



Benefits Overview 2021-2022



2020-2021 Payroll Deductions

Florida Blue	EE Only Inst/Admin	\$76.57
Florida Blue	EE Only Non/Inst	\$57.43
Florida Blue	EE Family Non/Inst	\$418.96
Florida Blue	EE Family Inst/Admin	\$418.96
CHP	EE Only Inst/Admin	\$76.57
CHP	EE Only Non/Inst	\$57.43
CHP	EE Family Inst/Admin	\$418.96
CHP	EE Family Non/Inst	\$418.96
Lincoln	Basic Employee Board Paid	\$0.00
Lincoln	Voluntary Life	Based on Amount and Age
Lincoln	STD	Based on Amount and Age
Lincoln	LTD	Based on Amount and Age
Standard - Dental	Employee Low Board Paid	\$0.00
Standard - Dental	Employee High	\$3.96
Standard - Dental	Family Low	\$32.08
Standard - Dental	Family High	\$39.98
The Standard - Vision	Employee	\$4.04
The Standard - Vision	Employee & SP	\$7.98
The Standard - Vision	Employee & Ch	\$8.69
The Standard - Vision	Family	\$12.90

Employees electing dependent coverage on medical and dental will have both the employee and family deductions.

Items to know

1. All payroll deductions will be semi/monthly
2. Medical deductions will be deducted in advance
3. All other deductions will be deducted in the month of the effective date.
4. For all future qualifying events, you must notify the District or Brad Hoard within 30 days. Payroll deductions for qualified events must be caught up in the next payroll cycle.



To: Duel Employees of Franklin County School District

Re: Medical and Dental Insurance Payroll Deductions

Franklin County School District contributes \$612.58 per month for instructional staff, 650.86 for non-instructional staff and \$30.76 for Dental. If both you and your spouse are benefit eligible employees, the School District will combine both contributions for family coverage. Semi-Monthly Payroll Deductions for family coverage are as follows


CHP or Florida Blue	2 Non-Instructional	\$150.96
CHP or Florida Blue	1 Instructional and 1 Non-Instructional	\$170.10
CHP or Florida Blue	2 Instructional	\$189.24
Standard	Family Dental Low	\$16.70
Standard	Family Dental High	\$24.60

Payroll deductions will be split between each employee's pay checks.



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.capitalhealth.com/sbc. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-850-383-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Medical: \$2,000 single coverage / \$4,500 family coverage. Pharmacy: \$4,600 single coverage \$8,700 family coverage.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers .	Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: \$15 / visit Telehealth: \$15 / visit	Not Covered	Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
	Specialist visit	Office: \$40 / visit Telehealth: \$40 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
	Preventive care/screening /immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	\$100 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	\$15/30-day supply \$30/60-day supply \$45/90-day supply (retail & mail order)	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
	Tier 2 drugs	\$30/30-day supply \$60/60-day supply \$90/90-day supply (retail & mail order)	Not Covered	
	Tier 3 drugs	\$50/30-day supply \$100/60-day supply \$150/90-day supply (retail & mail order)	Not Covered	

	Specialty drugs	\$50 /30-day supply	Not Covered	Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: \$100 / visit Hospital: \$250 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	\$40 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	\$300 / visit \$250 / observation	\$300 / visit \$250 / observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status, an additional copayment may apply based on services rendered.
	Emergency medical transportation	\$100 / transport	\$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit	Urgent care center: \$25 / visit Telehealth: \$25 / visit Amwell: \$15 / visit	Telehealth – Services are provided by <u>network providers</u> through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 / admission \$250 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted \$40 /provider for observation	Not Covered	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 / visit	Not Covered	—————none—————
	Inpatient services	\$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	\$40 / visit	Not Covered	—————none—————
	Childbirth/delivery professional services	No Charge	Not Covered	—————none—————
	Childbirth/delivery facility services	\$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.

If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Rehabilitation services	\$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	Not Covered	Not Covered	—————none—————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	\$15 / visit	Not Covered	—————none—————
	Children's glasses	Not Covered	Not Covered	—————none—————
	Children's dental check-up	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Cosmetic Surgery • Dental care (Adult) • Dental care (Child) 	<ul style="list-style-type: none"> • Glasses • Habilitation services • Hearing aids • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the US • Private-duty nursing • Routine foot care • Weight loss programs 	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 850-383-3311, 1-877-247-6512.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$250
■ Other copayment	\$0

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$560

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$250
■ Other copayment	\$50

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$250
■ Other copayment	\$0

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.


Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-Network: \$2,500 Per Person. Out-of-Network: \$5,000 Per Person.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$500 Out-of-Network Per Admission <u>Deductible</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Yes. In-Network: \$5,800 Per Person. Out-Of-Network: \$11,600 Per Person.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Primary Care Visits: <u>Deductible</u> + 20% <u>Coinsurance</u> / Virtual Visits (Telemedicine): <u>Deductible</u> + 20% <u>Coinsurance</u>	Primary Care Visits: <u>Deductible</u> + 40% <u>Coinsurance</u> / Virtual Visits (Telemedicine): Not Covered	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: <u>Deductible</u> / Independent Diagnostic Testing Center: <u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com/tols-resources/pharmacy/medication-guide	Generic drugs	<u>Deductible</u> + \$10 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$25 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	<u>Deductible</u> + \$50 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$125 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	<u>Deductible</u> + \$80 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$200 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	<u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 40% <u>Coinsurance</u> / Hospital: In-Network <u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	In-Network <u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
	<u>Urgent care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: <u>Deductible</u> + 20%	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40%	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
		<u>Coinsurance</u>	<u>Coinsurance</u>	share.
	Physician/surgeon fees	Deductible + 20% <u>Coinsurance</u>	In-Network Deductible + 20% <u>Coinsurance</u>	_____none_____
	Outpatient services	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Deductible + 20% <u>Coinsurance</u>	In-Network Deductible + 20% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
	Office visits	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	Deductible + 20% <u>Coinsurance</u>	In-Network Deductible + 20% <u>Coinsurance</u>	_____none_____
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 20% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + Deductible + 40% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Home health care	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Coverage limited to 20 visits.
If you need help recovering or have other special health needs	Rehabilitation services	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	Hospice services	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	_____none_____
	Children's eye exam	Not Covered	Not Covered	Not Covered
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--------------------------------|-----------------------------|--|
| • Acupuncture | • Hearing aids | • Pediatric glasses |
| • Bariatric surgery | • Infertility treatment | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Adult) | • Pediatric dental check-up | • Routine foot care unless for treatment of diabetes |
| • <u>Habilitation services</u> | • Pediatric eye exam | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|--|--|--|
| • Chiropractic care - Limited to 35 visits | • Most coverage provided outside the United States. See www.floridablue.com . | • Non-emergency care when traveling outside the U.S. |
|--|--|--|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>No Charge</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,800
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,390

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$100
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,160

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電1-800-352-2583 (TTY: 1-800-955-8770)。FEP: 請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-955-8770). FEP: اتصل برقم 1-800-333-2227.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો [1-800-352-2583](tel:1-800-352-2583) (TTY: [1-800-955-8770](tel:1-800-955-8770)). FEP: ફોન કરો [1-800-333-2227](tel:1-800-333-2227)

ประกาศ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรศัพท์ **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ FEP โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره 1-800-352-2583 (TTY: 1-800-955-8770) تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíik'eh, ná hóló. Kojí' hodiíłnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éi kojí' hodiíłnih 1-800-333-2227.

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$5,000 Per Person/ \$5,000 Family. Out-of-Network: \$10,000 Per Person/ \$10,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your deductible. See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$500 Out-of-Network Per Admission <u>Deductible</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: \$6,850 Per Person/ \$11,600 Family. Out-Of-Network: \$23,200 Per Person/ \$23,200 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Primary Care Visits: <u>Deductible</u> + 20% <u>Coinsurance</u> / Virtual Visits (Telemedicine): <u>Deductible</u> + 20% <u>Coinsurance</u>	Primary Care Visits: <u>Deductible</u> + 40% <u>Coinsurance</u> / Virtual Visits (Telemedicine): Not Covered	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: <u>Deductible</u> / Independent Diagnostic Testing Center: <u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	<u>Deductible</u> + \$10 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$25 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	<u>Deductible</u> + \$50 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$125 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	<u>Deductible</u> + \$80 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$200 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	<u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 40% <u>Coinsurance</u> / Hospital: In-Network <u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	In-Network <u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
	<u>Urgent care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: <u>Deductible</u> + 20%	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40%	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-

For more information about limitations and exceptions, see the [plan](#) or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		<u>Coinsurance</u>	<u>Coinsurance</u>	share.
	Physician/surgeon fees	Deductible + 20% <u>Coinsurance</u>	In-Network Deductible + 20% <u>Coinsurance</u>	_____none_____
	Outpatient services	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Inpatient services	Deductible + 20% <u>Coinsurance</u>	In-Network Deductible + 20% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
	Office visits	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant	Childbirth/delivery professional services	Deductible + 20% <u>Coinsurance</u>	In-Network Deductible + 20% <u>Coinsurance</u>	_____none_____
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 20% <u>Coinsurance</u>	Per Admission Deductible + Deductible + 40% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Home health care	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Coverage limited to 20 visits.
If you need help recovering or have other special health needs	Rehabilitation services	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	Hospice services	Deductible + 20% <u>Coinsurance</u>	Deductible + 40% <u>Coinsurance</u>	_____none_____
	Children's eye exam	Not Covered	Not Covered	Not Covered
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--------------------------------|-----------------------------|--|
| • Acupuncture | • Hearing aids | • Pediatric glasses |
| • Bariatric surgery | • Infertility treatment | • Private-duty nursing |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Adult) | • Pediatric dental check-up | • Routine foot care unless for treatment of diabetes |
| • <u>Habilitation services</u> | • Pediatric eye exam | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|--|--|--|
| • Chiropractic care - Limited to 35 visits | • Most coverage provided outside the United States. See www.floridablue.com . | • Non-emergency care when traveling outside the U.S. |
|--|--|--|

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> <u>Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>No Charge</u>	\$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,500
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,590

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> <u>Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$20
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Joe would pay is	\$5,880

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$5,000
■ <u>Specialist</u> <u>Coinsurance</u>	20%
■ Hospital (facility) <u>Coinsurance</u>	20%
■ Other <u>Coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):

Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電1-800-352-2583 (TTY: 1-800-955-8770)。FEP: 請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-352-2583 (رقم هاتف الصم والبكم: 1-800-333-2227). 7222

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો [1-800-352-2583](tel:1-800-352-2583) (TTY: [1-800-955-8770](tel:1-800-955-8770)). FEP: ફોન કરો [1-800-333-2227](tel:1-800-333-2227)

ประกาศ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรศัพท์ **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ FEP โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره 1-800-352-2583 (TTY: 1-800-955-8770) تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojí' hodiíłnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éi kojí' hodiíłnih 1-800-333-2227.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

Franklin County School District Medical Plan

What are the differences in the medical plans?

What is Capital Health Plan?

A regional health maintenance organization(HMO) health insurance plan serving Calhoun, Franklin, Gadsden, Jefferson, Leon, Liberty and Wakulla counties in Florida.

What is Florida Blue?

A Statewide preferred provider organization(PPO) serving all counties in Florida.

What is the difference in cost?

Both Florida Blue and Capital Health Plan have the same cost.

Is there out of network benefits?

Florida Blue *YES* – Capital Health Plan *NO* (emergency only)

Is there a deductible?

Florida Blue *YES*- Capital Health Plan *NO*

Is there a Maximum out of Pocket?

Florida Blue *YES* – Capital Health Plan *YES*

Are there co pays for office visits, testing, emergency and hospitals?

Florida Blue No (deductible applies) - Capital Health Plan *YES*

Are there prescription copays?

Florida Blue *YES* (after deductible is met) – Capital Health Plan *YES*

This a brief question and answer regarding the medical insurance choices. For a summary of benefits please see the attached plan summaries.



Franklin County School District provides this
valuable benefit at no cost to you.

Full-Time Employees

Life and AD&D Insurance

Safeguard the most important people in your life.

Think about what your loved ones may face after you're gone. Term life insurance can help them in so many ways, like covering everyday expenses, paying off debt, and protecting savings. AD&D provides even more coverage if you die or suffer a covered loss in an accident.

AT A GLANCE:

- A cash benefit of \$25,000 to your loved ones in the event of your death, plus a matching cash benefit if you die in an accident
- A cash benefit to you if you suffer a covered loss in an accident, such as losing a limb or your eyesight
- *Accident Plus* - If you suffer an AD&D loss in an accident, you may also receive benefits for the following on top of your core AD&D benefits: coma, plegia, education, child care, spouse training, and more.
- *LifeKeys*® services, which provide access to counseling, financial, and legal support
- *TravelConnect*™ services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

**You also have the option to increase your cash benefit by securing additional coverage at affordable group rates.
See the enclosed life insurance information for details.**

ADDITIONAL DETAILS

Conversion: You can convert your group term life coverage to an individual life insurance policy without providing evidence of insurability if you lose coverage due to leaving your job or for another reason outlined in the plan contract. AD&D benefits cannot be converted.

Benefit Reduction: Coverage amounts begin to reduce at age 70 and benefits terminate at retirement. See the plan certificate for details.

For complete benefit descriptions, limitations, and exclusions, refer to the certificate of coverage.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

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Franklin County School District Dental Highlight Sheet



Low Plan 1: Dental Plan Summary

Effective Date: 1/1/2018

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	\$50/Calendar Year Type 2 & 3 Waived Type 1 \$150/family
Maximum (per person)	\$1,000 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK AssistSM	None
Annual Open Enrollment	None

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum (per person)	\$1,000
Waiting Period	None

Sample Procedure Listing (Current Dental Terminology © American Dental Association.)

Type 1	Type 2	Type 3
<ul style="list-style-type: none"> • Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 in 12 months) • Sealants (age 13 and under) • Space Maintainers 	<ul style="list-style-type: none"> • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Simple Extractions • Anesthesia 	<ul style="list-style-type: none"> • Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years) • Complex Extractions

About The Standard

As a leading provider of employee benefits products and services, Standard Insurance Company is dedicated to meeting the unique insurance needs of each customer. More than 27,100 groups trust The Standard for group insurance products and services, and the company covers nearly 7 million employees.

Founded in Portland, Oregon, in 1906, The Standard has built a national reputation for delivering quality insurance products, personalized service and strong financial performance. The Standard wrote its first group insurance policy in 1951, and it remains in force today as a testament to the company's commitment to building successful long-term relationships.

Customer Service

Your local Standard Insurance Company Employee Benefits Sales and Service Office will provide most of the ongoing service for your plan and can be reached at 800.633.8575 during normal business hours. We will assign your company a service representative who will provide regular contact and address questions and concerns related to the plan or the services we provide.

Standard Insurance Company
Benefit and Cost Summary Highlight Sheet

Franklin County School District

Dental Highlight Sheet



We also make it easy for covered employees and dentists to contact us to confirm eligibility or request claims information by calling **1-800-547-9515**. Our customer service representatives are available Monday through Thursday from 5:00 a.m. until 10:00 p.m. Pacific Time and until 4:30 p.m. Pacific Time on Friday. For plan information any time, access our automated voice response system or go online to standard.com.

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: <http://www.standard.com/dental> and click on "Find a Dentist."

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

Franklin County School District

Dental Highlight Sheet



High Plan 1: Dental Plan Summary

Effective Date: 1/1/2018

Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	\$50/Calendar Year Type 2 & 3
	Waived Type 1
	\$150/family
Maximum (per person)	\$1,500 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Eye Exam	None
LASIK AssistSM	None
Annual Open Enrollment	Included

Orthodontia Summary - Child Only Coverage

Allowance	U&C
Plan Benefit	50%
Lifetime Maximum (per person)	\$1,000
Waiting Period	None

Sample Procedure Listing (Current Dental Terminology © American Dental Association.)

Type 1	Type 2	Type 3
<ul style="list-style-type: none"> • Routine Exam (1 in 6 months) • Bitewing X-rays (1 in 12 months) • Periapical X-rays • Cleaning (1 in 6 months) • Fluoride for Children 13 and under (1 in 12 months) • Sealants (age 13 and under) • Space Maintainers 	<ul style="list-style-type: none"> • Full Mouth/Panoramic X-rays (1 in 5 years) • Restorative Amalgams • Restorative Composites • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Simple Extractions • Complex Extractions • Anesthesia 	<ul style="list-style-type: none"> • Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Denture Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 10 years)

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Franklin County School District

Dental Highlight Sheet



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Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member dentist are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit: <http://www.standard.com/dental> and click on "Find a Dentist."

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on January 1.

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard [or your employer] for additional information, including costs and complete details of coverage.

Franklin County School Board
Eye Care Highlight Sheet



Plan 1: Balanced Care Vision I Plan Summary

Effective Date: 1/1/2015

	VSP Network	Out of Network
Deductibles		
	\$10 Exam	\$10 Exam
	\$10 Eye Glass Lenses or Frames*	\$10 Eye Glass Lenses or Frames
	Covered in full	Up to \$52
Annual Eye Exam		
Lenses (per pair)		
Single Vision	Covered in full	Up to \$55
Bifocal	Covered in full	Up to \$75
Trifocal	Covered in full	Up to \$95
Lenticular	Covered in full	Up to \$125
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to \$60	No benefit
Elective	Up to \$130	Up to \$105
Medically Necessary	Covered in full	Up to \$210
Frames	\$130	Up to \$70
Frequencies (months)		
Exam/Lens/Frame	12/12/24	12/12/24
	Based on date of service	Based on date of service

*Deductible applies to a complete pair of glasses or to frames, whichever is selected.

Lens Options (participant cost)*

	VSP Network	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Trifocal allowance.
Std. Polycarbonate	Covered in full for dependent children	No benefit
	\$25 adults	
Solid Plastic Dye	\$13	No benefit
	(except Pink I & II)	
Plastic Gradient Dye	\$15	No benefit
Photochromatic Lenses	\$27-\$76	No benefit
(Glass & Plastic)		
Scratch Resistant Coating	\$15-\$29	No benefit
Anti-Reflective Coating	\$39-\$75	No benefit
Ultraviolet Coating	\$14	No benefit

*Lens Option participant costs vary by prescription, option chosen and retail locations.

Monthly Rates

Employee Only (EE)	
EE + Spouse	
EE + Children	
EE + Spouse & Children	

Additional Balanced Care Vision I Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact lens fit & follow up exam allowance, the cost of the fitting and evaluation is deducted from the contact allowance.
Additional Glasses	20% discount off the retail price on additional pairs of prescription glasses (complete pair).
Frame Discount	VSP offers a 20% discount off the remaining balance in excess of the frame allowance.
Laser VisionCare	VSP offers an average discount of 15% on LASIK and PRK. The maximum out-of-pocket per eye for participants is \$1,800 for LASIK and \$2,300 for custom LASIK using Wavefront technology, and \$1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to \$1,000 is covered every two years).

Eye Care Plan Participant Service

Balanced Care Vision I eye care from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: standard.com/services

View plan benefit information at: vsp.com

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

This form is a benefit highlight, not a certificate of insurance.

Full-Time Employees of Franklin County School District

Benefits At-A-Glance

Supplemental Life and AD&D Insurance

The Lincoln Term Life and AD&D Insurance Plan:

- Provides a cash benefit to your loved ones in the event of your death
- Provides an additional cash benefit to your loved ones if you die — or to you if you lose a limb or your eyesight — in a covered accident
- Features group rates for Franklin County School District employees
- Includes *LifeKeys*® services, which provide access to counseling, financial, and legal support services
- Also includes *TravelConnect*SM services, which give you and your family access to emergency medical assistance when you're on a trip 100+ miles from home

Employee	
Guaranteed coverage amount during initial offering or approved special enrollment period	\$150,000
Newly hired employee guaranteed coverage amount	\$150,000
Continuing employee guaranteed coverage annual increase amount	Choice of \$10,000 or \$20,000
Maximum coverage amount	5 times your annual salary (\$300,000 maximum in increments of \$10,000)
Minimum coverage amount	\$10,000
AD&D coverage amount	Equal to the life insurance amount chosen
Spouse	
Guaranteed coverage amount during initial offering or approved special enrollment period	\$30,000
Newly hired employee guaranteed coverage amount	\$30,000
Continuing employee guaranteed coverage annual increase amount	Choice of \$5,000 or \$10,000
Maximum coverage amount	50% of the employee coverage amount (\$150,000 maximum in increments of \$5,000)
Minimum coverage amount	\$5,000
AD&D coverage amount	Equal to the life insurance amount chosen
Dependent Children	
6 months to age 26 guaranteed coverage amount	\$10,000
Age 14 days to 6 months guaranteed coverage amount	\$250

What your benefits cover

Employee Coverage

Guaranteed Life and AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to \$150,000 without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by \$10,000 or \$20,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to \$20,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 5 times your annual salary (\$300,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.
- Your coverage amount will reduce by 50% when you reach age 70

Spouse Coverage - You can secure term life and AD&D insurance for your spouse if you select coverage for yourself.

Guaranteed Life and AD&D Insurance Coverage Amount

- Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 50% of your coverage amount (\$30,000 maximum) for your spouse without providing evidence of insurability.
- Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse by \$5,000 or \$10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.
- If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense.
- You can increase this amount by up to \$10,000 during the next limited open enrollment period.

Maximum Life Insurance Coverage Amount

- You can choose a coverage amount up to 50% of your coverage amount (\$150,000 maximum) for your spouse with evidence of insurability.
- Coverage amounts are reduced by 50% when an employee reaches age 70

Dependent Children Coverage - You can secure term life insurance for your dependent children when you choose coverage for yourself.

Guaranteed Life Insurance Coverage Options: \$10,000

Supplemental Life and AD&D Insurance Benefits At-A-Glance

Additional Plan Benefits

Accelerated Death Benefit	Included
Premium Waiver	Included
Conversion	Included
Portability	Included
Seat Belt & Airbag	Included with AD&D
Common Carrier	Included with AD&D

Benefit Exclusions

Like any insurance, this term life and AD&D insurance policy does have exclusions.

For life insurance, a suicide exclusion may apply.

For AD&D, benefits will not be paid if death results from suicide, or death/dismemberment occurs while:

- Inflicting or attempting to inflict injury to one's self
- Participating in a riot or as a result of war or act of war
- Serving as a member of the military, including the Reserves and National Guard
- Committing or attempting to commit a felony
- Deliberately inhaling gas (such as carbon monoxide) or using drugs other than those prescribed by a physician and administered as prescribed
- Flying in a non-commercial airplane or aircraft, such as a balloon or glider
- Driving while intoxicated (with a blood alcohol level of .08 grams or more per 100 milliliters of blood)

In addition, the AD&D insurance policy does not cover sickness or disease, including the medical and surgical treatment of a disease.

A complete list of benefit exclusions is included in the policy. State variations apply.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. TravelConnectSM travel assistance services are provided by On Call International, Salem NH. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. ComPsych® and On Call International are not Lincoln Financial Group companies and Lincoln Financial Group does not administer these Services. Each independent company is solely responsible for its own obligations. Coverage is subject to contract language that contains specific terms, conditions, and limitations.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.



Monthly Supplemental Life and AD&D Insurance Premium

Here's how little you pay with group rates.

Employee Age Range	Life & AD&D Premium Rate
0 - 29	0.0000670
30 - 34	0.0000870
35 - 39	0.0000970
40 - 44	0.0001270
45 - 49	0.0002070
50 - 54	0.0003070
55 - 59	0.0004170
60 - 64	0.0005670
65 - 69	0.0010370
70 - 74	0.0018870
75 - 79	0.0054970
80 - 99	0.0054970

Group Rates for You

The estimated monthly premium for life and AD&D insurance is determined by multiplying the desired amount of coverage (in increments of \$10,000) by the employee age-range premium rate.

$$\begin{array}{ccccc} \$ & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & = & \$ \underline{\hspace{2cm}} \\ \text{coverage amount} & & & \text{premium rate} & & \text{monthly premium} \end{array}$$

Note: Rates are subject to change and can vary over time.

Employee Age Range	Life & AD&D Premium Rate
0 - 29	0.0000670
30 - 34	0.0000870
35 - 39	0.0000970
40 - 44	0.0001270
45 - 49	0.0002070
50 - 54	0.0003070
55 - 59	0.0004170
60 - 64	0.0005670
65 - 69	0.0010370
70 - 74	0.0018870
75 - 79	0.0054970
80 - 99	0.0054970

Group Rates for Your Spouse

The estimated monthly premium for life and AD&D insurance is determined by multiplying the desired amount of coverage (in increments of \$5,000) by the employee age-range premium rate.

$$\begin{array}{ccccc} \$ & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & = & \$ \underline{\hspace{2cm}} \\ \text{coverage amount} & & & \text{premium rate} & & \text{monthly premium} \end{array}$$

Note: Rates are subject to change and can vary over time.

Dependent Children Monthly Premium for Life Insurance Coverage

Coverage Amount	Monthly Premium
\$10,000	\$1.68

Group Rates for Your Dependent Children

One affordable monthly premium covers all of your eligible dependent children.

Note: You must be an active Franklin County School District employee to select coverage for a spouse and/or dependent children. To be eligible for coverage, a spouse or dependent child cannot be confined to a health care facility or unable to perform the typical activities of a healthy person of the same age and gender.

The Lincoln National Life Insurance Company
Please see prior page for product information.

Supplemental Life and AD&D Insurance Premium Calculation

Full-Time Employees of Franklin County School District

Benefits At-A-Glance

Voluntary Long Term Disability Insurance

The Lincoln Long-term Disability Insurance Premier Plan:

- Provides a cash benefit after you are out of work for 90 days or more due to injury, illness, or surgery
- Features group rates for Franklin County School District employees
- Includes *EmployeeConnect*SM services, which give you and your family confidential access to counselors as well as personal, legal, and financial assistance

Long-term Disability

Monthly benefit amount	60% of your monthly salary, limited to \$5,000 per month
Elimination period	90 days
Coverage period for your occupation	24 months
Maximum coverage period	Up to age 65 or Social Security Normal Retirement Age (SSNRA), whichever is later

Elimination Period

- This is the number of days you must be disabled before you can collect disability benefits.
- The 90-day elimination period can be met through either total disability (out of work entirely) or partial disability (working with a reduced schedule or performing different types of duties).

Coverage Period for Your Occupation

- This is the coverage period for the trade or profession in which you were employed at the time of your disability (also known as your own occupation).
- You may be eligible to continue receiving benefits if your disability prohibits you from any employment for which you are reasonably suited through your training, education, and experience. In this case, your benefits are extended through the end of your maximum coverage period (benefit duration).

Maximum Coverage Period

- This is the total amount of time you can collect disability benefits (also known as the benefit duration).
- Benefits are limited to 24 months for mental illness; 24 months for substance abuse.

Pre-existing Condition

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Additional Plan Benefits	
Premium Waiver	Included
Progressive Income Benefit	Included
Family Care Expense Benefit	Included
Family Income Benefit	Included

Open Enrollment

- When you are first offered this coverage (and during approved open enrollment periods), you can take advantage of this important coverage with no health examination.

Benefit Exclusions & Reductions

Like any insurance, this long-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- You are not under the regular care of a doctor when you request disability benefits
- Your disability occurs while you are committing a felony or participating in a riot
- Your disability occurs while you are imprisoned for committing a felony
- Your disability occurs while you are residing outside of the United States or Canada for more than 12 consecutive months for a purpose other than work

Your benefits may be reduced if you are eligible to receive benefits from:

- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation
- Salary continuance
- Sick leave

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

EmployeeConnectSM services are provided by ComPsych[®] Corporation, Chicago, IL. ComPsych[®] and GuidanceResources[®] are registered trademarks of ComPsych[®] Corporation. ComPsych[®] is not a Lincoln Financial Group[®] company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations.

Insurance products (policy series GL3001) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.



Voluntary Long Term Disability Insurance

Here’s how little you pay with group rates.

Your estimated monthly premium is determined by multiplying your monthly salary amount (up to \$8,333) by your age-range premium rate. If your monthly salary exceeds \$8,333, multiply \$8,333 by your premium rate.

\$

X

= \$

monthly salary

premium rate

monthly premium

Age Range	Premium Rate
0 - 24	0.00100
25 - 29	0.00160
30 - 34	0.00230
35 - 39	0.00290
40 - 44	0.00410
45 - 49	0.00590
50 - 54	0.00840
55 - 59	0.01000
60 - 64	0.01050
65 - 69	0.00970
70 - 99	0.00970

The Lincoln National Life Insurance Company
Please see prior page for product information.

Voluntary Long-term Disability Insurance Premium Calculation | Premier Plan

Full-Time Employees of Franklin County School District

Benefits At-A-Glance

Voluntary Short Term Disability Insurance

The Lincoln Short-term Disability Insurance Plan:

- Provides a cash benefit when you are out of work for up to 11 weeks due to injury, illness, surgery, or recovery from childbirth
- Provides a partial cash benefit if you can only do part of your job or work part time
- Features group rates for Franklin County School District employees
- Offers a fast, no-hassle claims process

Short-term Disability	
Weekly benefit amount	60% of your weekly salary, limited to \$900 per week
Sickness elimination period	14 days
Accident elimination period	14 days
Maximum coverage period	11 weeks

Sickness Elimination Period

- You must be out of work for 14 days due to an illness before you can collect disability benefits. You can begin collecting benefits on day 15.

Accident Elimination Period

- You must be out of work for 14 days due to an accidental injury before you can collect disability benefits. You can begin collecting benefits on day 15.

Pre-existing Condition

- If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Benefits Integration

- Your short-term disability benefits can coordinate with income from other sources, such as continued income or sick pay from your employer, during your disability.
- This allows you to receive up to 100% of your pre-disability income.

Additional Plan Benefits	
5% Rehabilitation Assistance	Included
Premium Waiver	Included
Family Income Benefit	Included
Portability	Included

Open Enrollment

- When you are first offered this coverage (and during approved open enrollment periods), you can take advantage of this important coverage with no health examination.

Benefit Exclusions & Reductions

Like any insurance, this short-term disability insurance policy does have some exclusions. You will not receive benefits if:

- Your disability is the result of a self-inflicted injury or act of war
- You are not under the regular care of a doctor when you request disability benefits

Your benefits may be reduced if you are eligible to receive benefits from:

- A state disability plan or similar compulsory benefit act or law
- A retirement plan
- Social Security
- Any form of employment
- Workers' Compensation

A complete list of benefit exclusions and reductions is included in the policy. State restrictions may apply to this plan.

This is not intended as a complete description of the insurance coverage offered. Controlling provisions are provided in the policy, and this summary does not modify those provisions or the insurance in any way. This is not a binding contract. A certificate of coverage will be made available to you that describes the benefits in greater detail. Refer to your certificate for your maximum benefit amounts. Should there be a difference between this summary and the contract, the contract will govern.

Insurance products (policy series GL1101) are issued by The Lincoln National Life Insurance Company (Fort Wayne, IN), which does not solicit business in New York, nor is it licensed to do so. Product availability and/or features may vary by state. Limitations and exclusions apply.



Voluntary Short Term Disability Premium

Here’s how little you pay with group rates.

Your estimated monthly premium is determined by multiplying your weekly salary amount (up to \$1,500) by your age-range premium factor. If your weekly salary exceeds \$1,500, multiply \$1,500 by your premium factor.

\$

weekly salary

X

premium factor

= \$

monthly premium

Age Range	Premium Factor
0 - 24	0.01140
25 - 29	0.03720
30 - 34	0.03300
35 - 39	0.02760
40 - 44	0.02520
45 - 49	0.02760
50 - 54	0.03360
55 - 59	0.04080
60 - 64	0.04620
65 - 69	0.05940
70 - 99	0.05940

The Lincoln National Life Insurance Company
Please see prior page for product information.

Voluntary Short-term Disability Insurance Premium Calculation

An identity is stolen every two seconds.¹

̄URA™



IDENTITY
GUARD

Cybercrime has become the number one threat facing our world today.² With the amount of our personal information online, it's become easier for your identity to be stolen. The need to protect yourself and your family is more important than ever.

Are you at risk?

Our daily online activity makes us vulnerable to data breaches and identity theft. No one is immune to cybercrime. It impacts every person regardless of age, gender, income level, and location.³ Aura™ Identity Guard® is designed to keep your entire household safe from the effects of cybercrime, not only shielding your personal data from getting into the wrong hands, but also protecting you and your children online.

The Solution

Aura Identity Guard combines superior IBM® Watson™ technology with around-the-clock, outstanding service to save you time and stress.



Monitor

We scan billions of online sources and suggest ways to reduce your exposure to cybertheft



Alert

Within seconds, we alert you to possible threats from activities, so you can act quickly



Recover

Our team of dedicated experts can help you recover lost information and assist you in the case of identity theft



Insure

Your \$1 million insurance policy covers you from any losses or stolen funds⁶



THE COST OF IDENTITY THEFT



Out-of-pocket fraud costs doubled from 2016 to 2018 to \$1.7 Billion.⁴



More than 1 million children in the U.S. were victims of identity theft in 2017, costing families \$540 million in out-of-pocket expenses.⁵

¹IBM Security. "2019 Cost of a Data Breach Report." July 2019.

²Ernst & Young. "EY CEO Imperative Study 2019," July 2019.

³Identity Theft Resource Center. "2019 End-of-Year Data Breach Report." January 2020.

⁴Ponemon Institute. "2016 Cost of Data Breach Study," June 2016.

⁵Javelin Strategy & Research. "2018 Child Identity Fraud Study," April 2018.

⁶Identity Theft Insurance underwritten by insurance company subsidiaries or affiliates of American International Group, Inc. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

The Premier Plan

For a low monthly payment, the Premier Plan provides coverage to keep you and your family safe.

IDENTITY SECURE FEATURES

- ✓ Near Real-Time Alerts
- ✓ Auto-On Monitoring
- ✓ Credit and debit card monitoring
- ✓ Bank account transaction monitoring
- ✓ 401(k) investment account monitoring
- ✓ Student loan activity alerts
- ✓ High Risk Transaction Monitoring
- ✓ Bank Account Opening & Takeover Monitoring
- ✓ Address Monitoring
- ✓ Criminal Record Monitoring
- ✓ Fictitious Identity Monitoring
- ✓ Home Title Monitoring
- ✓ Sex Offender Monitoring
- ✓ Dark Web Monitoring
- ✓ Human-sourced intelligence

- ✓ Compromised credentials
- ✓ Stolen fund reimbursement
- ✓ 401(k) and HSA reimbursement
- ✓ \$1M Identity Theft Insurance
- ✓ Security Freeze Assistance
- ✓ Threat Alerts
- ✓ Risk Management Score
- ✓ Social Insight Report
- ✓ Lost Wallet Protection
- ✓ 3 Bureau Credit Monitoring
- ✓ 3 Bureau Annual Credit Report
- ✓ Monthly Credit Score
- ✓ Credit Score Tracker
- ✓ Cyberbullying and Social Media Monitoring

DEVICE SECURE FEATURES

- ✓ Safe Browsing Software

Why wait another minute when you're at risk right now?

Aura Identity Guard can keep you and your family protected. You'll feel confident that your personal information is in good hands.