out of PPO Network
2334 four or more surfaces	100% (In PPO Network) / 75% (Out of PPO Network	100% (In PPO Network) / 75% (Out of PPO Network
Restorative Services:		
2930 Prefabricated stainless steel primary tooth	75% for children to age 16	75% for children to age 16
Root canals:		
3310 Anterior	75%	75%
3320 Bicuspid	75%	75%
3330 Molar	75%	75%
3410 Apicoectomy	75%	75%
Extractions:		
7111 single tooth	75%	75%
7140 Extraction, erupted tooth or exposed tooth	75%	75%
7210 surgical extraction of erupted tooth	75%	75%
Periodontics: (gum treatment)		
4341 Periodontal scaling & root planing- per quadrant	75%	75%
4210 Gingivectomy/gingivoplasty - per quadrant	75%	75%
4910 Periodontal maintenance procedures	75%	75%
TYPE III	**STANDARD**	**ENRICHED**
Crown & Bridge:		
2791 Crown full cast predominately base metal	50%	50%
2751 Crown Porcelain fused to base metal	50%	50%
Pontics:		
6210 Full cast	50%	50%
6240 Porcelain fused to metal	50%	50%
Prosthodontics (Dentures):		
5110 Complete upper	50%	50%
5120 Complete lower	50%	50%
5213/14 Partial upper or lower - cast metal base	50%	50%
ORTHODONTIA		
Consultation	Not Covered	Adult & Child covered at 50% after a one time deductible of $50 per person. $1,000 lifetime maximum benefit
Evaluation	Not Covered	
Records	Not Covered	
Children-Normal Class II	Not Covered	
Adult - Normal Class II	Not Covered	
8750 Retention	Not Covered	
VISION		
Examination	Not Covered	Not Covered
SINGLE VISION LENSES	Not Covered	Not Covered
Bifocal Lenses	Not Covered	Not Covered
Trifocal Lenses	Not Covered	Not Covered
Contact Lenses - Non-Elective	Not Covered	Not Covered
Contact Lenses - Elective	Not Covered	Not Covered
Frames	Not Covered	Not Covered

*All Type II and III charges subject to annual deductible.

Guardian DHMO Dental Plan

	STANDARD (U50)	ENRICHED (U60)
CHOICE OF DENTIST	Limited to Participating Dentists in Private Practice	
MAXIMUM BENEFIT/DEDUCTIBLE	No Maximum, No Deductible	
TYPE I	**STANDARD**	**ENRICHED**
	You Pay	You Pay
1110/20 Prophylaxis	No Charge	No Charge
0120 Periodic Oral Exam	No Charge	No Charge
0150 Comprehensive Oral Evaluation - New or Established	No Charge	No Charge
1203 Fluoride Treatment (children up to the age 19)	No Charge	No Charge
1351 Sealant- per tooth	$5.00	No Charge
1510 Space Maintainers	$30.00	No Charge
TYPE II	**STANDARD**	**ENRICHED**
Fillings: (silver)		
2140 one surface	$5.00	No Charge
2150 two surfaces	$5.00	No Charge
2160 three surfaces	$10.00	No Charge
2161 four or more surfaces	$13.00	No charge
Root canals		
3310 Anterior	$75.00	$70.00
3320 Bicuspid	$85.00	$80.00
3330 Molar	$150.00	$140.00
3410 Apicoectomy	$100.00	$90.00
Extractions:		
7111 single tooth	$10.00	$10.00
7140 Extraction, erupted tooth or exposed tooth	$10.00	$10.00
7210 surgical extraction of erupted tooth	$30.00	$35.00
Periodontics: (gum treatment)		
4210 Gingivectomy/gingivoplasty - per quadrant	$75.00	$60.00
4341 Periodontal scaling & root planing- per quadrant	$30.00	$25.00
4910 Periodontal maintenance procedures	$15.00 each (Twice every 12 months)	$15 each (Twice every 12 months)
Two additional every 12 months	$60.00 each	$60.00 each
TYPE III	**STANDARD**	**ENRICHED**
Crown & Bridge:		
2751 Crown Porcelain fused to base metal	$180.00	$95.00
2791 Crown full cast predominately base metal	$180.00	$95.00
2930 Prefabricated stainless steel	$15.00	$10.00
Prosthodontics (Dentures):		
5110 Complete upper	$190.00	$110.00
5120 Complete lower	$190.00	$110.00
5213/14 Partial upper or lower - cast metal base	$220.00	$130.00
ORTHODONTIA Consultation Evaluation Records Children-Normal Class II Adult - Normal Class II 8680 Retention	This plan covers orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800	This plan covers orthodontia as follows: Comprehensive for dependent children under age 19: $1,500. Adults: $2,800

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Dental Biweekly Rates

DENTAL BIWEEKLY RATES	EMPLOYEE CONTRIBUTION	
	STANDARD	ENRICHED
Guardian **Dental PPO**		
Employee Only	$0.00	$4.45
Employee + One†	$14.09	$22.89
Employee + 2 or more†	$31.53	$45.72
Guardian **DHMO**		
Employee Only	$0.00	$2.10
Employee + One†	$2.42	$6.52
Employee + 2 or more†	$5.64	$13.10

† Option also applies to Domestic Partners and/or Children of Domestic Partners and eligible dependents.

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Guardian/Davis Vision Plan

The Guardian Davis Vision Plan offers a network of providers that service your eyecare needs with only a modest member copayment shown in the Schedule of Benefits. The out of-network-benefit allows you to select any out of-network provider and reimburses a fixed dollar amount based on the schedule shown for the out of-network services. The chart below indicates the benefits the plan pays for the services you receive. For more information, see the Guardian Davis plan literature.

Covered Services	In-Network	Out-Of-Network
One-time copayment (Applied to first service provided - exam or materials)	$10	N/A
Vision Exam (once every plan year) Single Lenses (once every plan year) Bifocal Lenses (once every plan year) Trifocal Lenses (once every plan year) Transition Lenses[3] Polycarbonate Lenses[4] Standard Progressive Lenses Premium Progressive Lenses	Paid in full Paid in full Paid in full Paid in full Paid in full Paid in full Paid in full $40-$90	up to $40 up to $40 up to $60 up to $80 N/A N/A N/A N/A
Frames from Davis' Fashion, Designer, or Premier collections [1] Frequency	Up to $160 retail In-network Once every plan year in and out of network. Once every year	up to $50 Once every plan year
Contact lenses Elected by insured Medically necessary	Covered up to $120 allowance Covered in full	Covered up to $120 up to $210
Contact Lenses Fitting Fee and Follow-Up	Covered in full	N/A
Mail Order Contact Replacement (Treated as out-of-network provider)	N/A	N/A
LASIK Surgery (at VCP contracted facilities)	Average discount of approximately 25%	N/A

1. During any plan year, the member may elect either the frames and/or lenses covered service or the contact lenses allowance, but not both.
2. Polycarbonate lens option covered in full for dependents under 19 years of age.
3. Tints are covered in network. No coverage out of network.
4. UV protection and Photochromic lenses - In Network: Plastic : $65/Glass: Covered. Out of network: No coverage.

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Guardian Davis Vision Plan

How to use a Guardian Davis Vision Provider

1. Obtain a listing of participating optometrists and ophthalmologists during Open Enrollment or access the list online at **davisvision.com.**
2. Identify yourself as an Guardian Davis member when you make an appointment.
3. The eye doctor's office will handle all claim forms.

How to use a Guardian Davis Vision Out-Of-Network Doctor

To use an out-of-network provider, the insured will need to pay at the time the services are rendered and submit the claim form to Guardian/Davis for reimbursement.

LASIK

Please call Guardian Davis Vision member services: 877-393-7363 before making your appointment to ensure the doctor of your choice is a member of the Davis Vision network.

Vision Biweekly Rates

Guardian	
Employee Only	$1.91
Employee & One Dependent†	$3.83
Employee & Family†	$7.03

† Option also applies to Domestic Partners and/or Children of Domestic Partners and eligible dependents.

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Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA)

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

Health Care FSA

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

Dependent Care FSA

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

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

Annual Contribution Limits

For Health Care FSA:

Minimum Annual Contribution: $260
Maximum Annual Contribution: $2,550*

For Dependent Care FSA:

Minimum Annual Contribution: $260
The maximum contribution depends on your tax filing status.

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

*Including administrative fees

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) 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 Explanation of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you're a new health care FSA member, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA.

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FSA Appeals & Managing Your FSA Online

Appeals Process

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

Mail to:
PayFlex Systems USA, Inc.
P.O. Box 981158
El Paso, TX 79998-1158
or Fax to: 855-703-5305

Your appeal must include:
- the name of your employer;
- the date of the services for which your request was denied;
- a copy of the denied request;
- the denial letter you received;
- why you think your request should not have been denied; and
- any additional documents, information or comments you think may have a bearing on your appeal.

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

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

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Managing your FSA online

Filing a Claim with PayFlex

If you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **payflex.com** or through the PayFlex Mobile® app to pay yourself back for your out of pocket expenses. Or you can fill out a paper claim form and fax or mail it to PayFlex. This form can be found in the Resource Center at **payflex.com** or you may call PayFlex at 844-PAYFLEX to request a form.

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

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

How to Register Online

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

Enroll in Direct Deposit

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

FSA Worksheets

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

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

Health Care FSA Worksheet

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

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ ___________
Coinsurance or copayments	$ ___________
Vision care	$ ___________
Dental care	$ ___________
Prescription drugs	$ ___________
Travel costs for medical care	$ ___________
Other eligible expenses	$ ___________
TOTAL CONTRIBUTION (cannot exceed $2,550)	$ ___________
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ ___________
This is your pay period contribution.	$ ___________

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

Dependent Care FSA Worksheet

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

CHILD CARE EXPENSES

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

ELDER CARE SERVICES

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

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

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

Please note the bank information entered will be sent to the bank to confirm the account number. Any reimbursements issued during this pre-note 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.

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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.

PayFlex has a new debit card design. You'll only receive this new card if:

- You're a new Health Care FSA member and you don't have a card yet
- You lost your card and request a replacement on or after December 1, 2015
- Your current card expired and you request a replacement on or after December 1, 2015
- You order a new card for your dependent or spouse on or after December 1, 2015

If you currently have a card that hasn't expired and you enroll in a Health Care FSA, you should continue using that card for the upcoming plan year.

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 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 **payflex.com** and click on **Individuals.** You can also find a list after logging in, under **Quick Links.**

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 medicines such as pain relievers, cold and flu remedies, or allergy and sinus products. To get reimbursed for OTC drugs and medicines, you'll need a written prescription from your doctor. After you get the prescription, you must pay for the OTC drug or medicines 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 **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 800-284-4885 to report a lost or stolen card. Do not order another card online.

IMPORTANT: Request for Documentation Alerts and Letters

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

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

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The PayFlex Card® & PayFlex Mobile™ App

How to Respond to a Request for Documentation Alert or Letter

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

1. **Send us the Explanation of Benefits (EOB) or detailed receipt for the card payment.** You can upload to **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.*

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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 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 **payflex.com** in the Resource Center.

Questions?

Visit **payflex.com** or call PayFlex at 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.

Worklife, Legal and Financial Services

These Services are provided FREE to all Jackson Health System Employees

Do you spend on-the-job or free time trying to find solutions for child care, elder care or care for a person with a disability? Do you have legal or financial concerns, but don't know who to consult?

Would you like to find answers to questions like:

- Where can I find information about college financing for my children?
- How do I locate trustworthy resources and support if I am considering adopting a child?
- Where can I find reliable information about health issues?
- How can I find a fitness center near me?
- Are there pet groomers and veterinarians in my neighborhood?
- Can you help me find child care for my toddler and an after-school program for my third grader?

Thanks to Employee Work & Family Benefits (WFB), you can make **one toll-free phone call** and find assistance in each of these areas, and many others. **The WFB Package is a plan provided to all Jackson Health System employees**. You have this benefit right now. Are you using it?

Plan Features

Dependent Care Consultation and Referral

Please call WFB for a confidential telephone consultation if you need help finding dependent care. A counselor is always available to assist you. Your counselor will conduct extensive research using national databases of regulated care providers. The counselor will also contact all potential providers and provide you with information about prices, availability, and locations to help you make the best decision for your needs.

Within 48-72 hours, you receive a complete referral packet that includes:

- **Customized WFB Profiles** which contain detailed, completely up-to-date information addressing your personal care concerns.
- **Educational materials** which include our comprehensive WFB Guidebooks, as well as relevant, educational WFB Notes to help you make a decision about care.

Work & Family Benefits saves you time and legwork, and leads to real solutions for you and your family. This service is provided free of charge to Jackcon Health System and its employees as an expansion of the services offered by Employee Work/Life Services – EAP.

Legal Services

Our legal services are designed to put you in touch with an appropriate plan attorney, based on your legal questions or needs. Services include:

- A thirty-minute initial consultation with an attorney in the plan for every new, eligible legal matter. The number of new legal matters is unlimited and the initial consultation can be in person or by telephone.
- Guaranteed reduced hourly rates when you use plan attorneys for complex legal matters.
- Assistance with the completion of a simple will kit.
- An online legal library and sample generic documents addressing consumer rights, family law, property issues, small claims, and other legal matters.

Financial and Credit Counseling

WFB's financial counseling services include:

- Guidance on budgeting.
- Advice on debt management and payoff plan structuring.
- Help in developing a plan for the future to begin a more comfortable, new "Financial Management Lifestyle."
- "Ask an expert" for all financial planning questions.

Online Resources - "My Life Values"

Jackson Health System employees have all the benefits of WFB's personalized referral, consultation, financial, and legal services plus the value of WFB's superior online service — My Life Values. Employees can access round-the-clock help right on their own computers. Simply go to **www.mylifevalues.com**, and with username "jackson" and password "health".

WFB's online worklife platform, My Life Values, provides you with the tools you need, right at your fingertips, to help you gather information and make important decisions about your family, health, leisure time, and getting the most for your money. The focused, proprietary content that makes up My Life Values was assembled after careful research into the issues that are most important to the majority of working people, including:

- Child care and elder care searches and information resources.
- Public and private school searches.
- School planning resources.
- College searches.
- Adoption resources.
- Veterinarian and pet care searches.
- Health and wellness resources including videos.
- Behavioral health resources.
- Health assessments and tools.
- Online concierge services.
- Internet-based shopping rewards and discount programs.

Plan Provider

Work & Family Benefits provides this plan. To access all of these services, call 786-466-8377 or visit **www.mylifevalues.com** and login with username "jackson" and password "health". No enrollment is required.

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Short-Term Disability Income Protection

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

Option I: This insurance plan provides up to 60 percent of your weekly covered earnings to a maximum of $425 per week.

Option II: This insurance plan provides up to 60 percent of your weekly covered earnings to a maximum of $700 per week.

How do I Enroll?

You may enroll during your initial eligibility period or annually during Open Enrollment.

How long must I be sick or injured before I receive benefits?

Prior to becoming eligible for benefits, there is a Benefit Waiting Period of whichever comes later:

- Use of all extended illness/accumulated sick leave, or
- For Accident: 14 days
- For Sickness: 14 days

You must maintain your premium while on out-of-pay status.

How long are my benefits payable?

The Maximum Benefit Period for one period of disability is 24 weeks.

How will I determine if I am totally disabled?

You are considered totally disabled if, because of injury or sickness, you are unable to perform all the material and substantial duties of your regular occupation and are under the regular care of a physician.

Is coverage guaranteed?

Employees are guaranteed coverage. However, coverage is subject to pre-existing condition limitations. Benefits will not be paid for a Total Disability:

1. Caused by;
2. Contributed to by; or
3. Resulting from;

A pre-existing Condition unless the Insured has been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the date he/she became an Insured.

Pre-existing Condition means any Sickness or Injury for which the Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to the Insured's effective date of insurance. Routine follow-up care to determine whether breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical treatment, consultation, care or services for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

Increasing coverage amounts while on disability:

With respect to persons electing to change their level of coverage during an approved enrollment period, any benefit increase (due to this change) will not be paid for a Total Disability:

1. Caused by;
2. Contributed to by; or
3. Resulting from;

A pre-existing Condition unless the Insured has been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the date of the increase.

Pre-existing Condition means any Sickness or Injury for which the insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to the effective date of the increase. Routine follow-up care to determine whether breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical treatment, consultation, care or services for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

What illnesses or injuries do these plans exclude?

Benefits are not payable for disability resulting from:

- An intentionally self-inflicted injury; or
- An act of war, declared or undeclared; or
- Your committing a felony; or
- A sickness which is covered by a Worker's Compensation Act, or other worker's disability law; or
- An injury which occurs out of or in the course of work for wage or profit.

How do I file a Short-Term disability claim?

- Call Matrix Absence Management at the toll-free hotline below, as soon as possible.
  866-533-3438 (24/7 for telephonic claims filing)
- You may also file your claim online, 24 hours a day, seven days a week at: **www.matrixeservices.com**
  Please be prepared to supply the following information when filing a short-term disability claim:
  - Your name, last four digits of your Social Security Number and your company name
  - Your supervisor's name and telephone number
  - Your treating physician's name, address, telephone number and fax number
  - A description of your illness or injury
  - A description of your occupation

Short-Term Disability Income Protection

What rates will I pay for these plans?

The cost of this insurance program is paid for by you. Use the chart below to determine the amount for your age group. Please indicate your disability plan choice (or your decision not to select coverage) on your enrollment form. You must authorize payroll deduction for premium payments.

ATTAINED AGE	BIWEEKLY RATES SHORT-TERM	
	Option I Rate ($425 maximum)	Option II Rate ($700 maximum)
Age 18 — 29	$7.51	$9.78
Age 30 — 39	$9.41	$12.25
Age 40 — 49	$12.26	$15.95
Age 50 — 59	$15.23	$19.80
Age 60 and over	$18.30	$23.80

This information is a brief description of the important features of the plan. It is not the contract. Terms and conditions of coverage are set forth in Reliance Standard group policy number STD 670378. The group policy is subject to its laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference. Eligibility for Insurance

Eligibility for Insurance

Employees, as shown in the Schedule of Benefits, are eligible to be insured on the policy effective date or the day he or she completes the Eligibility Waiting Period, if later. The Eligibility Waiting Period is the period of time the Employee must be in active service to be eligible for coverage. It will be extended by the number of days the Employee is not in active service. Except as noted in the Reinstatement Provision, if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is on an approved leave of absence or on a temporary lay-off and returns to active work within 30 days. Furthermore, if an Employee requests insurance after terminating coverage at his or her request or for failure to pay premium when due, proof of good health must be approved before the insurance coverage may be reinstated.

To be eligible an Employee must also be an active, full-time or part-time Employee scheduled to work at least 60 hours per pay period.

Covered Earnings

Covered Earnings, as used in the Schedule of Benefits, means the Insured's weekly salary as reported by the Employer on the day just before the date of disability. Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of change, provided the Insured is actively at work on the effective date of the change. If the Insured is not actively at work on that date, the effective date of the change will be deferred until the date the Insured returns to active work.

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Long-Term 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, the Long-Term Disability plan can help you keep up by providing a stable monthly income.

Option I: This insurance plan provides 60 percent of your monthly covered earnings up to a maximum of $2,500 per month. Select this plan if your monthly salary is $4,166.67 or less.

Option II: This insurance plan provides 60 percent of your monthly covered earnings up to a maximum of $6,000 per month. This plan is for employees whose monthly salary is more than $4,166.67, however, you may select Option I.

How long must I be sick or injured before I receive benefits?

You must be totally disabled for 180 consecutive days.

How long are my benefits payable?

If you are disabled before age 62, you can receive monthly payments up to age 65. For disabilities that commence between ages 62 and 69, you can receive payments on a decreasing scale, with a maximum one year benefit period for disabilities that commence at age 69 or older.

How will I determine if I am disabled?

You are considered totally disabled if, because of injury or sickness, you are unable to perform all the material and substantial duties of your regular occupation. After monthly benefits have been payable for 24 months, you are considered disabled if you are unable to perform all of the material and substantial duties of any occupation normally performed in the national economy for which you are reasonably suited based on your education, training or experience.

What if my disability results from a condition that existed before I became insured under this plan?

Benefits will not be paid for a Total Disability:

1. Caused by;
2. Contributed to by; or
3. Resulting from;

A pre-existing Condition unless the Insured has been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the date he/she became an Insured.

Pre-existing Condition means any Sickness or Injury for which the Insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to the Insured's effective date of insurance. Routine follow-up care to determine whether breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical treatment, consultation, care or services for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

Mental illness or nervous disorders and substance abuse limitations

Monthly benefits for Total Disability caused by or contributed by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless the Insured is in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.

If an Insured was confined in a Hospital or Institution and:

1. Total Disability continues beyond discharge;
2. The confinement was during a period of Total Disability; and
3. The period of confinement was for at least fourteen (14) consecutive days; then upon discharge, Monthly Benefits will be payable for the greater of:

1. The unused portion of the twenty-four (24) month period; or
2. Ninety (90) days;

but in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits.

Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while the Insured is a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.

Long-Term Disability Income Protection

Increasing coverage amounts while on disability:

With respect to persons electing to change their level of coverage during an approved enrollment period, any benefit increase (due to this change) will not be paid for a Total Disability:

1. Caused by;
2. Contributed to by; or
3. Resulting from;

A pre-existing Condition unless the Insured has been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the date of the increase.

Pre-existing Condition means any Sickness or Injury for which the insured received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines, during the three (3) months immediately prior to the effective date of the increase. Routine follow-up care to determine whether breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical treatment, consultation, care or services for purposes of determining pre-existing conditions unless evidence of breast cancer is found during or as a result of the follow-up care.

Example: While Mary is on leave and receiving disability benefits, the annual open enrollment occurs and she enrolls for additional disability benefits. Her new plan year begins, but Mary's disability insurance payments did not increase with the new plan year. Why? Though Mary increases her coverage at open enrollment, the increase is subject to the plans pre-existing condition limitation. Mary's benefit amount in effect at her time of disability will remain in effect throughout her disability, regardless of her elected increase.

Is coverage guaranteed?

Employees are guaranteed coverage. However, coverage is subject to pre-existing condition limitation.

Important facts about Long-Term Disability

Work Incentive Benefits – are designed to allow a disabled employee to return to work while considered disabled and to continue to receive monthly benefits. During the first 12 months you return to work, if, for any month during this period, the sum of your long-term disability benefit, current earnings and any additional other income benefits exceeds 100% of your covered earnings, your disability benefit will be reduced by the excess amount.

If an Insured is receiving a Monthly Benefit because he/she is considered Totally Disabled after 12 months and is able to perform Rehabilitative Employment, you will continue to receive the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

Rehabilitation During Disability – An Insured will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist determines that he/she can perform such employment. If an insured refuses such Rehabilitative Employment, benefits will terminate.

Reasonable Accommodation Benefits – The insurance carrier may reimburse your employer for expenses incurred in making a reasonable accommodation to return the disabled employee to any occupation for your employer. The maximum reimbursement will not exceed $2,000.

What illnesses or injuries do these plans exclude?

A Monthly Benefit will not be payable for any Total Disability caused by:

- An act of war, declared or undeclared; or
- An intentionally self-inflicted Injury; or
- The Insured committing a felony; or
- An Injury or Sickness that occurs while the Insured is confined in any penal or correctional institution.

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Long-Term Disability Income Protection

What if I receive benefits from another group disability plan, Social Security, or a retirement plan?

Long-Term Disability benefits coordinate with benefits payable under Workers Compensation, any statutory disability law, the Federal Social Security Act, and any other federal, state, county or municipal retirement acts or laws. These benefits also coordinate with any other group policies you may have that provide disability benefits. Employer-sponsored salary continuation or retirement program benefits are also coordinated. This means that if you receive income from one or more of these sources, the total benefits you receive from the other sources is subtracted from the amount which would be paid under this plan. Your monthly benefit will not be less than $100 or 10% of the covered monthly earnings multiplied by the monthly benefit percentage (60%), regardless of any reduction due to other income benefits.

Effects of other income benefits:

Disability insurance is designed to help you meet your financial obligations, if you cannot work as a result of a covered injury or sickness. However, this plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, this plan's benefits are reduced by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents.

Example: John is on leave and receiving monthly disability benefits of $1,500 (the maximum amount payable for his plan and income level). When he is approved for $800 in Social Security, his disability payments will be reduced to $700. The disability plan coordinates with other benefits; it does not pay in addition to other benefits.

How do I report a Long-term disability claim?

Claim forms can be obtained by calling 800-866-2301.

What rates will I pay for these plans?

The cost of this insurance program is paid for by you. Use the chart below to determine the amount for your age group. Please indicate your disability plan choice (or your decision not to select coverage) on your enrollment form. You must authorize payroll deduction for premium payments.

ATTAINED AGE	BIWEEKLY RATES LONG-TERM	
	Option I Rate ($2,500 maximum)	Option II Rate ($6,000 maximum)
Age 18 — 29	$2.47	$3.70
Age 30 — 39	$4.58	$6.88
Age 40 — 49	$11.18	$16.77
Age 50 — 59	$22.27	$33.40
Age 60 and over	$18.25	$27.38

This information is a brief description of the important features of the plan. It is not the contract. Terms and conditions of coverage are set forth in Reliance Standard group policy number LTD 669887. The group policy is subject to its laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

Covered Earnings

Covered Earnings, as used in the Schedule of Benefits, means the Insured's monthly salary as reported by the Employer on the day just before the date of disability. Earnings does not include commissions, overtime pay, bonuses or any other special compensation not received as basic salary. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the date of change, provided the Insured is actively at work on the effective date of the change. If the Insured is not actively at work on that date, the effective date of the change will be deferred until the date the Insured returns to active work.

Eligibility for Insurance

Employees, as shown in the Schedule of Benefits, are eligible to be insured on the policy effective date or the day he or she completes the Eligibility Waiting Period, if later. The Eligibility Wait Period is the period of time the Employee must be in active service to be eligible for coverage. It will be extended by the number of days the Employee is not in active service. Except as noted in the Reinstatement Provision, if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period if insurance ends because he or she is on an approved leave of absence or on a temporary lay-off and returns to active work within 30 days. Furthermore, if an Employee requests insurance after terminating coverage at his or her request or for failure to pay premium when due, proof of good health must be approved before the insurance coverage may be reinstated.

To be eligible an Employee must also be an active, full-time or part-time Employee scheduled to work at least 60 hours per pay period.

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Disability Income Protection Plans

	SHORT-TERM DISABILITY INCOME PROTECTION	LONG-TERM DISABILITY INCOME PROTECTION
How do the disability plans protect me?	• Provides replacement income quickly.	• Provides replacement income for an extended period of time.
How much are the benefits?	• Option I: 60% of your weekly salary up to a maximum of $425 per week. • Option II: 60% of your weekly salary up to a maximum of $700 per week.	• Option I: 60% of your monthly salary up to a maximum of $2,500 per month. • Option II: 60% of your monthly salary up to a maximum of $6,000 per month. Min = $100 or 10% per month on both options
How long is the benefit period?	• Up to 24 weeks for one period of disability.	• To age 65 or later, depending on the age at which you were disabled.
How long must I be disabled before I receive benefits?	• The latter of: - Use of all extended illness/accumulated sick leave, or - 14 consecutive days.	• 180 consecutive days of Total Disability.
What is considered a disability?	• Unable to do the material duties of your job; and • Under the regular care of a physician	• As a result of injury or sickness. • For the first 24 months for which a Monthly Benefit is payable, you cannot perform the substantial and material duties of your Regular Occupation • After a Monthly Benefit has been paid for 24 months, you cannot perform the material duties of Any Occupation.
Must I pay my premiums after my disability claim is approved?	• Yes	• No premium is due for Insured while he/she is receiving Monthly Benefits.
What if I am partially disabled? (Residual Disability)	• Not applicable	• "Partially Disabled" and "Partial Disability" mean that as a result of an injury or sickness you are capable of performing the substantial and material duties of your Regular Occupation on a part-time basis or some of the substantial and material duties on a full-time basis. An Insured who is Partially Disabled will be considered Totally Disabled, except during the Elimination Period. • "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability.
What happens to my coverage if I leave Jackson Health System employment?	• Not applicable	• If you terminate employment or if coverage ends for any reason (except non-payment of premium), you can convert this plan to an individual policy by applying for conversion within 31 days of termination of insurance. You do not have to submit evidence of good health if you are applying within 31 days. Contact Reliance Standard Customer Service at 800-351-7500 to obtain a conversion application.
What happens if I'm on a leave of absence and/or on an out of pay status?	• Coverage will terminate. However, if an employee is currently under a disability claim and Leave of Absence from Jackson Health System occurs, the employee is able to make payments for benefits through FBMC. Payments must be made for the duration of the claiming period.	• If an employee is currently under a disability claim and Leave of Absence from Jackson Health System occurs, the employee is able to make payments for benefits through FBMC. Payments must be paid until the claim has been approved.

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Group & Optional Term Life Insurance & Additional Benefits

What life insurance benefits are available?

Group Term Basic Life and Accidental Death and Dismemberment Insurance:

Jackson Health System provides eligible employees with Group Term Basic Life Insurance in the amount of one times the employee's annual base salary. In addition, Jackson Health System provides Group Accidental Death and Dismemberment Insurance (AD&D) with a value equivalent to the employee's annual base salary in the event of death resulting from accidental injuries sustained whether on or off duty. Dismemberment benefits are payable for loss of hand, foot or sight of eye resulting from an accident. See your handbook for further details and plan limits.

Premiums for the Group Term Basic Life and AD&D coverages are paid in full by Jackson Health System.

Group Term Optional Life Insurance:

Jackson Health System also offers additional life insurance, called Optional Life, at the employee's expense. You may elect to purchase between one and five times your annual base salary for a maximum coverage of $2 million. You may obtain up to three times your basic annual salary without being subject to medical approval during your initial eligibility period. If you choose not to enroll during your initial eligibility period, you may apply during the current open enrollment period. You may submit an application at this time; however, you will be subject to medical approval.

Premiums for Optional Life are based on your age and the amount of coverage you are purchasing and will be payroll deducted. Contact your HR Service Center office for further details.

Imputed Income:

Jackson Health System provides one times your annual salary of basic group term life insurance. If the amount of life insurance exceeds $50,000, Jackson Health System is required to withhold taxes on the amount above $50,000.

NOTE: You can cancel or decrease coverage at any time but you can only increase coverage during open enrollment. Your premiums are affected by salary and age changes (in five year increments). Beneficiaries for Life Insurance may be changed at any time.

Conversion:

If your Basic Life and Optional Life Insurance ceases due to termination of employment or membership in an eligible class, you may have the option to continue coverage through the Conversion option. Contact Reliance Standard Customer Service at 800-351-7500 to obtain the application.

Additional Benefits

Your employee benefits package is an important and valuable part of your overall compensation package. In addition to the group medical plans, group dental plans, group vision plan, and the Flexible Benefits Plan, the benefits package for eligible employees includes:

- Paid personal leave/extended illness (annual and sick leave for some classifications)
- 13 paid holidays (for those classifications under annual and sick leave plan)
- Membership in the employer and employee-paid retirement plan with retirement, survivor and disability benefits
- Workers' Compensation
- Unemployment Compensation
- Social Security
- Employee Discount Program
- Tuition Reimbursement
- Tax Deferred Annuities 403(b) and
- Deferred Compensation Plan (457)

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Allstate Benefits Group Critical Illness Insurance

No one knows what lies ahead on the road through life. Will you be diagnosed with cancer? Will you suffer a stroke, heart attack or the complete loss of hearing? The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed.

Critical Illness coverage can help offer peace of mind when a critical illness diagnosis occurs. The plan provides an immediate pre-selected lump sum, cash benefit upon first diagnosis of a covered specified critical illness (heart attack, stroke, or cancer) after the plan's effective date, subject to the pre-existing condition limitation. Your benefit is paid in full regardless of whether you have started treatment and allows you to decide how to use your benefit money.

The basic benefit amount range is $10,000 - $25,000. The plan also includes a Wellness Benefit of $100 for one screening test per calendar year.

You choose the level of coverage with benefit amounts of $10,000, $15,000, $20,000 or $25,000. During this open enrollment, you are eligible to purchase this coverage for yourself on a guaranteed issue basis (no medical underwriting). Your spouse and children, if you elect family coverage, are covered at 50% of your benefit amount. Coverage under this plan is available to children at no additional premium under the insured's plan.

Meeting your needs

Our critical illness coverage helps offer financial support should a covered illness be diagnosed.

- Guaranteed issue amounts available— which means no evidence of insurability required at initial enrollment*
- 4 Benefit Categories plus an Additional Wellness Benefit
- Benefits paid directly to you
- Coverage supplements your existing medical benefits
- Covered dependents receive 50% of your basic-benefit amount
- Premiums are affordable
- Portable

*Enrolling after your initial enrollment period requires evidence of insurability.

Your Benefit Coverage

A percentage of the basic-benefit amount is payable for each covered person in the Initial Critical Illness benefits, Cancer Critical Illness benefits, a Second Event benefit, Supplemental Critical Illness benefits, and an Additional benefit.

Initial Critical Illness Benefits

- Heart Attack (100%) - Pays a benefit when you have a heart attack. (A cardiac arrest is not a heart attack, and is not covered by this benefit.)
- Stroke (100%) - Pays a benefit when you have a stroke.
- Coronary Artery Bypass Surgery (25%) - Pays a benefit when you have coronary artery bypass surgery.
- Major Organ Transplant (100%) - Pays a benefit when you have a heart, lung, liver, pancreas or kidney transplant (must be a human donor).
- End Stage Renal Failure (100%) - Pays a benefit when you have peritoneal dialysis or hemodialysis.
- Waiver of Premium (Employee only) - Pays your premium if you are disabled for 90 days in a row, due to a critical illness, as long as the disability lasts up to 2 years.

Cancer Critical Illness Benefits

- Invasive Cancer (100%) - Pays a benefit when you are diagnosed with invasive cancer (includes Leukemia and Lymphoma).
- Carcinoma in Situ (25%) - Pays a benefit when you are diagnosed with cancer in situ.

Second Event Benefit

Second Event Initial Critical Illness Benefit - Pays a benefit when you are diagnosed for the second time with a previously paid Initial Critical Illness Benefit.

Supplemental Critical Illness Benefits

- Advanced Alzheimer's Disease (25%) - Pays a benefit when you are diagnosed with Alzheimer's by a psychiatrist or neurologist.
- Advanced Parkinson's Disease (25%) - Pays a benefit when you are diagnosed with Parkinson's by a psychiatrist or neurologist.
- Benign Brain Tumor (100%) - Pays a benefit when you are diagnosed with a brain tumor by biopsy, surgery or examination.
- Coma (100%) - Pays a benefit when you are unconscious more than 14 consecutive days, due to sickness or brain injury (a medically induced coma is not covered).
- Complete Blindness (100%) - Pays a benefit when you are diagnosed with irreversible loss of sight in both eyes by an ophthalmologist.
- Complete Loss of Hearing (100%) - Pays a benefit when you are diagnosed with total and irreversible loss of hearing in both ears.
- Paralysis (100%) - Pays a benefit when you suffer a complete and permanent loss of use of two or more limbs.
- Occupational HIV (100%) - Pays a benefit when you are infected with HIV during the normal duties of your occupation.
- Portability Privilege - Coverage may be continued under the Portability Provision when coverage under the policy ends.

Additional Benefit

Wellness Benefit - Pays a $100 benefit annually when you receive one of the following:

- Biopsy for skin cancer
- Blood test for triglycerides
- Bone Marrow Testing
- CA15-3, CA125, CEA and PSA (blood tests for breast, ovarian, colon and prostate cancer)
- Chest X-ray
- Colonoscopy
- Doppler screenings for carotids and peripheral vascular disease
- Echocardiogram
- EKG (Electrocardiogram)
- Flexible sigmoidoscopy

- Hemoccult stool analysis
- HPV Vaccination (Human Papillomavirus)
- Lipid panel (total cholesterol count)
  Mammography, including Breast Ultrasound
  Pap Smear, including ThinPrep Pap Test
- Serum Protein Electrophoresis (test for myeloma)
- Stress test on bike or treadmill
- Thermography
- Ultrasound screening for abdominal aortic aneurysms

True Guaranteed Issue

- Benefit amounts are available on a Guaranteed Issue basis for all employees during this initial enrollment only in amounts from $10,000 - $25,000.
- For employees enrolling after their initial enrollment period benefit amounts over the limits listed above, Evidence of Insurability (AWD4504FL) will be requested.
- It is a requirement that the name and address of the proposed insured's personal physician be included in the Required Health History section for all applications.

Benefit Conditions

Benefits are not payable for any critical illness diagnosed prior to the effective date. Benefits are also subject to the Pre-Existing Condition Limitation, as well as all other limitations and exclusions. All critical illnesses must meet the definitions and dates of diagnoses stated in the policy and be diagnosed by a physician while coverage is in effect. The date of diagnosis for each illness must be separated by 90 days. Emergency situations while you are outside the U.S. will be considered when you return to the U.S.

Pre-Existing Condition Limitation - (a) We do not pay benefits for a critical illness that is, caused by, contributed to by or results from, a pre-existing condition when the date of diagnosis is within 12 months after the effective date of coverage. (b) A pre-existing condition is a condition, whether diagnosed or not, for which symptoms existed within the 12-month period prior to the effective date; or (c) medical advice or treatment was recommended or received from a medical professional within 12 months prior to the effective date.

Current AHL Critical Illness Participants
If you are currently enrolled in Critical Illness through Allstate Benefits (AHL), you may continue your coverage. See your Benefit Enroller for more information about the coverage.
Group Voluntary Critical Illness
You are also eligible to enroll in the Group Voluntary Critical Illness (GVCI). The GVCI is available during this enrollment period on a Guarantee Issue basis up to $25,000. See your Benefit Enroller for more information and details on how to enroll.

State Variations

Florida (changes affect item (b) above) – In the Pre-Existing Condition Limitation paragraph, the following is added to item (b): The exception is follow-up care for breast cancer: If you have been previously found to be free of breast cancer, routine follow-up care does not constitute medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during, or as the result of, the follow-up care. The Advanced Alzheimer's Disease Conditions paragraph is replaced with: must have impaired memory and judgment, and be unable to perform 2 or more daily activities.

Exclusions and Limitations - We do not pay benefits for: (a) war, participation in a riot, insurrection or rebellion; (b) intentionally self-inflicted injury or action; (c) illegal activities or occupations; (d) suicide while sane, or self-destruction while insane, or any attempt at either; or (e) substance abuse, including alcohol, alcoholism, drug addiction, or dependence upon any controlled substance.

Stroke Exclusions - Does not include transient ischemic attacks (TIAs), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

Coronary Artery Bypass Surgery Exclusions - Does not include abdominal aortic bypass, balloon angioplasty, laser embolectomy, atherectomy, stent placement, or other non-surgical procedures.

Invasive Cancer Exclusions - Does not include carcinoma in situ, tumors related to HIV, non-invasive or metastasized skin cancer, or early prostate cancer.

Carcinoma in Situ Exclusions - Does not include other skin malignancies, pre-malignant lesions (such as intraepithelial neoplasia), or benign tumors or polyps.

Second Event Initial Critical Illness Benefit Conditions – There must be at least 12 months between each diagnosis. A covered person can receive a Second Event Benefit only once for each initial critical illness.

Advanced Alzheimer's Disease Conditions - Must have impaired memory and judgment, and be unable to perform 3 or more daily activities.*

Advanced Parkinson's Disease Conditions - Must have 2 or more physical signs and be unable to perform 3 or more daily activities.*

*Daily activities are: bathing, dressing, toileting, continence, transferring and eating.

Benign Brain Tumor Exclusions - Does not include: tumors of the skull, pituitary adenomas, or germinomas.

Occupational HIV - Exposure must be accidental and during the normal course of duties of the covered person. The covered person must not have previously tested HIV positive.

Universal Life Insurance

How would your family get by if something happened to you suddenly and they could no longer rely on your paycheck? With Premier Universal Life Insurance, you can give your family added financial protection in the event something unexpected happens.

Eligibility Requirements

Employee
An employee eligible for participation in this program must be a full-time benefits eligible employee working 30 or more hours per week. You must be actively at work for the enrollment. Eligible employees ages 15 through 65 years will be Guaranteed Issue offered coverage amounts up to the amount of coverage $14 per week would buy, not to exceed $100,000. Employees ages 66 through 70 are eligible for up to $25,000. Amounts above Guaranteed / Contingent Issue are available with additional underwriting. These requirements are specific to Premier Universal Life Insurance and may differ from other eligibility explained in this booklet. To discuss the options available you should meet with an Enrollment Representative who is a licensed insurance producer.

Spouse
Contingent issue coverage is available for eligible spouses ages 15 through 65, for the amount of insurance purchased by $5 per week premium or $10,000, whichever is greater. Spouses ages 66 through 70 years will be fully underwritten. Amounts above Contingent Issue are available with additional underwriting. . Higher amounts will be subject to additional underwriting.

Children/Grandchildren
Contingent Issue coverage is available for eligible children and grandchildren ages 15 days through 24 years in the amount of $25,000.

A Children's Term Insurance rider is also available. Details are provided in the section on riders. If the policy owner would like to purchase both a Premier Policy and the Children's Term Insurance Rider for the same child, the individual policy will be fully underwritten.

Guaranteed Issue Amounts

- Newly eligible Employees (ages 15 through 65) – a maximum of $14 per week up to $100,000
- Existing Employee Policy increases – may increase coverage not to exceed the original Guaranteed Issue offer of $14 per week up to $100,000.

Contingent Issue Amounts

- Employees (ages 66 through 70) – up to $25,000.
- Spouses (ages 15 through 65) – a maximum of $5 per week or $10,000, whichever is greater.
- Children and/or Grandchildren – $25,000 per individual

Simplified Issue Amounts For Late Entrants

- Employees age 15-70 – Greater of $7 weekly premium or $10,000 death benefit, not to exceed $100,000 benefit.

Suicide

If the Insured commits suicide within two years of the Issue Date, We do not pay the Death Benefit. Instead, We refund all premiums paid on this policy minus any Policy Loans and Partial Withdrawals.

If you make a Face Amount Increase or a premium payment which requires proof of insurability, the corresponding Death Benefit Increase has its own two year suicide limitation measured from the earliest of the Issue Date or Effective Date of the increase in Death Benefit. If the Insured commits suicide within two years of the effective date of the increase, we pay the Death Benefit prior to the increase and refund the Cost of Insurance for that increase and any Monthly Charge per $1,000 associated with that increase.

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Coverage Amounts Above Guaranteed & Contingent Issue Amounts

Information in addition to the questions on the application may be required if you desire coverage amounts greater than the Guaranteed Issue or Contingent Issue offer. If ReliaStar Life Insurance Company finds it necessary to decline the amount of coverage above the Guaranteed/Contingent Issue amount, the face amount of the policy will be reduced to the maximum issued amount for which you are eligible.

Included Riders

Waiver of Monthly Deduction Rider

The Waiver of Monthly Deduction Rider (WMD) is designed to allow the continuation of your life insurance policy if you become disabled. The benefit begins after the insured has been totally disabled, as defined in the rider, for four consecutive months and will continue for the duration of disability.

Exclusions: No monthly deduction will be waived under the terms of this rider if total disability results from an intentionally self-inflicted injury. This rider and policy must be in force when disability begins.

Form #RL-UL3-WMD-07-FL

Accelerated Benefit Rider

If an insured has a death benefit of $20,000 or greater, has been diagnosed with a terminal illness by a physician, and has fewer than 12 months to live, the policy owner can elect to receive up to 50 percent of the death benefit up to $250,000 but not less than $10,000. The Accelerated Benefit will be used to re-pay any outstanding loans and interest due. The rider allows this one-time lump sum payment in the form of a policy lien, which accrues interest. Proceeds are paid upon receipt of written proof of the terminal illness. Proof must be provided by a licensed physician. When the insured dies, the policy death benefit will be reduced by the amount already paid under this rider, as well as any unpaid interest on the accelerated amount.

Limitations: The insurer will not pay the Accelerated Benefit Rider:

- If either you or the insured is required by a government agency to use the Accelerated Benefit in order to apply for, obtain, or otherwise keep a government benefit or entitlement;
- If either you or the insured is required by law to use the Accelerated Benefit to meet the claims of creditors, whether in bankruptcy or otherwise;
- If the Terminal Illness results from intentionally self inflicted injuries;
- If the policy is in force as either Extended Term Insurance or Reduced Paid-up Insurance;
- If the policy is legally or equitably assigned, except to us as security for the lien;
- If any part of the Death Benefit under the policy is contestable;
- If the policy is not in force or the Death Benefit under the policy is not payable for any reason;
- If the amount of the Accelerated Benefit, plus the amount of all Accelerated Benefits on the insured from all policies issued by the insurer exceeds $250,000; or
- If there has already been an Accelerated Benefit paid on this policy through this Accelerated Benefit Rider.

Form #RL-UL3-ABR-07-FL

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Universal Life Insurance

Optional Riders

Accidental Death Benefit Rider

Any employee or spouse age 15 through 60 is eligible to add this rider to his/her policy. It provides an added benefit equal to the basic policy face amount (up to $150,000) if the insured dies in a covered accident. Should the accident occur in a public conveyance (i.e., commercial airplanes, trains, buses, etc.), the benefit is payable at twice the death benefit.

Exclusions: This benefit will not be paid if death is the result of a disease, illness, mental illness, or the medical or surgical treatment of them; any poison, gas, fumes, drug, or sedative voluntarily taken, injected or inhaled by the insured; suicide whether sane or insane; committing or attempting to commit a felony; travel in or descent from an aircraft while giving or receiving aviation training; or when the purpose of the flight was for descent by anyone from such aircraft while in flight.

Form # RL-UL3-ADB-07-FL

Face Amount Increase Rider

Offers the insured (employee or spouse) the option of purchasing additional insurance, regardless of any change in health. This rider automatically increases the insurance amount on the next policy anniversary and policy anniversaries thereafter, for a pre-selected amount of premium and years. An employee may elect either a $1 per week plan or a $2 per week plan, for five consecutive years. The $2 per week program is available for employees only when their base premium is $15 per week or more. A spouse is eligible for a $1 per week plan for three consecutive years.

Exclusions: If the insured commits suicide, while sane or insane, within two years of the rider effective date, no death benefit will be paid corresponding to the increased amounts purchased under the provisions of the rider.

Portability: Like your policy, this benefit is portable and any remaining increases will occur even if you leave the hospital or retire, unless you choose to cancel them.

Form # RL-ULU-FAIR-99-FL

Children's Term Insurance Rider

Any employee **or** spouse (not both) age 15 through 60 can purchase life insurance for all your unmarried, dependent children ages 15 days through 24 years. Insurance coverage ranges from $2,000 to $10,000. One premium covers all eligible dependent children. The rider also has a conversion privilege at age 25 to an individual whole life insurance policy or endowment plan for a maximum of five times the rider insurance amount, without evidence of insurability.

Exclusions/Limitations: Grandchildren are not eligible unless they meet the definition of a dependent.

Form # RL-UL3-CTR-07-FL

Termination of Employment or Retirement

After the first payroll deduction has been made, you may continue coverage at the same rates with no change in coverage or benefits should you terminate employment or retire. The insurance company will bill you directly.

Insurer

ReliaStar Life Insurance Company underwrites this plan.

- A.M. Best: A (Excellent) is the third highest of 15 ratings. A.M. Best Company assigns ratings from A++ to F based on a company's financial strength and ability to meet obligations to contract holders.
- Fitch: A (Strong) is the sixth highest of 19 ratings.
- Fitch assigns ratings from AAA to C based on a company's financial strength.
- Moody's Investor Service: A2 (Good) is the sixth highest of 21 ratings. Moody's Investor Service (Moody's) assigns ratings from AAA to C based on a company's financial security.
- Standard & Poor's: A (Strong) is the sixth highest.
- Standard & Poor's assigns ratings from AAA to CC based on a company's financial security.

Premier Universal Life Insurance is available on a post-tax basis.

A separate application is required.

This employer-provided information is in advance of more complete coverage information from the insurer.

Policy Form RL-UL3-POL-07-FL

This brochure is a summary only. The policy and riders should be reviewed for complete provisions, conditions on benefit determination, exclusions and limitations. The policy and riders have exclusions and terms under which they may be continued in force or discontinued. For costs and complete details of coverage, call or write Voya Employee Benefits. All products are issued by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Product availability and specific provisions may vary by state.

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Unum Whole Life Insurance

with Long-Term Care Rider

How would your family get by if something happened to you suddenly and they could no longer rely on your paycheck? With Unum's Permanent whole life insurance, you can help give your family the added financial protection they may need in the event something unexpected happens.

Plan Features

- Voluntary, individual coverage is available for employees, with multiple family coverage options available.
- No physical exams are required to apply for coverage. Policy issue may depend upon answers to health questions contained in the application.
- Premiums are guaranteed level based on your age at the time of policy issue and do not increase due to age.
- Cash value is based on a tabular rate of 4.5%.
- The policy contains a reduced paid-up provision, which allows you to use your accumulated cash value to purchase a smaller, paid-up policy with no further premiums due.
- Coverage may be continued as long as sufficient premiums are paid.
- A Living Benefit Option rider is automatically included at no extra premium on all policies. This feature allows the policy owner to request up to 100% of the death benefit (to a maximum of $150,000) if the insured is diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout reduces the death benefit.
- A Long Term Care rider is automatically included at the initial offering to employees and spouses ages 15 to 70 who have policies with face amounts of at least $10,000.
- The policy is individually owned, which means you can take the policy with you should you retire or leave the hospital.

Eligibility

Employee

- Issue ages: 15 – 80
- Must be actively at work at time of application
- Must work at least 20 hours per week

Being "actively at work" means that on any day the employee applies for coverage, he/she is working at one of their company's business locations, or is working at a location where he/she is required to represent the company. If he/she is applying for coverage on a day that is not a scheduled workday, then he/she will be considered actively at work if he/she meets this definition as of the last scheduled workday. Employees are not considered actively at work if their normal duties are limited or altered due to their health, or if they are on a leave of absence.

Spouse

- Issue ages: 15 – 80

Child – Standalone Policy

- Issue ages: 14 days – 26 years
- Available to children, grandchildren, stepchildren, and legally adopted children of the employee between the ages of 14 days and 26 years
- Children must reside in the United States

Underwriting Levels

Guaranteed Issue (GI)

- Current and newly eligible employees
- Participants with existing coverage who wish to increase to GI limit
- Must meet the "actively at work" definition
- No health questions

Spouse Conditional Guaranteed Issue (CGI)

One qualifying health question must be answered. The question states: "During the last 12 months, has the spouse been hospitalized or treated, including medication, for an injury or sickness, excluding pregnancy, colds, flu and back problems?" If qualifying health question is answered "yes", Simplified Issue underwriting will be required.

Re-enrollment Underwriting Guidelines:

Have your Enrollment Counselor complete the Unum Whole Life Insurance application.

All employees have the opportunity to enroll on a guaranteed issue basis during this enrollment period. This includes employees declined or applications which were previously declined, not taken, cancelled or lapsed.

Current and newly eligible employees

Guaranteed Issue (GI) for Employees and Dependent Children; Conditional Guaranteed Issue (CGI) for Spouses.

- Employees: Amount purchased by up to $30 per week to a maximum of $300,000 (GI).
- Spouses (CGI): Amount purchased by up to $5 per week to a maximum of $75,000 (CGI).
- Children: Available for $1–$3 (GI) per week.

Participants with existing coverage

- **Participants with active Unum VWL coverage may increase under GI underwriting** up to the original GI amount of $30.00 per week to a total benefit cap of $300,000.
- Spouses may increase coverage under CGI underwriting up to the original CGI amount of $5 per week to a maximum of $75,000.
- Children: Available for $1–$3 (GI) or $4–$5 (SI) per week.

Benefits in excess of the amount purchased by the above stated premium levels will be underwritten on a Simplified Issue basis.

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Unum Whole Life Insurance

with Long Term Care Rider

Employee Weekly Premium Limits

Guaranteed Issue*	Simplified Issue
$3 - $30	$31 - $40

Spouse Weekly Premium Limits

Conditional Guaranteed Issue*	Simplified Issue
$3 - $5	$6 - $10

* Applies to newly eligible employees, spouses and participants with existing coverage who wish to increase coverage up to the GI limit.

Coverage Levels

- The overall maximum face amount for employees is $300,000.
- The overall maximum face amount for spouses is $75,000.
- Minimum premium of $3 per week and minimum face amount of $2,000 is required for employee and/or spouse coverage.
- Simplified Issue underwriting maximums include the Guaranteed Issue premium. The amount above the Guaranteed Issue weekly maximum is the Simplified Issue underwritten amount.

Family Coverage Options

Spouse Coverage

- Cash value is based on a tabular rate of 4.5%.
- The employee does not have to apply for coverage to purchase spouse coverage.
- Minimum is $2,000 face amount and $3 weekly premium.
- Premiums are based on the issue age of the spouse.
- The policy is individually owned, so coverage can be continued if the employee retires or leaves the hospital.

Children's Coverage

Adult insureds have the option of choosing a standalone policy for each child or adding the Children's Term Rider to the base policy. Children may be covered under a policy or a rider.

Children's Voluntary Whole Life Insurance

- The employee does not have to apply for coverage to purchase coverage for children.
- Available for $1 to $3 (guaranteed issue) or $4 - $5 (simplified issue) per week.
- Premiums are based on the issue age of the child.
- The policy can build cash value that earns interest. Interest earned on the policy is tax deferred under current laws.
- Individually owned policy, so coverage can be continued if the employee retires or leaves the hospital.

Children's Term Rider

- Available to children, stepchildren, and legally adopted children of the primary insured between the ages of 14 days and 25 years who are unmarried, reside with and are dependent on the employee for at least half of their support.
- The rider may be added to the employee or spouse policy, but not both. Employee or spouse must be age 64 or younger.
- Guaranteed level premium rider coverage with available benefit amounts of $1,000 - $10,000 in $1,000 increments. Premium is $6.00 per $1,000 annually.
- This rider must be added during an enrollment period when the first child is at least 14 days old in order for that child and all future children to have coverage.
- All future children are automatically covered after 14 days of age with no increase in premium.
- Death of the primary insured results in paid-up term coverage for each child until that child reaches age 25.
- As each child reaches age 25, he or she may purchase level premium coverage, other than term life, at current rates, up to five times the amount of coverage in force, up to a maximum of $50,000, subject to minimum policy requirements that apply to that contract. The insured is responsible for notifying Unum in writing at least 31 days prior to the child's 25th birthday if this change is desired.

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Unum Whole Life Insurance

with Long Term Care Rider

Additional Coverage Options

Accidental Death Benefit Rider

The Accidental Death Benefit Rider provides an additional death benefit equal to the base policy face amount if the insured dies before age 70 as a result of an accident as defined in the policy.

- Available to employees and spouses between the ages of 15 – 65 and only at initial enrollment
- Maximum available benefit is $150,000

Waiver of Premium

Waives the policy's monthly premium during disability if the insured employee becomes disabled prior to age 65 and remains disabled for at least six months.

- Available to employees between the ages of 15 – 55, and only at initial enrollment.
- Premiums paid during the six-month waiting period can be refunded and will be waived as long as the disability continues, as defined in the policy.

Long-Term Care Rider

- Available to employees and spouses ages 15 - 70 with face amounts of $10,000 or more automatically receive the LTC Rider.
- For a long term care facility, nursing home care or assisted living facility, this rider provides a maximum monthly benefit that is the lesser of 6% of the death benefit, less any policy debt at the end of the waiting period, or $3,000.
- For home health care or adult day care, this rider provides a maximum monthly benefit that is the lesser of 4% of the death benefit, less any policy debt at the end of the waiting period; your actual monthly expenses; or $1,500.
- This rider allows the policy owner access to the death benefit after the insured has been receiving long term care for 90 days, subject to rider conditions.
- If you are receiving benefits, you don't have to pay the policy's monthly premiums, even if your policy does not have the Waiver of Premium Rider.
- The maximum lifetime value is equal to 100% of the death benefit, less any policy debt at the end of the waiting period for each benefit period.
- The rider is tax-qualified, which means that any benefits you receive will not be taxed.

Exclusions

If the insured commits suicide within two years from the policy date, Unum's liability will be the refund of premiums paid, without interest, less the sum of any debt, any partial surrender and the cost of any supplementary benefit riders.

Terminations

All coverage under this policy will terminate when any of the following occurs:

- the insured's request to terminate the policy
- the insured dies
- the policy matures, or
- the grace period ends.

Plan Provider

Provident Life and Accident Insurance Company, a subsidiary of Unum Corporation, underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates Unum "A" Excellent (rating effective as of January, 2012).

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. Unum Corporation complies with Act 91, the Vermont Civil Union Endorsement Law and the California Insurance Equity Act.

Unum is the marketing brand of Unum Corporation's insuring subsidiaries. Provident Life and Accident Insurance Company, 1 Fountain Square, Chattanooga, TN 37402

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ARAG® Legal Insurance

The Freedom and Control to Embrace Life's Opportunities

At Jackson Health System, we want you to embrace life's opportunities with fewer worries. That's why we're excited to provide you with legal insurance from ARAG. It's affordable and reliable legal counsel for everyday life matters – like a dispute with a contractor, buying or selling a home or the need for estate planning. The plan provides you with the peace of mind knowing that attorney fees for most covered legal matters are 100% paid in full when you work with a Network Attorney. That means you'll avoid paying high-cost attorney fees, which currently average $323 an hour.*

Resolve Your Legal Issues with a Network Attorney by Your Side

When a life event turns into a legal issue, ARAG will be there for you, backed by a nationwide network of more than 10,000 credentialed attorneys. They can review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation, and represent you in court. Rely on legal help and protection with a wide range of covered services, including:

	UltimateAdvisor®	UltimateAdvisor Plus™
Civil Damage Claims (Defense)		
Civil Damage	•	•
Pet-Related Matters	•	•
Consumer Protection Issues		
Auto Repair	•	•
Buying a New or Used Vehicle	•	•
Consumer Fraud	•	•
Consumer Protection for Goods or Services	•	•
Home Improvement/Contractor Issues	•	•
Personal Property Protection	•	•
Credit Records Correction	-	•
Criminal Matters		
Habeas Corpus	•	•
Juvenile Matters	•	•
Misdemeanor Matters	-	•
Debt-Related Matters		
Bankruptcy (Chapter 7 & 13)	•	•
Debt Collection Matters	•	•
Garnishment	•	•
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Domestic Violence	•	•
Guardianship/Conservatorship	•	•
Incapacity	•	•

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ARAG® Legal Insurance

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Divorce/Annulment/Separation (up to 10 hours)	•	-
Divorce/Annulment/Separation (up to 15 hours)	-	•
Post-Nuptial Agreements	-	•
Alimony (up to 8 hours)	-	•
Child Custody (up to 8 hours)	-	•
Child Support (up to 8 hours)	-	•
Caregiving (annual check-up)	-	•
School Issues	-	•
Government Benefits		
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Social Security Disputes	•	•
Veterans Benefits Disputes	•	•
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Eviction as a Tenant	•	•
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Document Preparation of Deeds, Mortgages, Affidavits, Demand Letters, Promissory Notes	•	•
Other Coverage (up to 4 hours per year)	-	•
Real Estate Matters		
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Buying/Selling a Secondary Home	•	•
Foreclosure (primary residence)	•	•
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Neighbor Disputes/Easements (primary residence)	•	•
Neighbor Disputes/Easements (secondary residence)	•	•
Real Estate Disputes (primary residence)	•	•
Real Estate Disputes (secondary residence)	•	•

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IRS Collection Defense	•	•
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Traffic Tickets (unlimited)	-	•
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Living Will	•	•
Revocable Trust	•	•
Standard Will	•	•

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Preexisting and personal legal matters not listed above
For any legal matters not covered and not excluded, you can still receive at least 25% off the Network Attorney's normal hourly rates.

For additional details regarding your plan's specifically-covered services, visit **ARAGLegalCenter.com** and enter Access Code 17845jhs.

Call for questions or legal assistance
You can also get assistance form trusted professionals and an award-winning Customer Care Center, with dedicated representatives who will help you navigate your legal issues. You'll benefit from the following services:

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	UltimateAdvisor	UltimateAdvisor Plus
Call a Network Attorney who can provide legal advice and help you better understand your covered legal issues and how to address them. Plus, they can help you review or prepare documents, including a Standard Will.	•	•
Receive **Financial Education and Counseling Services** on a wide range of financial topics - cash and debt management, budgeting, retirement planning, federal tax information and more - from a certified Financial Counselor.	•	•
With **Immigration Services**, you can always speak with a Network Attorney over the phone who can offer legal advice and consultation, file and process applications or petitions, provide guidance regarding immigration benefits, asylum, business visas and much more.	•	•
Rely on **Identity Theft Services** provided by Customer Care Specialists who have earned the Certified Identity Theft Risk Management Specialist** (CITRMS) designation. They can guide you through the steps of prevention and are there to assist you in recovery if your identity is stolen.	•	•
Look to **Caregiving Services** for legal advice from Network Attorneys who focus on Elder Law Issues, as well as caregiving services from Elder care Specialists to assist you with your parents' and grandparents' everyday lives.		•

Go online to learn more about legal issues

Your path to legal protection starts with easy-to-use online resources at **ARAGLegalCenter.com** to help you handle legal issues on your own, including:

	UltimateAdvisor	UltimateAdvisor Plus
The Education Center™ contains Guidebooks, hundreds of articles, newsletters and more to help you learn more about everyday legal issues.	•	•
DIY Docs® offer the convenience and control of creating your own state-specific, legally-valid documents online.	•	•
Online Financial Tools help you map out a solid financial strategy with a self-guided money management tool, online chat feature with a Financial Counselor, educational articles, calculators and more.	•	•
Caregiving Resources inform you about the financial, legal and emotional aspects of caring for your parents and grandparents.		•

Identity Theft Protection provides a formidable front line of protection against identity theft. This service includes:

	UltimateAdvisor®	UltimateAdvisor Plus™
Identity Theft Insurance: Coverage up to $1 million for expenses associated with restoring your identity.		•
Full Service Identity Restoration: Restoration Specialists will guide you to help clear your name and restore your identity.		•
Lost Wallet Services: Restoration Specialists will help you cancel and reissue credit cards, driver's license, etc.		•
Credit Monitoring: Monitors and informs members of changes to their credit report.		•
Internet Surveillance: Monitors websites and other data points to alert you if your personal information is being traded and/or sold.		•
Child Monitoring: Monitors your minor's identity to alert you if their personal information is being traded and/or sold.		•

Choose a Plan that Empowers You – and Enroll Today!
Take a proactive step toward embracing life's opportunities, with fewer worries when you enroll in one of the following legal plans:

Bi-Weekly Price	UltimateAdvisor®	UltimateAdvisor Plus™
Individual	$6.15	$7.88
Family	$8.12	$10.41

Visit **ARAGLegalCenter.com** and enter Access Code 17845jhs to learn more about what these plans offer, research specific legal topics and more. Or call 800-247-4184 to speak with an ARAG Customer Care Specialist.

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

**Certified Identity Theft Risk Management Specialist (CITRMS)® is a certification mark owned by the Institute of Consumer Financial Education, Inc.

Unum Voluntary Accident Insurance

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If you have an accident, will it hurt your bank account too?

Unum's Voluntary Accident Insurance covers a wide variety of injuries and accident related expenses, such as hospitalization, physical therapy, hospital intensive care, transportation and lodging, associated with the loss of income due to a covered on or off-job accident.

Eligibility Requirements

Voluntary Accident Insurance is available to:

- eligible employees (ages 17 to 80 who are actively at work),
- their spouse (ages 17 to 80 who are actively at work or not disabled), and/or
- their dependent children ages 14 days to 26, regardless of martial or student status.

Biweekly Rates

Coverage	Rate
Employee	$7.56
Employee and Spouse	$10.80
One Parent Family	$14.40
Two Parent Family	$17.64

Plan Description

Voluntary Accident Insurance pays for covered accidents while you are on the road to recovery. This plan is being offered on a Guarantee Issue basis, meaning there are no medical questions to answer in order to qualify. Additionally, the policy is fully portable. Participants own their policies and can keep the coverage even if they change employers. Unum will simply bill participants directly for the same premium amount. Unum's coverage provides a lump sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:

- broken bones
- burns
- torn ligaments
- concussion
- eye injuries
- ruptured discs
- cuts repaired by stitches

Some covered expenses include:

- emergency room treatment
- doctor office visit
- hospitalization
- physical therapy

See schedule of benefits for a full list of covered injuries and expenses.

Optional Hospital Sickness Confinement Rider

For an additional premium, this rider will pay the insured employee, spouse or child(ren) a daily benefit if he or she is in the hospital for a covered illness (sickness).

- The benefit amount is $300 per day for an employee or spouse up to a maximum of 30 days. $225 per day for children up to a maximum of 30 days.
- The eligible age for employee and spouse is 17 to 67 and 14 days through 26 years for children.
- This rider is available to family members who are covered by the base plan and includes a 12-month pre-existing condition limitation and a nine-month pregnancy exclusion. Employees and their spouses need to answer 4 health questions when applying for this rider.

Biweekly cost for the HSC rider

Coverage	Cost
Employee	$1.62
Employee and Spouse	$3.24
One Parent Family	$2.76
Two Parent Family	$4.38

What's Not Covered

This plan will not pay benefits for losses that are caused by or occur as a result of the insured's:

- Involvement in war or act of war, whether it is declared or undeclared;
- Riding in or driving any motor vehicle in a race, stunt show or speed test;
- Operating, learning to operate, serving as a crew member of or jumping, parachuting or falling from any aircraft or hot-air balloon, including those which are not motor-driven. This does not include flying as a fare-paying passenger;
- Engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or any similar activities;
- Participating or attempting to participate in an illegal activity; and/or being incarcerated in a penal institution;
- Committing or trying to commit suicide or injuring him/herself intentionally, whether he/she is sane or not;
- Having any sickness or declining process caused by a sickness, including physical or mental infirmity. We also will not pay benefits to diagnose or treat the sickness. Sickness means any illness, infection, disease or any other abnormal physical condition which is not caused by an injury;
- Practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received; or
- Having a work related injury, unless an On-Job Accident Coverage Type is part of the policy.

Plan Provider

Unum Life Insurance Company of America underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates Unum "A" Excellent.

For use with Policy form L-21762

Allstate Benefits Hospital Indemnity Protection

- Guarantee Issue
- All benefits are paid direct to insured, unless assigned
- Benefits increase 5% each year for the first 6 years the policy remains in force at no corresponding increase in premium
- Rates are age banded; unisex
- 4 Tier Coverage options include: Employee Only, Employee + Spouse, Employee + Children and Employee + Family
- Eligible to full time and permanent part-time employees; excludes temporary and seasonal employees
- This plan is not HSA compatible

Group Voluntary Hospital Indemnity Insurance (GVSP1(FL)) Policy Benefits

Policy GVSP1 pays the following benefits for services and treatments administered to or received by a covered person. Such treatment or service must be (a) incurred by a covered person while coverage under the policy and certificate is in force on that person; (b) necessary for the care and treatment of sickness or injury of a covered person; and (c) recommended by a physician. Any loss not stated is not covered. Treatment must be received in the United States or its territories. Benefits increase each coverage year up to year 6.

Terms of Coverage

Family Plan coverage may include employee/member, spouse and dependent children as defined in the policy. Individual and Spouse coverage includes employee/member and spouse. Individual and Children coverage includes employee/member and eligible children as defined in the policy.

Effective Date

The effective date of coverage will be the policy date assigned by the Home Office and shown on the certificate specification page, not the application date.

Pre-Existing Condition Limitation

Allstate Benefits does not pay for any loss due to a pre-existing condition as defined during the 12-month period beginning on the date that person became a covered person. A Pre-Existing Condition is a disease or physical condition for which: symptoms existed within the 12 month period prior to the effective date of coverage; or medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage. A pre-existing condition can exist even though a diagnosis has not yet been made.

Policy Limitations and Exclusions

Allstate Benefits does not pay benefits caused by or resulting from:

- injury or sickness incurred prior to the covered person's effective date of coverage subject to the Pre-Existing Condition Limitation and Incontestability provisions; or
- any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
- suicide, or any attempt at suicide, whether sane or insane; or
- any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician; or
- participation in any form of aeronautics (including parachuting, parasailing and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or
- injury incurred while engaging in an illegal occupation or committing or attempting to commit an assault or felony; or
- dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an injury; or (b) correct a disorder of normal bodily function; or
- alcoholism, drug addiction, or dependence upon any controlled substance; or
- mental or nervous disorders; or
- intentionally self-inflicted injuries; or
- a newborn child's routine nursing or routine well baby care during the initial hospital confinement; or
- childbirth occurring within the first 10 months of the covered person's effective date of coverage (complications of pregnancy are covered to the same extent as a sickness); or
- hospitalization that begins before the covered person's effective date of coverage; or
- the reversal of a tubal ligation and vasectomy; or
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law; or
- routine eye examinations or fitting of eye glasses; or
- hearing aids or fitting of hearing aids; or
- dental examinations or dental care other than expenses resulting from an accident; or
- driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.

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Allstate Benefits Hospital Indemnity Protection

Termination of Coverage

The insured employee's/member's coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which any required premium payments were made; or the last day the insured employee/member is in active employment, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision in the policy; or the date the insured employee/member is no longer in an eligible class; or the date the insured employee's/member's class is no longer eligible. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. Coverage for your child will end on the issue day of the month that follows when the child reaches age 26 or unless otherwise continues to meet the requirements of an eligible dependent.

Portability Privilege

If your coverage terminates for reasons other than non-payment of premium, or if coverage of a spouse terminates due to divorce or your death, or if coverage of a child terminates due to the dependent child reaching age 26, the covered person will be eligible for portability coverage. This means the covered person may continue the same benefits you had under the group policy, subject to the conditions defined in the policy, as long as premiums are paid directly to the insurance company.

Coverage Subject to Policy

Coverage under the certificate is subject in every way to the terms of the policy that is issued to the policyholder. The group policy may at any time be amended or discontinued by agreement between Allstate Benefits and the policyholder. The certificate holder's consent is not required for this. Nor is Allstate Benefits required to give the certificate holder prior notice. This illustration highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy and sets fourth, in detail, the rights and obligations of both the insured and the insurance company.

The policy is Limited Benefit Insurance which supplemental benefits as defined in the policy. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review the Medicare Supplement Buyer's Guide, available from The Allstate Corporation.

Allstate Benefits Hospital Indemnity Protection

Initial Hospitalization Confinement Benefit	Year	Low Plan	Medium Plan	Standard Plan
Allstate Benefits pays the benefit amount shown for the first confinement to a hospital during a coverage year, provided a benefit is paid under the Daily Hospital Confinement Benefit. The benefit is payable only once per covered person per continuous hospital confinement and per coverage year. The benefit is not paid for normal pregnancy or complications of pregnancy, or for a newborn child's initial hospitalization after birth.	1	$415.00	$1,245.00	$2,075.00
	2	$435.75	$1,307.25	$2,178.75
	3	$456.50	$1,369.50	$2,282.50
	4	$477.25	$1,431.75	$2,386.25
	5	$498.00	$1,494.00	$2,490.00
	6+	$518.75	$1,556.25	$2,593.75
Daily Hospital Confinement Benefit	**Year**	**Low Plan**	**Medium Plan**	**Standard Plan**
Allstate Benefits pays the benefit amount shown for each day a covered person is admitted to and confined as an inpatient in a hospital as a result of an injury or sickness. Maximum of 180 days for each period of continuous hospital confinement. The benefit is not payable for a newborn child's routine nursing or routine well baby care during the initial hospital confinement.	1	$165.00/day	$495.00/day	$825.00/day
	2	$173.25/day	$519.75/day	$866.25/day
	3	$181.50/day	$544.50/day	$907.50/day
	4	$189.75/day	$569.25/day	$948.75/day
	5	$198.00/day	$594.00/day	$990.00/day
	6+	$206.25/day	$618.75/day	$1,031.25/day
Hospital Intensive Care Benefit	**Year**	**Low Plan**	**Medium Plan**	**Standard Plan**
Allstate Benefits pays the amount shown for each day a covered person is confined to a hospital intensive care unit, provided a benefit is also paid under the Daily Hospital Confinement Benefit. The covered person must provide proof for each day that a hospital intensive care room and board charge is incurred. Paid in addition to the Daily Hospital Confinement Benefit. Maximum of 60 days for each period of continuous hospital confinement.	1	$165.00/day	$495.00/day	$825.00/day
	2	$173.25/day	$519.75/day	$866.25/day
	3	$181.50/day	$544.50/day	$907.50/day
	4	$189.75/day	$569.25/day	$948.75/day
	5	$198.00/day	$594.00/day	$990.00/day
	6+	$206.25/day	$618.75/day	$1,031.25/day

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Allstate Benefits Hospital Indemnity Protection

Surgery Benefit	Year	Plan
Allstate Benefits pays a benefit up to the amount shown, depending on the surgery, for a surgical operation performed in a hospital or an ambulatory surgical center. Two or more procedures performed at the same time through one incision are considered one operation; Allstate Benefits pays the amount shown in the Schedule of Operations for the operation with the largest benefit. If any operation other than those listed is performed, Allstate Benefits pays an amount based upon the amount stated in the Schedule of Operations for the most comparable procedure.	1	$33.00 to $825.00
	2	$34.65 to $866.25
	3	$36.30 to $907.50
	4	$37.95 to $948.75
	5	$39.60 to $990.00
	6+	$41.25 to $1,031.25
Anesthesia Benefit	**Benefit Amount – All Plans**	
Pays 25% of surgical benefit for anesthesia received by a covered person during the course of a covered surgical operation.	25% of Surgery Benefit	
Inpatient Physician's Treatment Benefit	**Year**	**Plan**
Allstate Benefits pays the amount shown for each day a covered person requires and receives the services of a physician (other than a surgeon) during a covered hospital confinement. The benefit is payable for the number of days the Daily Hospital Confinement Benefit is payable.	1	$41.00/day
	2	$43.05/day
	3	$45.10/day
	4	$47.15/day
	5	$49.20/day
	6+	$51.25/day
Outpatient Emergency Accident Benefit	**Year**	**Plan**
Allstate Benefits pays the amount shown for each visit a covered person, as a result of an injury, requires medical or surgical treatment in an emergency treatment center. Limited to 2 visits per covered person per coverage year.	1	$415.00/visit
	2	$435.75/visit
	3	$456.50/visit
	4	$477.25/visit
	5	$498.00/visit
	6+	$518.75/visit
Outpatient Physician's Treatment Benefit	**Year**	**Plan**
Allstate Benefits pays the amount shown if a covered person is treated by a physician for any cause outside of a hospital. Limited to 5 visits per covered person per coverage year; and a maximum of 10 visits per coverage year for Individual and Spouse coverage or Individual and Children coverage; or a maximum of 15 visits per coverage year if Family Coverage.	1	$41.00/visit
	2	$43.05/ visit
	3	$45.10/ visit
	4	$47.15/ visit
	5	$49.20/ visit
	6+	$51.25/ visit

Allstate Benefits Hospital Indemnity Protection

At Home Nursing Benefit	Year	Plan
Allstate Benefits pays the amount shown for each day a covered person requires at home nursing care during the 60 days following a hospital confinement covered under the policy. At home nursing services must be required and authorized by the attending physician. The benefit is limited to 1 visit per day and a total of 30 visits within the 60 days following a covered hospital confinement.	1	$83.00/day
	2	$87.15/day
	3	$91.30/day
	4	$95.45/day
	5	$99.60/day
	6+	$103.75/day

Ambulance Benefit	Year	Plan
Allstate Benefits pays the amount shown for transfer by a licensed ambulance service or hospital owned ambulance to a hospital or emergency treatment center (for air ambulance, the benefit pays 2 times the amount stated). Limited to a maximum of 3 trips per covered person, per coverage year.	1	$249.00/trip
	2	$261.45/trip
	3	$273.90/trip
	4	$286.35/trip
	5	$298.80/trip
	6+	$311.25/trip

Non-Local Transportation Benefit	Year	Plan
Allstate Benefits pays the amount shown when a covered person requires hospital confinement for treatment prescribed by the local attending physician that cannot be obtained locally. Non-local treatment must be received beyond a 100-mile radius from the home of the covered person. Limited to 3 round trips per covered person per coverage year.	1	$249.00/trip
	2	$261.45/trip
	3	$273.90/trip
	4	$286.35/trip
	5	$298.80/trip
	6+	$311.25/trip

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Allstate Benefits Hospital Indemnity Protection

Biweekly Rates

Low Biweekly Premium Plan 1 Unit Hospital Benefits, 1 Unit Surgery & Related Benefits, 1 Unit Outpatient Benefit				
Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
18-35	$9.86	$18.86	$16.56	$25.06
36-49	$11.48	$22.02	$19.00	$29.02
50-59	$14.04	$27.64	$21.80	$34.80
60-64	$18.36	$36.72	$26.34	$44.00
65+	$24.18	$48.36	$32.90	$56.26

Medium Biweekly Premium Plan 3 Units Hospital Benefits, 1 Units Surgery & Related Benefits, 1 Units Outpatient Benefit				
Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
18-35	$19.66	$36.82	$31.10	$47.74
36-49	$23.10	$43.46	$36.04	$55.86
50-59	$29.00	$56.62	$41.24	$68.28
60-64	$39.14	$78.26	$49.78	$88.20
65+	$52.84	$105.68	$62.82	$114.82

High Biweekly Premium Plan 5 Units Hospital Benefits, 1 Units Surgery & Related Benefits, 1 Units Outpatient Benefit				
Age	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
18-35	$29.46	$54.76	$45.64	$70.42
36-49	$34.74	$64.90	$53.08	$82.68
50-59	$43.96	$85.62	$60.68	$101.76
60-64	$59.90	$119.80	$73.20	$132.40
65+	$81.50	$163.00	$92.72	$173.40

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Pet Assure Program

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

You will save hundreds on your pets' medical care for only $7 month. Pet Assure is the nation's oldest and largest veterinary discount plan and has been saving pet caretakers money on pet expenses since 1995.

Here's what your membership includes:

- **25% off all medical services** each and every time you visit a network veterinarian. With Pet Assure, you'll receive your discount right at the vet's office. This plan is not insurance so there are no hassles, no claim forms and no deductibles. Savings are instant! (See details below.)
- **Any type of pet** with absolutely no exclusions can receive the discounts. There are no exclusions based on type, breed, age, past medical history, or pre-existing conditions. Do you have one dog, five cats, a lazy iguana and a donkey? One Pet Assure membership covers them all.
- **5% – 35% off on pet products and specialty items** at over 1,000 participating national pet product retailers! (See details below.)
- **10% – 35% savings on pet services**, such as boarding, grooming, training, pet day care, etc. (See details below.)
- **24/7 Pet Assure Locator Service** (PALS). Don't worry about your pet getting lost anymore! Every pet that joins gets enrolled in Pet Assure's 24/7 Lost Pet Recovery Service. (See details below.)

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

If you have any questions, please call Pet Assure at:
888-789-PETS (7387).

Using Your Pet Assure Membership is Simple!

Here's How

Simply present your Pet Assure membership card to any participating provider when paying for services and receive instant savings with no paperwork, no deductibles and no hidden fees. Pet Assure is not insurance, so the veterinarian applies the discount directly to your bill and you don't have to wait for reimbursements or fill out time-consuming claim forms.

What's included?

Members receive 25% off all in-house medical services, including:

- Wellness examinations
- Sick visits
- Emergency visits
- Immunizations
- Nutrition counseling
- Geriatric Care
- Behavioral counseling
- Orthopedic surgery
- Soft tissue surgery
- Elective surgery

Biweekly Premium: $3.23†

† Membership must be for a term of no less than three months.

- Routine spay and neuter
- Puppy tail and dewclaw removals
- Tumor removal
- Intensive care cages
- Hospitalization
- Serum chemistries, hematology, serology
- Parasite testing
- Urinalysis
- Complete Blood Counts
- Dental Exams
- Tooth scaling & polishing
- Fluoride application
- Tooth Extractions
- Dental X-rays
- Periodontal disease treatment
- Radiology (X-rays)
- Ultrasound
- Electocardiography (EKG)

And any other medical service provided by the veterinarian in his office. There are no exclusions! All pets are eligible for discounts regardless of type, age, health status, previous health history, or any health related conditions that may arise in the future. There are no usage limits and you can use your card as long as you're an active member.

What's not included?

The practice is not required to discount: 1) Outsourced services, e.g., blood work sent to a lab or an outside specialist, 2) Non-medical services, e.g., routine grooming and boarding, 3) Mileage fees and 4) Products taken home, e.g., medications and food. May not be combined with other discounts, coupons or service packages.

Find a vet near you

Find participating veterinarians in your area on our website at **www.petassure.com**. Our network reaches across all 50 States, Washington DC and Puerto Rico. Enter your **ZIP code in the search box** on the bottom of every page to search for providers.

More savings on retail products

Save on food, supplements, medications, toys, kitty litter, boarding, grooming, pet sitting, training, and so much more. To locate a participating retail provider near you, log on to **www.petassure.com** or call customer service toll free at **888-789-PETS (7387)**.

Lost Pet Recovery Service

For many pet owners, a lost pet is like a lost member of the family, and in our big world a missing pet can be hard to find. Each pet enrolled in PALS, Pet Assure's Locator Service, receives a unique lightweight Pet ID tag with a unique pet ID numbers linked to the pet's confidential information. PALS has reunited thousands of lost pets with their families.

Join today to start saving!

ConstantCredit

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It's YOUR credit. Keep it that way with ConstantCredit.

ConstantCredit monitors your credit report for any changes that may indicate suspicious activity or possible fraud. With ConstantCredit, you can be more aware of your credit health by receiving alerts when changes are reported. You will also receive information on your credit score, and access to tools that allow you to keep track of how your current and future activities may affect your credit score.

Features and Benefits:

Level 3 (L3) Verification
You will first verify your identity before monitoring begins. This ensured you are the only person to have access to your personal information through ConstantCredit.

Full Access to Credit Reports
With ConstantCredit, you have access to your full credit report at any time, regardless of what level of plan you have.

Credit Monitoring
ConstantCredit monitors bureau activity and alerts you to any reported changes on your credit report. The sooner you find out if someone is acting on your behalf, the sooner you can act to mitigate the damage.

Score Tracker
Score Tracker is a monthly report based on four credit factors, showing you graphically how your credit score changes over time.

Score Simulator
Score simulator is a tool that helps you determine how certain actions will affect your credit, such as opening a new line of credit or paying off a loan.

Resource Center
At the Resource Center, you can find recent news and articles on issues related to financial health and other information to educate you on the importance of a healthy credit record.

Have Questions? Need Help? Call ConstantCredit at 855-592-7940.

ConstantCredit Rates	
Employee	$5.31
Employee + Spouse	$10.62

Frequently Asked Questions

Q. What should I do if I think my personal information has been compromised?
A. If you receive an alert indicating suspicious activity associated with your personal information or you see unfamiliar charges or transactions within your account(s), contact your provider (bank, credit card issuer, etc.) and the reporting credit bureau immediately.

Q. How do you keep my information safe?
A. We maintain a highly secure environment with specific security measures and policies in place to ensure the utmost secure handling of all data.

Q. What is credit monitoring, and why is it important?
A. Credit monitoring is the monitoring of an individual's credit report for changes in order to detect suspicious activity or possible fraud. By using a credit report and monitoring service, you can be more aware of your credit health and will receive alerts when changes are reported. While credit monitoring cannot protect you from all types of fraud, being familiar with the latest activity on your credit report is the first step to being empowered and mitigating risk.

Q. Why is my credit score so important?
A. In the United States, a credit score is much more than a number – it's an important part of your everyday life. Lenders use credit scores to evaluate risk, so that one number can decide whether or not you qualify for a loan, at what interest rate and under what limits.

And not just banks use credit scores – mobile phone companies, insurance companies and government bodies also use similar methodologies to determine if a consumer becomes a customer.

ID Commander

Identity theft is the fastest growing crime in America, with an identity stolen once every four seconds. ID Commander, a leader in proactive identity theft protection, uses a variety of industry-leading tools to help protect you from the growing crime of identity theft:

- Advanced Identity Monitoring and Alerts
- $1 Million Identity Theft Insurance Policy, with $0 deductible
- Full-service Identity Restoration
- 24/7 Lost Wallet Assistance
- Award-winning Computer Protection Software

ID Commander's comprehensive identity theft protection plans are available to both individuals and families, with complete access to benefits the moment membership begins. The ID Commander Family Protection Plan provides a truly managed household program and empowers individual family members with the tools and data they need to proactively manage the health and well-being of their identities.

If the worst happens, and you become the victim of identity theft while covered by ID Commander, we will restore your identity and any related credit accounts to pre-theft status. No limits, no fine print, no "service guarantee." In addition, if you suffer any covered out-of-pocket expenses as a result of a breach, you're covered by a real insurance policy that will put money in your hands for qualified losses.

Take command of your future with ID Commander – sign up today!

Plan	Ultimate
Individual	$4.85
Family	$10.38

Ultimate Protection Plan

Restoration:

- Full-service identity restoration
- 24/7 lost wallet assistance
- $1 million insurance policy
- Identity safety resource center

Detection:

- Internet surveillance monitoring and alerts
- Social Security monitoring and alerts
- Change of address monitoring and alerts
- Court/criminal monitoring and alerts
- Sex offender monitoring and alerts
- Payday loan monitoring and alerts

Protection:

Computer Detection Software

ID Commander

PLAN FEATURES	ULTIMATE Our most comprehensive protection package
IDENTITY INSURANCE	✓
FULL-SERVICE IDENTITY THEFT RESTORATION SERVICES	✓
IDENTITY THEFT PROTECTION RESOURCE CENTER	✓
24/7 LOST WALLET ASSISTANCE	✓
INTERNET SURVEILLANCE MONITORING & ALERTS	✓
SOCIAL SECURITY MONITORING & ALERTS	✓
CHANGE OF ADDRESS MONITORING & ALERTS	✓
COURT AND CRIMINAL RECORDS MONITORING & ALERTS	✓
NON-CREDIT LOAN MONITORING & ALERTS	✓
SEX OFFENDER MONITORING & ALERTS	✓
ANTI-VIRUS / ANTI-SPYWARE SOFTWARE	✓
ANTI-PHISHING, ANTI-SPAM SOFTWARE	✓
SOFTWARE FIREWALL	✓
DIGITAL VAULT	✓
DIGITAL FILE SHREDDER	✓

1 Member must provide a Social Security Number in order for the SSN Trace functionality to monitor SSN activity.

Note: Email Address is require to receive notifications.

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2016 Important Notice About Your Prescription Drug Coverage and Medicare From Jackson Health System To Active Employees & Dependents Participating in the Following Sponsored Health Plans: AvMed First HMO – AvMed JHS Select HMO – AvMed Standard HMO – AvMed POS

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Jackson Health System and prescription drug coverage for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. Jackson Health System has determined that the prescription drug coverage offered by the above listed Jackson Health System plans, on average for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Jackson Health System prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of you current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Jackson Health System and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the following November to enroll.

For more information about your current prescription drug coverage, refer to your certificate of coverage issued by your medical insurance plan, or visit **www.avmed.org/jhs.**

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is available 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 prescription drug plans. More information about Medicare prescription drug plans is available from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.**socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Last Updated: October 15, 2015

Name of Entity: Jackson Health System
Contact-Position/Office:
Human Resources Department
Benefits Administration Unit
Address: 1801 NW 9th Ave., #712, Miami
Phone Number: 786-466-8378

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Marketplace Coverage Options & Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

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 begins 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 your employer does not offer coverage, or 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 employer-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?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Jackson Health System	59-1713947
5. Employer address	6. Employer phone number
1611 NW 12th Ave	305-585-1111

7. City	8. State	9. ZIP code
Miami	FL	33136-1096

10. Who can we contact at this job?
The Benefits Department

11. Phone number (if different from above)	12. Email address
305-585-6512	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

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Premium Assistance Under Medicaid & 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.

Once it is determined that 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).

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

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

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COBRA Q&A

What is continuation coverage?

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

How long will continuation coverage last?

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

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

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Keep Your Address Updated

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

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

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 or FBMC On-site Service Center at 305-585-6512.

Upon Termination of employment or loss of coverage during the plan year, except as otherwise provided by law and in accordance with your employer's plan(s), terminated employees are covered through the last day of the pay period in which employment ends, unless you decide to extend coverage under COBRA or until coverage for the plan year expires.

Can I receive COBRA benefits while on FMLA leave?

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

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 pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax 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.

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

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcare expenses you incur, if these premiums were paid with pre-tax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

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

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums on a pre-tax basis, for the first $50,000 of life insurance. However, you must pay tax on any coverage exceeding $50,000 with after-tax money.

Social Security

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

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Service Center at 855-56JHS4U (855-565-4748) 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 time to time adopted.

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FBMC Privacy Notice

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 vary depending on the products or services you request and may include:

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

II. Under Federal Law you have certain rights with respect to your protected health information.

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

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

We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance 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 under our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

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

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

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

Miracles made daily.

Office Hours: 7:30 a.m. - 4:30 p.m. Monday - Friday ET.

On-site FBMC Service Center
Jackson Memorial Hospital
1611 N.W. 12th Avenue
Park Plaza West L-109B
Miami, FL 33136-1096
(305) 585-6512

HR Service Center
Jackson Memorial Hospital
Highland Professional Building
1801 NW 9th Avenue, Suite #150A, room 101
Miami, FL 33136
(305) 585-6771

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
FBMC Service Center 855-56JHS4U (855-565-4748)
www.myFBMC.com

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

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