FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

HERE FOR YOU HERE FOR GOOD

YMCA OF FLORIDA'S FIRST COAST

Employee Benefits Handbook
October 1, 2015 – September 30, 2016

CONTENTS

We genuinely care.

The YMCA of Florida's First Coast is pleased to offer full-time employees a comprehensive benefits package which includes a choice of four group health plans with Florida Blue, a dental plan with Sun Life, a group vision plan with Humana, Pre-Paid Legal and Identity Theft Protection with Legal Shield, Basic Life, Voluntary Life, EAP, Short and Long Term Disability as well as Supplemental Accident and Critical Illness/Cancer Protection all with Lincoln Financial Group.

This Employee Benefits Handbook has been produced to assist you with the plan offerings that are available to YMCA employees from 10/1/2015 through 9/30/2016, in addition to employee wellness initiatives.
Benefits become effective on the first day of the month following 60 days of full-time employment.

In addition, there are a multitude of value-added services including Travel Connect, Beneficiary Connect Employee Assistance Plan, On-line will preparation with Lincoln and Florida Blue 365 Discount Programs which are made available to employees at no additional cost.

You will also find important carrier contact information for self-service, healthcare reform information, access to many robust websites as well as dedicated YMCA employee assistance provided by The Bailey Group for all of your benefit needs.

GROUP VISION PLAN

PROVIDED THROUGH HUMANA/COMPBENEFITS

EYE EXAM: at Participating Provider (once every 12 months) ..... **$10 COPAY**

MATERIALS: ..... **$15 COPAY**

CHOOSE ONE: PRESCRIPTION EYEGLASSES

Lenses (once every 12 months)
Single Vision, Lined Bifocals, and lined trifocal or lenticular lenses
Frames (once every 24 months)

CONTACT LENSES (in lieu of glasses, once every 12 months) ..... **UP TO $150 ALLOWANCE**

EXTRA DISCOUNTS AND SAVINGS:

- Average of 70% savings off retail price for elective vision care options such as scratch resistant & anti-reflective coatings and progressive lenses or lens treatments. Additional 20% off a second pair.
- LASIK surgical vision correction procedure discounts are available from TLC vision care participating providers.
- Preferred member pricing for other contacts, frame and lens options when rendered at participating Humana/CompBenefits locations.
- Expanded network now includes the following retailers: Pearle Vision, Sears, Target, jcpenney, LensCrafters

VISION RATES
(Semi-monthly, pre-tax deduction)

EMPLOYEE	$ 4.14
EMPLOYEE + SPOUSE	$ 8.26
EMPLOYEE + CHILD(REN)	$ 7.83
FAMILY	$ 12.30

Visit **humanavisioncare.com** to find a local participating provider.

Coverage is available for dependents up to age 26, regardless of status. Customer Service: 1.800.865.3676.

GROUP DENTAL PLANS
PROVIDED THROUGH SUN LIFE

	PPO CHOICE PLAN
Calendar Year Deductible (Does not apply for preventive or ortho services)	$50 Individual $150 Family Maximum
IN-NETWORK SERVICES	**United Concordia – Alliance**
PREVENTIVE SERVICES Oral Examinations (0120) Cleanings (1110, 1120) X-Rays (0210-0330)	100%
BASIC SERVICES Extraction (7120) Fillings (Silver or white) Removal of Impacted tooth (7220-7240)	90%
MAJOR SERVICES Crowns (2740-2790) Partials (5211-5226) Dentures (5110-5140)	60%
ORTHODONTIC SERVICES **For children up to age 19**	50%
OUT OF NETWORK SERVICES	
No balance billing protection when services are rendered by a non-participating dental provider	
PREVENTIVE SERVICES	100% of maximum allowable
BASIC SERVICES	80% of maximum allowable
MAJOR SERVICES	50% of maximum allowable
ORTHODONTIC SERVICES	50% of maximum allowable
BENEFIT MAXIMUMS	
ANNUAL BENEFIT MAXIMUM	$1,500 person/calendar year
UNUSED BENEFIT ROLLOVER	Up to $750 claims = $300 rollover (requires annual exam & 100 days covered)
ORTHODONTIC LIFETIME BENEFIT	$1,500 (lifetime per child under age 19)
DENTAL RATES (Semi-monthly, Pre-tax deduction)	
EMPLOYEE ONLY	$13.70
EMPLOYEE + SPOUSE	$27.33
EMPLOYEE + CHILD(REN)	$36.19
EMPLOYEE + FAMILY	$56.33

Coverage is available for dependents up to age 26, regardless of status. Waiting periods may apply for major services when late elections are made. Visit **sunlifedentalbenefits.com** to locate an in-network dentist.

CUSTOMER SERVICE: 1.888.222.3660 CLAIMS MAILING ADDRESS: P.O. Box 69421 Harrisburg, PA 17106

WHAT HEALTH CARE REFORM MEANS FOR ME
A SUMMARY OF IMPACTS ON EMPLOYEES

The impact of health care reform on employees in 2015 requires you to take action – enroll yourself in minimum essential coverage or pay a penalty.

The Patient Protection and Affordable Care Act, also known as health care reform or the Affordable Care Act, was enacted on March 23, 2010, and has been amended many times already. In its current form, the law has resulted in a steady stream of regulations and guidance as various governmental entities clarified employers' requirements under the law over the past three years. The aspect of the legislation that will affect you as an individual is known as the individual mandate, and was effective in 2014. Most Americans are now required to purchase health insurance coverage that meets a certain minimum standard. If such coverage is not secured, individuals will pay an additional tax on his or her 2015 personal income tax return filed in 2016 and beyond.

As your employer, we continue to implement provisions to comply with the requirements of the health care reform law. This summary focuses on the changes that affect you as an individual, as well as changes in the benefit programs we offer. We encourage you to pay careful attention to your health care benefits so you can keep up with the changes.

What coverage must I carry to avoid paying a penalty?

Nearly all Americans are required to carry "minimum essential coverage" or pay a penalty beginning in 2015. Most employer-sponsored group health insurance qualifies as minimum essential coverage, as does governmental coverage (like Medicare, Medicaid, CHIP and TRICARE), retiree coverage, COBRA coverage and individual policies. The coverage we offer you qualifies as minimum essential coverage. If you decide not to take our coverage, the penalty amount applies if you go without minimum essential coverage for at least three months in 2015 (you cannot have a gap in coverage for more than a continuous three-month period). The penalty is assessed when you file your taxes will be a flat dollar amount or a percentage of income amount, illustrated in the table below.

FLAT DOLLAR MINIMUM			PERCENTAGE OF INCOME
YEAR	ADULTS IN HOUSEHOLD	CHILDREN IN HOUSEHOLD 18 YEARS OR YOUNGER	CALCULATED WHEN FILING TAXES FOR THE APPLICABLE YEAR*
2014	$95	$47.50	1%
2015	$325	$162.50	2%
2016	$695	$347.50	2.5%

*The penalty amount is determined by subtracting exemptions and standard deductions from household income. The resulting figure is multiplied by the percentage of income. If this figure is greater than the flat dollar amount, the taxpayer pays the percentage of the income penalty.

Who doesn't have to pay a penalty?

Uninsured people won't have to pay a penalty if they:

- Are insured for fewer than three months of the year; Have very low income and coverage is considered unaffordable;
- Are not required to file a tax return because their income is too low; Are a member of a federally recognized Indian tribe;
- Would qualify under the new income limits for Medicaid, but their state has chosen not to expand Medicaid eligibility;
- Participate in a health care-sharing ministry; Are a member of a recognized religious sect with religious objections to health insurance.

If you don't qualify for these situations, you can apply for an exemption asking not to pay a penalty. You do this in the Marketplace.

To avoid a penalty, you need insurance that qualifies as minimum essential coverage.

If you're covered by any of the following in 2015-16, you're considered covered and don't have to pay a penalty:
Any Marketplace plan, or QHP individual insurance plan you already have; Medicare; Medicaid;
The Children's Health Insurance Program (CHIP), TRICARE (for veterans and their families); Veterans' health care programs; Peace Corps Volunteer plans; Employer QHP plan (including COBRA and retiree plans).

What kinds of health insurance don't qualify as coverage?

Health plans that don't meet minimum essential coverage don't qualify as coverage.
If you have only these types of coverage, you may have to pay the penalty:
Coverage only for vision care or dental care; Workers' compensation; Coverage only for a specific disease or condition; Plans that only offer discounts on medical services.

Do I have to take the coverage my employer offers me?

No, but you should be aware that in most cases, the election you make is considered irrevocable and cannot be reversed if you change your mind. If you decide not to take employer-sponsored coverage in 2015, you should purchase coverage elsewhere, such as through a health insurance exchange, discussed next.

In some cases you could experience a qualifying event that would allow you to enroll in our coverage midyear. Examples might include if you get married, have a baby or adopt a child midyear, qualify for premium assistance through CHIP or lose coverage (through Medicare or Medicaid or another employer-sponsored plan). If the plan we offer is a non-calendar year plan, we may elect to include an optional Section 125 qualifying event to allow you to enroll or drop our coverage midyear. Importantly, not paying premiums for an individual policy or having a change in financial condition will not allow you to join our plan mid year. Ask your Human Resources representative for more information about this. In all cases, we are not permitted to retaliate against you for choosing to enroll in coverage somewhere other than our plan.

Where can I get coverage for myself or my dependents if I do not want my employer's coverage?

The federal government and states are in the process of setting up online public health insurance exchanges. You may hear these referred to as marketplaces. The federally facilitated marketplace website is **www.healthcare.gov** oryou can call **customer service: 1-800-318-2596**.

Coverage for children under age 19 is also available via Florida Kidcare and can be obtained at **www.floridakidcare.org** or **1-888-540-5437**. Premium assistance may be available to some families who qualify based on household size and income.

Where can I get additional information or assistance?

For local, personalized assistance with comparing plans, applying for or obtaining a subsidy, you may contact The Bailey Group at **(904) 461-1800**.

What should I consider when deciding whether to enroll in coverage offered through my employer versus an exchange?

Employer-sponsored coverage is subsidized by the employer offering the coverage. This means the cost to you is most likely less than it would be if you purchased it on your own. Government subsidies are not available to employees who are offered affordable, minimum value coverage by their employer. However, the plan of your choice is available to you and your dependents on a guarantee-issue basis via the marketplace. Another reason to consider employer-sponsored coverage is the tax implications of paying for coverage on your own. Coverage purchased through a public exchange cannot be on a pre-tax basis. However, paying for coverage offered through your employer can be done on a pre-tax basis. Depending on the amount of premiums paid and your individual effective tax rate, you may see a significant savings in your taxes by paying for employer-sponsored coverage on a pre-tax basis.

GROUP MEDICAL PLANS
PROVIDED THROUGH FLORIDA BLUE

PROVIDER NETWORK	HIGH OPTION Blue Options	HDHP w/HSA Blue Options	HMO PLAN Blue Care	LOW OPTION Blue Options
PHYSICIAN OFFICE SERVICES				**=Copayment applies for the first six visits in network, then subject to CYD + coinsurance
In Network Family Physician	$30	CYD + 20%	$35	$30**
In Network Specialist	$55	CYD + 20%	$65	$55**
In Network e-Visit	$10	CYD + 20%	$10	$10
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD+50%
Allergy Injections				
In Network	$10	CYD + 20%	$10	$10
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
PREVENTIVE/ROUTINE WELLNESS SERVICES (See complete preventative service guidelines on page 30–31.)				
Annual Physical	$0 copay	$0 copay	$0 copay in network only	$0 copay
In or Out of Network	$0 copay	$0 copay	$0 copay in network only	$0 copay
Routine Labwork @ QUEST LAB only				
In Network	$0 copay	$0 copay	$0 copay in network only	$0 copay
Routine Mammogram				
In or Out of Network	$0 copay	$0 copay	$0 copay in network only	$0 copay
Routine Colonoscopy		(Routine for age 50+ then frequency schedule applies)		
In or Out of network	$0 copay	$0 copay	$0 copay in network only	$0 copay
Women's Preventative Health Services				
Annual Well Woman Exam (OB-GYN)	$0 copay	$0 copay	$0 copay in network only	$0 copay
Contraceptive & STD Counseling	$0 copay	$0 copay	$0 copay in network only	$0 copay
Domestic Violence Screening & Counseling	$0 copay	$0 copay	$0 copay in network only	$0 copay
Screening for Gestational Diabetes	$0 copay	$0 copay	$0 copay in network only	$0 copay
Breastfeeding Support & Supplies	$0 copay	$0 copay	$0 copay in network only	$0 copay
Immunizations (Age Applicable)				
In or Out of network	$0 copay	$0 copay	$0 copay in network only	$0 copay
Flu (Influenza) Shot Annually				
In or Out of network	$0 copay	$0 copay	$0 copay in network only	$0 copay
THERAPY SERVICES				
Combined Special Services: Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations	35 combined visits max per calendar year	35 combined visits max per calendar year (26 manipulative visits max)	35 combined visits max per calendar year	25 combined visits max per calendar year
In Network @ Outpatient Therapy Center	$55 copay	CYD + 20%	$65	$55 copay
In Network @ Outpatient Hospital Facility Services	$55 or $80 copay	CYD + 20%	$65	$65 or $75 copay
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Mental Health Outpatient Office Visit				
In Network Specialist	$0 copay	CYD + 20%	$0	$0
Out of Network	50% coinsurance	CYD + 50%	Not covered	CYD + 50%

PROVIDER NETWORK	HIGH OPTION Blue Options	HDHP w/HSA Blue Options	HMO PLAN Blue Care	LOW OPTION Blue Options
FINANCIAL FEATURES		*=CYD is aggregate for those enrolled with any number of dependents.		
Calendar Year Deductibles, Coinsurance and Out-of-Pocket Maximums				
In Network Deductible (Individual/Family)	$1,500/$4,500	$1,250/$2,500*	$2,000/$6,000	$5,000/$15,000
Out of Network Deductible (Ind/Fam)	$4,500/$13,500	$2,500/$5,000*	Not covered	$10,000/$30,000
In Network Coinsurance: Carrier/Member	80% - 20%	80% - 20%	70% - 30%	70% - 30%
Out of Network Coinsurance: Carrier/Member	50%/50%	50%/50%	Not covered	50%/50%
In Network, Out of Pocket Maximum (Ind/Fam)	$4,500/$9,000	$5,000/$5,000	$6,350/$12,700	$6,350/$12,700
Out-of-Network, Out of Pocket Maximum (Ind/Fam)	$9,000/$18,000	$10,000/$10,000	Not covered	$20,000/$40,000
HOSPITAL & SURGICAL SERVICES				
Inpatient Hospital Services				
In Network	CYD + 20%	CYD + 20%	$100 per Admission Deductible & CYD + 30%	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Outpatient Hospital Services				
In Network	CYD + 20%	CYD + 20%	CYD + 30%	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Ambulatory Surgery Center				
In Network	$200 copay	CYD + 20%	$250	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatroy Surgery Center				
In Network	$55	CYD + 20%	$65	CYD + 30%
Out of Network	$55	CYD + 50%	Not covered	CYD + 50%
Mental Health Hospitalization				
In Network	$0 copay	CYD + 20%	$0	$0 copay
Out of Network	50% coinsurance	CYD + 50%	Not covered	50% coinsurance
Outpatient Mental Health Hospitalization				
In Network	$0 copay	CYD + 20%	$0	$0 copay
Out of Network	50% coinsurance	CYD + 50%	Not covered	50% coinsurance
Provider Services @ Hospital or ER				
In Network	CYD + 20%	CYD + 20%	CYD + 30%	CYD + 30%
Out of Network	CYD + 20%	CYD + 50%	Not covered	CYD + 50%
Provider Services @ Location other than Office, Hospital or ER				
In Network	$30 PCP/$55 Specialist	CYD + 20%	$35 PCP/$65 Specialist	CYD + 30%
Out of Network	CYD + 50% coinsurance	CYD + 50%	Not covered	CYD + 50%
Ambulance Services				
In or Out of Network	In Network CYD + 20%	In Network CYD + 20%	CYD + 30%	In Network CYD + 30%
Emergency Room				
In or Out of Network	$250	CYD + 20%	$300	$300** First 2 ER visits, CYD+50%
Urgent Care Center				
In Network	$60	CYD + 20%	$70	$60**
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%

PROVIDER NETWORK	HIGH OPTION Blue Options	HDHP w/HSA Blue Options	HMO PLAN Blue Care	LOW OPTION Blue Options
OUTPATIENT DIAGNOSTIC SERVICES				
Independent Diagnostic Testing				
In Network Diagnostic Test (non-AIS)	$50	CYD + 20%	$50 copay	CYD + 30%
In Network AIS-Advanced Imaging Services	$250	CYD + 20%	$300 copay	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Independent Clinical Lab	QUEST LAB is EXCLUSIVE LAB for all FLORIDA BLUE PLANS			
In Network	$0	CYD + 20%	$0	$0
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
MISCELLANEOUS SERVICES				
Durable Medical Equipment (DME)				
In Network	CYD + 20%	CYD + 20%	$0 or $500 Motorized Wheelchair	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Home Health Care (20 Visits Max Per Year)				
In Network	CYD + 20%	CYD + 20%	$0	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Skilled Nursing Facility (60 Day Max Per Year)				
In Network	CYD + 20%	CYD + 20%	CYD + 30%	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
Hospice Care				
In Network	CYD + 20%	CYD + 20%	CYD + 30%	CYD + 30%
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
PHARMACEUTICAL SERVICES		Pharmacy services apply to the CYD then are available on copay.		
30-Day Supply at Retail Pharmacy				
Generic/Tier 1	$10	CYD then $10	$10	$10
Tier 2	$50	CYD then $50	$50	Not covered
Tier 3	$80	CYD then $80	$80	Not covererd
90-Day Supply at mail Order Pharmacy	2.5 x copay	CYD then 2.5 x copay	2.5 x copay	N/A
Medical Pharmacy Physician Administered Medications				
In Network Provider	20% coinsurance	CYD + 20%	20% coinsurance	20% coinsurance
In Network Monthly Medical Pharmacy Maximum	$200	N/A	$200	$200
Out of Network	CYD + 50%	CYD + 50%	Not covered	CYD + 50%
COST ANALYSIS				
Employee's Cost Per Pay Period				
Employee Only	$140.50	$99.00	$87.50	$56.50
Employee + Spouse	$481.00	$380.00	$355.00	$280.50
Employee + Child(ren)	$336.00	$258.00	$238.50	$181.00
Full Family	$612.50	$479.50	$447.00	$349.50

Please refer to the Florida Blue detailed plan summary for additional benefit information/clarification.
Coverage is available for dependents up to age 26, regardless of status.

DISCLAIMER: The information contained within this benefit booklet is merely a highlight of the various plan offerings available to employees at the YMCA of Florida's First Coast and should not be considered proof of any coverage. The coverage options featured within this benefit booklet are controlled by the actual contracts of the various insurance carriers of each line of coverage. For the complete details of any plan coverage limitations and exclusions, consult the actual summary plan description (SPD) within the group's wrap document. Every attempt is made to provide employees with the most accurate information available at the time of publication however, healthcare reform is frequently subject to legislative changes, mandate modifications and unanticipated additional regulatory guidance. We will make every effort to thoroughly communicate any changes that may arise and/or have an impact upon your coverage throughout the upcoming plan year.

HOW DOES THE HSA PLAN WORK?

It's really two parts that work together:

FLORIDA BLUE

Present your Florida Blue card whenever you seek services at a doctor, hospital, pharmacy, etc.

- Preventive Services (in-network) covered at 100%
- **ALL** other services apply towards the calendar year deductible (doctor, hospital, pharmacy, etc.)
- Discounts provided for services that apply toward the deductible (Doctor, Hospital, Pharmacy, etc.)
- When deductible has been met, all covered in-network services are paid by Florida Blue at 80% for the remainder of the calendar year

VYSTAR CREDIT UNION

Present your VyStar Credit Union DEBIT card whenever you pay for services at a doctor, hospital, pharmacy, etc.

- Preventive Services (in-network) covered at 100%
- **ALL** services that apply toward the calendar year deductible should be paid for with your HSA funds
- Funds that are not spent roll over into the next year
- Savings Account is interest bearing and in YOUR name
- You can use your debit card or HSA checks to pay for other **qualified** healthcare expenses (including dental and vision), even if they do not count towards your Florida Blue calendar year deductible

When you enroll in the HDHP plan, you will have the option to deposit pre-tax dollars via payroll deduction into a Health Savings Account (HSA) which is set up in your name at VyStar Credit Union. YOU own it and are not at risk of losing the money you put in it. For 2015, the IRS will allow those with individual coverage to deposit up to $3,360 in HSA pre-tax deposits OR for those employees with any number of dependents covered on the plan with them, up to $6,750 in HSA pre-tax deposits. The limits will likely change in 2016. Catch-up contributions of up to an additional $1,000 are optional if over age 55. Unused HSA monies roll over from year to year and interest does accumulate.

When you enroll in the HDHP plan, you will be responsible for **ALL** services except for Preventive/Wellness visits with your HSA dollars **until your calendar year deductible has been met**. You will receive the benefit of the deep Florida Blue discounts from participating doctors, hospitals and pharmacies. However, you pay the full allowable charges. For example, if a doctor's visit costs $200 and Florida Blue allows $131.50, then you pay $131.50 from your HSA. If a prescription costs $175 and Florida Blue allows $97.20, then you pay $97.20 from your HSA. If the hospital charges $4,000 and Florida Blue allows $3,210 you only pay $1,250 to satisfy your deductible and then Florida Blue pays 80% of the remainder, you pay 20%. After the deductible gets met, prescriptions are also available on copay.

Frequently Asked Questions

Q: Is there any way that I could be ineligible to participate in the HSA?

A: You are not eligible if you are enrolled in Medicare (Parts A or B), you are covered by another health plan that is not a HDHP (spouse's plan, etc.), you are covered by a non-HDHP such as Tri-care, you can be claimed as a dependent on someone else's tax return or if you are covered by VA medical benefits.

Q: What happens to my HSA money if I don't use it all by the end of the year?

A: HSA funds are set up in an interest-bearing HSA account at VyStar Credit Union in the employee's name. Any monies that are not spent roll over into the next year for future medical expenses. At age 65, monies can be withdrawn on a tax-free basis, like a medical IRA.

Q: Can I use my VyStar Credit Union HSA debit card to pay for dental or vision care services which are not covered by my Florida Blue health plan?

A: Yes, although dental, vision and some other qualified health related products or services are not going to be eligible for credit towards satisfying the Florida Blue calendar year deductible, you can use your debit card to pay for your **qualified** dental and/or vision care expenses per the IRS guidelines.

Q: What happens if I don't have enough money in my HSA account when I need to either have medical services rendered or pick up a prescription at the pharmacy?

A: You would have to use another means, besides your Vystar debit card, to pay the bill. Save your receipt. After you have had additional deposits made into your HSA account, you can then pay yourself back.

FloridaBlue.com is at your service.

Wherever you go, whenever you need it, you have access to your Florida Blue personal health care information.

As a member, you can log in any time and find everything you need to know about your health plan, plus free tools and resources.

If you haven't already registered--it's easy! Just visit FloridaBlue.com. All you need is your member number (located on your member ID card). You'll have access to all the information you need to take control of your health, right at your fingertips.

FloridaBlue.com gives you **personal health information** when **you** need it.

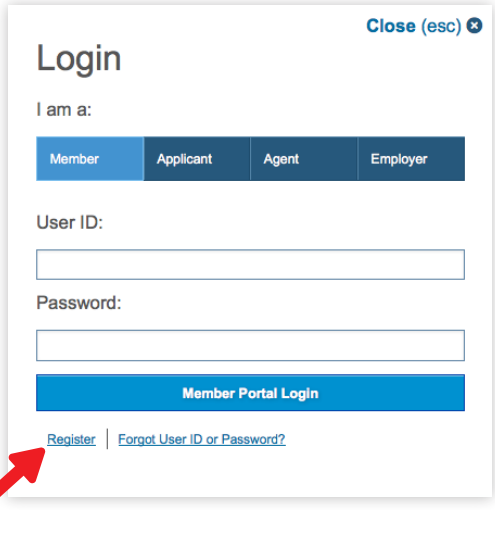
- Review your plan benefits and find out where you stand with your deductible.
- Find a doctor or hospital in your plan's network and details such as hospital quality ratings, or special programs doctors participate in, the doctor's age and gender, and reviews by patients.
- Compare and estimate your costs for office visits, imaging services and surgeries so you know before you go.
- Compare drug prices with the Pharmacy Shopping Tool.
- View claim activity, status and history.
- Create a Personal Health Record so your doctor visits and lab results are all in one secure place.
- Access your monthly health statement, which gives you an overview of savings, claims and expenses.
- Print a temporary ID card or request a new member ID card.
- Take your Personal Health Assessment to get a clear picture of your health status and create action plans that work with your personal needs and lifestyle.
- Use the Health Assistant to set personal health goals, choose activities, create plans and track your progress in areas like exercise, nutrition, stress and weight management.
- Research health topics from A-Z with the aid of pictures, videos and a variety of tools.
- Get access to health-related member discounts such as gym memberships, weight loss programs, visioin and hearing care.
- And remember, we're here to answer any questions you may have. Just call the toll-free number on the back of your member ID card!

Florida Blue

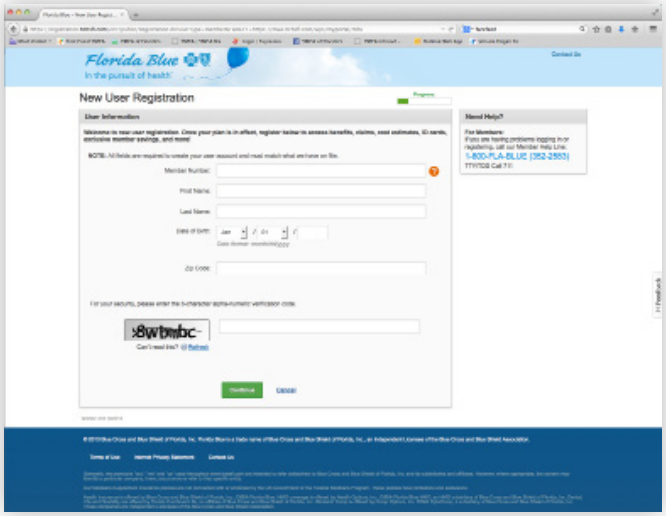
In the pursuit of health®

Visit FloridaBlue.com to Register and Log In

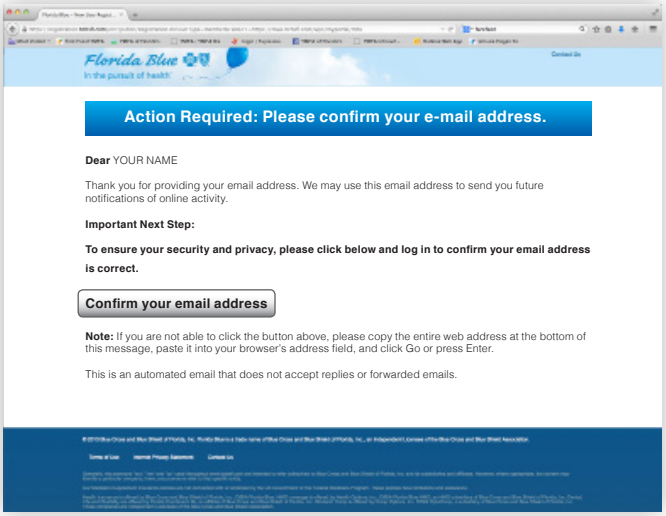
To log in, click on the button in the top right "Login/Register" button.



Step 1: Click on "register" in the bottom left corner. You'll need your Member Number (shown on your ID card) and a valid email address.



Step 2: Fill in all of the boxes and click Continue.



Step 3: Look for an email from us. In the email, click on "confirm your email address" to confirm your identity. Check your spam or junk mail if you don't see the email. Your registration is complete. **Now you can log in!**

Florida Blue

In the pursuit of health®

SHORT TERM DISABILITY

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

ALSO KNOWN AS...PAYCHECK PROTECTION

Short Term Disability pays you a benefit of 60% of your weekly earnings (up to $1,500 per week) if you are unable to work due to either an injury or an illness. The benefit will begin on the 15th day of disability and can last for up to 11 weeks, as long as you are deemed by a medical doctor to be physically unable to perform the duties of your own occupation. Maternity coverage is included. C-section standard benefit is 8 weeks. Pre-existing condition limitation of 3/6 applies only to new elections. Short Term Disability is available on a guarantee issue basis for all new hires and guaranteed renewable thereafter. For late electors (non-new hires) the completion of an Evidence of Insurability (EOI) form will be required before coverage can be approved.

To calculate your cost,
Take your **weekly** salary: _____
Multiply by 60% _____
Divide by 10 _____
Multiply by 0.34 _____
Divide by 4 _____

This is your semi-monthly post-tax deduction. The monthly premium will now be paid 50 percent by the employee and 50 percent by the Y.

EXAMPLE:

If you make $30,000/year:

Weekly salary	$576.92
X .60 = weekly benefit	$346.15
Divide by 10 = units	34.62
Multiply by $.34=total mo. premium	$ 11.77
Divide by 4	$ 2.94

This is your semi-monthly post-tax deduction.

LONG TERM DISABILITY

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

Long Term Disability benefits pay you 60% of your monthly earnings if you are unable to work due to either an illness or an injury. You must be disabled for at least 90 days before the benefits begin. LTD benefits may continue for the first 24 months, if you are unable to perform your own occupation. If you are not at all capable of being gainfully employed, the LTD benefits may continue to age 65 or normal social security retirement age. In addition, this plan includes a family survivor benefit which pays a single lump sum equal to 3 months benefit in the case of death while out on LTD for 3 or more consecutive months. The rates for Long Term Disability coverage are determined by your level of income and are $0.421/$100 of your monthly salary or wages. The premium is deducted on a post-tax basis, therefore, benefits are paid in the same manner. Long Term Disability is available on a guarantee issue basis for all new hires and guaranteed renewable thereafter. For late electors (non-new hires) the completion of an Evidence of Insurability (EOI) form will be required before coverage can be approved.

To calculate, take your **monthly** income: _____
Divide by $100 _____
Multiply by $0.421 _____
This will show the total monthly premium _____
Divide by 2 _____
You pay half, the Y pays the other half per month

Divide by 2 again since there are 2 pay periods per month, this is your semi-monthly post-tax deduction _____

EXAMPLE:

If you make $30,000/year:

Monthly salary / 12	$ 2,500
Divided by 100 / units	25
Multiply by 0.421	10.52
Divide by 2	5.26
Divide by 2 again	$ 2.63

This is your semi-monthly post-tax deduction.

EMPLOYEE CONNECT

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

There are times in all of our lives when we need a little help. No matter what the issue is, Employee Connect is available 24 hours a day, seven days a week with support, guidance and resources. This service includes:

- **Assistance for you or an immediate household family member**
- **Up to four in-person counseling sessions**
- **24 x 7 x 365 telephone and Web access**
- **Telephone access to legal counsel**
- **A 25-percent discount for services resulting from an attorney referral**
- **Confidentiality**

Family and Caregiving	Working Smarter	Daily Living	Emotional Well-being	Health and Wellness
Parenting	Workplace stress	Financial	Grief and loss	Health challenges
Child care	Career development	Legal	Mental health	Infant/toddler health
Older adults	Effective managing	Fraud/Theft	Addiction	Adolescent health

BDA EAP Counselors will see family members individually when appropriate, ages 16 years and older. They will also see children 12 to 16 years of age and older with parents. Because EAP Providers do not tend to be specialists in issues surrounding children, we refer issues with children to the most appropriate resource in the employee's living area. An employee benefit plan may be accessed if appropriate or a referral to local community services. If it is an abusive situation, the counselor will report the issue to children's services. Please keep in mind that these age guidelines exist because of state restrictions surrounding children.

For more information visit our website at GuidanceResource.com (username= LFGsupport, password = LFGsupport1) or talk with a specialist at 1-888-628-4824.

TRAVEL CONNECT

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

Travel Services

- Destination Information: Weather, currency, cultural and more.
- Lost/Stolen Travel Documents: MEDEX provides assistance for replacing passports, tickets, and other travel documentation.
- Emergency Pet Services: MEDEX will arrange for a pet's boarding or safe return home, if needed, due to a traveler's medical emergency.

Medical Evacuation and Repatriation

- Medical Evacuation: In an injury or illness emergency, MEDEX will arrange and pay for a supervised medical evacuation to the nearest healthcare facility if adequate care is not available locally.
- Family Member Transportation: If a traveler is alone and hospitalized for more than seven days, MEDEX will arrange and pay for a family member to be with them.
- Repatriation: MEDEX will handle the arrangements and pay to have a traveler who passes away to be returned to their home location.

MEDEX Assistance Corporation is one of the world's leading providers of emergency medical and security assistance to business and leisure travelers. For more information about TravelConnect℠, call 1.800.527.0218 and use the group ID number 322541, or visit www.medexassist.com.

Medical Assistance

- Medication, Vaccine, or Blood Delivery: In the event medication, vaccines or blood are not available, or a prescription is lost or stolen, MEDEX coordinates delivery to the traveler.
- Doctor or Specialist Dispatch: If a traveler cannot be assessed by telephone for evacuation and local expertise is not available, MEDEX will dispatch a qualified practitioner to the traveler.

Security and Political evacuation

- Security Evacuation: In the event of an Emergency Security Situation, MEDEX will arrange evacuation from an international airport (or other safe departure point) to the nearest safe haven.
- Political Evacuation: In the event a traveler's home country issues a written recommendation that a traveler leave a host country, or a traveler is expelled or declared a "persona non grata," MEDEX will arrange evacuation from an international airport (or other safe departure point) to the nearest safe haven.

BASIC GROUP LIFE INSURANCE

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

A Basic Life insurance benefit of the equivalent of **one times the employee's annual salary**, rounded up to the nearest $1,000 is provided by the YMCA at no cost to the employee. The Basic Life benefit also includes AD&D (Accidental Death & Dismemberment) coverage which, in the case of an accidental death, doubles the benefit amount. All employees who are enrolled in the Basic Life benefit are entitled to all of the following Lincoln value-added services as well: Employee Assistance Plan (EAP), Beneficiary Connect and Travel Connect. **IT IS IMPERATIVE THAT EVERYONE COMPLETE AND MAINTAIN A LIFE INSURANCE BENEFICIARY FORM AND PROVIDE CURRENT CONTACT INFORMATION FOR THEM.**

BENEFICIARY CONNECT

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

If needed, Lincoln Financial offers free beneficiary assistance to help you cope with difficult and emotional periods. Services include:

- **Unlimited phone contact with grief counselors and legal advisors**
- **Up to six sessions or equivalent professional time for grief and/or legal consultation**
- **Memorial planning assistance**
- **Child and elder care referrals**
- **Other support services including financial counseling and moving/relocation services**
- **Assistance available to members with multi-cultural, bilingual and TTY/TTD (Telecommunication Device for the Deaf) needs**
- **Will prep (www.guidanceresources.com)**
  Click on "First Time User" to register. Organization Web ID: **lifekeys**

To utilize Beneficiary Connect services, please contact BDA at 800-580-0576. BDA employs experienced counselors to assist with a wide variety of topics and, if needed, referral to other resources. These services are available to you for one full year.

PERSONAL ACCIDENT LIFE INSURANCE

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

Accidents are the leading cause of death for Americans under the age of 44. Personal accident life insurance pays a benefit if you, your spouse or your child are killed in a covered accident. In addition, if there is a serious injury such as paralysis, loss of limb, speech, hearing or a coma, a portion of the principal sum is made payable. Please refer to the schedule of benefits table for a complete listing of all eligible benefits. This insurance coverage is available on a guaranteed issue basis, with no medical questions asked, with or without voluntary life insurance. Rates per pay period are as follows:

EMPLOYEE COVERAGE OPTIONS:

$10,000	$50,000	$100,000	$200,000	$300,000	$400,000	$500,000
$0.19	$0.96	$1.92	$3.84	$5.76	$7.68	$9.60

SPOUSE COVERAGE OPTIONS:

$10,000	$20,000	$30,000	$40,000	$50,000
$0.23	$0.45	$0.70	$0.91	$1.13

CHILD(REN) COVERAGE:

$10,000
$0.23

Life Insurance Mandatory Age Reduction

At age 65, benefits will reduce by 35% of the original amount.
At age 70, benefits will reduce an additional 20% of the original amount.
Benefits will terminate upon retirement.

VOLUNTARY LIFE INSURANCE

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

Additional life insurance is available to employees as well as dependents on a voluntary basis. Employees may purchase up to 5 times their annual salary. Employee elections are available in $10,000 increments. The minimum is $20,000 and the maximum election is $500,000. The guarantee issue amount (with NO medical questions asked) for everyone is $100,000. Those with prior coverage will be grandfathered at their current level or may choose to elect up to 2 additional units of coverage on a guarantee issue basis, without any medical questions asked. For new but late electors or elections in excess of the guarantee issue level, the completion of an evidence of insurability (EOI) form will be required before coverage can be approved.

SEMI-MONTHLY, POST-TAX RATES ARE AS FOLLOWS:

EMPLOYEE	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
25 –29	$0.70	$1.05	$1.40	$1.75	$2.10	$2.45	$2.80	$3.15	$3.50
30 –34	$0.80	$1.20	$1.60	$2.00	$2.40	$2.80	$3.20	$3.60	$4.00
35 –39	$1.00	$1.50	$2.00	$2.50	$3.00	$3.50	$4.00	$4.50	$5.00
40 –44	$1.30	$1.95	$2.60	$3.25	$3.90	$4.55	$5.20	$5.85	$6.50
45 –49	$2.10	$3.15	$4.20	$5.25	$6.30	$7.35	$8.40	$9.45	$10.50
50 –54	$3.20	$4.80	$6.40	$8.00	$9.60	$11.20	$12.80	$14.40	$16.00
55 –59	$5.40	$8.10	$10.80	$13.50	$16.20	$18.90	$21.60	$24.30	$27.00
60 –64	$9.20	$13.80	$18.40	$23.00	$27.60	$32.20	$36.80	$41.40	$46.00
65 –69	$14.80	$22.20	$29.60	$37.00	$44.40	$51.80	$59.20	$66.60	$74.00

The coverage is also available for spouses, but cannot exceed 50% of the employee's election. The spouse elections are available in $5,000 increments. The minimum is $10,000 and the maximum election is $50,000. The guaranteed issue amount (with NO medical questions asked) for the spouse of a new hire is $25,000. Those with prior coverage will be grandfathered at their current level or may choose to elect up to 2 additional units of coverage on a guarantee issue basis, without any medical questions asked. For new but late electors or elections in excess of the guarantee issue levels, the completion of an evidence of insurability (EOI) form is required.

SEMI-MONTHLY, POST-TAX RATES ARE AS FOLLOWS:

SPOUSE	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
25 –29	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.58	$1.75
30 –34	$0.40	$0.60	$0.80	$1.00	$1.20	$1.40	$1.60	$1.80	$2.00
35 –39	$0.50	$0.75	$1.00	$1.25	$1.50	$1.75	$2.00	$2.25	$2.50
40 –44	$0.65	$0.98	$1.30	$1.63	$1.95	$2.28	$2.60	$2.93	$3.25
45 –49	$1.05	$1.58	$2.10	$2.63	$3.15	$3.68	$4.20	$4.73	$5.25
50 –54	$1.60	$2.40	$3.20	$4.00	$4.80	$5.60	$6.40	$7.20	$8.00
55 –59	$2.70	$4.05	$5.40	$6.75	$8.10	$9.45	$10.80	$12.15	$13.50
60 –64	$4.60	$6.90	$9.20	$11.50	$13.80	$16.10	$18.40	$20.70	$23.00
65 –69	$7.40	$11.10	$14.80	$18.50	$22.20	$25.90	$29.60	$33.30	$37.00

CHILD(REN)	$10,000*
Must qualify as dependent	$0.90

Coverage for dependent child or children is one flat rate regardless of the number of children covered. EOI is not required.

* = Benefit amount from ages 6 mos to 26 years, regardless of status. Between the ages of 14 days to 6 mos, the benefit is $250.

IT IS IMPERATIVE THAT EVERYONE COMPLETE AND MAINTAIN A LIFE INSURANCE BENEFICIARY FORM AND PROVIDE CURRENT CONTACT INFORMATION FOR THEM. THE Y CAN BE NAMED AS A BENEFICIARY FOR VOLUNTARY LIFE COVERAGE.

ACCIDENT PROTECTION

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

Pays you a benefit if you are injured and need services. Employees are empowered to protect their income from unexpected expenses related to an accident. Annual Health Assessment (Wellness) Benefit is included. Coverage is available on a guaranteed issue basis and is a guarantee renewable with no rate increases for the lifetime of the policy. Coverage is fully portable.

EMERGENCY SERVICES BENEFITS			
AMBULANCE	$500	AIR AMBULANCE	$1,650
EMERGENCY ROOM	$200	MAJOR DIAGNOSTIC CARE	$150
HOSPITALIZATION BENEFITS			
HOSPITAL ADMISSION	$2,000	HOSPITAL DAILY BENEFIT	$500
INTENSIVE CARE DAILY BENEFIT	$725	ALTERNATE CARE/REHAB DAILY BENEFIT	$100
TREATMENT CARE BENEFITS			
INITIAL PHYSICIAN OFFICE VISIT	$120	FOLLOW-UP DOCTOR VISIT (6 MAX)	$50
TRANSPORTATION FOR CARE	$650	COMPANION LODGING (UP TO 30 DAYS)	$150
FRACTURES	Non-surgical	**FRACTURES**	Surgical
FINGER OR TOE	$150	FINGER OR TOE	$300
ANKLE, FOOT, KNEECAP	$450	ANKLE, FOOT, KNEECAP	$900
ARM, ELBOW, WRIST, SHOULDER BLADE	$450	ARM, ELBOW, WRIST, SHOULDER BLADE	$900
HIP, UPPER LEG, PELVIS, SKULL	$2,250	HIP, UPPER LEG, PELVIS, SKULL	$4,500
LOWER LEG, VERTEBRAE	$1,200	LOWER LEG, VERTEBRAE	$2,400
BONES OF FACE, JAW, STERNUM	$450	BONES OF FACE, JAW, STERNUM	$900
RIB(S), NOSE	$450	RIB(S), NOSE	$900
COCCYX	$300	COCCYX	$600
SPECIFIC INJURIES/TREATMENTS			
COMA	$14,000	CONCUSSION	$150
ARTHROSCOPIC SURGERY	$300 - $1,500	BURNS	$200 - $15,200
JOINT REPLACEMENT	$1,500 - $2,000	LACERATIONS	$50 - $600
TRANSITIONAL CARE BENEFITS			
CRUTCHES	$25	PROSTHESIS PER LIMB/DEVICE	$750
WHEELCHAIR	$50 - $350	MODIFICATIONS TO HOME OR VEHICLE	$2,500
WALKER	$25 - $50	OTHER DME	$25
ACCIDENTAL DEATH (AD&D)			
EMPLOYEE	$75,000	LOSS OF USE OF ONE: HAND, EYE, FOOT	$750
SPOUSE	$75,000	MODIFICATIONS TO HOME OR VEHICLE	$2,500
CHILD	$25,000	OTHER DURABLE MEDICAL EQUIPMENT	$25
Semi-monthly, Post-tax deduction			
EMPLOYEE ONLY	$9.58		
EMPLOYEE + SPOUSE	$14.06		
EMPLOYEE + CHILD(REN)	$15.73		
EMPLOYEE + FAMILY	$21.53		

CRITICAL ILLNESS/CANCER PROTECTION

PROVIDED THROUGH LINCOLN FINANCIAL GROUP

Pays you a benefit if you are injured and need services. Coverage is available on a limited guaranteed issue basis at the time of the initial offering and coverage is guaranteed renewable thereafter. Benefits are paid per occurrence with a 200% per category recurrence maximum. Rates are guaranteed to lock in for the life of the policy. Coverage is fully portable. Semi-monthly post-tax rates illustrated below. Late electors subject to completion of EOI.

EMERGENCY SERVICES BENEFITS			
PRINCIPAL LUMP SUM BENEFIT – EMPLOYEE	$10,000	ASSESSMENT (WELLNESS) BENEFIT	$50
PRINCIPAL LUMP SUM BENEFIT – SPOUSE	$5,000	FAMILY CARE BENEFIT	$25
PRINCIPAL LUMP SUM BENEFIT – CHILD	$5,000	(See full detailed description of services)	Included
HEART CATEGORY		**ORGAN CATEGORY**	
HEART ATTACK	100%	END STAGE RENAL FAILURE	100%
STROKE	100%	MAJOR ORGAN TRANSPLANT	100%
HEART TRANSPLANT	100%	ACUTE RESPIRATORY DISTRESS	25%
CANCER CATEGORY			
INVASIVE CANCER	100%	BENIGN BRAIN TUMOR	25%
CANCER IN SITU	25%	BONE MARROW TRANSPLANT	25%
QUALITY OF LIFE CATEGORY			
ALS/LOU GEHRIG'S DISEASE	100%	ADVANCED PARKINSON'S DISEASE	100%
ADVANCED ALZHEIMER'S DISEASE	100%	LOSS OF SIGHT, HEARING OR SPEECH	25%
EMPLOYEE COVERAGE $10,000			
ISSUE AGE 17 – 30 (NON-SMOKER)	$2.81	ISSUE AGE 17 – 30 (SMOKER)	$4.12
ISSUE AGE 31 – 40 (NON-SMOKER)	$4.45	ISSUE AGE 31 – 40 (SMOKER)	$8.48
ISSUE AGE 41 – 50 (NON-SMOKER)	$9.32	ISSUE AGE 41 – 50 (SMOKER)	$17.87
ISSUE AGE 51 – 60 (NON-SMOKER)	$16.41	ISSUE AGE 51 – 60 (SMOKER)	$34.47
ISSUE AGE 61 – 70 (NON-SMOKER)	$28.98	ISSUE AGE 61 – 70 (SMOKER)	$62.21
SPOUSE COVERAGE $5,000		**SPOUSE COVERAGE $5,000**	
SPOUSE AGE 17 – 30 (NON-SMOKER)	$1.41	SPOUSE AGE 17 – 30 (SMOKER)	$2.07
SPOUSE AGE 31 – 40 (NON-SMOKER)	$2.24	SPOUSE AGE 31 – 40 (SMOKER)	$4.26
SPOUSE AGE 41 – 50 (NON-SMOKER)	$4.67	SPOUSE AGE 41 – 50 (SMOKER)	$8.95
SPOUSE AGE 51 – 60 (NON-SMOKER)	$8.22	SPOUSE AGE 51 – 60 (SMOKER)	$17.25
SPOUSE AGE 61 – 70 (NON-SMOKER)	$14.50	SPOUSE AGE 61 – 70 (SMOKER)	$31.12
CHILD(REN) COVERAGE $5,000		**OPTIONAL ADD-ON TREATMENT CARE RIDER**	
PARENT AGE 17 – 30 (NON-SMOKER)	$0.84	EMPLOYEE/SPOUSE AGE 17 – 40	$2.40
PARENT AGE 31 – 40 (NON-SMOKER)	$1.13	EMPLOYEE/SPOUSE AGE 41 – 60	$10.95
PARENT AGE 41 – 50 (NON-SMOKER)	$1.15	EMPLOYEE/SPOUSE AGE 61 – 70	$13.95
PARENT AGE 51 – 60 (NON-SMOKER)	$0.93	DEPENDENT CHILD	$1.81
PARENT AGE 61 – 70 (NON-SMOKER)	$0.76	RIDER ONLY AVAILABLE AS ADD ON	
TREATMENT CARE (OPTIONAL RIDER)			
AMBULANCE TRANSPORTATION	$300	AIR AMBULANCE	$2,500
HOSPITAL ADMISSION	$1,000	HOSPITAL CONFINEMENT	$200/Day
ICU/CRITICAL CARE	$400/Day	FOLLOW UP CARE	$50/Visit
TRANSPORTATION	$75/Trip	LODGING	$75/Night

LEGALSHIELD COMPREHENSIVE PLAN

Your LegalShield provider law firm will be there to offer advice or assistance on a variety of issues. Below is a brief sampling of the areas that the LegalShield Comprehensive Legal Plan offers.

FAMILY MATTERS

- Uncontested Adoption Representation
- Alimony
- Child Custody
- Child Support
- Child Visitation Rights
- Conservatorship
- Domestic Violence Protection
- Guardianship
- Insanity/Infirmity
- Juvenile Court Proceedings
- Uncontested Name Change Assistance
- Parental Responsibilities
- Prenuptial Agreements
- School Administrative Hearing
- Uncontested Divorce Representation
- Uncontested Separation Representation

AUTO

- Drivers License Restoration
- Drivers License Revocation
- Drivers License Suspension
- Minor Traffic Ticket
- Motor Vehicular Homicide Defense

ESTATE ISSUES

- Codicils
- Health Care Power of Attorney
- Irrevocable Trust
- Living Will
- Revocable Trust
- Standard/Complex Wills

FINANCIAL

- Affidavits
- Bankruptcy
- Civil Damage Claims Defense
- Consumer Credit
- Consumer Protection
- Contracts/Financial Disputes
- Debt Collection
- Durable/Financial Power of Attorney
- Estate Administration/Closing
- Inheritance Rights Protection
- Installment Sale Contracts
- IRS Audit Protection
- IRS Collection Defense
- Lease Contracts
- Medical Disputes
- Personal Property Disputes
- Promissory Notes
- Social Security Disputes
- Veterans Benefits Disputes

HOME

- Building Code Disputes
- Contractor Disputes
- Deeds
- Evictions
- Foreclosure
- Neighbor Disputes/Easements
- Primary Residence Refinancing
- Purchase/Sale of House
- Real Estate Contracts/Financial Disputes
- Secondary Residence Coverage
- Security Deposits
- Smalls Claims Assistance
- Zoning Variances
- Mortgage Documentation Preparation

WHO YOUR PLAN COVERS

- **The member**
- **The member's spouse**
- **Never-married dependent children under age 21 living at home**
- **Dependent children under the age of 18 for whom the member is legal guardian**
- **Full-time college students up to age 23; never married, dependent children**
- **Physically or mentally challenged children living at home**

25% off additional legal services
If you are in need of additional legal services, you may continue to use your provider law firm for legal situations that extend beyond plan coverage. The additional services are 25% off the law firm's standard hourly rates. Your provider law firm will let you know when the 25% discount applies and will go over these fees with you.

Legal services may vary by state.

Please note: Class actions, interventions, or amicus curiae filings in which you are part or potential part are not covered by the LegalShield membership.

Marketed by: Pre-Paid Legal Services, Inc. and subsidiaries; Pre-Paid Legal Casualty℠, Inc.; Pre-Paid Legal Access, Inc. **In FL:** Pre-Paid Legal Services, Inc. of Florida; **In VA:** Legal Service Plans of Virginia, Inc.; and PPL Legal Care of Canada Corporation

YOUR COST:
$7.88 PER PAY PERIOD

For detailed information about the areas in which we provide advice or assistance, go to **http://www.legalshield.com/info/comprehensiveplan**.

LegalShield℠

LEGALSHIELD IDENTITY THEFT PLAN℠

Your identity is personal. Keep it that way. Identity theft affects millions of Americans each year. And while it can take just minutes to happen to you, recovering from the financial damage and emotional toll it inflicts often takes years. Victims of identity theft can face issues such as lost job opportunities, problems with securing a loan, harassment from debt collectors, or even possible arrest for crimes committed by the identity thief. To avoid these issues, the LegalShield Identity Theft Plan equips you with the information and expertise you need to help prevent theft and resolve issues related to identity theft.

RESTORATION PREPARATION

BENEFIT	LIMITED POA	NO POA
Assist in organizing details of issues	X	X
Explain fraud victim's rights	X	X
Educate you on the process and your responsibilities	X	X
Assist in gathering and completing paperwork, including police reports	X	X
Send Fraud Packet to victim with list of contact numbers (for immediate fraud alerts): • **Equifax Fraud Center** • **Experian Fraud Center** • **TransUnion Fraud Center** • **Federal Trade Commission** • **Social Security Administration** • **United States Postal Service**	X	X
Issue Fraud Alert to all three credit repositories	X	X
Provide fraud victim assistance material	X	X
Assist you with questions as you work through the process	X	X

RESTORATION PROCESS

Within 24 hours of receiving the signed Limited Power of Attorney, we will:

BENEFIT	LIMITED POA	NO POA
Issue fraud alert to Social Security Administration	X	
Issue fraud alert to Federal Trade Commission	X	
Issue fraud alert to U.S. Postal Service (USPS)	X	

After receiving both signed Limited Power of Attorney and tri-merged credit report, we will:

BENEFIT	LIMITED POA	NO POA
Issue Fraud Victim statements and work with all three national repositories (Experian, TransUnion, Equifax) to restore credit accuracy	X	
Review credit history with you and verify if fraud includes items like: • **Public Records** (Liens, judgements, bankruptcies) • **Credit Accounts** (New and/or derogatory) • **Address** • **Prior Employment**	X	X
Issue fraud alert to and work with affected financial institutions and credit card companies	X	

WHENEVER A FRAUD ISSUE WARRANTS

BENEFIT	LIMITED POA	NO POA
Determine if creditors extended credit due to misuse of your identifying information	X	X
Confirm creditor contact information	X	X
Contact creditors and collection agencies to dispute all fraudulent accounts	X	X
Turn over any current accounts to fraud requesting affidavits of documentation forwarded to you	X	X
Search criminal data in your country of residence to look for criminal activity being committed in your name	X	X
Search US Criminal Records indicator to search a wide variety of national criminal databases	X	X
Search Department of Motor Vehicles records in your state	X	X
Perform a Social Security trace to look for additional addresses that may be attached to your name	X	X
Perform a search to verify if you have been submitted to Social Security Administration as dead for insurance fraud or other reasons	X	X
Request a check clearinghouse file disclosure to determine if you have been submitted as having been involved in fraudulent banking activities	X	X
Assist you in working with law enforcement personnel	X	X
Use licensed attorneys where appropriate to perform these duties	X	X
Offer additional assistance we can reasonably provide based on your issue	X	X
Provide a list of attorneys who may be able to help you with legal issues–any subsequent relationship is exclusively between you and the attorney	X	X

CASE CLOSING PROCESS

BENEFIT	LIMITED POA	NO POA
Provide a tri-merged credit bureau report follow up 120 days after resolution of your identity theft issues	X	X
Update member	X	X
Continue restoration until complete	X	X
Responsibility for Kroll's Fraud Solutions Practice will cease when Kroll receives verification from you that the issue is resolved.	X	X

YOUR COST: $6.48 PER PAY PERIOD

BOTH PLANS: $12.85 PER PAY PERIOD

YMCA RETIREMENT FUND

The YMCA of Florida's First Coast participates in the YMCA Retirement Fund which is administered by the National Retirement Fund. The YMCA and participating members are subject to the Retirement Fund By-Laws. As an employee of the YMCA of Florida's First Coast, you will participate in the YMCA Retirement Fund, which provides retirement, permanent disability and death benefits for its participants and their designated beneficiaries, upon completion of the eligibility requirements. Under our Association's "Special Agreement" with the YMCA Retirement Fund, participation in the Retirement Plan is a condition of employment once eligibility is met.

YOU MAY NOT WAIVE YOUR PARTICIPATION.

You will become enrolled in the Fund when you:

- Are at least 21 years old
- Have completed 1,000 hours of service during each of any two 12-month periods, beginning with your date of hire or anniversary date.

Employees have the option to make additional contributions to their retirement account through payroll deduction. All employees are immediately eligible to contribute to a 403(b) Smart Account upon their date of hire. Contributions to the Smart Account are tax-deferred and employees can start, stop, or change the amount of contribution at any time. Once enrolled in the YMCA Retirement Plan, employees also have the option to contribute to an After-Tax account. Please note that additional contributions are subject to certain limits set by the IRS each year.

If you have any questions regarding your retirement you may contact **Sonya Leroy** in Human Resources at **904.265.1825** or **lleroy@firstcoastymca.org**. Additional information is available by logging onto the national website **www.yretirement.org** where you can:

- CHECK YOUR ACCOUNT BALANCES
- SEE HOW THE FUND COMPARES
- CONTRIBUTION LIMITS WORKSHEET
- Y'S WAYS TO FISCAL FITNESS
- OBTAIN FORMS & PUBLICATIONS
- PERSONAL FINANCIAL PLANNING
- RECENT ARTICLES
- BASICS & FAQS

The YMCA of Florida's First Coast reserves the right to amend its participation in the National YMCA Retirement Fund at any time within the terms and conditions set by the Metropolitan YMCA's Board of Directors and the Fund.

MEMBERSHIP BENEFITS

- All full-time staff will receive a Florida's First Coast membership for employee (adult) or employee with spouse and legal dependents (family).

- All part-time staff will receive a branch-exclusive membership at his/her home branch for employee (adult) or employee with spouse and legal dependents (family). If an employee's home branch does not have a wellness center (i.e. Tiger Academy, Youth Development), then the employee can choose their membership home branch.

Part-time employees interested in a Florida's First Coast membership would be required to pay for an upgraded membership. No joining fees will be charged to YMCA employees. Please remember, employees may not use any facility during peak usage hours, nor may they displace a paying member on any equipment or in any class.

PROGRAM FEES

- Child Care (PrYme Time/Day Camp) - All staff will receive child care for their children while they are working, space permitting. Full price will be charged to staff for child care during their non-working hours.

- Full-time staff will pay 50% of the member rate for all programs, with the exception of those involving private instruction. This discount will apply to sports, aquatics, group wellness, nutrition classes, family programming and one week each summer at Camp Immokalee.

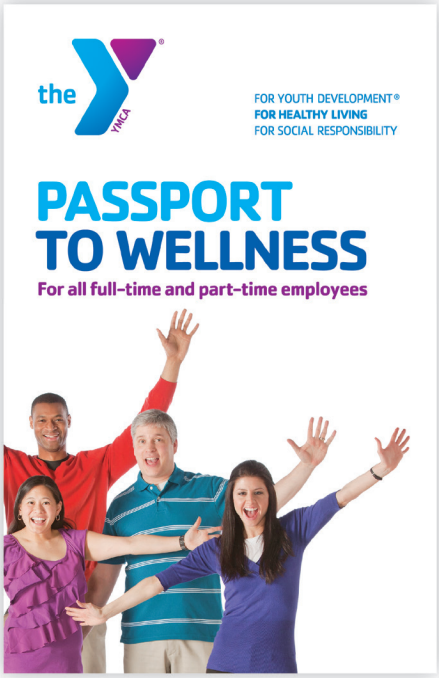
- Part-time staff will pay 75% of the member rate for all programs, with the exception of those involving private instruction. This discount will apply to sports, aquatics, group wellness, nutrition classes, family programming and one week each summer at Camp Immokalee.

- All programs involving private instruction (e.g. personal training, tennis and/or private swim lessons, and nutrition consultations) will cost the full rate.

- Staff may not displace any paying member or participant enrolled in a program.

EMPLOYEE WELLNESS PASSPORT

Throughout the year, Y employees can earn points by participating in various activities to improve their overall state of health. All YMCA employees are encouraged to participate in The Employee Wellness Passport Program. You can get more information on our Passport Program by visiting The HUB (employee Intranet) or by contacting your branch wellness representative.



FEDERAL NOTICES

IMPORTANT NOTICE 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 YMCA of Florida's First Coast 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:
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.

It has been determined that the prescription drug coverage offered by the YMCA of Florida's First Coast Group Medical Plans & Florida Blue are, on average for all participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered to be Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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 YMCA of Florida's First Coast Group Medical Plan prescription coverage will be affected. You can not keep your coverage with the YMCA of Florida's First Coast plan if you elect Part D coverage. If you decide to join a Medicare drug plan and drop your current coverage under the Nassau County Medical Plan, be aware that you and your dependents will not be able to get this coverage back. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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 the YMCA of Florida's First Coast Group Medical Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary

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

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact your Human Resources Department at 904.265.1818. 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 with Florida Blue changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

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

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

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

Date: October 1, 2015
Name of Entity/Sender: YMCA of Florida's First Coast
Address: 12735 Gran Parkway Suite 250, Jacksonville, FL 32258
Phone Number: (904) 296-3220

FEDERAL NOTICES

Continuation of Coverage—COBRA Benefits After Termination
An employee's health insurance coverage ceases at the end of the month following the termination date. The COBRA administrator will mail a written notice to each terminated employee describing the employee's rights and obligations under COBRA.
Through federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may choose to continue coverage by paying the full monthly premium cost plus an administrative charge of 2%. Each individual who is covered by a YMCA of Florida's First Coast plan immediately preceding the employee's COBRA event has independent election rights to continue his or her health, dental, and/or vision coverage.
The right to continuation of coverage ends at the earliest when:

- You, your spouse or dependents become covered under another group health plan; or, you become entitled to Medicare;
- You fail to pay the cost of coverage;
- Your COBRA Continuation Period expires.

Who Can Continue Coverage?
COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." Depending on the type of qualifying event, a qualified beneficiary can be a covered employee, a covered employee's spouse and/or a covered employee's dependents who were covered by one of YMCA of Florida's First Coast Health Plans the day before a qualifying event.

Definition of Qualified Beneficiaries
The following individuals can become qualified beneficiaries under COBRA:

- An employee or a former employee;
- The spouse of any of the above; and
- The dependent child(ren) of any of the above.

COBRA COVERAGE (administered by Ceridian)

Loss of coverage is due to:	Maximum COBRA continuation for you, covered spouse, covered child(ren)
Your employment ending for any reason (except gross misconduct) or your hours are reduced so you are no longer eligible for medical, dental, vision, and the health care flexible spending account.	18 months
You or your covered spouse or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event, or becomes disabled during the first 60 days of COBRA continuation	29 months
Your death	36 months
Your divorce or legal separation	36 months
You become entitled to Medicare	36 months
Your covered child no longer qualifies as a dependent	36 months

There may be other guarantee issue coverage options for you and your family via www.healthcare.gov. In the Marketplace, you could be eligible for a subsidy that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additional assistance is available by contacting The Bailey Group at (904) 461-1800.

HIPAA—Privacy Act Legislation

- YMCA of Florida's First Coast and your health insurance carrier(s) are obligated to protect your confidential protected health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses.
- YMCA of Florida's First Coast and your health insurance carrier(s) are required to notify you and your beneficiaries about our policies and practices to protect the confidentiality of your protected health information.

(SBC) Summary of Benefits/Coverage & Glossary of Terms

- A Uniform Summary of Benefits/Coverage will be provided to all benefit-eligible employees not less than 60 days prior to the effective date. A Uniform Glossary of terms can be provided upon request.

FEDERAL NOTICES

Newborns' 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).

Section 125 Qualifying Events & Benefit Election Changes
Under IRC I 125, you are allowed to pay for certain group insurance premiums with tax-free dollars. This means your premium deductions are taken out of your paycheck before federal income and Social Security taxes are calculated. You must make your benefit elections carefully, including the choice to waive coverage. Your pretax elections will remain in effect until the next annual Open Enrollment period, unless you experience an IRS-approved qualifying event. A qualifying event, also known as a "Family Status Change," is a change in your personal life that may impact you or your dependents' eligibility for benefits under the YMCA of Florida's First Coast Group Medical Plan. Qualifying events include, but are not limited to:

- Marriage or divorce
- Death of spouse or other dependent;
- Birth or adoption of a child;
- A spouse's employment begins or ends;
- A dependent's eligibility status changes due to age, student status, marital status, or employment status; and
- You or your spouse experience a change in work hours that affects benefit eligibility.

Please note that your qualified status change must be consistent with the event. You must notify Human Resources within 30 days of your qualifying event.

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free Or Low Cost Health Coverage To Children And Families
If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can 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, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. You may be eligible for assistance paying your employer health plan premiums. The following information for Florida is current as of February 16, 2010. You should contact the State of Florida for further information on eligibility – Florida Medicaid: Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml / Phone: 1-866-762-2237.

For additional information on any of the state of Florida programs offered through Florida KidCare (Medicaid, Healthy Kids, CMS or Medi-Kids) call 1-888-540-5437 or log on to www.floridakidcare.org
Seperate notice with all states is available in the EMB Portal.

Women's Health & Cancer Rights Act of 1998 (WHCRA) Notice
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; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator, Florida Blue, at 1.800.322.2808.

Lifetime Limit No Longer Applies and Enrollment Opportunity
The lifetime limit on the dollar value of benefits under your employer group medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan would now be eligible to enroll in the plan again. Individuals have 30 days from the date of this notice to request an enrollment.

Notice of Opportunity to Enroll in Connection with PPACA Extension of Dependent Medical Coverage to Age 26
Individuals whose coverage ended, or who were denied medical coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the group medical plan, providing documentation of proof of eligibility.

NOTICES

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

MHPAEA applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. MHPAEA also applies to health insurance issuers who sell coverage to employers with more than 50 employees.

The DOL and the IRS generally have enforcement authority over private sector employment-based plans that are subject to ERISA. HHS has direct enforcement authority with respect to self-funded non-Federal governmental plans. While State insurance commissioners have primary authority over issuers in the large group market, HHS has secondary enforcement authority.

MHPAEA supplements prior provisions under the Mental Health Parity Act (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. DOL, HHS and Treasury issued regulations under MHPA in 1997. The MHPAEA interim final rule amends and modifies certain provisions in the MHPA regulations.

Although MHPAEA provides significant new protections to participants in group health plans, it is important to note that MHPAEA does not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the MHPAEA's parity provisions. Also, MHPAEA does not apply to issuers who sell health insurance policies to employers with 50 or fewer employees or who sell health insurance policies to individuals.

FMLA – The Family Medical Leave Act
The Family and Medical Leave Act (FMLA) provides eligible employees up to 12 workweeks of unpaid leave a year, and requires group health benefits to be maintained during the leave if employees continued to work instead of taking leave. Employees are also entitled to return to their same or an equivalent job at the end of their FMLA leave.

The FMLA also provides certain military family leave entitlements. Eligible employees may take FMLA leave for specified reasons related to certain military deployments of their family members. Additionally, they may take up to 26 weeks of FMLA leave in a single 12-month period to care for a covered service member with a serious injury or illness.

In order to be eligible to take leave under the FMLA, an employee must: work for a covered employer;have worked 1,250 hours during the 12 months prior to the start of leave; (special hours of service rules apply to airline flight crew members); work at a location where the employer has 50 or more employees within 75 miles; and have worked for the employer for 12 months. The 12 months of employment are not required to be consecutive in order for the employee to qualify for FMLA leave. In general, only employment within seven years is counted unless the break in service is (1) due to an employee's fulfillment of military obligations, or (2) governed by a collective bargaining agreement or other written agreement.

A covered employer must grant an eligible employee up to a total of 12 workweeks of unpaid, job-protected leave in a 12-month period for one or more of the following reasons:

- For the birth of a son or daughter, and to bond with the newborn;
- For the placement with the employee of a child for adoption or foster care, and to bond with that child;
- To care for an immediate family member (spouse, child or parent – but not a parent "in-law") with a serious health condition;
- To take medical leave when the employee is unable to work because of a serious health condition; or
- For qualifying exigencies arising out of the fact that the employee's spouse, son, daughter or parent is on covered active duty or call to covered active duty status as a member of the National Guard, Reserves, or Regular Armed Forces.

The FMLA also allows eligible employees to take up to 26 workweeks of unpaid, job-protected leave in a "single 12-month period" to care for a covered service member with a serious injury or illness.

The FMLA only requires unpaid leave. However, the law permits an employee to elect, or the employer to require the employee, to use accrued paid vacation leave, paid sick or family leave for some or all of the FMLA leave period. An employee must follow the employer's normal leave rules in order to substitute paid leave. When paid leave is used for an FMLA-covered reason, the leave is FMLA-protected.

NOTICES

PPACA/Healthcare Reform "Grandfathered Plans"

The YMCA of Florida's First Coast group sponsored medical plans are not "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PATIENT PROTECTION MODEL DISCLOSURE

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

YMCA of Florida's First Coast HMO plan generally encourages the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Florida Blue designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator or issuer at FloridaBlue.com and access the "Blue Care" network.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

You do not need prior authorization from Florida Blue 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, 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 or issuer at FloridaBlue.com and access the "Blue Care" network.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

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; and
- 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 benefits 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 Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.html.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

PAID TIME OFF (PTO)

PROCEDURES

The YMCA believes that PTO is beneficial to the health and welfare of employees and should be taken each year. PTO may be used for vacation, holiday, sick, bereavement and any other personal need. If a location is closed 8 hours of PTO must be submitted for a full day's pay. If one of our employees is a certified Y-USA trainer and they are asked to teach, we would not have to use their PTO when they are out teaching and supporting the YMCA cause. The time away from the branch teaching would require a supervisor's approval.

PTO is not cumulative from one year to the next. PTO balances are reset October 1, with the start of the fiscal year. PTO is pro-rated from the month of hire. Upon voluntary separation, PTO will be paid out at 50% of the amount earned, but not taken. Once an employee resigns, they would not be allowed to take any PTO that was not previously submitted and approved by their supervisor.

PTO requests will be submitted electronically using Time Off Work. PTO requests should be submitted prior to you taking time off.

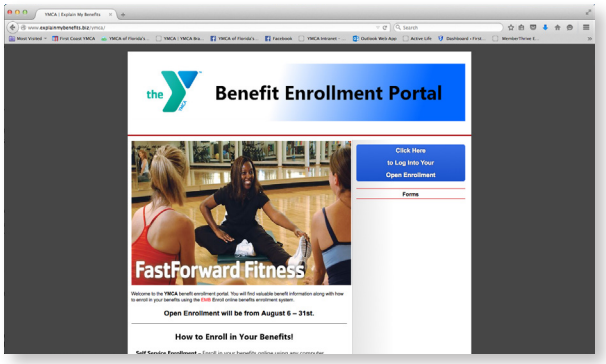
ALLOWANCE

FULL TIME NON EXEMPT 0 – 4 YEARS OF SERVICE	25 days = 200 hours
FULL TIME NON EXEMPT 5 – 14 YEARS OF SERVICE	30 days = 240 hours
FULL TIME NON EXEMPT 15 – 19 YEARS OF SERVICE	35 days = 280 hours
FULL TIME NON EXEMPT 20+ YEARS OF SERVICE	40 days = 320 hours
FULL TIME EXEMPT 0 – 4 YEARS OF SERVICE	30 days = 240 hours
FULL TIME EXEMPT 5 – 14 YEARS OF SERVICE	35 days = 280 hours
FULL TIME EXEMPT 15 – 19 YEARS OF SERVICE OR YMCA ORGANIZATIONAL LEADER CERTIFICATION	40 days = 320 hours
FULL TIME EXEMPT 20+ YEARS OF SERVICE	45 days = 360 hours

EXPLAIN MY BENEFITS (EMB)
ENROLLMENT PORTAL

Throughout the year, you will have access to EMB Enroll 24/7 to view your current benefit elections or report any qualifying event changes. For additional information, please contact our Human Resources Department.

HOW TO ACCESS YOUR ONLINE ENROLLMENT



1. **Access your Online Enrollment at:**
   www.explainmybenefits.biz/ymca
2. **Enter the Enrollment ID:**
   85063
3. **Enter your 9-digit Social Security Number** (no dashes)**:**
   XXXXXXXXX
4. **Enter your 4 digit PIN (birth year):**
   XXXX
5. **Record your confirmation #:**

DEPENDENT INFORMATION

If you intend to elect ANY benefits for your spouse and/or eligible dependents, they must be listed as dependents in the system and you MUST have their SSN to input them. Spouse, children and family coverage levels will not be available for you to select if the dependent information is not included.

FREQUENTLY ASKED QUESTIONS

1. **How do I see previous enrollments or what I am currently enrolled in?**
   Simply log in to the system and you will see a confirmation number(s) for all confirmed enrollments on the top left corner of the screen. This is a link to their Benefit Summary Confirmation and can be printed or saved.
2. **Do I need my spouse or children's SSN to enroll them in benefits?**
   YES. You will not be able to proceed with your enrollment and confirm your elections without inputting the SSNs for your spouse and/or dependents.
3. **Can my enrollment be saved if I am not able to complete it?**
   NO. Please make sure you have all information on dependents (SSN) at the time you start your enrollment. If you do not complete your enrollment and see your confirmation number in BOLD on the bottom of the screen, your enrollment will not be saved and processed.
4. **How do I add a beneficiary while processing my enrollment?**
   From the Beneficiary Collection Screen, which will appear after selecting your insurance amount:
   - Click the "Manage Beneficiary List" button.
   - Select the relationship of the beneficiary from the drop down box.
   - Click the "Add New Beneficiary" button.
   - Input beneficiary information (i.e. name, phone number).
   - Click "Continue."
   - Click "Continue" again.

   Now, you will see the new beneficiary in the drop down box as a selectable beneficiary.
5. **Will documentation be required for benefit or coverage changes?**
   New hires will only need to submit the Evidence of Insurability form if electing a coverage amount that exceeds the Guaranteed Issue amount.
   Any benefit changed as a result of a Qualifying Life Event will require documentation prior to your coverage being activated by the carrier(s).

2015 Preventive Care Guidelines: To discuss with your Health Care Provider

Adult (age 19+) Preventive Schedule

Be sure to verify your benefits for preventive services.

Routine Health Guide	
Physical Examination and Routine Blood Work	Annually
Diet/Physical Activity Counseling	Annually
Dental Exam	Once or twice a year (These services may not be covered by your medical benefits plan. Check your plan documents.)
Vision Exam	Discuss with your doctor (These services may not be covered by your medical benefits plan. Check your plan documents.)
Recommended Diagnostic Checkups and Screenings for At-Risk Patients	
Abdominal Aortic Aneurysm Check	One-time screening for men ages 65 to 75 who have ever smoked
Bone Mineral Density Screening & prescribed medication for Osteoporosis	Women beginning at age 65 or older; and in younger women who have an increased risk
Cholesterol Screening	Ages 35+: All Men: Annually and Ages 20+: Men & Women at increased risk: Annually
Colorectal Cancer Screening	Ages 50-75; With either a colonoscopy, fecal occult blood test or sigmoidoscopy
Mammogram	Annually at ages 40+ (per the American Cancer Society)
Pap Test	Women age 21-65 should have Pap Test every 3 years or women age 30-65 should have Pap Test/HPV combined testing every 5 years; Ages 65+: Discuss with your doctor.
HIV and other Sexually Transmitted Infections (STIs) Screening and Counseling	As indicated by history and/or symptoms. Discuss with your doctor behavioral risks
Lung Cancer Screening	Ages 55-80; 30 pack smoker history,current smoker/quit within past 15 years
Prostate Cancer Screening	Discuss with your doctor
Skin Cancer Screening	Discuss with your doctor
Guidance	
Fall Risk/Unintentional Injury	Discuss exercise, home safety and vitamin D supplementation with your doctor
Screen/Counseling: Depression, Tobacco, Alcohol, Pregnancy, Substance Abuse and Injury/Domestic Violence Prevention	Every visit, or as indicated by your doctor
Advance Directives	Annually
Immunizations* (Routine Recommendations)	
Tetanus, Diphtheria, Pertussis (Td/Tdap)	Ages 19+: Tdap vaccine once, then a Td booster every 10 years**
FLU (Influenza)	Annually during flu season
Pneumococcal*** PCV13 and PPSV23	Ages 19-64: if risk factors are present; Ages 65+: 1 dose (per CDC); Ages 50+:1 dose (Florida Blue Benefits**)
Shingles (Zoster)***	Ages 60+: 1 dose (per CDC); Ages 50+:1 dose (Florida Blue Benefits**)
Haemophilus Influenzae Type b (HIB) Hepatitis A, Hepatitis B, Meningococcal	Ages 19+: if risk factors are present
Human Papillomavirus (HPV), Measles/Mumps/Rubella (MMR), Varicella (Chickenpox) & Hepatitis C (HCV) Infection Screening	Physician recommendation based on past immunization or medical history

* Some immunizations are contraindicated for certain conditions, discuss with your doctor.
** If you are pregnant, talk to you doctor about getting a Tdap vaccine during 3rd trimester of every pregnancy to protect your baby from pertussis (whopping cough).
*** Florida Blue Pharmacy benefits cover Shingles (Zostavax) and Pneumonia (Pneumovax) vaccine under Preventive Service benefit when services are rendered by an in-network pharmacy which administers these vaccines.

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Live a Healthy Lifestyle

- Get your annual wellness exam to review your overall health plan and keep follow-up visits with your doctor.
- Find out if you are at risk for health conditions such as diabetes.
- Get your vaccines, preventive screenings and labs.
- Human Papillomavirus (HPV) vaccine 3 dose series is recommended for men and women ages 19 through 26 years if not previously vaccinated prior to age 13.
- Talk with your doctor about the medications and over-the-counter/vitamins you are taking to reduce side effects and interactions.
- Get a Flu Vaccine every year to prevent illness and related hospitalizations.

We're here to help:

Call

Customer Service
1-800-FLA-BLUE (1-800-352-2583)
TTY/TDD Call 711

Care Consultant Team
1-888-476-2227

24-Hour Nurseline
1-877-789-2583

Click

Visit **FloridaBlue.com**

Visit a Florida Blue Center

Go to **FloridaBlueCenters.com** for locations or call 1-877-352-5830

Sources: These guidelines are recommendations from the organizations listed below and were not developed by Florida Blue.
www.ahrq.gov
www.cdc.gov

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2015 Preventive Care Guidelines: To discuss with your Health Care Provider

Children & Adolescents (Birth–18 years of age) Preventive Schedule

Routine Health Guide	
Physical Exam and Autism/Development Behavioral Assessment	Newborn up to age 3: Frequent Wellness Check-ups; Age 3-18: Annual Wellness Check-up
Body Mass Index (BMI): Height & Weight	Every visit, BMI beginning at age 2
Blood Pressure	Annually, beginning at age 3
Hearing/Dental/Vision Screenings (These services may not be covered by your medical benefits plan. Check your plan documents.)	Hearing: Newborn then annually beginning at Age 4; Dental: Regularly, beginning at age 1; Vision: Annually, beginning at age 3
Recommended Screenings for At-Risk Patients	
Cholesterol Screening	Annually, beginning at age 2
Lead test, TB, Sickle Cell & Blood Sugar	As indicated by history and/or symptoms
HIV and other Sexually Transmitted Infections (STIs) Screening and Counseling	Discuss with your physician behavioral risks
Skin Cancer Screening	Discuss with your doctor
Guidance	
Injury/Violence Prevention	Annually, more often if indicated by your doctor
Diet/Physical Activity/Emotional Well-Being Counseling	Every visit
Tobacco/Alcohol/Substance Abuse/Depression/Pregnancy Screening and Counseling	Every visit starting at age 11, earlier if indicated by your doctor

Immunizations*	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-6 years	11-12 years	13-14 years	15 years	16-18 years
Hepatitis A						2 doses, 12-23 months								
Hepatitis B	•	— • —				— • —								
Diphtheria, Tetanus, Pertussis (DTaP)			•	•	•		— • —			•				
Tetanus, Diphtheria, Pertussis (Tdap)											•			
Haemophilus Influenzae Type b (Hib)			•	•	•	— • —								
Inactivated Poliovirus			•	•		— • —				•				
Measles, Mumps, Rubella (MMR)						— • —				•				
Varicella						— • —				•				
Pneumococcal			•	•	•	— • —								
FLU (Influenza)					— • — (Annually during flu season)									
Rotavirus			•	•	•									
Meningococcal											•			• (booster)
Human Papillomavirus (HPV)											• (3 doses)			

— • — Represents a range of recommended ages. CARE FOR PATIENTS WITH RISK FACTORS: Appropriate testing should be done at the doctor's discretion, based on family history and personal risk factors.

* These are routine immunizations based upon cdc.gov recommendations. Range of recommended ages for catch-up or certain high-risk groups is at the doctor's discretion based on the member's family history and personal risk factors.

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Are your children up-to-date with vaccinations?

Getting the recommended sequence of vaccinations is always a good idea to protect your child from illnesses from birth to 18 years of age. Most of these vaccinations require additional doses or boosters over time. As children grow up to become teenagers, they may come in contact with different diseases. Here are vaccines that can help protect your preteen or teen from these other illnesses and infections:

Tdap Vaccine

Age 11 or 12. Protects against tetanus (lock jaw), diphtheria and acellular pertussis (whooping cough). This is a booster shot of the same vaccine given during early childhood.

Meningococcal Vaccine (MCV4)

Two doses beginning at 11 or 12 years, with a booster dose at age 16. Protects against meningitis , sepsis (a blood infection) and other meningococcal diseases. Children with higher risk factors may need additional doses.

Human Papillomavirus (HPV) Vaccine

Three doses over six months, beginning at ages 11 and 12, up to age 26. Protects boys and girls against HPV, which can lead to cancers and genital warts.

Flu Vaccine

Every year after six months of age.

Protects individuals from getting the influenza virus.

Keep your teens safe from preventable, painful and life-threatening diseases by staying in touch with your pediatrician's office or health clinic. Be sure to verify your benefits for preventive services.

Source: These guidelines are recommendations from the organizations listed below and were not developed by Florida Blue. CDC.gov, aap.org

IMPORTANT CONTACT INFORMATION

YMCA HUMAN RESOURCES

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HEALTH PLAN

FLORIDA BLUE | Group #51898
1.877.352.2583
www.floridablue.com

HSA BANKING

VYSTAR CREDIT UNION
www.vystarcu.org

DENTAL PLAN

SUN LIFE | Group #231962
1.888.222.3660
sunlifedentalbenefits.com

VISION PLAN

HUMANA | Group #VS5653
1.800.865.3676
www.humanavisioncare.com

LEGAL SERVICES

LEGAL SHIELD | Group #47200
www.legalshield.com

LIFE OR DISABILITY PLAN

LINCOLN FINANCIAL GROUP
LIFE, ACCIDENT, CRITICAL ILLNESS
SUPPLEMENTAL DISABILITY: 1.800.423.2765
www.lfg.com

RETIREMENT PLAN

NATIONAL YMCA RETIREMENT
1-800-738-9622
www.yretirement.org

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