MOUNTAINEER FLEXIBLE BENEFITS

FBMC BENEFITS MANAGEMENT

2018 EMPLOYEE REFERENCE GUIDE






PUBLIC EMPLOYEES INSURANCE AGENCY

Jim Justice
Governor of West Virginia

February 22, 2017

Dear Public Employee:

Once again, it is time for this year's Mountaineer Flexible Benefits open enrollment sponsored by the Public Employees Insurance Agency. During the Mountaineer Flexible Benefits enrollment, you may select to enroll in Flexible Spending Accounts and Health Savings Accounts, as well as Dental, Vision, Hearing Aid, Short- and Long-Term Disability insurance, and a Legal Plan. These benefits will begin on July 1, 2017 and continue through June 30, 2018. The open enrollment period begins (April 2, 2017, and changes must be submitted by May 15, 2017.

I urge you to learn more about the benefits offered to you by attending one of the PEIA Benefit Fairs in your area. Enrollment Counselors will be on hand to answer any questions you may have regarding these plans. The Benefit Fairs run from April 5 through April 19. You can find a schedule guide on the back of this reference guide.

The State of West Virginia's goal is to provide quality benefits to its employees. Together, we can reach this goal with your participation. We strive to provide the best program options for you and your family. I encourage you to learn more about this program and take advantage of their benefits.

Sincerely,

Jim Justice
Governor

State Capitol | 1900 Kanawha Blvd., East, Charleston, WV 25305 | (304) 558-2000

Benefits Directory

Delta Dental of West Virginia
(Dental) Plan #01058
Customer Service
Mon – Fri, 8 a.m. – 8 p.m. ET
1-800-932-0783
www.deltadentalins.com

EPIC Hearing Service Plan
(Hearing Benefits)
Mon – Fri, 9 a.m. – 9 p.m. ET
1-866-956-5400
www.epichearing.com

FBMC Benefits Management, Inc.
(Contract Administrator)
FBMC Service Center
Mon – Fri, 7 a.m. – 7 p.m. ET
1-844-55-WVA4U (1-844-559-8248)
www.fbmc.com

Hyatt Legal Plans, Inc.
(Legal)
Client Service Center
Mon – Fri, 8 a.m. – 7 p.m. ET
1-800-821-6400
info.legalplans.com/WVA

MetLife
(Vision)
Customer Service
Mon – Fri, 8 a.m. – 11 p.m. ET
Sat, 10 a.m. – 11 p.m. ET
Sun, 10 a.m. – 10 p.m. ET
1-855-638-7339 (855-MET-SEE9)
mybenefits.metlife.com/westvirginia

Standard Insurance Company
(STD/LTD Claims)
(STD) Policy #611506-B
(LTD) Policy #611506-A
Mon – Fri, 10 a.m. – 9 p.m. ET
1-800-368-2859
www.standard.com

Trustmark Insurance Company*
(LifeEvents®)
Customer Care
Monday - Thursday, 7 a.m. - 7 p.m.
Friday, 7 a.m. - 6 p.m.
1-800-918-8877
www.trustmarksolutions.com

*Trustmark no longer offers new LifeEvents® policies. Employees who currently have LifeEvents® may continue coverage.

Important Dates to Remember
Your Open Enrollment dates are:
April 2, 2017, through May 15, 2017.

Your Period of Coverage dates are:
July 1, 2017, through June 30, 2018.

PayFlex
(Flexible Spending Accounts)
(Health Savings Accounts)
Customer Service
Mon-Fri, 7 a.m. - 7 p.m. CT
Saturday, 9 a.m. - 2 p.m. CT
1-844-PAYFLEX (1-844-729-3539)
Toll-Free Claims Fax
1-888-238-3539
www.payflex.com

PayFlex Card
(Lost or Stolen Card)
Customer Service
Mon-Fri, 7 a.m. - 7 p.m.
1-844-PAYFLEX (1-844-729-3539)
www.payflex.com

PayFlex Systems USA, Inc.
COBRA
State of West Virginia Mountaineer Flexible
Benefits Call Center at 1-844-559-8248
Mon - Fri, 8 a.m. - 7 p.m. ET
www.payflex.com

Mountaineer Flexible Benefits Plan

Table of Contents

What's New?

Get ready for benefits open enrollment! Here's what's changing for your upcoming Mountaineer Flexible Benefits Plan Open Enrollment:

- This is a Changes Only enrollment. If you do not make changes, your benefits will rollover and your premiums will be adjusted to reflect the new rates.
- The dental rates for the Routine Plan and Assistance Plan are slightly increasing. Basic and Enhanced dental plans are remaining the same. See page 12 for new rates.
- Your Hearing benefit allowance is now $500 per ear per device during the plan year. Your hearing plan premium slightly increased. See page 9 for new rates.
- Your Health Care Flexible Spending Account (FSA), Dependent Care (FSA), Health Savings Account (HSA) and Limited Health Care (FSA) are now administered by PayFlex. See page 20 for FSA details.
- Mountaineer Flexible Benefits will maintain its Flexible Spending Account grace period, in lieu of a $500 rollover. See page 21.
- Your FSA minimum contribution is now $150 and the maximum FSA contribution increased to $2,600. See page 20 for details.
- An individual with HSA single coverage may now contribute up to $3,400 a year to an HSA. See page 23 for details.
- Your HSA custodian fee will decrease to $2.50. See page 23 for details.

Enrollment at a Glance

Important Enrollment Information

- Open Enrollment is April 2, 2017, through May 15, 2017.
- For an easy enrollment, please visit **www.myFBMC.com** and enroll online or return your completed enrollment form to your Benefit Coordinator by May 15, 2017, to enroll for or make changes to your benefits.
- This is a changes-only enrollment. Therefore, all benefit selections will continue for the new plan year as currently enrolled. Complete an enrollment form if you would like to add, change or cancel coverage.
- Your 2018 Plan Year is July 1, 2017, through June 30, 2018.
- For more information, go to **www.myFBMC.com**, or call 1-844-55-WVA4U (1-844-559-8248), 7 a.m. – 8 p.m. ET, Monday through Friday.

Making your benefits work for you — it's easy!

- FBMC Benefits Management, Inc., your employee benefits manager, along with your employer, offers you a wide selection of benefits to choose from during your open enrollment. FBMC specializes in enrollment management; partner relations and brokerage; communication and education; and administration and compliance.
- FBMC provides you with convenient ways to track your benefit transactions, including online review, telephone tracking and statements.

Your FSA Administrator is Changing!

Starting July 1, 2017, your Flexible Spending Account plans will be moved to a new system supported by FBMC's outsource partner, PayFlex. The new system is robust with a number of participant conveniences we are confident you will enjoy. It will be important to know where to submit your claims during this transition period. Effective July 1, 2017, PayFlex will process all 2018 Plan Year claims. You must continue to submit your 2017 Plan Year claims to WageWorks in order to exhaust your WageWorks account. Any funds remaining in your WageWorks account at the end of the run-out period will be forfeited.

- Before you sign up for an FSA, review the FSA guidelines and become familiar with how the program works. See how to save yourself and your family a significant amount of taxes. For more information, refer to the Flexible Spending Accounts section beginning on page 20 of this reference guide.
- Submit your supporting documentation and completed WageWorks Pay Me Back claim form (for paper claims) to WageWorks, for reimbursement processing. Once the plan year ends, you have a 120-day (Oct. 31, 2017), run-out period to submit your supporting documentation.
- You may visit FBMC's website at **www.wageworks.com** for more FSA information. You may also contact WageWorks at 1-877-924-3967.

Benefit Fairs

Benefit Fairs will take place from April 5, 2017, through April 19, 2017. Benefit Fairs allow you access to specific information on each of your benefits. You're invited to ask questions, share your concerns and gain more knowledge about the coverages you select.

Mountaineer Flexible Benefits Representatives will be available at the Benefit Fairs to:

- Provide you with detailed benefit information
- Answer any benefit questions, and
- Help you complete your enrollment form.

Bring your dependents' Social Security numbers and dates of birth with you to complete the dependent section of the enrollment form.

Remember, a Mountaineer Flexible Benefits Representative's incentive and objective is your satisfaction!

See the schedule of Benefit Fairs on the back of this reference guide for times and locations.

Enrollment Forms

- **Enrolling for the first time?** You must complete an enrollment form and make your benefit selections by checking the "Add Coverage" box.
- **Changing your benefits?** You must complete an enrollment form and change your selections by checking the "Change Coverage" box. Complete the line with the new coverage information.
- **Adding a new benefit?** You must complete an enrollment form and make your selections by checking the "Add Coverage" box. Complete the line with the new coverage information.
- **Keeping all of your current benefits?** All benefits will continue as currently enrolled.
- **Canceling current benefits?** You must complete an enrollment form and check the "Cancel Coverage" box for the benefit you want to cancel; otherwise it will automatically continue for the 2018 Plan Year.
- **Transferring to a new agency?** If you transfer from one agency to another, your benefits will remain the same. You must complete an enrollment form, mark box "Transfer" and turn the form in to your Benefits Coordinator.

  If an employee currently has benefits with FBMC and is transferring from one participating agency to another participating agency and wants to keep their benefits with FBMC, the employee must meet with their Benefits Coordinator at the NEW agency to complete an enrollment form and mark it "transfer."

  When an employee transfers, it is the employee's responsibility to provide their current benefits to the new agency. In the event that the new employee is unsure of his or her current benefits, the employee needs to contact the old agency to confirm coverage.

  If an employee transfers from agency that did not participate to an agency that does participate, they will be treated as a "new hire".

Enrollment Deadline: Sign and date your enrollment form. Submit your enrollment copy to your Benefit Coordinator **no later than May 15, 2017.**

Keep Your Address Updated

In order to protect your family's rights, you should keep your employer and FBMC Benefits Management informed of any changes in the addresses of family members. You should also keep a copy, for your records of any notices you send to your employer and FBMC Benefits Management. Please see your Benefits Coordinator to complete the FBMC Demographic Change Form.

Managing Your Benefits

Accessing Your Benefits Online

Go to **www.myFBMC.com** to begin. Your first step is to register, using your name, mailing zip code, email address and one of the following: FBMC ID or Social Security number (current users will continue to use your existing login credentials.)

Fill out the registration form, enter the random image string into the text box, read the user acceptance agreement and then click the "I agree. Complete my registration" button. You will receive an email shortly to finalize the registration. Follow the instructions within the email.

If you previously registered an email address and password on FBMC's website, you may continue using this information.

Managing Your Account

You can manage and check your account online. The "Claims and Activity" page online details all your account activity and will even alert you if any card transactions are in need of verification.
For the latest information, visit **www.wageworks.com** and link to your account information 24/7. In addition to reviewing your most recent FSA activity, you can:

- Update your account preferences and personal information.
- View your transactions and account history for current and past plan years.
- Download applicable forms.
- Schedule payments to health care and dependent care providers.
- Check the complete list of eligible expenses for FSA program.
- Order additional WageWorks® Health Care cards for your family.
- Manage your account while on the go via the mobile website.
- Download the EZ Receipts® app so that you are able to file claims and take care of card use paperwork from your smartphone.

Filing an Enrollment Appeal

If you have an enrollment change or request for a mid-plan year election change, you have the right to appeal the decision by sending a written request for a review within 30 days of the initial denial.

Your appeal must include:

- The name of your employer
- Your contact information, including an email address so that you may be contacted easily and timely
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal.

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

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

For appeals involving your enrollment elections or mid-year changes:
FBMC Benefits Management
Attn: Enrollment Appeal; Mail Slot 51
PO Box 1878
Tallahassee, FL 32302-1878

How to Enroll

Who needs to complete a form?

- New participants who want to enroll for the first time
- Employees who want to add, change or cancel coverage for the new plan year and who don't want to use the online system
- Employees who need to update dependent information

If you are not making any changes to your benefits, you do not need to complete an enrollment form.

Enrollment Form Section 1

Please follow the instructions in this section.

Enrollment Form Section 2

Complete all of your personal information.

Enrollment Form Section 3

For each benefit you are adding, changing or canceling, you must check the appropriate box next to the corresponding benefit. For the benefit selections you are not altering, check the "Keep Coverage" box. If you complete an enrollment form, but do not indicate your desire to cancel or change an existing benefit, that benefit will continue regardless of other benefits which may or may not be indicated on the enrollment form.

Remember to complete all requested information for your benefits.

Hearing Benefit: If you are selecting 'Employee & Children,' 'Employee & Spouse' or 'Employee & Family' coverage, you must complete the dependent information in Section 4.

Dental Care: Select a Delta Dental plan.

- All employees are eligible to enroll in any Delta Dental plan.
- Check the type of coverage you are choosing and enter the cost per-pay-period amount in the box on the right.
- If you are selecting 'Employee & Children,' 'Employee & Spouse' or 'Employee & Family' coverage, you must complete the dependent information in Section 4.

Vision Care: MetLife Vision Plan continues to be your vision plan provider. You may choose either the Full Service plan or the Exam Plus plan, but not both. Check the type of coverage you are choosing, and enter the cost per pay period in the box on the right. If you select 'Employee & Family' coverage, you must complete the dependent information in Section 4.

Long-term Disability Income Plans: This benefit is for employees only. You must select a plan with a coverage level of either 70 percent or 50 percent of your salary. See page 17 for help in calculating your per-paycheck deduction amount, then enter this cost per pay period on your enrollment form.

Short-term Disability Income Plan: This benefit is for employees only. See page 18 for help in calculating your per-paycheck deduction amount, then enter this cost per pay period on your enrollment form.

Health Care Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on page 22 for help in computing your amount.

Dependent Care Flexible Spending Account: Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on page 22 for help in computing your amount.

Health Savings Account: If you are enrolled in PEIA Plan C, you may also enroll in a Health Savings Account (HSA). If enrolling in the HSA, you may also enroll in a Limited Health Care FSA to increase your tax savings.

Limited Health Care FSA (for HSA participants only): Enter your per-pay-period contribution in the space to the right. Refer to the FSA worksheets on page 22 for help in computing your amount.

Hyatt Legal Plan: You must complete the dependent information in Section 4.

Cost Per Pay Period: Your cost per pay period is based on your number of payrolls per plan year. Please check with your Benefit Coordinator if you have questions.

Enrollment Form Section 4

If you selected dependent coverage (child, spouse, family) for dental, vision or legal benefits, you must complete this section. This includes the dependents' names, relationship to you, birth dates and Social Security numbers. Use an additional sheet of paper as needed for additional dependents.

Sign and date the form at the bottom. Return your completed enrollment form to your Benefit Coordinator no later than May 15, 2017.

Web Enrollment is an easy option!

Accessing the online enrollment website:

- Log in to **www.myFBMC.com.**
- Follow the instructions to set up your own username and password.
- Click the "Web Enrollment" link.
- Verify your demographic information.
- Add or update any dependent or beneficiary information.
- Begin the enrollment process.
- For each benefit, choose your coverage level or election amounts and then go to the next benefit.
- Continue until enrollment is complete.
- Print out your confirmation statement containing all your benefit elections for you and your family.

Employees may choose to enroll at **www.myFBMC.com.** You must be registered to access the web enrollment. If you have not already, you will need to register following the first time user link provided. Once registered, you may access the web enrollment instructions at the "Resources" tab.

You may not enroll on our website, but must use an enrollment form, if you:

- Are a new hire after 3/1/17
- Currently do not participate and work for a non-state agency or a County Board of Education.

Note: This is a "changes only" enrollment. If you have no changes, you do not have to do anything and your benefits will remain the same. In addition, if FBMC does not have your annual salary amount, you must enroll via paper application.

Eligibility Requirements

Who is Eligible?

All active benefit-eligible employees of state agencies, colleges and universities and participating County Boards of Education are eligible to participate in this program. This program is also offered to some non-state agencies. Please check with your benefits department to see if you are eligible.

Upon certain qualifying events, spouses, children and employees may be eligible for group health plan coverage under COBRA law. Please contact FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248) for more information.

A provision in the Patient Protection and Affordable Care Act (PPACA) allows for an employee's adult child to be covered under the employee's healthcare plan through the end of the month in which the adult child turns age 26. Coverage is in effect whether the adult child is/is not married or is/is not a student. For more information please read the FAQs at **www.myFBMC.com**.

Period of Coverage

Your period of coverage begins on July 1, 2017, and continues until June 30, 2018, unless you:

- Terminate employment
- Go on an unpaid leave of absence or
- Change your benefit elections in limited circumstances as further discussed under "Changing Your Coverage."

COBRA Coverage

If you terminate employment, retire or go on unapproved leave, you can continue certain benefits by calling FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248). According to federal and state law, you can continue your own and your dependents' coverage if you terminate employment or have certain other qualifying events under COBRA. You will be notified of your rights and any continuable benefits you may have after you have notified FBMC that you have a qualifying event. Call FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248) for details.

If you participated in a Health Care FSA and a triggering event occurred during the plan year, making you eligible to continue your Health Care FSA under COBRA until that plan year ended, your Health Care FSA coverage will be canceled at the end of the plan year in which the triggering event occurred, unless otherwise required by law.

Retiree Coverage

During the 90 days prior to your anticipated retirement date, contact FBMC for your retiree enrollment packet. When you retire, the benefits that are currently offered are Dental, Vision, Hearing and Legal. Flexible Spending Accounts are not offered to retirees. If you are retiring, you have the option to meet with a Benefits Coordinator (BC) to discuss retiree benefits available and complete your enrollment form.

HIPAA-Special Enrollment Rights Pertaining to Group Health Plans

If you are declining enrollment for yourself or your dependent(s) (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan – provided that you request enrollment within 30 days after the other coverage ends.

Employees on Leave

Approved Medical Leave: If you go on medical leave because of your own disability (which includes pregnancy and disabilities resulting from pregnancy complications), your premium deductions will continue through the Mountaineer Flexible Benefits Plan as long as you receive a salary. The Family and Medical Leave Act may affect your rights concerning the continuation of your health benefits while on unpaid leave. Contact your BC for further information. For addition questions, call FBMC at 1-844-55-WVA4U (1-844-559-8248).

Approved Unpaid Leave: You can continue to receive coverage for certain benefits for the duration of your leave if you pay your premium to FBMC on an after-tax basis.

If you have not maintained a current premium status while on leave, you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law. Call FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248) for further information on billing if you go on approved, unpaid leave.

If you are planning on a Leave of Absence, you will need to contact your BC to advise. To remit payment while on leave, you will need to send your payment to their BC. The BC will submit the payment with the Mt. Flex personal pay summary form to FBMC.

Hearing Health Care

Why have a Hearing Plan?

Hearing is one of the five natural senses that allow us to enjoy life and the world around us. Music, radio, television, movies, and theater all become less accessible and enjoyable without the benefit of hearing. And the loss of sounds like sirens and alarms can actually endanger your life.

Hearing is a valued life asset that can be protected, treated and assisted through a program for hearing healthcare. The EPIC Hearing Service Plan provides easy access to hearing health professionals–primarily physicians and audiologists who can help you achieve your maximum hearing potential throughout your life.

EPIC's Five-Step Plan

The EPIC Hearing Service Plan starts with an evaluation of your ears and hearing. Diagnostic tests and measures will determine the course of treatment most likely to help you hear better. The EPIC Hearing Plan's 5 Basic Steps to Good Hearing include:

1. Pure Tone Hearing Test – to determine if a hearing problem exists
2. Functional Assessment – to define the magnitude of the problem and the technology best suited to treat it
3. Hearing Aid Evaluation – to determine your ability to wear a hearing aid and select the best model and make
4. Fitting and Programming your hearing aid
5. Therapy and Training – to fine tune your device and maximize the benefits you receive.

How the EPIC Plan Works

1. Call EPIC at 866-956-5400.
2. A hearing counselor will register you and assist in determining your healthcare needs.
3. You will receive a Hearing Service Plan booklet outlining all plan benefits, services and pricing.
4. A hearing counselor will coordinate a referral to a provider location near your home or work.
5. Contact the provider; follow through with an appointment, examination and treatment.
6. EPIC will coordinate and manage the provider network, provider fee schedule, provider referral, customer service, account management and client reporting.
7. EPIC will assist you in coordinating any insurance benefits or coverages when applicable.
8. Contact EPIC at any time for assistance, advice or additional information at 866-956-5400.

When to call EPIC

If you or a family member experience any of the following, you may have a hearing problem that could be helped by a hearing health professional:

- Difficulty understanding voices and words (especially those of women and children)
- Occasional ringing in one or both ears
- Itching in the ear canals
- Difficulty understanding in noisy situations
- Turning up the television volume to understand the dialogue

In addition, some more serious symptoms merit immediate attention by a physician.

- A sudden hearing loss
- Spinning and dizziness with vomiting
- Persistent ringing in one ear
- Blood or fluid draining from one or both ears
- Persistent pain in one or both ears

Underwritten by Fidelity Security Life Insurance Company, Kansas City, MO Policy Form #M-9091.

The per pay period rates are as follows:

	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee Only:	**$2.35**	**$1.96**	**$1.31**	**$1.18**	**$1.12**	**$1.07**	**$0.98**	**$0.90**
Employee + Spouse:	**$4.67**	**$3.89**	**$2.59**	**$2.33**	**$2.22**	**$2.12**	**$1.95**	**$1.80**
Employee + Children:	**$3.46**	**$2.88**	**$1.92**	**$1.73**	**$1.65**	**$1.57**	**$1.44**	**$1.33**
Employee + Family:	**$5.76**	**$4.80**	**$3.20**	**$2.88**	**$2.74**	**$2.62**	**$2.40**	**$2.22**

Hearing Health Care

FEATURE	BENEFIT AMOUNT	FREQUENCY
Examination		
• Adults	$70	Adults: Once every 2 years
• Children	$70	Children: Once every year
Hearing Aid Device		
• Adults	$500 per ear device benefit	Adults: Once every 5 years
• Children	$500 per ear device benefit	Children: Once every 2 years

Summary of Additional Hearing Products at Discounted Prices*

- Hearing Device Batteries – Discount battery program provides savings up to 40 percent off MSRP on name brand batteries. Orders are shipped direct with no shipping fees. EPIC will provide a one-year supply of batteries for any hearing aid(s) purchased in-network at the completion of the trial period.
- Custom Ear Protection
- Custom Swim Plugs
- Custom Musician Plugs
- Hearing Aid Cleaning Supplies
- Telephone Amplification
- Wireless TV Amplification
- Hearing Aid Compatible Cell Phones
- Assistive/Alerting Devices
- Product Warranties - EPIC provides an extended 3-year warranty on all hearing aid purchases at no additional cost to you.

Call EPIC to order or for more information, 1-866-956-5400.

* These are discounted items and are not insured benefits.

Dental Plans

Strong, healthy teeth create beautiful smiles. To give your smile the care and attention it deserves, Delta Dental offers you the Routine, Assistance, Basic and Enhanced Indemnity dental care plans.

With Delta Dental, you have complete freedom of choice in selecting a dentist. You can choose a dentist from the Delta Dental Premier® or Delta Dental PPO℠ networks, or a dentist who does not participate in either network. Your choice of dentist can determine your cost savings.

Delta Dental PPO dentists will accept the Delta Dental PPO Maximum Plan Allowance (MPA)* or the dentist's fee – whichever is less (the PPO Allowed Amount) – as payment in full for covered services. Copayments and deductibles may also apply.

Delta Dental Premier dentists will accept the Delta Dental Premier MPA (a slightly higher MPA) or the dentist's total charge – whichever is less (Premier Allowed Amount) – as payment in full for covered services. Copayments and deductibles may also apply.

Non-participating dentists do not contract with Delta Dental to limit their costs. For services received from non-participating dentists, you may be responsible for these dentists' total charges without limit by Delta Dental, including applicable Copayments and deductibles. Delta Dental will reimburse you for its portion of the PPO Allowed Amount.

Your total out-of-pocket payment is less if you go to a PPO dentist, and more if you go to a Premier dentist, and likely will be highest if you go to a non-participating dentist. Please call Delta Dental to find a participating dentist in your area at **1-800-932-0783**, or visit **www.deltadentalins.com**.

Employees who visit a dentist under the Delta Dental PPO network or the Delta Dental Premier network, will receive the benefit of increased plan year maximums.

This year, you may enroll in any of the following four dental programs:

* Maximum Plan Allowance is an amount, determined by Delta Dental, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. These charges are blended by Delta Dental with dentist fee information from a number of other sources, using various factors, subject to regulatory limitations and adjustment for extraordinary circumstances, such as extreme difficulty or unusual circumstances.

Routine Plan

The Routine plan is a discounted plan designed to cover diagnostic and preventive services only.

Assistance Plan

The Assistance plan is a discounted open network, managed-cost dental plan that allows employees the freedom to choose any dentist for treatment, but they receive the greatest benefits when they visit a Delta Dental participating dentist.

Basic Plan

The Basic plan is a low-cost plan designed to cover preventive and basic services only. Please look carefully at the plan descriptions in the chart before making your choice.

Enhanced Plan

The Enhanced plan is the most comprehensive coverage offered with this program and covers preventive, basic and major restorative, orthodontic and TMJ services.

Further Information

Eligible employees may cover your eligible dependent children to age 26, and spouses.

See the chart on page 12 for a partial list of covered services. Call Delta Dental for more information concerning your benefits, to view a list of exclusions or to request a claim form. Certificates of Coverage can be found at **www.myfbmc.com**.

There are no I.D. cards distributed with these plans. Submit claim forms to:

Delta Dental of West Virginia Plan #01058
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Customer Service: 1-800-932-0783 TTY/TDD: 1-888-373-3582.

How to Print your ID card

1. Go to **www.deltadentalins.com.**
2. Log in to Online Services with your username and password. (If you don't already have a username or password, click "Register Today" link to complete the quick registration process.)
3. Once you've logged in, click the "Eligibility & Benefits" tab.
4. Select "Print ID card" on the left-hand side of the page. (If you do not see this option, in some instances you may also need to click on the "Eligibility & Benefits" link on the left-hand side of the page before you have the option to select "Print an ID card.")
5. Click "Print."

NOTE: The card is not required to obtain services.

Plan #01058

Dental Plans

Your Tax-Free Rates

Routine	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$13.40	$11.17	$7.45	$6.70	$6.38	$6.09	$5.59	$5.16
Employee & Children	$26.88	$22.40	$14.93	$13.44	$12.80	$12.22	$11.20	$10.34
Employee & Spouse	$29.99	$24.99	$16.66	$14.99	$14.28	$13.63	$12.50	$11.53
Employee & Family	$43.54	$36.28	$24.19	$21.77	$20.73	$19.79	$18.14	$16.74

Dental Assistance	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$14.48	$12.07	$8.05	$7.24	$6.90	$6.58	$6.04	$5.57
Employee & Children	$29.04	$24.20	$16.13	$14.52	$13.83	$13.20	$12.10	$11.17
Employee & Spouse	$32.40	$27.00	$18.00	$16.20	$15.43	$14.73	$13.50	$12.46
Employee & Family	$47.03	$39.19	$26.13	$23.51	$22.39	$21.38	$19.60	$18.09

Basic	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$20.72	$17.27	$11.51	$10.36	$9.87	$9.42	$8.64	$7.97
Employee & Children	$41.50	$34.58	$23.05	$20.75	$19.76	$18.86	$17.29	$15.96
Employee & Spouse	$46.25	$38.54	$25.69	$23.12	$22.02	$21.02	$19.27	$17.79
Employee & Family	$67.07	$55.89	$37.26	$33.53	$31.94	$30.49	$27.95	$25.80

Enhanced	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$34.46	$28.72	$19.15	$17.23	$16.41	$15.67	$14.36	$13.26
Employee & Children	$68.93	$57.44	$38.29	$34.46	$32.82	$31.33	$28.72	$26.51
Employee & Spouse	$80.04	$66.70	$44.47	$40.02	$38.11	$36.38	$33.35	$30.78
Employee & Family	$114.34	$95.28	$63.52	$57.17	$54.45	$51.97	$47.64	$43.98

Dental Tips:

- Twice-a-year dental cleanings are an important part of maintaining your oral and overall health. Call your dentist for an appointment today.
- Your toothbrush won't last forever. Three months is a typical lifespan, but whenever the bristles start to become bent, its time to go shopping.

Dental Plans

Partial List of Covered Services

Call Delta Dental for more information concerning your benefits, to view a list of exclusion or to request a claim form. Certifcates of Coverage can be found at **www.myFBMC.com**.

	ROUTINE PLAN	ASSISTANCE PLAN	BASIC PLAN	ENHANCED PLAN
DEDUCTIBLE **(per person per plan year)** Maximum total family deductible	No deductible	You pay $25 (applies to all services)† $75	You pay $25 (applies to all services)† $75	You pay $50 (diagnostic, preventive and ortho are exempt) $150
Plan year max (per person) Delta Dental network dentist Non-participating dentist	 $500 $500	 $750 $500	 $750 $500	 $1,250 $1,000
OTHER MAXIMUMS Ortho Lifetime Max TMJ Disorder	 N/A N/A	 N/A N/A	 N/A N/A	 $1,000 $500
BENEFIT	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**	**PLAN PAYS**
Diagnostic/Preventive Services*** Visits/Exams (twice in a plan year) - Routine cleaning (twice in a plan year) - Fluoride treatments (to age 19, twice in a plan year) - Bitewing X-rays (twice in a plan year) - Space maintainers (to age 14) - Sealants (to age 14, once in any 36-month period on unfilled permanent first and second molars)	**100%***	**100%***	**80%***	**100%***
Basic Restorative - Amalgam ("silver") and composite ("white") on anterior teeth and the facial surface of bicuspids	**N/A**	**25%***	**80%***	**80%***
Oral Surgery - Extractions - Oral surgery procedures (Medical is primary for impactions) - General anesthesia and IV sedation are benefitted with all covered oral surgery procedures and with select endodontic and periodontic surgeries.	**N/A**	**25%***	**80%***	**80%***
Endodontics - Pulpal therapy - Root canal therapy	**N/A**	**25%***	**80%***	**80%***
Periodontics*** Treatment for gums and supporting structures	**N/A**	**25%***	**80%***	**80%***
Major Restorative** Inlays, onlays, crowns (crowns for natural teeth, not implants)	**N/A**	**NOT COVERED**	**NOT COVERED**	**50%***
Prosthodontic** - Bridges, Full and partial dentures, Denture adjustments/relining	**N/A**	**NOT COVERED**	**NOT COVERED**	**50%***
Orthodontia** For eligible dependent children to age 26, employees and spouses	**N/A**	**NOT COVERED**	**NOT COVERED**	**50%***
TMJ	**N/A**	**NOT COVERED**	**NOT COVERED**	**50%***

† Deductible waived for diagnostic/preventive procedures at Delta Dental PPO Provider. Deductible applies to all services rendered by Delta Dental Premier and non-participating dentists.

* Percentage is based on Delta Dental's applicable Maximum Plan Allowance or the dentist's fee, whichever is less (the Allowed Amount). The Delta Dental payment under the program, plus the patient payment, equals the Allowed Amount, which is accepted by Delta Dental participating dentists as full payment. Participating dentists are paid directly by Delta Dental, and by agreement cannot bill you more than the applicable Copayment, deductible or charges where maximums have been exceeded for covered services. By selecting a participating dentist, you always limit your out-of-pocket costs. For services performed by non-participating dentists, Delta Dental sends the benefit payment directly to you. You are responsible for paying the non-participating dentist's total fee, which may include amounts in addition to your share of Delta Dental's Allowed Amount. Out-of-pocket costs may also include applicable Copayments, deductibles, charges where maximums have been exceeded, and services not covered by the Group Dental Service Contract. Maximum Plan Allowance is an amount, determined by Delta Dental, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area. These charges are blended by Delta Dental with dentist fee information from a number of other sources, using various factors, subject to regulatory limitations and adjustment for extraordinary circumstances, such as extreme difficulty or unusual circumstances.

** Major Restorative, Prosthodontics, and Orthodontics require six month plan participation.

*** Enhanced benefits for pregnancy, which include an additional oral evaluation and a choice of an additional periodontal scaling, root planing or prophylaris, or additional periodontal maintenance procedure are covered.

Vision Plans

MetLife Vision Plan continues to be your vision plan provider. MetLife Vision offers you the Full Service or Exam Plus vision coverage plans to help pay for your eyecare needs.

You may choose to cover your family by selecting the "Employee & Family" rates. You may cover your spouse and any children, stepchildren or foster children up to age 26.

	FULL SERVICE VISION PLAN		EXAM PLUS VISION PLAN	
	METLIFE MEMBER DOCTOR	**NON-MEMBER DOCTOR**	**METLIFE MEMBER DOCTOR**	**NON-MEMBER DOCTOR**
Copayments†				
Exam Copay	$20	Covered up to $35 allowance	$10	Covered up to $35 allowance
Exam Frequency	Once Per Year	Once Per Year	Once Per Year	Once Per Year
Prescription Glasses	$20	$0	Not covered	Not covered
Vision Examination (every plan year)	Covered In Full after copay	$35	Covered In Full after copay	$35
Lenses (every plan year)***				
Single Vision Lenses**	Covered In Full	$25	20% savings at private practice locations only	Not covered
Bifocal Lenses	Covered In Full	$40		
(including progressive lenses)**				
Trifocal Lenses	Covered In Full	$55		
Lenticular Lenses**	Covered In Full	$80		
Frames (every other plan year) (Up to $150 allowance)	Covered in full*	$45	20% savings at private practice locations only	Not covered
Contact Lenses** (in place of lenses & frames)				
Necessary	Covered in full***	Exam & $210	15% savings at private practice locations for Necessary only. Elective/ Fitting and evaluation for contact lenses are not covered.	Not covered
Elective	$150 allowance	Exam & $105		
Fitting and evaluation	Services are covered in full once every plan year, after a maximum $60.00 Copayment****	$0		
Prescription Glasses Discount	20% - Savings on additional pairs of prescription glasses, non-prescription sunglasses and lens enhancements from a MetLife Vision Member Doctor.	- Single vision $25 allowance - Lined bifocal $40 allowance - Lined trifocal $55 allowance - Lenticular $80 allowance	20% - Discount will be applied to a MetLife Vision doctor's usual and customary fee for prescription glasses and spectacle lens options, such as scratch coating and anti-reflective coating.	NONE
Prescription Contact Lenses Discount	Standard or Premium fit covered in full with a copay not to exceed $60	Applied to the allowance for contact lenses	15% savings at private practice locations only	Not covered
Laser Vision Care Program Discount Average 15 percent off the regular price or five percent off a promotional offer for laser surgery, including LASIK, Custom LASIK and PRK surgeries. This offer is only available at MetLife participating locations.	15%	NONE	15%	NONE

† Copayments apply in-network (MetLife Vision Member Doctor) at the time of service.

* Within Plan Limitations. If you select a frame that costs more than your plan allowance, there will be an additional charge you will pay out of pocket. When you visit a MetLife Vision member doctor, ask him/her which frames are covered in full. The allowance is very competitive and ensures a good choice with little or no out-of-pocket cost.

There will be an extra cost if you select materials or services that are elective or cosmetic in nature, such as tints and scratch coatings.

** Exam and contact lenses are also covered once every plan year, if necessary, provided you have not received spectacle lenses in the same plan year. You may receive eyeglass frames every other plan year. You may receive either spectacle lenses or contact lenses in the plan year, but not both.

*** There is a single materials Copayment of $20 on lenses and frames or medically necessary contact lenses.

**** Fifteen percent discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Vision Plans

Value-Added Benefit

Diabetic Eyecare Program – Provides additional coverage through medical diagnosis and procedure codes specifically targeted toward members with Type 1 diabetes.

How To Use These Plans

To obtain vision care benefits, call a MetLife Vision member doctor, identify yourself as a MetLife Vision patient and make an appointment. The doctor's office will verify the patient's eligibility and plan coverage and obtain authorization from MetLife Vision. There are no I.D. cards distributed with these plans.

The doctor will explain any additional charges. After you pay your Copayment, the doctor will take care of all the paperwork.

If you prefer, you can visit a non-member doctor and pay the doctor's normal charges. Save your itemized receipt and mail it, along with the MetLife Vision Member Reimbursement Form, within six months of service date to:

MetLife Vision Claims
P.O. Box 385018
Birmingham, AL 35238-5018

Claim forms with the correct address can be downloaded from mybenefits.metlife.com/westvirginia. For more information, contact MetLife Vision's Customer Service Line at 1-855-638-7339 (855-MET-SEE9).

MyBenefits – MetLife's Self-Service Website

Logging on to the MyBenefits:

1. Go to the MyBenefits website at **mybenefits.metlife.com/westvirginia**
2. Complete the Account sign-in process by entering your User Name and password or
3. If you are a first time user, click on the "Register Now" button
   - Provide your first name, last name, date of birth, Social Security number and email address
   - Create your own user name and password
   - Select three security questions and provide your answers, in the event you forget your user name or password in the future
4. Read and agree to the MyBenefits website's terms of use
5. You will see a "Thank You" page and a registration confirmation email will be sent to the email address you provided while registering.

Find a participating eye care professional

1. Click on the Find a Vision Provider near you link at: **mybenefits.metlife.com/westvirginia**
2. Enter your zip code or address
3. Add additional information to refine your search for a vision provider
4. Select your plan: Full Service Vision or Exam Plus Vision Plan.

You can also call MetLife Vision at 1-855-MET-SEE9 (1-855-638-7339) for access to the 24/7 Interactive Voice Response system.

Print a personalized Vision ID card

- **A Vision ID card is not required to obtain services**
- Please note you will not be able to obtain an ID card until you are enrolled in the MetLife Vision Plan.

1. Click on Get My Vision ID card (located on right side of the landing page)
2. Select the state where you reside
3. The vision identification card will be displayed
4. Using the printer icon located on top right of page – print your card

Your Tax-free Rates

Full Service plan	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$8.74	$7.28	$4.86	$4.37	$4.16	$3.97	$3.64	$3.36
Employee & Family	$22.57	$18.81	$12.54	$11.29	$10.75	$10.26	$9.41	$8.68

Exam Plus plan	**10 pay**	**12 pay**	**18 pay**	**20 pay**	**21 pay**	**22 pay**	**24 pay**	**26 pay**
Employee Only	$1.46	$1.22	$0.82	$0.73	$0.70	$0.67	$0.61	$0.57
Employee & Family	$3.32	$2.77	$1.85	$1.66	$1.59	$1.51	$1.39	$1.28

Long-term Disability Income Plans

Employee Only, Pre-tax Benefit

Long-term Disability (LTD) insurance can help safeguard your family's lifestyle and provide some peace of mind in the event you become disabled and are unable to work.

Because the State of West Virginia's retirement plan may not provide you adequate protection in the event you become disabled, you should consider enrolling in one of the two Long-term Disability insurance plans offered by Standard Insurance Company.

When am I considered disabled?

During the benefit waiting period and the next 24 months you are considered disabled if, due to injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of your own occupation, or you are unable to earn more than 80 percent of your pre-disability earnings while working in your own occupation.

Thereafter, you are considered disabled if, due to an injury, physical disease, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience, or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own or any other occupation.

What is the LTD benefit?

The monthly LTD benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings. The group policy has an actively-at-work requirement you must meet before your insurance will become effective.

You may apply for coverage under either Plan 1 or Plan 2. The monthly benefit under each plan is determined as follows:

Plan 1: 50 percent of the first $6,000 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $3,000.

Plan 2: 70 percent of the first $8,571 of your monthly pre-disability earnings, reduced by deductible income. The maximum monthly benefit is $6,000.

Both plans have a minimum monthly LTD benefit of $100.

What is deductible income?

Deductible Income is income you receive or are eligible to receive from other sources. It includes, but is not limited to: sick pay or other salary continuation, workers' compensation benefits, Social Security benefits, disability benefits from any other group insurance, 50 percent of earnings from work activity while you are disabled (after the first 12 months of your disability), and disability or retirement benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law or your retirement plan.

When do LTD benefits become payable?

If your LTD claim is approved by Standard Insurance Company, LTD benefits become payable at the end of the 180-day benefit waiting period. Refer to the Beyond Your Benefits section for information on taxes you may have to pay on insurance payments you receive.

How long can LTD benefits continue?

If you become continuously disabled before age 62, LTD benefits can continue during disability until age 65, or three years and six months if longer. If you become continuously disabled at age 62 or older, LTD benefits can continue during disability for a limited time. See the chart on page 17.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a pre-existing condition (except as provided in your Certificate), 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for more than 24 months for each period of disability caused or contributed to by a mental disorder, or for any period when you are not under the ongoing care of a physician.

What is the definition of a pre-existing condition?

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you received medical treatment or services, took prescribed drugs or medicines, or consulted a Physician within three (3) months before the most recent effective date of your insurance, you will receive no monthly benefit for that condition. However, this exclusion does not apply to a period of Disability that begins after you have been insured under the plan for 12 consecutive months.

The Pre-existing Condition Exclusion will apply to any added benefits or increases in benefits.

What are some of the features of this coverage?

- Coverage for disabilities occurring 24 hours a day both on or off the job.
- Insurance continues without premium payments while LTD benefits are payable.
- A survivors' benefit may be applicable if you die while LTD benefits are payable.

Assisted Living Benefit:

This benefit is available when LTD benefits are payable. It provides additional income replacement if you become disabled and cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. It increases the income replacement to 80 percent of your pre-disability earnings. The additional benefits paid under the Assisted Living Benefit are not reduced by deductible income. The maximum benefit amount for the Assisted Living Benefit cannot exceed $1,800 for Plan 1 or $857 for Plan 2. This benefit is available on both Plan 1 and Plan 2.

Lifetime Security Benefit:

This benefit provides a lifetime income to severely disabled employees, extending LTD benefits indefinitely by continuing to pay benefits, beyond the regular Maximum Benefit Period of age 65,until death at the original 70 percent level. Severely disabled means you cannot perform two of six activities of Daily Living or suffer a Severe Cognitive Impairment, and the condition is expected to last 90 days or more. Benefits paid under the Lifetime Security Benefit are reduced by deductible income. This benefit is available on Plan 2.

Long-term Disability Income Plans

How long are benefits payable?

Your benefits are payable according to the following schedule:

Age	Maximum Benefit Period
age 61 or younger	to age 65 (or 3 years, 6 months, if longer)
age 62	3 years, 6 months
age 63	3 years
age 64	2 years, 6 months
age 65	2 years
age 66	1 year, 9 months
age 67	1 year, 6 months
age 68	1 year, 3 months
age 69 +	1 year

Benefits are limited to 24 months for each period of continuous disability caused or contributed by a mental disorder. This limitation will not apply if you are continuously confined in a hospital at the end of the 24 months.

This description is designed to answer some common questions about the Long-term Disability coverage. It is not intended to provide a detailed description of the plans. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this Reference Guide.

PRE-TAX RATES FOR PLAN 1 (50% Coverage Level)

Age*	Monthly Premium Rate per $100 of Salary
to 29	$.14
30-34	$.16
35-39	$.20
40-44	$.29
45-49	$.42
50-54	$.61
55-59	$.86
60-64	$.97
65-69	$1.23
70 and over	$1.58

* Age as of July 1, 2017. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $6,000) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months). _____ Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____ Per Paycheck Deduction

PRE-TAX RATES FOR PLAN 2 (70% Coverage Level)

Age*	Monthly Premium Rate per $100 of Salary
to 29	$.24
30-34	$.29
35-39	$.37
40-44	$.52
45-49	$.76
50-54	$1.12
55-59	$1.47
60-64	$1.57
65-69	$1.76
70 and over	$1.88

* Age as of July 1, 2017. Disability Income Plan premiums are adjusted on an annual basis according to the employee's age and salary.

DISABILITY INCOME PROTECTION FORMULA

1. Enter your monthly salary (maximum $8,571) _____
2. Divide by 100 _____
3. Find your age on the chart above and enter the figure from the "Rate" column _____
4. Multiply the amount in Line 2 by the amount in Line 3 to get your monthly premium (based on 12 months). _____ Monthly Premium

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

5. Enter the monthly premium amount from Line 4 _____
6. Multiply by 12 _____
7. This is your annual premium _____
8. Divide by the number of regular paychecks you receive annually. _____ Per Paycheck Deduction

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies, rates Standard Insurance Company "A" Excellent.

West Virginia Public Employees Insurance Agency
Policy #611506-A
Standard Insurance Company
Mon – Fri, 10 a.m. – 9 p.m. ET
1-800-368-2859

Short-term Disability Income Plan

Employee Only, Pre-tax Benefit

When am I considered disabled?

You are considered disabled if, due to sickness, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of your own occupation or you are unable to earn more than 60 percent of your pre-disability earnings while working in your own occupation.

What is the STD benefit?

The weekly Short-term Disability (STD) benefit is based on your earnings from your public employer. The group insurance policy refers to these earnings as pre-disability earnings.

The weekly benefit is 70 percent of your pre-disability earnings, reduced by deductible income. The maximum weekly benefit is $750. The minimum weekly benefit is $15.

What is deductible income?

Deductible income includes 50 percent of earnings from work activity while you are disabled, and disability benefits you receive or are eligible to receive because of your disability under any state disability benefit law or similar law.

When do STD benefits become payable?

If your STD claim is approved by Standard Insurance Company, STD benefits become payable at the end of the 30-day benefit waiting period. During this 30-day period, no STD benefits are payable. The Group Policy has an actively-at-work requirement you must meet before your insurance will become effective.

How long can STD benefits continue?

STD benefits can continue during disability until no longer disabled, but no longer than the 180th day of disability.

What are the exclusions and limitations?

You are not covered for a disability caused or contributed to by: 1) a work-related injury, 2) an intentionally self-inflicted injury or 3) war or any act of war. Benefits are not payable for any period when you 1) receive or are eligible to receive sick leave, 2) are working for any employer other than the State of West Virginia or your public employer, 3) are eligible for any benefits under a workers' compensation act or similar law or 4) are not under the ongoing care of a physician.

This description is designed to answer some common questions about the Short-term Disability coverage. It is not intended to provide a detailed description of the plan. If you become insured, a more detailed description will be available in group insurance certificates provided to you. The controlling provisions are in the master group insurance policies. This description and the certificates do not modify the group policies or the insurance in any way.

For rules governing the taxes on the insurance payments you may receive, please read the Beyond Your Benefits section in the back of this Reference Guide.

Policy Provider

Standard Insurance Company underwrites this plan. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Standard Insurance Company "A" Excellent.

YOUR PRE-TAX RATES

Example:

If your weekly salary is $350, your monthly premium would be calculated: $350 x $0.0315 = $11.02 per month.

Worksheet

1. Your weekly salary (maximum $1071.00) _____
   X $0.0315
2. This is your monthly premium _____

If you are paid more than 12 times a year, you can calculate the amount to be deducted from your paycheck by completing the following chart.

3. Enter the monthly premium amount from Line 2 _____
4. Multiply by 12 _____
5. This is your annual premium _____
6. Divide by the number of regular paychecks you receive annually. _____

Per Paycheck Deduction

West Virginia Public Employees Insurance Agency
Policy #611506-B
Standard Insurance Company
Mon – Fri, 10 a.m. – 9 p.m. ET
1-800-368-2859

Group Legal Plan

A Payroll Deductible, Post-tax Benefit

Here's an affordable solution to help with your legal needs.

Finding an affordably-priced lawyer to represent you when you buy or sell your home or even prepare your will can be a challenge. Did you ever wish you could pick up the phone and call a lawyer for some quick advice? For just pennies a day, the Legal Plan gives you your own "attorney on retainer." The Legal Plan also covers full representation for many important personal legal services. There are no maximum coverage limitations, and you may use the plan for an unlimited number of personal legal matters.

How do I use the plan?

When you face a situation that you think may have legal implications, simply pick up the phone and call 1-800-821-6400 Monday-Friday, 8 a.m. to 7 p.m. (Eastern Time). A knowledgeable client service representative will be available to assist you in locating a Plan Attorney near your home or workplace. Plan Attorneys are generally available to meet with you on weekdays, evenings and even Saturdays. Or, visit **members.legalplans.com**.

In or Out-of-Network?

Hyatt has more than 4,000 law firms in its nationwide network. When you use a Plan Attorney, covered legal services are provided at no additional attorney fees. Of course, you also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule. You will be responsible to pay the difference between the plan's payment and the Attorney's fees. It's completely your choice.

What's covered?

- Living Wills
- Security Deposit Assistance
- Tax Audits
- Personal Injury Discounts
- Probate Discounts
- In-office Consultation & Telephone Advice with an attorney on virtually any personal legal matter
- Divorce & Separation (Available to the Plan Member only, not to a spouse or dependents)
- Wills and Codicils* (see note)
- Identity Theft Defense
- Sale, Purchase of your Home
- Eviction Defense & Tenant Negotiations
- Juvenile Court Defense
- Traffic Ticket Defense (except DUI)
- Restoration of Driver's License
- Criminal Misdemeanor Defense
- Consumer Protection Matters
- Debt Collection Defense
- Uncontested Adoption
- Powers of Attorney
- Uncontested Guardianship
- Preparation of Deeds, Mortgages, Notes and Demand Letters
- Small Claims Assistance
- Affidavits
- Document review
- Elder Law matters
- Prenuptial agreement
- **Immigration assistance**

* Preparing for the future may be the most important thing you'll ever do for your family. Estate planning can be complex, and may require tax planning. You may need assistance from an accountant or financial planner. If you do require tax planning, whether it's done by an accountant, a financial planner or your Plan Attorney, you are responsible for paying the portion of the fees charged for tax planning. The Legal Plan does not cover the tax planning necessary to decide what documents you need.

What's excluded?

- Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:
  - Employment-related matters, including company or statutory benefits
  - Matters involving the company, MetLife and affiliates, and Plan Attorneys
  - Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents
  - Appeals and class actions
  - Farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord
  - Patent, trademark and copyright matters
  - Costs or fines
  - Frivolous or unethical matters
  - Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

Group Legal Plan offered by Hyatt Legal Plans, Inc., Cleveland, OH. In certain states, provided through insurance coverage underwritten by Metropolitan Property and Casualty Company and Affiliates, Warwick, Rhode Island.

Your Rates for the Hyatt Legal Plan

	10 pay	12 pay	18 pay	20 pay	21 pay	22 pay	24 pay	26 pay
Employee & Family	$18.60	$15.50	$10.33	$9.30	$8.86	$8.45	$7.75	$7.15

This is a brief summary of the Legal Plan. For definitions of covered services, visit Hyatt at **members.legalplans.com** or call 1-800-821-6400 and request a Fact Sheet.

Flexible Spending Accounts (FSAs)

Your FSA Administrator is Changing!

Starting July 1, 2017, your Flexible Spending Account plans will be moved to a new system supported by FBMC's outsource partner, PayFlex. The new system is robust with a number of participant conveniences we are confident you will enjoy. It will be important to know where to submit your claims during this transition period. Effective July 1, 2017, PayFlex will process all 2018 Plan Year claims. You must continue to submit your 2017 Plan Year claims to WageWorks in order to exhaust your WageWorks account. Any funds remaining in your WageWorks account at the end of the run-out period will be forfeited.

Health Care FSA

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

Dependent Care FSA

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

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Annual Contribution Limits

For Health Care FSA:

Minimum Annual Deposit: $150

Maximum Annual Deposit: $2,600

For Dependent Care FSA:

Minimum Annual Deposit: $150

Maximum Annual Deposit: $5,000 maximum per household.

Typical FSA-Eligible Expenses

Use your FSA to save on hundreds of products and services for you and your family. Eligible expenses are defined by the IRS and your employer.

Eligible Medical Expenses

Please refer to **www.payflex.com** for all eligible expenses. Typically, your Health Care FSA covers:

- Acupuncture
- Ambulance service
- Birth control pills and devices
- Breast pumps
- Chiropractic care
- Contact lenses (corrective)
- Dental fees
- Diagnostic tests/health screening
- Doctor fees
- Drug addiction/alcoholism treatment
- Drugs
- Experimental medical treatment
- Eyeglasses
- Guide dogs
- Hearing aids and exams
- In vitro fertilization
- Injections and vaccinations
- Nursing services
- Optometrist fees
- Orthodontic treatment
- Over-the-counter items (some require prescription)
- Prescription drugs to alleviate nicotine withdrawal symptoms
- Smoking cessation programs/treatments
- Surgery
- Transportation for medical care
- Wheelchairs
- X-rays

Eligible Dependent Care Expenses

Your Dependent Care FSA typically covers expenses, such as:

- After school care
- Baby-sitting fees
- Day care services
- In-home care/au pair services
- Nursery and preschool
- Summer day camps

Typical Ineligible Expenses For Health Care FSA:

- insurance premiums
- vision warranties and service contracts
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition and
- over-the-counter items requiring a prescription

Flexible Spending Accounts (FSAs)

Using Your FSA Dollars

When you pay for an eligible health care or dependent care expense, you want to put your account to work right away. Using your FSA is easy with PayFlex.

Examples of how to use your FSA

Health Care FSA Example: Paying an office visit

After paying for your care at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with a claim form to PayFlex. Once your claim is processed and approved, you'll receive payment by check or direct deposit.

If you don't want to pay for the office visit out of your pocket, you can use your PayFlex debit card. Only use your card after insurance has covered their portion of the expense. Be sure to save your documentation from your card purchases. You may be asked to provide documentation to verify that your expenses were eligible. Failure to submit proper documentation can result in deactivation of your card and you may have to pay back the funds at the end of the plan year.

Dependent Care FSA Example: Paying for dependent care services

Once you have paid for (and received) a dependent care service, send a completed claim form to PayFlex, along with documentation showing the following:

- Provider Name – Facility name or person who provided the service.
- Dates of Service – Start and end dates for services provided.
- Service Description – Detailed description for services provided.
- Amount – The amount incurred for the services.
- Dependent Name & Age– Person who received the service.

If you don't have documentation to support your day care expense, you can have your provider sign a completed claim form and send to PayFlex. Once your claim is processed and approved, payment will be sent to you by check or direct deposit.

Use your PayFlex Card®, Your Account Debit Card

The PayFlex debit card is a convenient way to pay for eligible health care expenses. The card knows when the expense is eligible and whether you have funds available. When you use the card, save your Explanations of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you have a health care FSA, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA. If you need an additional debit card for your spouse or dependent, over the age of 18, you are able to request an additional card online or contacting customer service. You can order an additional card for your spouse or dependent online at no cost.

Filing a claim

Those who participate in a Flexible Spending Account can visit **www.payflex.com** to access their account information. For 2017 FSA claims to PayFlex, if you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **www.payflex.com** or through the PayFlex Mobile® app to pay yourself back for your out of pocket expenses. Or you can fill out a paper claim form and fax or mail it to PayFlex. This form can be found in the Resource Center at **www.payflex.com** or you may call PayFlex at **1-844-PAYFLEX (1-844-729-3539)** to request a form.

After you log in to **www.payflex.com**, click on the Financial Center tab and select your account from the drop down. Click on File a Spending Account Claim to get started. If you're a first time user, be sure to register first. Please see below for how to register online and for claim filing tips.

When you submit a claim, you need to include supporting documentation that shows the following:

- ✓ Date of service or purchase
- ✓ Detailed description
- ✓ Provider or merchant name
- ✓ Patient name
- ✓ Patient portion (or amount owed)

How to Register Online

Go to **www.payflex.com** and select "CREATE YOUR PROFILE." You will be asked to enter your last name, mailing address, zip code, last four characters of your ID number and date of birth. You will also need the last four digits of card number.

Once your information is authenticated, you can create a username and password, provide your phone number and e-mail address and select security questions/answers.

Note: If you already have a username and password for **www.healthhub.com**, you'll use that to log in to **www.payflex.com**.

Claim Filing Tips

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

FSA Grace Period and Run Out Period Dates

During the transition of your FSA administration from WageWorks to PayFlex, it is important to know where to submit your FSA claims during the FSA grace period and run out period.

Your **FSA grace period ends** two months and 15 days after the end of your plan year. During the FSA grace period, you may incur expenses and submit claims for those expenses. The grace period does not apply to Dependent Care FSAs.

Your **FSA run out period** is a 120-day run-out period after your plan year ends to submit reimbursement requests for all eligible FSA expenses (for both Health Care or Dependent Care FSAs) incurred DURING your plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period.

For WageWorks*:	**For PayFlex:**
Grace Period ends Sept. 15, 2017	Grace Period ends Sept. 15, 2018
Run Out Period ends Oct. 31, 2017	Run Out Period ends Oct. 31, 2018

*Your WageWorks FSA claims may continue to be submitted to WageWorks according to the 2017 Plan online to request reimbursement for your eligible expenses. To submit a paper claim by fax or mail, log into your account, download a Pay Me Back claim form and follow the instructions for submission. You may also contact Customer Service at 1-855-428-0446 to obtain a claim form.

FSA Worksheets

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

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

Health Care FSA Worksheet

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

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
TOTAL (cannot exceed $2,600)	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.	$ _____

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

Dependent Care FSA Worksheet

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

CHILD CARE EXPENSES

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

ELDER CARE SERVICES

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

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

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

Please note the bank information entered will be sent to the bank to confirm the account number. Any reimbursements issued during this prenote process will be issued as a check until this process has been completed. If you do not want your reimbursements sent via direct deposit, you may have your reimbursements sent via a check to your home address.

Health Savings Account (HSA)

What is a Health Savings Account?

Providing economical health care while costs are rising is a major issue facing the nation. To deal with this issue and help you plan for future health expenses, you will have the choice of enrolling in a Health Savings Account (HSA). This option allows you and your family to take greater responsibility for your medical care to reduce your insurance premiums and save money for future health expenses.

A Health Savings Account (HSA) is a tax-free account that can be used to pay health care expenses. Unlike money in a Flexible Spending Account, the funds do not have to be spent in the plan year they are deposited. Money in the account, including interest or investment earnings, accumulates tax-free, so the funds can be used to pay qualified medical expenses in the future[1]. An important advantage of an HSA is that it is owned by the employee. If you leave your job, you can take the account with you and continue to use it for qualified medical expenses.

Who is eligible to contribute to an HSA?

- Employees must be covered by an eligible, high deductible health plan (PEIA Plan C).
- Employees cannot be covered by any other health plan that is not a qualified high deductible health plan, including Medicare. However, they may be covered for specific injuries, accidents, disability, dental care, vision care and long-term care.
- Participants cannot be claimed as a dependent on another person's tax return.

How much can I contribute to my HSA?

If you enroll in an HSA and elect to make contributions, your contributions are deducted on a pre-tax basis. An individual with single coverage may contribute up to $3,400 a year to an HSA. Those covering more than one family member may contribute up to $6,750 a year. Please visit **www.irs.gov/pub/irs-pdf/p969.pdf** for updates. These limits, established by the federal government and subject to change, are tied to the rate of inflation. An individual age 55[2] and older may make "catch-up" contributions of up to $1,000 above the limits shown above in 2018.

You may also make after-tax contributions, which apply toward the maximum annual limit(s). You will receive additional information when you enroll.

Can I transfer funds from my IRA to my HSA?

A one-time irrevocable trustee-to-trustee transfer of IRA funds to an HSA will be allowed as long as the transferred amount does not exceed the annual HSA contribution limits[3]. Any transfer from an IRA to an HSA will reduce the maximum amount that may be contributed to an HSA during a calendar year.

[1] Please consult your tax advisor or IRS Publication 502 with questions regarding these expenses, qualified health plans, and tax information. Accounts opened prior to March 1, 2018 will continue their current fee structure of $2 per month maintenance fee waived with an average daily balance of $2,500 and a $0.50 per check written fee. Other fees may apply, including fees for insufficient funds. Refer to the PayFlex Fees and Charges for more information.

[2] The "catch-up" contribution rule applies to employees who are or become age 55 prior to 12/31 of the election year.

[3] Please consult a tax advisor. Certain restrictions apply.

How do I access my fund in my HSA account?

After electing the HSA, your information and account is established. Please go to www.payflex.com to open your account. You will receive a MasterCard with instructions on how to go to www.payflex.com and create your profile. You can link your bank account and set up for alerts. You may order additional cards at no charge online or by calling customer service at 844-729-3539. You may use your MasterCard to pay for eligible expenses. However, if you withdraw funds for ineligible expenses, you may have to pay taxes and penalties on those funds, unless you reimburse your HSA for the ineligible expense.

Will I be charged any banking or custodian fees?

There are no longer any per pay period administrative fees for using your HSA. However, the custodian will charge you $2.50 per month for your HSA. This fee includes the MasterCard® debit card, all transaction fees associated with the card. To make an HSA payment, use the online payment tool to pay your provider directly from your HSA. A check will be mailed to your provider at no additional cost. Other fees may apply, including fees for insufficient funds. Refer to the PayFlex Fees and Charges for more information.

Pre-tax Benefits Savings Example*

(With HSA)		*(Without HSA)*
$31,000	Annual Gross Income	$31,000
- 5,000	HSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,369	Federal, Social Security Taxes	-6,401
$20,631	Annual Net Income	$24,599
- 0	Cost of Recurring Expenses	-5,000
$20,631	Spendable Income	$19,599

By using an HSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of

$1,032!

* Based upon a 20.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Health Savings Accounts (HSAs)

How do I invest my HSA funds?

Your funds will be held initially in an interest-bearing checking account at PayFlex. Investments are allowed after balance achieves $1,000.

You can choose from a variety of mutual funds. If you're an HSA member, you can view these fund options in the Financial Center of the PayFlex member website. As an investor, you can:

- Transfer funds to and from your HSA
- Create recurring transfers to automatically take place each week, month or quarter
- View your investment account information, like investment balances, elections and recent transactions
- Manage your investment account by exchanging your investments with other investments or rebalancing your current investments to a certain percentage

Getting started with Investing

You may open an investment account once you reach the minimum balance, which is a $1,000 in your HSA. The minimum amount is determined by your employer. Any amount above the minimum balance can be transferred from your HSA to your investment account.

Once you open an investment account, you'll be charged a monthly account fee. This fee is automatically deducted from your HSA. If you're an HSA member, you can view the HSA fee schedule on the PayFlex member website in the Financial Center.

To continue to move funds into your investment account, you need to have the minimum balance in your HSA at the time you want to invest. Only the amount that exceeds the minimum balance is available for investing.

Questions?

Visit payflex.com, or call us directly at 1-844-PAYFLEX (1-844-729-3539). We're here to help Monday – Friday, 8 a.m. – 8 p.m. ET, and Saturdays, 10 a.m. – 3 p.m. ET.

Are there any special tax forms or tax reporting that I must complete when filing my income taxes?

The bank will send your tax filing information, after the end of the taxable year, for your use in reporting contributions to your HSA and to report any withdrawals or distributions from your HSA. It is important that you save receipts, invoices and any explanations of benefits received from your health insurance carrier as documentation, in case you are ever asked to show proof of qualified medical expenses to the IRS.

By the end of January, account holders can expect to receive Form 1099-SA reporting account distributions. Form 5498-SA reporting account contributions is sent by the end of May. It reports all contributions made for the tax year, including contributions made between December 31 and the tax filing deadline for the year (generally April 15).

May I have an HSA and a Limited Health Care FSA?

Yes, individuals may enroll in a Limited Health Care FSA to pay certain eligible expenses. The Limited Health Care FSA may be used to pay expenses not covered by your HSA or a high deductible health plan, including dental, vision and preventive care expenses not covered by PEIA Plan C. Dependent Care Spending Account eligibility is not affected by your HSA participation. You can save money and pay less tax too by enrolling in a Limited Health Care FSA, HSA or both. These are pre-tax benefits that you can take advantage of either independent of each other or together.

Remember, Limited Health Care FSAs are available to HSA participants. Dependent Care Spending Account eligibility is not affected by your HSA participation.

[1] Mutual fund investing involves risk, including loss of principal. Please carefully consider the fund's investment objective, risks, charges and expenses applicable to a continued investment in the fund before investing. For more information, please thoroughly read the prospectus prior to investing.

Limited Health Care FSA (LPFSA)

For HSA Participants Only

Minimum Annual Deposit: **$150**
Maximum Annual Deposit: **$2,600**

Limited Health Care FSA (LPFSA) is offered in conjunction with your Health Savings Account, should you elect. LPFSA funds can only be used for dental and vision.

Whose expenses are eligible?

Your LPFSA may be used to reimburse eligible expenses incurred by yourself, your spouse, your qualifying child or your qualifying relative.

When are my funds available?

Funds are available on day one of the plan. Once you sign up for a LPFSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible expenses at the start of your plan year, which is July 1, 2017.

FSA Grace Period and Run Out Period Dates

During the transition of your FSA administration from WageWorks to PayFlex, it is important to know where to submit your FSA claims during the FSA grace period and run out period.

Your **FSA grace period ends** two months and 15 days after the end of your plan year. During the FSA grace period, you may incur expenses and submit claims for those expenses. The grace period does not apply to Dependent Care FSAs.

Your **FSA run out period** is a 120-day run-out period after your plan year ends to submit reimbursement requests for all eligible FSA expenses (for both Health Care or Dependent Care FSAs) incurred DURING your plan year. Be sure to submit your grace period claims before the end of your 120-day run-out period.

For WageWorks*:	**For PayFlex:**
Grace Period ends Sept. 15, 2017	Grace Period ends Sept. 15, 2018
Run Out Period ends Oct. 31, 2017	Run Out Period ends Oct. 31, 2018

*Your WageWorks FSA claims may continue to be submitted to WageWorks according to the 2017 Plan online to request reimbursement for your eligible expenses. To submit a paper claim by fax or mail, log into your account, download a Pay Me Back claim form and follow the instructions for submission. You may also contact Customer Service at 1-855-428-0446 to obtain a claim form.

The PayFlex Card®

The PayFlex Card®

Instant Access to Your Money

The PayFlex Card makes it easy for you to spend the money in your Health Care FSA. If you enroll in an HSA, you'll also receive a PayFlex Card. When you use this debit card, it uses the money in your account to pay for eligible health care expenses.

Frequently Asked Questions

How Does the Card Work?

Your PayFlex Card may be used to pay for eligible health care products and services. When you receive the PayFlex Card in the mail, call the number on the card to activate it and get your personal identification number (PIN).

To use your card:

- simply swipe and select either "debit" or "credit." Please note that some merchants may ask you to select "debit." This means you'll need to enter your PIN to complete the transaction.
- If your spouse or dependent also has a PayFlex Card, they will use the same PIN you use.
- You can call Card Services for help if you forget your PIN or want to change your PIN.
- After you swipe, the card our system automatically checks to see if you have enough funds to pay for the expense.

Important Note: If you're enrolled in both the PayFlex Health Savings Account (HSA) and PayFlex Limited Health Care FSA (LPFSA), you'll use one PayFlex Card for both accounts. Eligible LPFSA expenses will automatically pull from your LPFSA funds first, before using your HSA funds.

Where Can I Use the Card?

You can use your card at qualified merchants where MasterCard® is accepted. This includes doctor and dental offices, hospitals, pharmacies (including mail-order prescriptions), and hearing and vision care centers. You may also use your card at some discount and grocery stores. These stores must have a system that can process health care cards.

What Can I Pay for with my Card?

You can use the card to pay for eligible expenses allowed under your plan. These generally include copays, prescriptions, vision and hearing products, and much more. To view a list of common eligible expenses, visit **www.payflex.com**. Click on Individuals and select explore common eligible health care expenses.

What if I Don't Use my Card to Pay for an Expense?

If you pay for an eligible expense with cash, check or a personal credit card, you can submit a claim for reimbursement online or through the PayFlex Mobile® app. You can also fill out a paper claim form and fax or mail it to PayFlex®. Note: You must include supporting documentation when you submit your claim.

Can I Use My Card for Prescription and Over-the-Counter (OTC) Expenses?

You may use your PayFlex Card at most retail or online locations to pay for prescriptions and certain OTC items. Such OTC items include bandages, contact lens solution, first aid kits, hot and cold packs, and thermometers. You cannot use the card to pay for OTC drugs and medicine such as pain relievers, cold and flu remedies, or allergy and sinus products. To get reimbursed for OTC drugs and medicine, you'll need a written prescription from your doctor. After you get the prescription, you must pay for the OTC drug or medicine with cash, check or personal credit card. Then submit a claim for reimbursement. Be sure to include the receipt and written prescription when you submit your claim.

Quick Tips

Spending made simple for the family — If you are a new member, you will automatically receive one card. You can order a card online for your spouse or dependent at no cost.

Save your receipts — If you receive a Request for Documentation letter or see an alert message on your account, this means we need documentation for a card purchase.

Access your account balance — Log in to your account through **www.payflex.com**. You can view your available balance on "My Dashboard".

The PayFlex Card® and PayFlex Mobile® App

Check your card's expiration date — Your card is valid for five years, as long as you are an active member. Before your card expires, you will receive a new card in the mail.

Replace lost or stolen cards — Please call us right away at 1-844-PAYFLEX (1-844-729-3539) to report a lost or stolen card. Do not order another card online.

IMPORTANT: Request for Documentation Alerts and Letters

There may be times that we need documentation from you to verify that your card was used to pay for an eligible item or service.

To help stay up to date on your card transactions, sign up for debit card notifications through email, web alert or both. Log in to www.payflex.com and click My Settings. Sign up for the **Debit Card Substantiation Notification and Request for Documentation Letter.**

How to Respond to a Request for Documentation Alert or Letter

If we need more information on a debit card purchase, send us the Explanation of Benefits (EOB) statement for the card purchase. You can upload your documentation to the PayFlex site, send it through the PayFlex app, or fax or mail it to us.

If you don't have an EOB, you have three other options:

1. Send us the itemized receipt for the card purchase.
2. Substitute another expense for the one in question.
3. Pay back your account for the amount in question.

Send a personal check or money order directly to PayFlex.

Note: If you don't respond to the request, your card may be suspended until you either send in the requested documentation or pay back the account.

PayFlex Mobile® Helping You Stay Connected

Get access to your FSA and HSA with our free** PayFlex Mobile application. This app makes it easy for you to manage your account virtually 24/7. It's available for iPhone® and iPad® mobile digital devices, as well as Android™ smartphones.

The PayFlex Mobile app lets you:

- View your account balance and manage your account funds.
- Request reimbursement and view transaction history.
- View PayFlex Card®, your account debit card, purchases and submit documentation.
- View your benefits plan information.
- View a list of common eligible expense items.

Security is our Priority

PayFlex Mobile is a secure and safe way to view your account information. PayFlex uses the same security for the app as the PayFlex member website.

Learn More About How to Use the App

After you enroll in an FSA, be sure to check out our PayFlex Mobile Quick Reference Guide to help you get started. You can find this guide on via the resource center, once you're logged into your account.

Questions?

Visit www.payflex.com or call us at 1-844-PAYFLEX (1-844-729-3539). Customer service representatives are available Monday - Friday, 8 a.m. - 8 p.m. ET and Saturday, 10 a.m. - 3 p.m. ET.

**Standard text messaging and other rates from your wireless carrier still apply.

Changing Your Coverage

Changing your benefits during the plan year

You will have the month of and two months following a qualifying event to submit an election form and supporting documentation to your Benefits Coordinator. Upon the approval of your election change request, your existing benefit elections will be stopped or modified (as appropriate). However, if your benefit election change request is denied, you will have **60 days**, from the date you receive the denial, to file an appeal with your employer. For more information, contact FBMC Service Center or your Benefits Coordinator. Visit **www.myFBMC.com** for information on rules governing periods of coverage and IRS Special Consistency Rules.

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

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

COBRA

What is continuation coverage?

Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Health Care FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan.

How long will continuation coverage last?

For Health Care FSAs:

If you fund your Health Care FSA entirely, you may continue your Health Care FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, **if** you have not already received, as reimbursement, the maximum benefit available under the Health Care FSA for the year. For example, if you elected a Health Care FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Health Care FSA for the remainder of the plan year or until such time that you receive the maximum Health Care FSA benefit of $1,000.

If your employer funds all or any portion of your Health Care FSA, you may be eligible to continue your Health Care FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Health Care FSAs. If you have questions about your employer-funded Health Care FSA, you should call FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248).

For Dental, Vision or Hearing Plan Coverage(s):

At COBRA Open Enrollment, a qualified beneficiary is given the opportunity to change his or her group health plans (including dental, vision and/or hearing plans), or to drop dependents or to add eligible dependents who are not already on COBRA. If you have questions, you should call FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248).

For More Information

This COBRA section does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available from your employer. You can get a copy of your summary plan description from the Public Employees Insurance Agency (PEIA).

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **www.dol.gov/ebsa**.

COBRA benefits are administered by PayFlex.

Beyond Your Benefits

Deferred Compensation (457 Plan)

Participating in the Flexible Benefits Plan may affect your maximum annual contribution to the 457 plan. That is, Flexible Benefits Plan contributions reduce includible compensation* from which the maximum deferrable amount is computed. You should contact the Deferred Compensation vendor or the Tax Deferred Annuity (TDA) provider about the specific effect of the Flexible Benefits Plan.

* Includible compensation is the gross income shown on your W-2 form.

Taxable Benefits and the IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any payments received under the plan will be taxed on a pro rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

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

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

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

Notice of Administrator's Capacity

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

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.
2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

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

Social Security

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

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call FBMC Service Center at 1-844-55-WVA4U (1-844-559-8248) for an approximation.

Disclaimer – Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s) and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies and procedures from time to time adopted.

FBMC Privacy Statement

As a provider of products and services that involve compiling personal—and sometimes, sensitive—information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

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

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

We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena or to prevent fraud.

Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPPA). You may receive a Privacy Notice from your employer or from the providers of various health plans in which you enroll. You should read these statements carefully to assure you understand your rights under HIPPA.

Notes

2017 Benefit Fair Schedule

Date	Location	Time
Wednesday, **April 5**	Ramada Inn 20 Scott Avenue Morgantown, WV 26508	3 p.m. – 7 p.m.
Thursday, **April 6**	Holiday Inn 301 Foxcroft Avenue Martinsburg, WV 2540	3 p.m. – 7 p.m.
Tuesday **April 11**	Holiday Inn Express 100 Civic Center Drive Charleston, WV 25301	3 p.m. – 6 p.m.
Wednesday, **April 12**	Tamarack Conference Center 1 Tamarack Park Beckley, WV 25801	3 p.m. – 7 p.m.
Thursday,, **April 13**	Huntington Holiday Inn Express 800 3rd Ave	3 p.m. – 7 p.m.
Tuesday, **April 18**	Comfort Suites of Parkersburg 167 Elizabeth Pike Mineral Wells, WV 26150	3 p.m. – 7 p.m.
Wednesday, **April 19**	WV Northern Community College 1704 Market Street Wheeling, WV 26003	3 p.m. – 7 p.m.

FBMC
BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Service Center 1-844-55-WVA4U (1-844-559-8248)
Mon - Fri, 7 a.m. - 7 p.m. ET
www.myFBMC.com

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