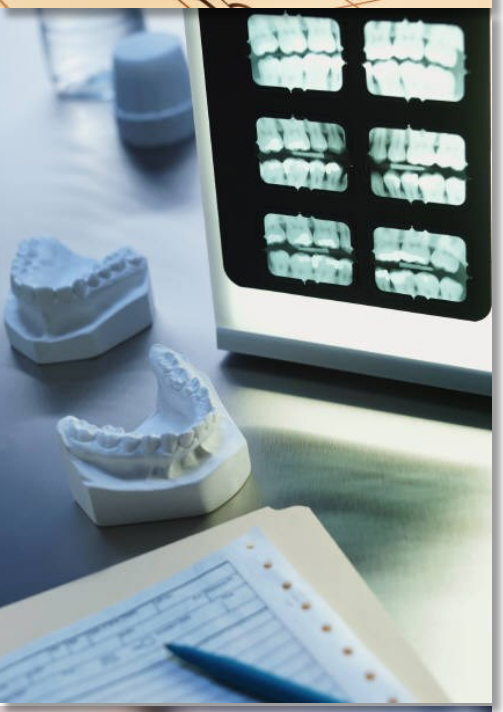

Employee Benefits Guide

Explain My Benefits

Your Health

Your Decision

2017

Plan Year

Important Contacts

Vendor	Phone Number	Website
Medical Medical Carrier	800-244-6224	www.medical.com
Dental Dental Carrier	800-244-6224	www.dental.com
Vision Vision Carrier	866-723-0513	www.vision.com
Flexible Spending Accounts FSA Carrier	800-422-4661	www.fsa.com
Short Term & Long Term Disability and Life Insurance Disability & Life Carrier	800-362-4462	www.dilife.com
Voluntary Benefits Trustmark Transamerica	800-918-8877 888-763-7474	www.trustmarksolutions.com www.transamericaemployeebenefits.com
Identity Theft LifeLock		www.lifelock.com
Pet Insurance Pet Insurance Carrier	877-738-7874	www.pets.com
Employee Assistance Plan EE Assistance Carrier	877-622-4327	www.eea.com
Florida Retirement System (FRS)	EE Hotline: 866-446-9377 Calculations: 888-738-2252	www.myfrs.com
HR Hotline	941-429-7200	hrservices@abccompany.com
Trustmark & Transamerica Claims Help Explain My Benefits	888-734-6937 Opt. 2	service@explainmybenefits.biz

Table of Contents

All benefits in this booklet are subject to change. This is an Employee Benefits Guide and not a contract. All benefits are subject to the provisions and exclusions of the master contract.

Online Benefit Enrollment

The company will continue to provide electronic enrollment through Explain My Benefits. Explain My Benefits provides benefit eligible employees the ability to make group insurance benefit elections and changes online during the annual open enrollment, new hire orientation and qualifying events. Open enrollment has never been easier. Accessible 24 hours a day during the open enrollment process, information about all of your employee benefits election options, including premiums and carrier contact information, are also available to help you make informed decisions. You can also log on to the Explain My Benefits portal at any time to review your benefits, access carrier links, update life insurance beneficiaries, and report qualifying events.

Open Enrollment Dates

August 21 - September 4

EMB Enroll will be available for self-enrollment using any computer with access to the internet.

September 1 - September 2

EMB benefit counselors will be on-site at Room A from 9:00am - 5:00pm, to assist employees that need help and answer questions. There will be computers accessible to complete your enrollment. To schedule a time for a counseling or kiosk session, go to www.explainmybenefits.biz/abc and click the button for the type of session you want.

Accessing Explain My Benefits Portal:

1. Log on to www.explainmybenefits.biz/abc
2. Click the Green Enroll Button at the Right of the Page.
3. Enter Explain My Benefits to review current elections, learn about your benefit options, and make any elections or changes.
4. You may also update your life insurance beneficiary designation(s).
5. You have the option to print out your enrollment summary statement containing all your benefit elections for you and your family including your life insurance beneficiary designations.
6. If you have questions or need assistance with your enrollment, please see a Benefit Counselor on the dates and time listed above or call the Explain My Benefits Call Center at 321-296-8060, Option 1 between 9:00am - 5:00pm, Monday through Friday.

DEPENDENT INFORMATION

If you intend to elect ANY benefit for your spouse and/or eligible dependents, they must be listed as dependents in the system and you MUST have their SSN to input into the system. You will not be able to proceed with your enrollment and confirm your elections without inputting the SSN's for your spouse and/or dependents. Spouse, Children and Family coverage levels will not be available for you to select if the dependent information is not present.

For more information about your Benefits Enrollment please visit:

www.explainmybenefits.biz/abc

Everyone must complete the online enrollment process, whether you are electing benefits, keeping benefits the same, making changes, or waiving all benefits, in order to confirm your choices. *ALL enrollments MUST be complete by 5pm on September 4th.*

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CORE Benefits

Plan Coverages at Time of Hire

The company's health insurance plan consists of the following core benefits:

- Medical Insurance (including prescription drug coverage)
- Dental Insurance
- Vision Insurance
- Basic Life Insurance
- Accidental Death and Dismemberment Insurance
- Employee Assistance Program

Medical, dental and vision coverage is offered to all benefit eligible employees as a package, however, you can elect to opt-out of dental and/or vision and remain on the medical plan only (please note that this will not affect your deduction). Electing dependent coverage also entitles your dependent(s) to receive these benefits with the exception of the Basic Life and Accidental Death and Dismemberment Insurance. The employee costs for these Core Benefits are payroll deducted under a pre-payment plan. Deductions are taken the month before the effective date of coverage. For example, if your effective date is December 1st, your payroll deductions would be taken in November. There are 26 deductions per year.

Employees will also be offered the following optional benefits that can be elected on a voluntary basis and payroll deducted:

- Short Term Disability Insurance
- Long Term Disability Insurance
- Flexible Spending Accounts (Medical & Dependent Care)
- Supplemental Insurance such as Optional Life, Critical and Accident Insurance, Hospital Indemnity

Open Enrollment

The company has an Open Enrollment period every year when changes to your benefit elections can be made that will be effective when the new plan year begins on October 1st. During Open Enrollment, employees may:

- Change your Section 125 Tax Election
- Add and/or Remove Dependents
- Apply for Short Term Disability and/or Long Term Disability
- Enroll in a Flexible Spending Account

During open enrollment, employees may also enroll or cancel the following Optional Plans:

- Critical Illness Policy
- Accident Policy
- Supplemental Term Life
- Hospital Indemnity

- **Transamerica Hospital Indemnity Coverage - Page 19**
  This policy pays a specified amount for each day a covered person is confined to the hospital and provides benefit for a range of other medical situations. Benefit payments go straight to you.
- **Long Term Disability through Disability Carrier - Page 15**

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The company's group insurance plan year is October 1st through September 30th.

Employee Eligibility

Employees are eligible to participate in the company's insurance plans if they are full-time employees working a minimum of 30 hours per week. Coverage will be effective the 1st of the month following 30 days of employment. For example: If you are hired on February 11th, your coverage will be effective on April 1st.

Termination

If you separate employment from the company, your insurance will continue through the end of the month in which the separation occurred.

Dependent Eligibility

A dependent is defined as the legal spouse and dependent child(ren) of the participant or the spouse. Dependent children may be covered through the end of the calendar year in which the child reaches age 30 for medical, dental, and vision (see below for additional information). The term "child" includes any of the following;

A natural child
A stepchild
A legally adopted child
A foster child
A newborn (up to age 18 moths) of a covered dependent (Florida)
A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Dependent Eligibility Age Requirements

Over-age Dependents may be covered by the medical, dental, and vision plans through the end of the calendar year in which the child turns age 26.

Medical, dental, and vision coverage may continue to the end of the calendar year in which the dependent reaches the age of 30, if the dependent is:

Unmarried with no dependents; AND
A Florida resident, or full-time or part-time student; AND
Otherwise uninsured; AND
Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is handicapped.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

1. The dependent is physically or mentally disabled and incapable of self-sustaining employment; AND
2. The dependent is otherwise eligible for coverage under the group medical plan; AND
3. The dependent has been continuously insured; AND
4. Coverage began prior to the age of 19.

Proof of disability will be required upon request. Please contact Employee Benefits Coordinator if further clarification is required.

Premium for OAD

Beginning October 1st of the calendar year in which the child reaches age 27 through the end of the calendar year in which the child reaches age 30, that portion of health insurance premium that is attributable to covering the overage dependent (the "OAD value") will be deducted on a post tax basis. If the OAD value is greater than the payroll deduction, the additional employer subsidized portion of the value (OAD value minus payroll deduction) will be reported as imputed income to the employee and included as income on the W-2.

IRS Code Section 125

Premiums for medical, dental, and vision insurance, and/or certain supplemental policies and contributions to FSA accounts (Health Care and Dependent Care FSAs) are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-tax to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event.

Under certain circumstances, you may be allowed to make changes to your benefits elections during the plan year, if the event affects your own, your spouse's, or your dependent's coverage eligibility. An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.

Examples of Qualifying Events

You get married or divorced
You have a child, gain legal custody or adopt a child
Your spouse and/or other dependent(s) die(s)
You, your spouse, or dependent(s) terminate or start employment
An increase or decrease in your work hours causes eligibility or ineligibility
A covered dependent no longer meets eligibility criteria for coverage
A child gains or loses coverage with an ex-spouse
Gain or loss of Medicare coverage
Losing eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60 day notification period).
Becoming eligible for State premium assistance under Medicaid or CHIP (60 day notification period).

Important

If you experience a qualifying event, *you must contact the Employee Benefit Coordinator within 30 days of the qualifying event* to make the appropriate changes to your coverage. Beyond 30 days, requests will be denied and the employee may be responsible both legally and financially for any claim and/or expense incurred as a result of the employee or a dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes will take place in accordance with the carrier's policies and procedures. However, newborns are effective on the date of birth. You may be required to furnish valid documentation supporting a change in status or "Qualifying Event".

HEALTH CARE COSTS continue to outpace general inflation and are under pressure by fees related to federal health reform, new technology, and late identification of serious medical conditions that require advanced treatments. This year, premium reductions will be available to further motivate participants to take proactive steps before conditions arise or become serious issues.

How To Reduce Your Premiums
A new program is being introduced to help you stay healthier and reduce your 2015 medical insurance premiums by 10% or 20%.

BI-WEEKLY PAYROLL DEDUCTIONS

Tobacco User and No Goals Achieved

Coverage Levels	HMO Mid	HMO High	Basic PPO
Employee Only	$XX.XX	$XX.XX	$XX.XX
Employee & Spouse	$XXX.XX	$XXX.XX	$XXX.XX
Employee & Child(ren)	$XXX.XX	$XXX.XX	$XXX.XX
Employee & Family	$XXX.XX	$XXX.XX	$XXX.XX

One Goal Achieved Tobacco Free or HRA/Biometric Screening

Coverage Levels	HMO Mid	HMO High	Basic PPO
Employee Only	$XX.XX	$XX.XX	$XX.XX
Employee & Spouse	$XXX.XX	$XXX.XX	$XXX.XX
Employee & Child(ren)	$XXX.XX	$XXX.XX	$XXX.XX
Employee & Family	$XXX.XX	$XXX.XX	$XXX.XX

New for 2015/2016 Two Goals Achieved Tobacco Free and HRA/Biometric Screening

Coverage Levels	HMO Mid	HMO High	Basic PPO
Employee Only	$X.XX	$XX.XX	$X.XX
Employee & Spouse	$XXX.XX	$XXX.XX	$XXX.XX
Employee & Child(ren)	$XXX.XX	$XXX.XX	$XXX.XX
Employee & Family	$XXX.XX	$XXX.XX	$XXX.XX

Medical Plan Comparison Chart

New Medical Plan Premium Reductions

Non-Smokers get 90% of the Employee premium for the Basic (PPO) plan paid by the company.

Smokers actively trying to quit get 90% of the Employee premium for the Basic (PPO) plan paid by the company if they complete the Health Risk Assessment and get a Biometric Screening.

Non-Smokers get 100% of the Employee premium for the Basic (PPO) plan paid by the company if they complete the Health Risk Assessment and get a Biometric Screening

Plans	HMO Mid	HMO High	Basic PPO	
	In Network Only	In Network Only	In Network	Out of Network
Deductible				
Individual	$1,000	$500	$500	$1,000
Family	$2,000	$1,500	$1,500	$2,000
Coinsurance	0%	20%	20%	40%
Out of Pocket Maximum (Includes Deductible, Coinsurance, Copay, Rx)				
Individual	$3,500	$3,000	$3,000	$6,000
Family	$10,500	$6,000	$6,000	$12,000
Preventive Care				
Office Visit Birth through age 15 Ages 16 and older	Covered 100%	Covered 100%	Covered 100%	40% Coinsurance Ded + 40%
Lab, X-ray, other preventive tests Birth through age 15 Ages 16 and older	Covered 100%	Covered 100%	Covered 100%	40% Coinsurance Ded + 40%
Physician Office Visit Sickness & Injury				
Primary Care	$30 Co-pay	$30 Co-pay	$25 Co-pay	Ded + 40%
Specialist	$70 Co-pay	$70 Co-pay	$50 Co-pay	Ded + 40%
Lab / X-rays Physician's Office Independent Lab Outpatient Facility	Covered 100%	$30 PCP/$70 Specialist Ded + 20% Ded + 20%	$25 PCP/$50 Specialist Ded + 20% Ded + 20%	Ded + 40% Ded + 40% Ded + 40%
Advanced Radiology Imaging Physician's Office Outpatient Facility	Covered 100% Deductible	Covered 100% Ded + 20%	Covered 100% Ded + 20%	Ded + 40% Ded + 40%
Hospital Services, Urgent Care				
In-Patient Hospital Services	Deductible	Ded + 20%	Ded + 20%	$300 PAD + Ded + 40%
Outpatient Surgery	Deductible	Ded + 20%	Ded + 20%	Ded + 40%
Emergency Room	$300 Co-pay	$300 Co-pay	$300 Co-pay	$300 Co-pay + Ded
Urgent Care	$50 Co-pay	$50 Co-pay	$50 Co-pay	$20 Co-pay + Ded

How to Locate A Provider - To search for a participating provider, go to www.medical.com, select "Find a Doctor", then click on "Select a Plan of your Search" and choose **"Open Access Plus Network"**. Fill in the rest of the search criteria and click "Search".

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Other Available Plan Resources

Medical offers all enrolled members and dependents additional services and discounts through value added programs. **For more details regarding other available plan resources, please refer to your Summary of Benefits and Coverage (SBC).**

24 Hour Help Information Hotline (800) MEDICAL-24

The Medical 24-Hour Health Information Line provides you access to helpful, reliable information and assistance from qualified health information nurses on a wide range of health topics 24 hours a day, any day of the year. Not sure what to do when your child has a fever in the middle of the night? Have you injured yourself and are not sure if you should seek treatment or go see a doctor? There are over 1,000 topics in the Health Information Library that include FREE audio, video and printed information on aging, women's health, nutrition, surgery and specific medical conditions to help you weigh the risks and advantages of treatment options. The call is FREE and strictly confidential.

Healthy Rewards

Medical's Healthy Rewards is provided to you automatically at no additional cost and offers access to discounted health and wellness programs at participating providers. Members can log on to www.mymedical.com and select Healthy Rewards to learn more about these programs or call (800) 870-3470.

- Vision Care
- Lasik Vision Correction Services
- Fitness Club Discounts
- Nutrition Discounts
- Hearing Care
- Tobacco Cessation
- Alternative Medicine

The myMedical Mobile App

The myMedical Mobile App gives you an easy way to organize and access your important health information. Anytime. Anywhere. Download it today from the App Store℠ or Google Play™. With the myMedical Mobile App you can:

- Find a doctor, dentist or health care facility
- Access maps for instant driving directions
- View ID cards for the entire family
- Review deductibles, account balances and claims
- Compare prescription drug costs
- Speed-dial Medical Home Delivery Pharmacy™
- Store and organize all important contact info for doctors, hospitals and pharmacies
- Add health care professionals to contact list right from a claim or directory search
- And, much more!

BENEFITS TIP

Local retail network pharmacies may provide free antibiotics, diabetes and blood pressure medications and $4 generic prescriptions. Take advantage of these programs to keep your costs down.

Prescription Coverage

Prescription Coverage				
	HMO Mid In Network Only	HMO High In Network Only	Basic PPO In Network	Basic PPO Out of Network
Retail Pharmacy				
Generic	$10 Copay	$15 Copay	$15 Copay	50% Coinsurance
Preferred	$30 Copay	$30 Copay	$30 Copay	
Non-Preferred	$50 Copay	$50 Copay	$50 Copay	
Mail Order (90 days)				
Generic	$20 Copay	$30 Copay	$30 Copay	50% Coinsurance
Preferred	$60 Copay	$60 Copay	$60 Copay	
Non-Preferred	$100 Copay	$100 Copay	$90 Copay	

Where can I find free or nearly free antibiotics?

Select Publix supermarket pharmacies offer some prescriptions for free, including certain antibiotics such as amlodipine, metformin and Lisinopril.

Target, Sam's Club and Walmart offer 30-day supplies of some generic drugs for $4 and a 90-day supply for $10.

Dental

The Dental PPO plan is "open access" and allows you to receive services from any dental provider with out selecting a Primary Dental Provider (PDP) and does not require referrals to specialists. The PPO plan provides benefits for services received from in-network and out-of-network providers.

Plan	Dental	
	In Network	**Out of Network**
Calendar Year Deductible Individual / Family	$50 / $100	$50 / $100
Annual Maximum	**$1,500**	**$1,500**
Preventative Services Exams, Cleanings, X-Rays, etc.	Plan pays 100% Deductible is waived.	
	Member Pays	
Basic Services Fillings, Simple extractions, Periodontics, Root Canals, etc.	10%	20%
Major Services Crowns, Dentures, Bridges, Implants, etc.	40%	50%
Orthodontics $1,500 Lifetime Maximum for child(ren) under age 19 Deductible does not apply to Orthodontic services.	50%	50%

BI-WEEKLY DEDUCTIONS

Employee Only	**$X.XX**
Employee & Spouse	**$X.XX**
Employee & Children	**$XX.XX**
Family	**$XX.XX**

To search for a participating provider, go to www.dental.com, select "Find a Doctor", then click on "Select a Plan for your Search" and choose **"Dental PPO"** then **"Radius Network"**. Fill in the rest of your search criteria and click Search.

You can increase your plan year maximum by $100 annually if you receive preventive services during the prior plan year.

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Vision

Vision Carrier is the company's carrier again this year. Your vision is important to your health. Whether you have 20/20 or less than perfect vision, everyone needs to receive regular vision care. Don't take chances with your vision; take advantage of this important benefit.

Description	In-Network Benefits	Out-of-Network Reimbursement
Exam *(every 12 months)*	$5 Copay	$18
Exam Options:		
Standard Contact Lens Fit & Follow-up	Up to $40	N/A
Premium Contact Lens Fit & Follow-up	10% off Retail Price	N/A
Frames: *(every 12 months)*	$0 Copay; $110 Allowance	$55
Any available frame at provider location	20% off balance over $110	
Standard Plastic Lenses: *(every 12 months)*		
Single Vision / Bifocal / Trifocal	$10 Copay	$13 / $23 / $40
Standard Progressive Lenses	$70 Copay	$25
Premium Progressive Lenses	$70 Copay, 80% of Charge less $120 Allowance	$25
Lens Options:		
UV Treatment	$12 Copay	$2
Tint (Solid and Gradient)	$12 Copay	$2
Standard Plastic Scratch Coating	$12 Copay	$2
Standard Polycarbonate - Adult	$35 Copay	$3
Standard Polycarbonate - Kids under 19	$35 Copay	$3
Standard Anti-Reflective Coating	$40 Copay	$23
Polarized & Other Add-Ons	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses		
(Contact lens allowance includes materials only)		
Conventional	$0 Copay; $120 allowance, 15% off balance over $120	$96
Disposable	$0 Copy; $120 allowance, plus balance over $120	$96
Medically Necessary	$0 Copay; Paid-in-Full	$200
Lasik or PRK from U.S. Laser Network	15% off Retail or 5% off promotional	N/A

BI-WEEKLY DEDUCTIONS

Employee Only	$X.XX
*Family	$X.XX

Additional Discount

Members can receive up to a 20% discount on items not covered by the plan at network providers. For more information, please visit the Vision website or contact customer service at 866-723-0513.

To search for a participating provider, go to www.vision.com, select "Find a Provider", enter your Zip Code and choose **"Select"** network and click Get Results.

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Flexible Spending Account

The Company offers Flexible Spending Accounts (FSA). The FSA Plan Year is October 1, 2015 through September 30, 2016. You may elect to participate in either FSA or both simultaneously.

If you have predictable medical expenses for yourself you're your family, such as deductibles and copays, or any work-related day care expenses, FSAs may be right for you. FSAs allow you to set aside money for reimbursement of healthcare and day care expenses you regularly pay. The amount you set aside is not taxed and is automatically deducted from your paycheck and deposited into the FSA. During the year, you have access to this account for reimbursement of some expenses that are not covered by insurance. An FSA not only results in a substantial tax savings, it also increases your spending power. There are two types of FSAs:

DEPENDENT CARE

This account allows you to set aside up to an **annual maximum of $5,000 if you are a single or married and file a joint tax return ($2,550 if you are married and file a separate tax return)** for work-related day care expenses. Qualified expenses include adult and child day care centers, preschool, and before/after school care for eligible children and adults.

Please note that if your family's annual income is over $20,000, this reimbursement option will most likely save you more money than the dependent care tax credit you take on your tax return. To qualify, your dependent must be:

A child under the age of 13, or
A child, spouse or other dependent that is physical or mentally incapable of self-care and spends at least 8 hours a day in your household.

Note: Unlike the Healthcare FSA, you will only be reimbursed up to the amount that has been deducted from your paycheck for Dependent Care expenses.

Medical Flexible Spending Accounts will be capped at $2,500.

MEDICAL FLEXIBLE SPENDING ACCOUNT

This money will not be taxable income to you ad can be used to offset the cost of a wide variety of eligible medical expenses that generate out-of-pocket costs for you or your qualified dependents. Employees can also receive reimbursement for expenses related to dental and vision care (that are not classified as cosmetic). **Note: The entire Health Care FSA election is available to you on the first day coverage is effective.**

A sample list of qualified expenses eligible for reimbursement include, but are not limited to:

- Ambulance service
- Chiropractic care
- Dental fees/Orthodontic fees
- Diagnostic tests/Health screenings
- Doctors fees
- Drug addiction/Alcoholism treatment
- Experimental medical treatment
- Eyeglasses/Contact lenses (corrective)
- Hearing aids and exams
- Injections & vaccinations
- Lasik surgery
- Mental healthcare
- Nursing Services
- Optometrist fees
- Physician office visits
- Prescription drugs
- Sunscreen
- Wheelchairs

FSA Guidelines

- You can enroll in either or both FSAs during open enrollment period, new hire eligibility, or a qualifying event only.
- You cannot transfer money between FSAs.
- You cannot pay a dependent care expense from your Health Care FSA or vice versa.
- You cannot deduct reimbursed expenses for income tax purposes.
- You cannot be reimbursed for a service which you have not received.
- You cannot receive insurance benefits or any other compensation for expenses which are reimbursed through your FSAs.
- Domestic partners are not eligible as federal law does not recognize them as a qualified dependent.

KNOW THE RULES

Login Information for TASC

1. **Login to your account.** Go to the MyFSA website at www.fsa.com
2. **Enter your 12 Digit ID Username.** This can be found on your blue FSA Card. Once logged in you can create your own Username.
3. **Enter your password.**
4. **If you are a New User or did not receive your Welcome Kit, click on New User.**

Once you login, you can:

1. Manage your Profile
2. Manage your Account
3. Request Reimbursement
4. Download Reimbursement Request Form

Requests for Reimbursement

When paying for an eligible expense, simply swipe your FSA Card at the point-of-purchase. If you pay for an expense without your FSA Card, simply submit a Request for Reimbursement via the onling MyFSA Mobile App or Request for Reimbursement Wizard in MyFSA, or fax or mail your personalized Request for Reimbursement form with substantiation to FSA.

FSA Card

The FSA Card provides a convenient method to pay for eligible healthcare and dependent care. MyBenefits is funded through equal pre-tax payroll deductions based on your annual benefit election.

Card purchases are limited to your Plan type, and also to merchants with an inventory information approval system in place to identify FSA-eligible purchases. Qualifying merchants may include doctors, dentists, vision care facilities, and day care centers. Simply swipe your card at the time you incur the eligible expense and the IIAS automatically approves the purchase of eligible items and deducts the amount from your MyBenefits account.

Spend your MyCash funds any way and anywhere you want! Visit the MyCash Manager within MyFSA (www.fsa.com) to view account activity, request an ATM PIN, make and manage transfers, view and manage multiple bank accounts, and more.

MYWay

- Access to two accounts on one card makes the FSA Card more versatile than ever!
- Avoid embarrassing declines. MyCash funds can be used to pay for eligible expenses if no funds are available in your MyBenefits account.
- Combine general retail items with healthcare expenses in one transaction. The TASC Card is smart enough to know that eligible expenses are deducted from your MyBenefits account while ineligible expenses are withdrawn from MyCash.
- Transfer MyCash funds via a quick, one-time, recurring, or automatic transfer from MyCash manager within MyFSA.

LIFE INSURANCE

BASIC TERM LIFE AND AD&D

The company provides Basic Life and AD&D Insurance through Life Carrier for all eligible employees at no cost to the employee.

Life Insurance			
	For You	**For Your Spouse**	**For Your Children**
Company Paid Coverage	1x annual salary, up to a maximum of $75,000	N/A	N/A
Additional Amount You May Purchase	Up to maximum of $500,000 (not to exceed 5x annual salary)	Up to a maximum of $250,000 (not to exceed 50% of employee life amount)	$5,000 or $10,000
What it will cost you	See Rate Chart Below	See Rate Chart Below	$.35 per pay or $.69 per pay
Dependent Only Life	N/A	$5,000 or $10,000	$2,000 or $5,000
What it will cost you	N/A	$.48 per pay or $1.03 per pay	Included in Spouse Rate

If coverage was not applied for at initial eligibility (or if an upgrade in coverage is requested at a late date) "Evidence of Insurability" must be provided, including health questions.

COSTS FOR VOLUNTARY SUPPLEMENTAL LIFE INSURANCE

Age	*Employee Monthly Rate per $1,000	*Spouse Monthly Rate per $1,000	Age	*Employee Monthly Rate per $1,000	*Spouse Monthly Rate per $1,000
<20 - 29	$.06	$.03	**55 - 59**	$.97	$.94
30 - 34	$.12	$.09	**60 - 64**	$1.42	$1.90
35 - 39	$.16	$.13	**65 - 69**	$2.31	$2.28
40 - 44	$.21	$.18	**70 - 74**	$4.27	$4.24
45 - 49	$.31	$.28	**75 - 100**	$14.17	$14.14
50 - 54	$.52	$.49			

*Rates are based on Employee Age for Employee coverage and Spouse Age for Spouse coverage

Example: A 36 year old female, Sally, wants to purchase $50,000 of term life insurance.

.16	x	50	=	$8.00	x 12 / 26 =	$3.69
Monthly rate per $1,000		# of units/$1,000		monthly premium		payroll deduction

Always remember to keep your beneficiary forms updated. Beneficiary information may be updated at any time through the Explain My Benefit portal.

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A disability can have significant financial impact on a family. Not only does the income from the disabled person stop, but expenses usually increase because of necessary medical and rehabilitation costs. The Company's disability coverage provides you with a source of income if you are unable to work because of a non-work related short or long-term illness or injury.

SHORT TERM DISABILITY

The Company provides Basic Short Term Disability (STD) insurance to all eligible employees, at no cost to you. Employees will be automatically enrolled in Basic STD.

The Company also offers a STD Buy-up plan that you can elect to purchase that would reduce your elimination period from 30 days to 7 days.

Basic Short Term Disability (*Employer Paid*)

Elimination Period for sickness, accident or pregnancy: 30 days

Maximum Benefit Period: 26 weeks for total or partial disability

Weekly Benefit: Up to 67% of your weekly earnings to a maximum of $1,000 benefit

Short Term Disability Buy-up (Employee Paid)

Elimination Period for sickness, accident or pregnancy: 7 days

Maximum Benefit Period: 26 weeks for total or partial disability

Weekly Benefit: Up to 67% of your weekly earnings to a maximum of $1,000 benefit

Cost: $.10 per $10 of weekly benefit

If you did not previously elect the STD Buy-up benefit, Evidence of Insurability and approval by Dental will be required.

- **STD coverage supplements your lost wages should you be unable to work due to a covered illness, injury or pregnancy.**
- **STD coverage begins after the specified elimination period due to a medically certified illness or injury. Benefits are payable up to the specified benefit duration period.**
- **Benefits are paid to you weekly as long as you are under the plan or the maximum payment period; remain disabled and under the regular care of a physician.**

Example for STD Buy-up: Employee with a weekly salary of $800, eligible for $530 of weekly STD benefit

.10	x	53	=	$5.30	x 12 / 26 =	$2.45
Monthly rate per $10		# of units/$10		monthly premium		payroll deduction

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LONG TERM DISABILITY

The Company is offering a Long Term Disability plan this year that you can elect to purchase that would pay 60% of your current earnings until you recover or reach the age of 65.

- **Long Term Disability (LTD) coverage generally picks up where STD left off.**
- **Benefits begin if you have been disabled for more than six months and meet the insurer's definition of disabled.**
- **LTD coverage supplements your lost wages should you be unable to work due to a covered illness or injury.**
- **LTD coverage begins after the specified elimination period due to a medically certified illness or injury. Benefits are payable up to the specified benefit duration period.**
- **LTD pays up to a maximum of $10,000 per month.**

Long Term Disability (*Employee Paid*)

Elimination Period for sickness, accident or pregnancy: 180 days

Maximum Benefit Period: Age 65 or to your normal retirement age

Weekly Benefit: Up to 60% of your monthly earnings to a maximum of $10,000 benefit

Pre-Existing Condition: Anything you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicine prescribed or taken in the 3 months prior to your insurance effective date will not be covered for the first 12 months of the policy.

Age	Monthly Rate Per $100 of Benefit	Age	Monthly Rate Per $100 of Benefit
<20 - 24	$0.0800	**50 - 54**	$0.8200
25 - 29	$0.1000	**55 - 59**	$0.8700
30 - 34	$0.1900	**60 - 64**	$0.9200
35 - 39	$0.3000	**65 - 69**	$0.9600
40 - 44	$0.4400	**70+**	$0.9800
45 - 49	$0.5900		

Example for LTD: Employee, age 40, with a monthly salary of $3,000

.4400	x	30	=	$13.20	x 12 / 26 =	$6.09
Monthly rate per $100		# of units/$100		monthly premium		payroll deduction

Behavioral Health - Employee Assistance Program

A comprehensive Employee Assistance Program (EAP) is available to you and each member of your family through Behavioral Health as part of your core benefits package. The EAP offers access to mental health professionals through a confidential program that is protected by State and Federal laws. The EAP program is available 24 hours a day, 7 days a week to help you gain a better understanding of problems that affect you and your family so that the best professional help can be located and utilized to help you establish a plan of action.

EAP Areas of Service:

- Child Care
- Legal Resources
- Mental / Relationship Issues
- Grief Issues
- Stress Management
- Work Related Issues
- Adult & Elder Dependent Assistance
- Parenting Issues
- Financial Resources

The Company recognized that employees' personal responsibilities may, at times, spill over into the work-place. To help ensure employees are able to address these concerns with minimal disruption, the program provides employees and their family members assistance through a variety of ways including 3 face-to-face sessions per issue per year, telephonic consultation, online material/tools and webinars.

Are your services confidential?

Yes, Receipt of EAP services is completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), they will ask permission to communicate certain aspects of your care (attendance at sessions, adherence to treatment plans, etc.) to your supervisor/manager. The referring supervisor will not, however, receive specific information regarding your case. The supervisor will only receive reports on whether the referred employee is complying with the prescribed treatment plan.

You can call the Employee Assistance Program any time, any day or visit
www.behaviorialhealth.com
1-877-622-4327

For additional information and resources visit www.behaviorialhealth.com
Employer ID: company

Group Retiree Health Plan

The Company's Group Retiree Health Plan will be provided by the insurance carrier(s) in force at the time of retirement and is subject to change if the Company changes carriers, benefits or rates. All of the following requirements must be met in order for a Company employee to be eligible for retiree insurance benefits (medical, dental & vision insurance).

- Employees must have a minimum of eight (8) years of service vested with the Company in conjunction with the Florida Retirement System (FRS).
- The employee must be eligible to receive and/or be receiving benefits from the FRS.
- Retirement age of 55 or above must be attained (unless the employee has 30 consecutive years of service with the FRS/25 Years for High Risk employees).
- Having a job elsewhere is not a factor

The Company's Retiree Health Plan will cease when the retiree becomes eligible for Medicare.

Monthly Premium for Retiree Core Benefits

Medical			
	Medical Mid HMO	Medical High HMO	Medical PPO
Employee Only	$XXX.XX	$XXX.XX	$XXX.XX
Employee & Spouse	$X,XXX.XX	$X,XXX.XX	$XXX.XX
Employee & Child(ren)	$XXX.XX	$XXX.XX	$XXX.XX
Family	$X,XXX.XX	$X,XXX.XX	$X,XXX.XX

Dental	
Employee Only	$XX.XX
Employee & Spouse	$XX.XX
Employee & Child(ren)	$XX.XX
Family	$XXX.XX

Vision	
Employee Only	$X.XX
Employee & Spouse	$XX.XX
Employee & Child(ren)	$XX.XX
Family	$XX.XX

Health Care Reform and the Health Insurance Marketplace:

What Does It Mean To YOU?

The Health Care Reform law says that essentially EVERYONE must have HEALTH INSURANCE or PAY A PENALTY.

How Can You Be Sure You and Your Family Members **DON'T GET PENALIZED?**

- Enroll in a Company medical plan, OR
- Have your spouse enroll you in their employer Plan as a dependent (assuming it meets "minimum essential coverage" Requirements as defined by the law), OR
- Purchase coverage from the new government-sponsored Health Insurance Marketplace (also referred to as Health Exchanges).

BEWARE!

Although you'll avoid the penalty for choosing one of the above approaches, make sure you choose the most cost-effective option for you and your family.
When compared to the Marketplace option, Company may be your best bet.

WHY?

1. The Company Pays a Big Portion of Your Total Premium Cost

The Company covers a substantial portion of the cost of coverage for its employees. If you purchase healthcare through the Marketplace rather than enroll in the Company coverage, the Company doesn't contribute to the cost - meaning you lose that employer contribution and must pay the full cost of the premium.

2. You Can Pay for Company Coverage Using PRE-TAX Dollars

The money you pay each month out of your paycheck to cover the cost of your Company healthcare coverage is deducted BEFORE taxes are taken out, which saves you money. Your payment for any coverage bought through the Marketplace must be made with AFTER-TAX dollars - meaning you lose that tax advantage.

3. You Don't Qualify for the Government Subsidy/Tax Credit*

Although it will be advertised that people can pay less through the Marketplace because of a government-sponsored tax credit/subsidy that will reduce the premium cost, only certain people actually qualify for that price break. And, because our employees have access to our coverage (which meets all requirements of the new law) and all our employees currently earn more than $8,337* a year, not a single Co. employee will qualify for a tax credit through the Marketplace! You'll pay the full cost!

BOTTOM LINE:

As a Company employee, you and your eligible family members have access to a very valuable benefit through our medical plans - a benefit that will be very hard to match! You do not need to buy coverage elsewhere, nor do you need to do anything outside the normal Company open enrollment period. But the choice is yours.

For more information about your benefit plans, go to:

www.explainmybenefits.biz/abc

Based on Towers Watson Minimum Value Test dated 10/14/2014

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Trustmark Voluntary Benefit Solutions

TRANSAMERICA

WHAT ARE VOLUNTARY BENEFITS?

Voluntary Benefits are offered to strengthen your overall benefits package. You customize the benefit based on need and affordability.

- Ownership – Policies are fully portable and belong to you if you leave your employer, same price and same plan
- Benefits are payroll deducted
- ***Cash benefits are paid directly to you, not to a hospital or to a doctor***
- ***Benefits are paid regardless of any other coverage you may have***
- Level premiums—Rates do not increase with age
- Guaranteed Renewable
- Designed to provide additional cash flow to assist with out of pocket medical costs and other bills

The Voluntary Benefits offered are an **Accident Plan, Critical Illness/Cancer Plan and Universal Life with Long Term Care** through Trustmark and ***new for this year*** **Hospital Indemnity** through Transamerica.

TRANSAMERICA

HOSPITAL INDEMNITY

Hospital Indemnity is a policy that pays a specified amount for each day a covered person is confined to the hospital and provides benefits for a range of other medical situations.

Benefit payments go straight to the insured for:	
• **Hospital Confinement Benefit** Pays each day a covered person is confined to a hospital for a minimum of 24 hours from admission	$1,000 **Maximum:** 1 day per confinement/1 day per calendar year
• **Daily-In Hospital Benefit** Pays each day a covered person is confined to a hospital	$200.00 per day **Maximum:** 31 days per confinement
Surgical & Anesthesia Benefit	
• Inpatient Surgery	$1,000
• Outpatient Surgery	$500
• Outpatient Minor Surgery	$100
• Anesthesia	30% of surgical benefit

BI-WEEKLY DEDUCTIONS

Employee	**$XX.XX**
Employee & Spouse	**$XX.XX**
Employee & Children*	**$XX.XX**
Family*	**$XX.XX**

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ACCIDENT PLAN

Trustmark Voluntary Benefit Solutions

The Accident Insurance helps pay for the unexpected expenses that can result from an accident.

- On– and off-the-job coverage (24/7)

Money is paid directly to you for (please see brochure for a complete list of benefits):

- Initial Doctor's Office Visit: **$200**
- Hospitalization: **$3,200** admission, **$500** per day
- Fractures: up to **$15,000**
- Dislocations: up to **$12,000**

BI-WEEKLY DEDUCTIONS

Employee	**$X.XX**
Employee & Spouse	**$XX.XX**
Employee & Children*	**$XX.XX**
Family*	**$XX.XX**

Wellness Benefit Included: A wellness benefit is paid for all routine physicals, vaccines, and health screening tests for each covered person. There is a 60-day waiting period, after initial enrollment, for this benefit.

This benefit pays $100 per test per person, twice each year (maximum of $200 annually per insured).

Examples of Health Screenings include:

- Low-dose Mammogram
- Serum Cholesterol
- Pap Smear
- Fasting Blood Glucose Test
- PSA Test
- Stress Test

**Dependents up to age 26 can be covered regardless of student status.*

CRITICAL ILLNESS / CANCER

Trustmark Voluntary Benefit Solutions

Critical Illness/Cancer is a benefit that will pay you a lump sum of money if you are diagnosed with a critical Illness, heart attack, internal cancer or stroke. The cash benefit is provided upon the first diagnosis of a covered condition to help you with associated costs and beyond.

Special Underwriting at Initial Offering
Guaranteed Issue
$15,000 employee / $7,500 spouse / $1,500 children

Examples of covered conditions:
Invasive Cancer, Heart Attack, Stroke, Renal (Kidney Failure), Blindness, ALS (Lou Gehrig's Disease), Major Organ Transplant, Paralysis of Two or More Limbs, Coronary Artery Bypass Surgery (25% benefit), Carcinoma In Situ (25% benefit)

A Health Screening Benefit is included in your Critical Illness/Cancer Policy and Trustmark pays $100 for each insured. Each covered person will get one immunization or one screening test per calendar year. (60 day waiting period for this benefit)

Examples of Health Screenings

- Low dose mammography
- Pap smear
- Serum cholesterol
- PSA Test
- Stress Test
- Colonoscopy
- Bone Marrow
- Chest X-ray

Also included is a Double Benefit Option that provides a second cash payment in the event a covered person is diagnosed with a different condition or illness. Pays an additional 100% of the original benefit.

Rates
This benefit is customized by each employee so rates vary, but can start as little as a few dollars a week.

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Universal Life with Long Term Care

Trustmark Voluntary Benefit Solutions®

Universal Life with Long Term Care includes both a death benefit and a living benefit.

- Trustmark Universal Life with Long Term Care is a permanent life insurance that is designed to match your needs throughout your lifetime. It pays a higher death benefit during your working years when expenses are high and you need maximum protection.
- The Universal Life with Long Term Care is priced to remain the same cost to you until age 100.
- The death benefit reduces at age 70 when the need for life insurance typically decreases.
- The Living Benefit, Long Term Care never reduces and is 4% of the original death benefit per month for up to 25 months.
- If you use the Long Term Care benefit, your death benefit amount does not reduce due to the Benefit Restoration feature included.
- Coverage available for spouse and children as well.

Special Underwriting at Initial Offering

Guaranteed Issue (Employee Only)

The lesser of the face amount purchased by $16 per week or $200,000

LifeEvents® with Long Term Care example: $100,000 Death Benefit

	Maximum Benefit Amount	
Long Term Care Benefit (LTC): Pays a monthly benefit equal to 4% of your death benefit for up to 25 months.	Before Age 70 **$100,000**	After Age 70 **$100,000**
Benefit Restoration: Restores the death benefit that is reduced to pay for LTC.	**$100,000**	**$33,333**
Total Maximum Benefit: Long Term Care Benefits may double the value of your insurance.	**$200,000**	**$133,333**

Rates

This benefit is customized by each employee so rates vary, but can start as little as a few dollars a week.

LifeLock Identity Theft Protection

LifeLock
#1 In Identity Theft Protection

Identity theft in the United States is a major problem that continues to be on the rise. Professional protection and assistance have become important tools in fighting the identity theft epidemic.

Thieves today can get a hold of your personal information from trash cans, dumpsters, stolen mail, and even shoulder surfing. Once thieves have your information, it's a simple matter to open new fraudulent accounts and make purchases in your name.

When you enroll in LifeLock, you can be confident knowing that they are available 24 hours a day, 7 days a week, and committed 100% to helping protect your information as if it were their own.

LifeLock offers Proactive Protection:

- LifeLock Identity Alert System
- eRecon
- TrueAddress
- WalletLock
- Reduction in Pre-Approved Credit Card offers
- Free Annual Credit Reports
- 24-Hour Customer Service

Did you know?

LifeLock provides a $1 Million Total Service Guarantee

LifeLock's proactive approach works to help stop identity theft before it happens. As a LifeLock member, if you become a victim of identity theft because of a failure in their service, they will help fix it at their expense, up to $1,000,000.

BI-WEEKLY DEDUCTIONS

Employee Only	**$X.XX**
Employee & Spouse	**$X.XX**
*Employee & *Children	**$X.XX**
*Family	**$XX.XX**

*Employee & Children and Family Tiers: You may enroll up to 8 children with 4 of those children between the ages of 18 and 26.

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most popular

Veterinary Pet Insurance®

the #1 choice in America for pet insurance

Voluntary Benefit - Will not be payroll deducted

Major Medical Plan
Comprehensive™

- Coverage for ongoing conditions
- Freedom to use any vet, anywhere
- Benefits renew in full each year
- \+ Double the benefit allowances of the Medical Plan
- \+ Limited hereditary coverage after the first year

$24 - 34/month†

Medical Plan
Economical™

- Coverage for ongoing conditions
- Freedom to use any vet, anywhere
- Benefits renew in full each year

$18 - 26/month†

Optional **routine care coverage** is available to complement any VPI® plan for as little as **$12/month**, with benefits for wellness exams, vaccinations and much more.

Injury, Feline Select® and Avian & Exotic plans are also available.

sample Major Medical Plan reimbursements*	vomiting (gastritis)	bladder infection (cystitis)	lymph node cancer (lymphosarcoma)	cruciate rupture - surgical repair
	veterinary fee $1,055	veterinary fee $767	veterinary fee $4,320	veterinary fee $3,697
	reimbursement **$860**	reimbursement **$667**	reimbursement **$3,230**	reimbursement **$3,290**

what's covered?

- Ear infections
- Skin rashes
- Accidents, including lacerations, poisonings, fractures, sprains, and wounds
- Vomiting
- Cancer
- Diabetes
- Kidney and bladder infections
- Leukemia
- Abscesses
- Respiratory problems
- And more

how does VPI work?

1. Visit Any vet.
2. Submit A claim.
3. Receive Reimbursement.

*These are actual claims from VPI policyholders who were enrolled prior to the introduction of the VPI Major Medical Plan and VPI Medical Plan. Claims were reimbursed according to the respective plan in which the policyholder was enrolled at the time. Amounts shown here reflect what would have been reimbursed through the updated plans based on a $100 annual deductible. Available deductible amounts are $100, $250, $500 and $1,000.

** rate discounts apply to the base medical plan only.

† Premiums vary based on the age of the pet, species, size (as an adult), plan type, deductible and state of residence.

Get your discount today**

877-PETS-VPI • www.petinsurance.com/abc

Veterinary Pet Insurance℠
a Nationwide Insurance® company

Brand Name Drug: A medication protected by patent for which a generic drug option is not available. It is generally more expensive than a generic equivalent.

Coinsurance: The remaining portion of the cost of medical services to be paid by the patient after first meeting any applicable deductible(s). Coinsurance amounts, which are a percentage of the cost, vary by type of service.

Copay: A specific dollar amount that you must pay for a specific service at the time when you receive the service.

Deductible: A fixed amount that an individual must pay for covered medical services before the health plan will begin to pay.

Dependent Care Spending Account: Lets you set aside pre-tax dollars to pay for eligible childcare expenses. Because the reimbursement account contributions are not taxed, you decrease your taxable income while increasing your available cash. Funds do not roll over from year to year, are not portable and do not accrue.

Explanation of Benefits (EOB): A form provided directly to the member to explain how a health benefits claim was paid. In addition to claims payment information, the EOB often includes information on the appeals process.

Flexible Medical Spending Account (FSA): A tax-advantaged account that can be used to pay for medical expenses. Contributions to the FSA are made by the employee. The contributions are free of federal, Social Security and most state taxes. Funds must be used in the year they are accrued; unused funds revert to the employer. Funds are not portable and do not accrue interest.

Formulary: A list of covered prescription drugs. Generally includes both brand name and generic prescription drugs. Within each category of covered drugs, there are different levels of coverage based on the drug's cost, efficacy or other considerations.

Generic Drug: A chemically equivalent version of a brand-name drug for which the patent has expired. Generic drugs are typically less expensive, and are sold under the common name for the drug, not the brand name.

In-Network Provider: A physician, hospital, nursing facility or other health care provider that has contracted with Medical to provide covered services for a negotiated charge.

Mail Order Pharmacy: Distributes prescribed medication directly to the patient via mail.

Maximum Out-of-Pocket: The limit on the amount an individual is required to pay for health care services covered by their medical plan. Out-of-network, out-of-pocket maximums are higher than in-network maximums.

Open Enrollment: A period of time when employees may make choices regarding their benefits for the following year. You should read enrollment materials carefully, since there are often substantial differences between health benefits plans.

Out-of-Network Provider: Generally refers to physicians, hospitals and other health care professionals who have not contracted with a health plan to provide services. Employees pay higher coinsurance rates for using an out-of-network provider.

PAD: Per Admission Deductible

Premium (Insurance): The amount charged, per pay period, for medical insurance. The cost of the premium is shared between the employee and Company. Your medical benefits are considered part of your total compensation (wages, vacation, training, etc.).

Preventive Exam: Exams or services that can help maintain good health (such as annual physical exams or immunizations) or are meant to detect early signs of disease (such as mammograms and colon cancer screenings).

Benefit Guide Description

Please Note: This Employee Benefit Brochure is designed to provide a brief overview of the benefit plans that are provided for and made available to employees of the Company and their families.