2021
Employee Benefit
— G — U — I — D — E —



SPC St. Petersburg College

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General Information

What is a "Copayment"?

- A copayment is a pre-determined amount you must pay out-of-pocket when seeing a service provider. It is paid directly to the provider and is due at the time services are rendered.

What is a "Deductible"?

- A deductible is a pre-determined amount that is paid by you before the insurer begins to pay.

What is "Coinsurance"?

- Coinsurance is the percentage paid by the insurer and the percentage paid by you after you have met the deductible.

What is "Precertification"?

- Certain services, such as hospitalization or outpatient surgery, may require prior authorization with your insurer to verify coverage for those services. When required, your participating physician must obtain a pre- certification for you prior to your treatment.

Where can I find an in-network provider?

- Directories of participating service providers may be found on Florida Blue's website. If you do not have internet access, you may call member services to find an in-network provider near you.

Should I use a convenient care center, an urgent care center or the emergency room?

- Convenient care centers (found in many Walgreen's stores) are a great way to address the common cough, cold and sore throat. Urgent care centers are another great alternative to the emergency room when your doctor's office is closed. The co-payments are normally a lot less than an emergency room visit. Further information can be found on page 13.

Qualifying Life Events

If you experience any of the qualifying life events listed below, you must contact Human Resources within 30 days of the event to be able to make changes to your benefits. Proof of the event is required in order to successfully make the requested changes to your plans.

- Marriage
- Divorce or legal separation (subject to State regulations)
- Death of spouse, child or other qualified dependent
- Birth or adoption of child
- Loss of other group coverage
- Change in employment status for employee, spouse or dependent
- Change in residence due to an employment transfer
- Change of dependent status

Lower your out-of-pocket

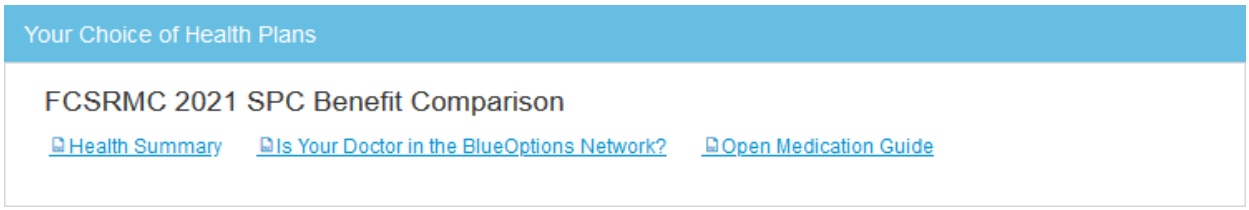
When you see a provider who participates in the BlueOptions or BlueCare network, your expenses for covered services will be lower. Under your BlueOptions plans that provide out of network coverage when you use out-of-network providers, your out-of-pocket costs for covered services may be higher, and you could be balance billed for any charges that are over Florida Blue's eligible charges. The BlueCare network is an HMO network, and you must use the in- network provider for any coverage.

Consider choosing a **Value Choice Provider**. This is a special designation by Florida Blue of network providers who offer coordinated care and reduced cost for some services.

Directories of participating network providers are found on the Florida Blue website and by accessing the eLearning Tool noted in the following pages. Under Floridablue.com at the top of the screen, click "Find A Doctor".

Digital Education Tool -Florida Blue Medical & Rx Plans

You will receive access to Florida Blue's E-Learning Tool, which provides you pharmacy and health plan comparison tools. There are links to a snapshot of benefits, the Medication Guide and resources which help you navigate the Florida Blue website. These include enrollment guides to your BlueOptions and BlueCare plans, how to Find a Primary Care Doctor and Member Website Registration Steps.



Note: If you are enrolling in the BlueCare HMO product, you should choose your primary care doctor (PCP) at enrollment. If you don't choose a PCP when you enroll, one will be chose for you. You can always change your PCP after your coverage is effective. You don't need a referral from your PCP to see a Specialist. Visit the eLearning Tool on How to Choose a Primary Care Doctor. Consider choosing a **Value Choice Provider**. This is a special designation by Florida Blue of network providers who offer coordinated care and reduced cost for some services.

https://gateway.bcbsfl.com/your-plans

Information provided by the Florida College System Risk Management Consortium (FCSRMC)

This Benefits-At-A-Glance booklet is designed to provide basic information to employees on benefit plans and programs available January 01, 2021 – December 31, 2021. It does not detail all of the provisions, restrictions and exclusions of the various benefit programs documented in the carrier contract or the Summary Plan

SPC St. Petersburg College

2021 Benefits Comparison

FCSRMC FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM	HMO BlueCare 58	PPO BlueOptions 03769	HDHP Blue Options HSA 05190 Individual Account Funding: EE Only=$500	HDHP Blue Options HSA 05191 Family Plan Account Funding: EE+1=$1,000 or EE+2=$1500
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)				
In-Network	NA	$800 / $2,400	$1,750 / NA	$3,500 / $3,500
Out-of-Network	NA	Combined w/ INN	$5,000 / NA	$10,000 / $10,000
Coinsurance (BCBSF pays / Member pays)				
In-Network	80% / 20%	80% / 20%	80% / 20%	80% / 20%
Out-of-Network	Not Covered	60% / 40%	60% / 40%	60% / 40%
Out of Pocket Maximum (Per Person/Family Aggregate)	**Includes Pharmacy**	**Includes Pharmacy**	**Includes Pharmacy**	**Includes Pharmacy**
In-Network	$6,000 / $12,000	$7,000 / $14,000	$4,500 / NA	$6,850 / $9,000
Out-of-Network	N/A	Combined w/ INN	$9,000 / NA	$18,000 / $18,000
Medical / Surgical Care by a Physician				
Office Services				
In-Network Family Physician	$40	$40	DED + 20%	DED + 20%
In-Network Specialist	$60	$60	DED + 20%	DED + 20%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%
Physician Services at Hospital				
In-Network	$0	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	INN DED + 20%	INN DED + 20%	INN DED + 20%
Medical / Surgical Care at a Facility				
Inpatient Hospital Facility (per admit)				
In-Network	$350 per day up to $1,750 max	Option 1: $1,250 Option 2: $2,250	Option 1: Ded + 20% Option 2: Ded + 25%	Option 1: Ded + 20% Option 2: Ded + 25%
Out-of-Network	Not Covered	Ded + 40%	$500 PAD + DED + 40%	$500 PAD + DED + 40%
Outpatient Hospital Facility (per visit) (Surgical)				
In-Network	$750	Option 1: Ded + 20% Option 2: Ded + 20%	Option 1: Ded + 20% Option 2: Ded + 25%	Option 1: Ded + 20% Option 2: Ded + 25%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%
Outpatient Hospital Facility (per visit) (Non-Surgical)				
In-Network	$750	Included with Surgical Services	Option 1: Ded + 20% Option 2: Ded + 25%	Option 1: Ded + 20% Option 2: Ded + 25%
Out-of-Network	Not Covered		DED + 40%	DED + 40%
Emergency and Urgent Care				
Emergency Room Facility (per visit)				
In-Network	20%	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	20%	INN DED + 20%	INN DED + 20%	INN DED + 20%
Urgent Care Centers				
In-Network	$80	$65	DED + 20%	DED + 20%
Ambulance				
In-Network	20%	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	20%	INN DED + 20%	INN DED + 20%	INN DED + 20%
Other Special Services				
Gastric Bypass	1 PBP	1 PBP	1 PBP	1 PBP
TeleMedicine Services	$10	$10	DED + Coin, Allowance Maximum $45	DED + Coin, Allowance Maximum $45
Prescription Drugs				
In-Network				
- Retail				
Generic/Brand/Non-Preferred/ Specialty RX Maximum	$15 / $45 / $65 /$250	$15 / $45 / $65 / $250	DED	DED
- Mail Order				
Generic/Brand/Non-Preferred	$30 / $90 / $130	$30 / $90 / $130	DED	DED

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Helpful Tools

Florida Blue's Member Online Account is a personalized web portal designed to help provide answers to some of your most common health needs. Your unique and confidential user identification code and password gives you access to your personal benefit information 24 hours a day, 7 days a week. With a Member Online Account, you can:

- Check the status of any claims
- Get details on your plan's benefits
- Order a replacement identification card
- Access claim forms and other frequently requested forms
- Search for a participating hospital or provider
- Access a map with detailed directions to participating providers and hospitals

Blue365™:

Florida Blue offers its members a program of products and services called Blue365™ to help offset the rising costs associated with healthcare by offering discounts on a variety of products and services. Some of these programs and discounts include:

- Enhanced vision care discount program
- Weight management programs
- Family health & wellness facilities
- Fitness centers
- Contact lens mail order service
- Hearing aid discount programs
- Alternative medicines and much more

For more information on Blue365™, access this information through the eLearning Tool.

Member Care Programs including Care Consultation & Advocacy Program

As a Florida Blue member, health-related information and support is available to you at no cost, 24 hours a day, 7 days a week. Information and support is provided through the Better You from Blue program, on lifestyle coaching at **800-477-3736, ext. 54837**, Care Consultants, 24 hour Nurse line and Disease Management programs, which help manage and coordinate care for chronic and acute conditions.

Professionals on the **Care Consultant Team** include nurse care advocates, benefit specialists and community resource experts. Their help can save you time and money and help you make informed health care decisions. Whether it is your first office visit, a series of ongoing medical treatments or a new medication, a call to a Care Consultant at **1-888-476-2227** will help you find out how your benefits work, what factors may affect your costs and how to plan your next steps.

24 Hour Nurse Line

Health questions can come up at any time. Whether you have an immediate health concern or a general question about your doctor's plan of treatment, the Nurse Line is always open at **1-877-789-2583**.

Florida Blue Mobile Phone App

Florida Blue's mobile app is designed for everyone and works on any Smartphone. Download the app, available through the Apple app Store or Google Play, and register. Log in by using your Florida Blue member account User ID and password. You can access health information, get a snapshot of your benefits and accumulators such as deductible and out of pocket maximum and access and see an image of your ID card. You can find a doctor, hospital or specialist in the provider directory customized to your plan.

Information provided by the Florida College System Risk Management Consortium (FCSRMC)

See the Open Medication Guide, which you can access through the eLearning Tool.

Pharmacy Plans	**Retail – In-Network** (30 day supply)	**Mail order** (90 day supply)
BlueOptions 03769 BlueCare 58	**$15** - generic **$45** - preferred brand **$65** - non-preferred brand **$250** - monthly member out-of pocket maximum per specialty prescription applies	**$30/$90/$130** Specialty drugs are cost share and not available through mail order

If a brand name Rx is purchased when a generic Rx is available and the physician has not indicated that a brand name Rx is medically necessary, you will be required to pay the difference between the cost of the brand name and generic Rx in addition to the Rx copay. Pharmacy expenses apply to out-of-pocket maxi- mums.
The Rx copay is waived for generic and preferred brand drugs classes, as applicable for the following:

- Depression
- Diabetes supply (including Insulin)
- High blood pressure
- High cholesterol
- Respiratory
- Smoking cessation

The eLearning Tool has cost comparison tools and all the information you need for Rx Mail Order Service and to learn about the features of your prescription plan.

Go to www.floridablue.com

- Click on the **Members** tab.
- Click on the **Login Now** button and either **Login** or **Register**.
- Once Logged in, click on **My Plan**, then select **Pharmacy** under Additional Items.
- Under Pharmacy Resources, click on **Medication Guide & Specialty Pharmacy**
- Under **Medication Guide/Approved Drug Lists**, click Open Medication Guide or Open Medication Guide Updates.
- Medication Guides and Medication Guide updates are posted every January, April, July and October.

Information provided by the Florida College System Risk Management Consortium (FCSRMC)

TELADOC.

FCSRMC
FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM

Getting started **with Teladoc**

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.

1

SET UP YOUR ACCOUNT

Set up your account by phone, web or mobile app.

Online:
Go to Teladoc.com and click **"set up account"**.

Mobile app:
Download the app and click **"Activate account"**. Visit teladoc.com/mobile to download the app.

Call Teladoc:
Teladoc can help you register your account over the phone.

2

PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

3

REQUEST A CONSULT

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

H.S.A. members pay $45 until deductible is met.

Talk to a doctor anytime for **$10/ HSA up to $45**

Teladoc.com
1-800-Teladoc (835-2362)

Available on the iPhone App Store
GET IT ON Google Play

Health Savings Account

HealthEquity

Provided by Health Equity | *www.healthequity.com* | *1 (877) 915-3233*

A health savings account (HSA) combines high deductible health insurance with a tax-favored savings account. Money in the savings account can help pay the costs of qualified medical expenses not covered by medical insurance for you and your dependents. Money left in the savings account earns interest and is yours to keep. **SPC will contribute the below amounts to an HSA for employees who enroll in the High Deductible Health Plan:**

- **$500 for employees with employee only coverage**
- **$1,000 for employees with 1 dependent**
- **1,500 for employees with more than 1 dependent**

MAXIMUM ANNUAL CONTRIBUTIONS*	2021
Self - Only Contribution Limit	$3,600
Family Contribution Limit	$7,200
Catch-up Contribution (Age 55 & Older)	$1,000

*The seed money reduces the amount that you can contribute per year

EMPLOYEE OWNED ACCOUNT

- Pre-tax contributions

Pay for any qualified medical, dental and vision expenses for yourself, spouse or dependents even if they are enrolled under another medical plan. (See IRS Publication 502 for a complete list of qualified medical expenses, examples below).

Acupuncture	Blood pressure monitor	Crutches/Wheelchair	Lasik/Vision Correction Surgery	Psychologist fees
Alcohol or Drug addiction treatment	Breast Pumps and Supplies/Accessories	Dental Services	Long-Term Care	Smoking Cessation
Ambulance	Chiropractor Care	Diabetic monitors, test kits, strips & supplies	Medicines (prescription & over-the-counter)	Speech Therapy
Bandages	Coinsurance & Copayments	Fertility Treatment	Oxygen	Sunscreen
Birth Control	Contact Lenses & Glasses	Hearing aids & batteries	Psychiatric Care	Vasectomy

To be HSA-eligible for a month, an individual must:

- Be covered by an HDHP on the first day of the month;
- Not be covered by other health coverage that is not an HDHP;
- Not be enrolled in Medicare; and
- Not be eligible to be claimed as a dependent on another person's tax return.

Why might an HSA be the right choice for you?

- It **saves you money**. For individuals with few regular health expenses, paying a traditional health plan premium can feel like throwing money out the window. HDHPs come with much lower premiums than traditional health plans, meaning less money is deducted from your paychecks. Plus, HSAs are basically "cash" accounts, so you may be able to negotiate pricing on many medical services.
- It's **portable**. Even if you change jobs, you get to keep your HSA.
- It's a **tax saver**. Contributions to your HSA are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you pay less in taxes.
- It allows for an **improved retirement account**. Funds roll over at the end of each year and accumulate tax-free, as does the interest on the account. Also, once you reach the age of 55, you are allowed to make additional "catch-up" contributions to your HSA until age 65.
- It puts **money in your pocket**. You never lose unused HSA funds. They always roll over to the next year.

https://sales.healthequity.com/floridablue/

Flexible Spending Account

Administered by Custom Benefit Services | *Myflexonline.com* | *1 (800) 809 - 8161*

WHAT IS A FLEXIBLE SPENDING ACCOUNT: An FSA is a pre-tax benefit account that is used to pay for eligible medical, dental and vision care expenses that are not covered by your health care plan. With an FSA, you use pre-tax dollars to pay for qualified out-of-pocket health care expenses.

WHAT ARE THE BENEFITS OF A FLEXIBLE SPENDING ACCOUNT (FSA):

There are a variety of different benefits of using a Flexible Spending Account (FSA), including the following:

- **It saves you money** by allowing you to put aside money tax-free that can be used for qualified medical expenses.
- **It's a tax saver.** Since your taxable income is decreased by your contributions, you'll pay less in taxes
- **You can use it for a variety of expenses.** Use your FSA for qualified medical, dental or vision expenses. (Remember to keep your receipts for audit purposes.)

You cannot stockpile your money in your FSA. **If you do not use it, you lose.** You should only contribute the amount of money you expect to pay out-of-pocket that year. The maximum you can contribute each year is **$2,750.**

WHAT IS A DEPENDENT CARE FSA: Dependent care FSAs allow you to contribute pre-tax dollars to pay for qualified dependent care. The maximum amount you may contribute each year is **$5,000 (or $2,500 if married and filing separately).** The dependent care FSA is also **use it or lose it.**

FSA CASE STUDY: Because FSAs provide you with an important tax advantage that can help you pay for health care expenses on a pre-tax basis, due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save you money.

Bob and Jane live in Texas and have a combined annual gross income of $45,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,000 in eligible medical expenses in the next plan year, they decide to direct a total of $2,750 (the maximum allowed amount per individual, for that taxable year) into their FSAs. The table demonstrates their savings.

	Without FSA	With FSA
Gross income	$45,000	$45,000
FSA contributions	$0	(-$2,750)
Gross income	$45,000	$42,250
Estimated taxes	(-$5,532)*	(-$4,999)*
After-tax earnings	$39,468	$37,251
Eligible out-of-pocket expenses	(-$3,000)	(-$300)
Remaining spendable income	$36,468	$36,951
Spendable income increase	--	$483

*Assumes standard deductions. Amounts can vary and are for illustrative purposes only.

Please note, the above example is for illustrative purposes only. Each situation varies, and it is recommended you consult a tax advisor for all tax advice.

Medical Plan Rates

Consortium Plan #	CY2021 Rates	Rate <45k	Rate 45-75k	Rate 75k+
05190	**HDHP** Employee Only	$ 41.36	$ 82.70	$ 103.38
05191	**HDHP** Employee plus Spouse	$ 82.76	$ 165.50	$ 206.88
05191	**HDHP** Employee plus Child/ren	$ 78.60	$ 157.20	$ 196.50
05191	**HDHP** Family	$ 128.26	$ 256.50	$ 320.64
03769	**New: PPO** Employee Only	$ 176.20	$ 220.26	$ 242.28
03769	**New: PPO** Employee plus Spouse	$ 352.40	$ 440.50	$ 484.56
03769	**New: PPO** Employee plus Child/ren	$ 334.80	$ 418.50	$ 460.36
03769	**New: PPO** Family	$ 682.76	$ 819.30	$ 887.58
58	**HMO** Employee Only	$ 129.90	$ 173.20	$ 194.86
58	**HMO** Employee plus Spouse	$ 259.96	$ 346.60	$ 389.94
58	**HMO** Employee plus Child/ren	$ 246.90	$ 329.20	$ 370.36
58	**HMO** Family	$ 537.20	$ 671.50	$ 738.66

Per Pay Consortium Plan #	Per Pay (24 Deductions) CY2021 Rates	Per Pay Rate <45k	Per Pay Rate 45-75k	Per Pay Rate 75k+
05190	**HDHP** Employee Only	$ 20.68	$ 41.35	$ 51.69
05191	**HDHP** Employee plus Spouse	$ 41.38	$ 82.75	$ 103.44
05191	**HDHP** Employee plus Child/ren	$ 39.30	$ 78.60	$ 98.25
05191	**HDHP** Family	$ 64.13	$ 128.25	$ 160.32
03769	**New: PPO** Employee Only	$ 88.10	$ 110.13	$ 121.14
03769	**New: PPO** Employee plus Spouse	$ 176.20	$ 220.25	$ 242.28
03769	**New: PPO** Employee plus Child/ren	$ 167.40	$ 209.25	$ 230.18
03769	**New: PPO** Family	$ 341.38	$ 409.65	$ 443.79
58	**HMO** Employee Only	$ 64.95	$ 86.60	$ 97.43
58	**HMO** Employee plus Spouse	$ 129.98	$ 173.30	$ 194.97
58	**HMO** Employee plus Child/ren	$ 123.45	$ 164.60	$ 185.18
58	**HMO** Family	$ 268.60	$ 335.75	$ 369.33

Information provided by the Florida College System Risk Management Consortium (FCSRMC)

Prescription Drug Cost Comparison Tools:

Use GoodRx and SingleCare's drug price search to compare prices (just like you do for travel or electronics on other sites) for your prescription at pharmacies near you. GoodRx as well as SingleCare do not sell the medications; the free website and mobile app will tell you where you can get the best deal on them. If you have insurance, your co-pay might not be the best price. Hundreds of generic medications are available for $4 or even free without insurance. Every week, both GoodRx and SingleCare collect millions of prices and discounts from pharmacies, drug manufacturers and other sources. GoodRx and SingleCare will show you prices, coupons, discounts and savings tips for your prescriptions at pharmacies near you. There is no cost or membership required to use either of these cost- saving tools. Please visit the websites at **www.goodrx.com and www.singlecare.com.**

You can also download these apps on your smartphone. Please note: amounts paid for prescriptions using GoodRx or SingleCare's discount programs do not apply toward your medical plan's deductible or annual out of pocket maximum.

Pharmacy Discount Programs:

Before you pay for your next prescription, check to see if they are available for free or at a lower cost than traditional copays. Pharmacies such as Walmart, CVS, Target and Costco offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30 day supply. Publix pharmacies also provide a list of free maintenance medications as well as antibiotics that they offer for free (with a prescription from your physician). If your local pharmacy is not listed, please check with them to see if they offer any discounts. Please note, CVS is not an in-network pharmacy, but you may still use their discount program when not using your medical insurance.

Please remember to check the Open Medication Guide via the eLearning Tool or directly through FloridaBlue.com to see which prescriptions are covered under your plan and the copay level/tier. This will help you make an informed decision about using a pharmacy discount program or your Florida Blue pharmacy plan.

CVS is not an in-network pharmacy provider through your Florida Blue pharmacy plan.

Where should I go when I need care?

Remember, where you go matters!

When you need care, choosing the right treatment option can help you avoid needless worry, higher out-of- pocket costs and hours of unnecessary waiting. Your primary care physician should be your first choice when seeking care. Your PCP can treat common illnesses (cold, flu, sore throat, etc.), minor injuries and conduct routine exams, vaccinations and screenings.

Use this simple guide to help you make the right decisions when you can't see your PCP.

Teladoc

Teladoc doctors (including pediatricians) are available via phone or video **24/7**, **365** days a year. Use Teladoc for conditions like:

- Upper respiratory infection
- Sinus infection
- Urinary tract infection
- Common cold
- Cough
- Flu

Learn More
Download the Teladoc app from your app store or visit www.teladoc.com to register.

Urgent Care Centers

Urgent care centers are **less expensive than ERs** and often have **shorter wait times**. Visit an urgent care center for conditions like:

- Cold, flu and fever
- Strains, sprains and/or breaks
- Infections
- Mild burns

To find an urgent care center close to you visit **floridablue.com**. and select Find a Doctor.

Emergency Room

Going to an ER for an issue that is not life threatening often results in long wait times and high medical bills. Examples of symptoms that require emergency room care:

- Severe chest pain (a possible heart attack)
- Signs of a possible stroke
- Severe or sudden shortness of breath
- Sudden or unexplained loss of consciousness

If you do have a life-threatening emergency, call 911 right away.

For more information on care options visit us online at **floridablue.com.**

Consider choosing a **Value Choice Provider** for your urgent care needs. This is a special designation by Florida Blue of network providers who offer coordinated care and reduced cost for many services.

Dental Coverage - PPO Options

Provided by Aetna | *www.aetna.com* | *1 (855) 281-8858*

Below are your PPO dental plans, which give you freedom to use in-network or out-of-network dentists. Since network providers offer reduced contracted rates, you save money by using network providers for all your dental needs. All benefits received from out-of-network dentists are subject to "reasonable and customary" fees. Any amount that exceeds the dental carrier's "reasonable and customary" amount is the patient's responsibility.

You can access the dental provider's network and find a dentist near you at www.aetna.com.

Dental Services	Aetna Low	Aetna High
Annual Maximum Benefit	$1,500	$2,000
Calendar YearDeductible:		
Individual/Family	$75/$225	$50/$150
PREVENTATIVE PROCEDURES:	Deductible Waived	
Routine Exams Teeth Cleaning Bitewing X-rays/Full Mouth X-rays Fluoride Treatments (under age 16) Sealants	Plan pays 100%	Plan pays 100%
BASIC PROCEDURES:	Deductible Applies	
Silver Fillings Simple Extractions Root Canal Therapy Anterior /Bicuspid teeth (Molars—Major)	Plan pays 80%	Plan pays 90%
MAJOR PROCEDURES:	Deductible Applies	
Periodontal Surgery Crowns and Bridges Root Canal Therapy, Molars Full & Partial Dentures	Plan pays 50%	Plan pays 60%
ORTHODONTIC PROCEDURES:	Deductible Waived	
Lifetime maximum	$1,500	$2,500
* Adults and Dependent Children to age 19	Plan Pays 50%	Plan Pays 50%
OUT-OF-NETWORK BENEFITS		
Aetna Low (Preventive/Basic/Major/Ortho)	50%/50%/50%/50% (80th of UCR)	
Aetna High (Preventive/Basic/Major/Ortho)	100%/80%/50%/50% (80th of UCR)	

Please see Aetna dental benefit summary for additional plan details

Dental plan rates

Based on your monthly deduction

Who is covered	Aetna Low	Aetna High
You Only	$0.00	$17.18
You + Spouse	$16.58	$48.52
You + Child(ren)	$16.58	$44.48
You + Family	$31.50	$98.34

Vision Coverage

Provided by EyeMed | *www.eyemed.com* | *1 (866) 939-3633*

Below are your two vision plan options through Eyemed. These plans cover eye exams, prescription lenses and frames, or contact lenses for you and your dependents when you receive services from in-network or out-of-network providers. As you can see from the table below, staying in-network cuts costs down and gives you more of a benefit.

To find a participating provider, log on to www.eyemed.com and choose the ***Insight Network.***

Vision Coverage Rates

Based on your monthly deduction

Who is covered	Low Plan Cost	High Plan Cost
You Only	$3.62	$4.77
You + Spouse	$7.24	$9.53
You + Child(ren)	$6.89	$9.07
You + Family	$11.83	$15.57

	Low Plan		High Plan	
Vision Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exams	$10 Copay	Up to $40	$10 Copay	Up to $40
Frequency	12 Months	12 Months	12 Months	12 Months
BASIC LENSES				
Frequency	12 Months	12 Months	12 Months	12 Months
Single vision	$15 Copay	Up to $30	$15 Copay	Up to $30
Bifocal vision	$15 Copay	Up to $50	$15 Copay	Up to $50
Trifocal vision	$15 Copay	Up to $70	$15 Copay	Up to $70
FRAMES				
Frequency*	24 Months	24 Months	12 Months	12 Months
Benefit	$100 Allowance (20% off balance)	Up to $70	$150 Allowance (20% off balance)	Up to $105
CONTACTS				
Frequency*	12 Months	12 Months	12 Months	12 Months
Benefit	$100 Allowance (15% off balance)	Up to $100	$150 Allowance (15% off balance)	Up to $150

*Contacts and eyeglasses cannot be purchased in the same year.

You may select any or all of these plans, even if you are not enrolled in any of SPC's other plans, as long as you are benefit eligible. Questions can be directed to Tom Watson, Custom Benefit Services at 1-800-809-8161

Accident Insurance—Allstate's Accident Insurance Plan provides coverage for events such as loss of limb, complete joint dislocation, fractures, lacerations and other medical expenses associated with an accident. This plan also provides subscribers with reimbursement for any outpatient physician's treatment, even if that treatment isn't associated with an accident.

Accident	*Low*	*High*
EE Only	$14.52	$20.70
EE + Spouse	$26.88	$39.24
EE + Child(ren)	$24.60	$35.82
Family	$36.96	$54.36
Ambulance	*$400*	*$600*
Lacerations	*$100*	*$150*
Admission	*$1,000*	*$1,500*

Cancer Insurance—Allstate's Cancer Insurance Plan can help insulate you from the costs associated with a cancer diagnosis and treatment. In addition to cancer, this plan provides coverage for 29 other specified diseases such as muscular dystrophy, multiple sclerosis, and cerebrospinal meningitis. This plan also provides sub- scribers with reimbursement for cancer-related screening visits even if there is no cancer diagnosis.

Cancer	*Rate*
EE Only	$18.84
Family	$31.60
Initial Diagnosis	*$2,000*
Confinement	*$200/day*
Surgery	*$3,000/$4,500*
Outpatient Lodging	*$50/day*
Radiation/Chemotherapy	*$7,500*

Hospital	*GIM1*	*GIM2*
EE Only	$31.72	$14.82
EE + Spouse	$56.80	$32.76
EE + Child(ren)	$49.96	$25.62
Family	$73.58	$43.68
Admission	*$1,100*	*$500*
Ambulance	*$300*	*$0*
Surgery	*$20—$500*	*$0*

Hospital Indemnity Insurance—Allstate's Group Hospital Indemnity Plan is designed to complement existing major medical insurance and help provide first dollar benefits to fill the gap between what your current major medical coverage pays and what your out-of-pocket expense is. The GIM1 also provides subscribers with reimbursement for any outpatient physician's treatment, even if that treatment isn't associated with a hospital admission. Due to regulations related to High Deductible Health Plans, those enrolled in the High Deductible Health Plan may only select the GIM2 Plan which does not include reimbursement for outpatient physician's treatment.

Please review the Allstate flyers for additional details.

You count on your income to provide the things you need today and to achieve the dreams you have for tomorrow. But what would happen if you were suddenly unable to earn a living because of an unexpected accident or illness? See the disability flyers for further details.

Short-Term Disability

SPC offers two levels of short-term disability coverage. With either level of coverage, employees may elect a flat weekly benefit amount from $200—$1,200 in increments of $100; not to exceed 60% of weekly earnings.

- 15/15 will provide you with income replacement of up to 60% of your income in conjunction with a qualified short - term disability event. Coverage will become effective on the 15th day after your event, and you will be paid for up to 13 weeks. Coverage is $3.40 per $100 of weekly benefit.
- 30/30 will provide you with income replacement of up to 60% of your income in conjunction with a qualified short-term disability event. Coverage will become effective on the 30th day after your event, and you will be paid for up to 13 weeks. Coverage is $2.50 per $100 of weekly benefit.

Long-Term Disability

SPC offers two options for long-term Disability coverage:

- **Option 1 is $.42 per $100 of covered payroll**
- **Option 2 is $.208 per $100 of covered payroll**

COVERAGE INFORMATION

COVERAGE LEVEL	BENEFIT PERCENTAGE (PERCENT OF YOUR EARNINGS)	MAXIMUM	MINIMUM (BASED ON MONTHLY INCOME LOSS BEFORE THE DEDUCTION OF OTHER INCOME BENEFITS)	BENEFIT STARTS (ELIMINATION PERIOD)	BENEFIT DURATION
Option 1	60%	$6,500	The greater of $100 or 10% of the benefit	After 90 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 4 years
Option 2	60%	$5,000	The greater of $100 or 10% of the benefit	After 90 days disabled	Disabled before: Age 63 Benefit duration: As long as you are disabled Benefit duration maximum: The greater of your Social Security Normal Retirement Age or 4 years

AM I GUARANTEED COVERAGE?

If this is the first time you are eligible to elect coverage, evidence of insurability is not required. If you did not elect coverage the first time it was offered to you, evidence of insurability is required to elect coverage.

Life and AD&D Coverage

THE HARTFORD

Provided by the Hartford | *www.thehartford.com* | *1 (888) 563-1124*

Life and AD&D insurance protects your family or other beneficiaries in the event of your death. The death benefit helps replace the income you would have provided and can help meet important financial needs. It can help you pay your mortgage or rent, run your household, send your children to college, pay off debts, etc. SPC provides eligible employees Basic Life and AD&D insurance with The Hartford in the amount of 2x's annual salary, up to $250,000, at no cost. SPC also provides eligible employees the opportunity to enroll in Voluntary Life and AD&D insurance with The Hartford at a group rate (located on the next page).
The following are attached to this group term life insurance policy:

- Waiver of premium
- Accelerated life benefit
- Portability
- Conversion

To find more information about the attachments above, refer to your Hartford Certificate of Benefits.

Summary of Voluntary Life and AD&D Insurance

If you chose to enroll in Voluntary Life insurance, you may also insure your spouse and eligible dependent children up to the age of 26. A summary of your life and AD&D insurance coverage is listed in the table below, if you should have questions on this policy see your Hartford Certificate of Benefits

Summary of Insurance	
Guaranteed Issue	Lesser of 3x's your annual salary or $150,000
Minimum Benefit Amount	1x's annual salary
Maximum Benefit Amount	$500,000
Increments of…	1-4x's annual salary up to a maximum of $500,000
Spouse Coverage	
Spouse Guarantee Issue	$20,000
Maximum Benefit Amount	$100,000 (not to exceed 50% of employee amount)
Increments of...	$5,000
Child(ren) Coverage - Up to age 26 (Life coverage only)	
Coverage amounts	$2,500, $5,000, $7,500, or $10,000

Employee/Spouse Monthly Cost:

If your coverage level is….	Your cost for each $1,000 of supplemental life and AD&D is...
Employee/Spouse Life and AD&D	$0.277

Dependent Children Monthly Cost:

If your coverage level is...	Your cost for each $1,000 of supplemental life is...
Child Life	$0.110

How to figure your voluntary life cost per paycheck:

1. Indicate your elected benefit amount (EBA)
2. Divide EBA by $1,000
3. Enter rates from the cost tables above
4. Multiply Step 2 by Step 3
5. Divide amount by 2 to get your cost per paycheck (based on 24 pay periods)

Additional Information

- Age reduction scale:
  50% of original amount at age 70
- Evidence of Insurability form is required for employees who do not enroll during their initial eligibility period or who want to increase coverage or add dependent coverage at Open Enrollment.

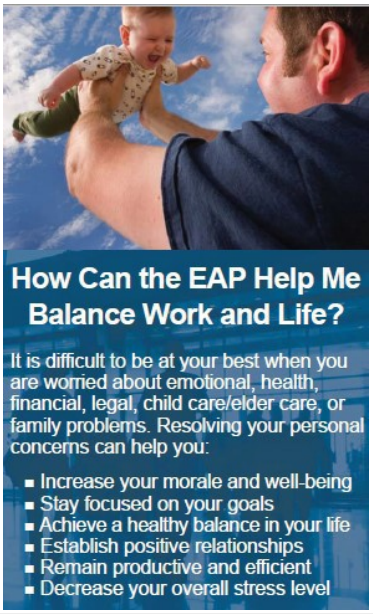
Employee Assistance Program

Provided by Deer Oaks | *1 (866) 327- 2400*

Employee Assistance Program

The Deer Oaks Employee Assistance Program (EAP) is a service provided to you, your dependents and household members by St. Petersburg College. The program offers a wide variety of counseling, referral and consultation services. These are all designed to assist you and your family in resolving work and life issues in order to live happier, healthier and more balanced lives. These services are completely confidential and can easily be accessed 24/7. You deserve around-the- clock assistance for all of life's challenges. **Access toll-free at 1-800-327-2400 or email: eap@deeroaks.com.**

- **Program Access**: You may access the EAP by calling the toll-free Helpline number, downloading the smartphone app or instant messaging with a consultant.
- **Telephonic Assessments & Support:** Available 24/7 along with intake and clinical assessments.
- **Short-term Counseling**: Up to eight counseling sessions with a qualified counselor to assist with a variety of issues via telephone, video and in-person.
- **Referrals & Community Resources:** Provides referrals to local community resources, member health plans, support groups, legal resources and child/elder care resources.
- **Advantage Legal Assist**: Free 30 minute telephonic or in –person consultation with a plan attorney; unlimited online access to educational legal resources.
- **Advantage Financial Assist**: Unlimited telephonic consultation with an Accredited Financial Counselor qualified to advise on a range of financial issues; unlimited online access to educational financial resources, links, tools and forms.
- **Identity Theft Assistance**: Free telephonic consultation with an Accredited Financial Counselor for information on steps that should be taken upon discovery of identity theft; referral to full- service credit recovery agencies; free credit monitoring service.
- **Work-life Services**: Consultants are available to assist you with a wide range of daily living resources. Simply call the Helpline for resource and referral information.
- **Child & Elder Care Referrals**: Specialists can help you with your search for licensed child and elder care facilities in your area. Searchable databases and other resources are also available on the Dear Oaks member website.
- **Take the High Road Ride Reimbursement Program**: Deer Oak reimburses members for their cab, Lyft and Uber fares in the event that they are incapacitated due to impairment by a substance or extreme emotional condition. This service is available once per year per participant, with a maximum reimbursement of $45 (excludes tips).



Important Notices

Health Insurance Portability and Accountability Act (HIPAA) Notice

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical conditions may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of such an event.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Note: The 60-day period for requesting enrollment applied only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applied to most special enrollments.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your plan administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at (312)353-0900. If you have any questions about this notice or the law, please contact your plan administrator at the number or location provided in your benefits booklet or summary plan description.

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources representative.

Notice of Privacy Practices: Plan administrators, clearinghouses, business associates and health care providers that transmit health information electronically or use electronic health records may not redistribute or unlawfully use electronic health records without permission from the insured. The insured may request information on how their electronic records are distributed, how frequently they are distributed, and who they are distributed to by contacting the U.S. Department of Health and Human Services.

Health Insurance Marketplace Coverage Notice

The Health Insurance Marketplace is available to assist you as you evaluate health insurance options for you and your family. This notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer. The Marketplace is designed to help you find private health insurance and compare private health insurance options. You may also be eligible for a new kind of tax credit under section 36B of Internal Revenue Code that could potentially lower your monthly premium. If you purchase a qualified health plan through the Marketplace, you may lose the employer contribution (if any) to any health benefit plan offered by your employer and all or a portion of that contribution may be eligible for exclusion from income for federal income tax purposes. More information on the health insurance Marketplace may be found at https://www.healthcare.gov.

Patient Protection Disclosure

If your plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and is available to accept you or your family members. Until you make this designation, the plan may designate one for you. For more information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator. If your plan re- quires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your plan provides coverage for obstetric and/or gynecological care and requires the designation of a primary care provider by a participant or beneficiary, you do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional; however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator.

Women's Health & Cancer Rights Act of 1998

The Women's Health and Cancer Act (WHCRA) requires group health plans to provide participants with notices of their rights under WHCRA, to provide certain benefits in connection with a mastectomy, and to provide other protections for participants undergoing mastectomies. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy – related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance amounts applicable to other medical and surgical benefits provided under the health plan offered by your employer.

Please keep this information with your other group health plan documents. If you have any questions about the Plan's coverage of mastectomies and reconstructive surgeries, please contact the Human Resources Department.

Important Notices

COBRA (Consolidated Omnibus Budget Reconciliation Act)

Cobra provides eligible individuals and their dependents who would otherwise lose group health coverage as a result of a qualifying life event with an opportunity to continue group health coverage for a limited time period under certain circumstances, such as:

- voluntary or involuntary job loss
- reduction in the hours worked
- transition between jobs
- death
- divorce
- other qualifying life events

If you are entitled to elect COBRA coverage, you will have 60 days (starting on the date you are furnished the election notice or the date you would lose cover- age) to choose whether or not to elect continuation coverage. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan.

COBRA generally requires that group health plans sponsored by groups with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

The duration of COBRA extends from the date of the qualifying event for a limited period of 18 or 36 months. The length of time depends on the type of qualifying life event that gave rise to the COBRA rights. A plan, however, may provide longer periods of coverage beyond the maximum period required by law.

COBRA Continuation coverage may be terminated earlier than the end of the maximum period for any of the following reasons:

- premiums are not paid in full on a timely basis
- the employer ceases to employ any group health plan
- a qualified beneficiary begins coverage under another group health plan after electing continuation coverage
- a qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage
- a qualified beneficiary engages in conduct that would justify the plan in terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage (such as fraud).

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage

If you decide to terminate your COBRA coverage early, you generally won't be able to get a Marketplace plan outside of open enrollment period. For more information on alternatives to COBRA coverage, or to find out how COBRA is administered at your workplace, reach out to your HR representative or plan administrator on alternatives to COBRA coverage, or to find out how COBRA is administered at your workplace, reach out to your HR representative or plan administrator.

USERRA (Uniformed Services Employment and Reemployment Rights Act)

Reemployment Rights: You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your employer receives advance written or verbal notice of your service
- you have five years or less of cumulative service in the uniformed services while with that particular employer
- you return to work or apply for reemployment in a timely manner after conclusion of service
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions

If you are eligible to be reemployed, you must be restored to the job and bene- fits you would have attained if you had not been absent due to military service or, in some cases, a comparable job. **Right to be free from discrimination and retaliation:** If you are a past or present member of the uniformed service, have applied for membership in the uniformed service, or are obligated to serve in the uniformed service, then an employer may not deny you initial employment, reemployment, retention in employment, promotion or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection. **Health Insurance Protection:** If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. **Enforcement:**

- The U.S. Department of Labor, Veterans Employment and Training Service(VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed athttp://www.dol.gov/elaws/userra.htm.
- If you file a complaint with VETS and VETS in unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Note: The rights listed here may vary depending on the circumstances.

Important Notices

Employee Rights Under the Family and Medical Leave Act (FMLA)

Leave Entitlements: Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or fostercare
- To bond with a child (leave must be taken within one year of the child's birth or placement)
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee'sjob
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child or parent

An eligible employee who is a covered service member's spouse, child, parent or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections: While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements: An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months
- Have at least 1,250 hours of service in the 12 months before taking leave*
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave: Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities: Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.
Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement: Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint: 1-866-4-USWAGE (1-866-487- 9243) or www.dol.gov/whd

Newborn's and Mothers' Health Protection Act

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July, 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**COLORADO – Health First Colorado & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay 711
FLORIDA – Medicaid	**GEORGIA – Medicaid**
Website: http://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
INDIANA – Medicaid	**IOWA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 Other Medicaid: Website: http://www.in.gov/medicaid/ Phone 1-800-457-4584	Website Hawki: http://dhs.iowa.gov/Hawki Website Medicaid: https://dhs.iowa.gov/ime/members Phone Hawki: 1-800-257-8563 Phone Medicaid: 1-800-338-8366
MAINE – Medicaid	**KENTUCKY – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine Relay 711 Private Health Insurance Page:https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800—977-6740 TTY: Maine Relay 711	Website: https://chfs.ky.gov Phone: 1-800-635-2570 https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 1-855-459-6328 KI-HIPP Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone:1-877-524-
LOUISIANA – Medicaid	**KANSAS – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid Hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.dkheks.gov/hcf/default.htm Phone: 1800-792-4884
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll Free number for the HIPP program - 1-800-852-3345, ext. 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html Phone: 1-800-701-0710
NEW YORK – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
NORTH CAROLINA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: https://www.coverva.org/hipp/	Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	**CALIFORNIA - Medicaid**
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa (1-866-444-3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov (1-877-267-2323) , menu opt. 4, ext 61565

Important Notice from St. Petersburg College About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. Petersburg College has determined that the prescription drug coverage offered by Florida Blue, on the BlueCare 58 HMO and BlueOptions 03769 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is; therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. *Please contact your plan administrator about the Blue Options High Deductible Plan BlueOptions H.S.A. 05190 and 05191 and whether or not the coverage is creditable.*

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December

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

For More Information About This Notice Or Your Current Prescription Drug Cover- age:

Contact Human Resources. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes through St. Petersburg College. You also may request a copy of this notice at any time.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current St. Petersburg College coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current St. Petersburg College coverage, be aware that you and your dependents will be able to get this coverage back at open enrollment if you remain a benefit-eligible employee.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with St. Petersburg College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug cover- age is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. You can also obtain a copy of the "Medicare & You" handbook on SPC's HRHub.

For More Information about Medicare Prescription Drug Coverage: •Visit www.medicare.gov •Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help •Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). **Remember: If you decide to join one of the Medicare drug plans, you may be required to provide a copy of your Medicare Part D creditable or non-creditable notice when you join to show whether or not you have maintained creditable coverage and; therefore, whether or not you are required to pay a higher premium (a penalty).**