BUILDING BETTER BENEFITS... TOGETHER
YOUR 2010 BENEFITS ENROLLMENT GUIDE
BENEFIT OPTIONS AND COSTS

CIGNA MEDICAL PLAN

<table>
<thead>
<tr>
<th></th>
<th>Employee Monthly Costs*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMPLOYEE ONLY</td>
</tr>
<tr>
<td>OAP-IN</td>
<td>$0</td>
</tr>
<tr>
<td>OAP</td>
<td>$0</td>
</tr>
<tr>
<td>Choice Fund HSA</td>
<td>$0</td>
</tr>
</tbody>
</table>

DENTAL PLAN

<table>
<thead>
<tr>
<th></th>
<th>Monthly Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHMO - 150C</td>
<td>$0</td>
</tr>
<tr>
<td>PPO</td>
<td>$0</td>
</tr>
</tbody>
</table>

VISION PLAN

| PPO               | $6.40          | $12.82          | $12.18               | $19.12     |

SUPPLEMENTAL LIFE

<table>
<thead>
<tr>
<th>Monthly Rate</th>
<th>Cost PER $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE AGE</td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>$0.05</td>
</tr>
<tr>
<td>25-29</td>
<td>$0.05</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.06</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.07</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.10</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.18</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.30</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.47</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.73</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.30</td>
</tr>
<tr>
<td>70 &amp; Over</td>
<td>$3.30</td>
</tr>
</tbody>
</table>

To calculate your monthly cost for Supplemental Life, please use the following formula:

\[
\frac{\text{Elected Life Benefits Amount}}{1000} \times \frac{\text{Rate From Above}}{\text{Your Monthly Cost}} = \]

SHORT-TERM DISABILITY

<table>
<thead>
<tr>
<th>Monthly Rate</th>
<th>Cost PER $10 WEEKLY BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE AGE</td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>.66</td>
</tr>
<tr>
<td>25-29</td>
<td>.70</td>
</tr>
<tr>
<td>30-34</td>
<td>.53</td>
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<tr>
<td>35-39</td>
<td>.41</td>
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<tr>
<td>40-44</td>
<td>.29</td>
</tr>
<tr>
<td>45-49</td>
<td>.32</td>
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<td>50-54</td>
<td>.38</td>
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<tr>
<td>55-59</td>
<td>.43</td>
</tr>
<tr>
<td>60-64</td>
<td>.49</td>
</tr>
<tr>
<td>65 &amp; Over</td>
<td>.54</td>
</tr>
<tr>
<td><strong>Maximum Weekly benefit $1,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

To calculate your monthly voluntary STD cost, please use the following formula:

\[
\frac{\text{Your Annual Earnings}}{52} \times .60 \div 10 \times \frac{\text{Rate From Above}}{\text{Your Monthly Cost}} = \]

SPOUSE LIFE INSURANCE

Spouse Life Insurance covers $25,000 for $7.50 per month premium.

CHILD(REN) LIFE INSURANCE

Child(ren) Life Insurance $5,000 for $.40 per month premium. Covers all eligible children.

SUPPLEMENTAL LONG-TERM DISABILITY

An employee electing this additional 10% of coverage will pay a premium of $ 0.14 per $100 of his or her eligible earnings.

LIFE AND AD&D

Life and AD&D insurance covers 1x employee’s yearly earning at no cost to the employee.

*A portion of the premium paid for a domestic partner must be paid on an after-tax basis as required by the IRS.*
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ABOUT THIS BENEFITS ENROLLMENT GUIDE

This Benefits Enrollment Guide describes the highlights of Hillsborough Community College Benefits Program in non-technical language. Your specific rights to benefits under this program are governed solely, and in every respect, by the official documents and not the information contained within this Benefits Enrollment Guide.

If there is any discrepancy between the descriptions of the program elements as contained within this Benefits Enrollment Guide or other benefits enrollment materials you receive and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Eligibility for any benefit plan is determined by applicable plan documents and policies. You should be aware that any and all elements of the HCC Benefits Program may be modified in the future to meet Internal Revenue Service rules, Federal & State legislation or otherwise as determined by HCC.
WELCOME

We are pleased to offer a benefits program as part of your total compensation that provides:

- A wide range of competitive benefit plans to accommodate your personal needs and protect you and your family from financial hardship;
- Tuition benefits for you, and your immediate family members;
- Generous time off programs to help you balance your work and family life.

HOW TO PROCEED

This Benefits Enrollment Guide will help familiarize you with the HCC Benefits Program. Carefully consider each benefit option, its cost and value to you and whether it meets your particular needs.

Get Benefits Information Online
http://hccfl.edu/dao/hr/benefits
or
- Go to www.hccfl.edu
- Click on “Human Resources” at bottom
- On the left, click on “Benefits”
- For Open Enrollment Information Click on “Benefit Open Enrollment”
PLAN YEAR
The Hillsborough Community College benefits plan year begins on July 1 and ends the following June 30. This Benefits Enrollment Guide outlines the benefits that apply to this plan year.

IN THIS GUIDE
This Benefit Enrollment Guide briefly describes your benefit options, including who is eligible to participate, how much benefits cost and what benefits are available. It provides an overview of your Medical, Dental, Vision, Flexible Spending Accounts, Life and Accident, Short-term and Long-term Disability, Legal, Cancer, and Long-term Care insurance policies and Pet-Insurance. This Benefits Enrollment Guide provides you with the information you need to make important decisions about your benefits. By taking the time to review this Benefits Enrollment Guide carefully, you can decide which benefits are best for you and your family. Together, you and HCC can build a benefit package that is suited to meet your needs.

ELIGIBILITY OF BENEFITS EMPLOYEES
You are eligible to participate in the HCC Benefits Program if you are:

- Administrators, professional/managerial, and classified employees appointed to a full-time regular position and scheduled to work 37 ½ hours per week.
- Administrators, professional/managerial, and classified employee appointed to a full-time temporary position or appointed in a temporary status to a full-time regular position and whose appointments are for six or more months.
- Faculty members appointed to a fulltime temporary position or appointed in a temporary status to a full-time regular position whose appointments are for more than one academic term.

DEPENDENT COVERAGE
Dependents eligible for coverage are spouses/domestic partners and unmarried, dependent children.

Dependents are defined as:
Your unmarried child who lives in your home and depends upon you for support or attends school full or part-time if he or she is:
- Your son or daughter
- Your legally appointed or adopted child
- Your dependent child(ren) between the ages of 25-30* who is/are:
  - Unmarried without dependents of their own
  - A Florida resident or a full or part-time student
  - Not entitled to coverage under any other health plan or policy

*This applies to medical coverage only.

Domestic partner is defined as someone who:
- Is at least 18 years old
- Is not legally married or in another domestic partnership
- Is not related in any way that would prohibit marriage in the State in which you reside
- Is your sole domestic partner
- Is sharing a permanent residence with you as a member of the same household for a period of (2) consecutive years
- Is in a committed relationship of mutual support and has shared financial obligations and living expenses with you
- Is not in a relationship solely to obtain insurance

See the following page for important information about domestic partner coverage
IMPORTANT INFORMATION ABOUT DOMESTIC PARTNERS

Due to IRS regulations, domestic partners and their children are not eligible to receive benefits from the:
- HSA - Medical Plan
- FSA – Health Care Account
- FSA – Dependent Care Account
- COBRA Continuation

In addition, there will be tax implications for covering your same-sex domestic partner and/or your domestic partner’s children under HCC benefits. Consider speaking with a tax advisor for more information.

If you wish to enroll your same-sex domestic partner for health coverage, contact your Benefits Department.

CHANGING YOUR BENEFITS

The Internal Revenue Service (IRS) states that employees enrolled in pre-tax benefit plans may only make benefit elections to these plans once a year. As such, your medical, dental, vision and flexible spending account benefit choices are binding through June 30. The following special circumstances are the ONLY reasons you may change your benefits during the plan year:
- Marriage
- Birth, adoption or placement for adoption of an eligible child
- Divorce, legal separation or annulment
- Loss of spouse’s job or change in work status where coverage is maintained through the spouse’s plan
- A significant change in your spouse’s health coverage attributable to your spouse’s employment
- The reduction or increase in hours of employment or other changes in employment category of you or your spouse or dependent
- Death of a spouse or dependent
- Loss of dependent status
- Becoming eligible for Medicare or Medicaid during the year
- Receiving a Qualified Medical Child Support Order (QMCSO)

For any allowable changes, you must notify the Benefit office within 30 calendar days of the Qualifying Event and provide proper documentation. If you lose Medicaid or a Children’s Health Insurance Plan (CHIP), you have 60 days from the date of loss to request enrollment in our medical program.
MEDICAL BENEFITS - Medical Plan Options

WELCOME TO CIGNA HEALTHCARE

CIGNA HealthCare will provide healthcare benefits for Hillsborough Community College employees and families effective July 1, 2010. CIGNA offers a national network of doctors, hospitals and pharmacies that provide healthcare services.

To address the needs of Hillsborough Community College employees, CIGNA will offer two Open Access Plus Plans and a Choice Fund HSA Plan. Preventative care services, including adult, well women, routine child physical exams and immunizations are available through both Open Access Plus Plans. To receive your maximum benefit, you should select a doctor from the CIGNA HealthCare list of participating providers.

The previous HMO plan will now be known as the Open Access Plus – In Network or OAP-IN plan.

The previous PPO plan will now be known as the Open Access Plus or OAP plan.

PLAN FINDER

<table>
<thead>
<tr>
<th>If You’re Currently In:</th>
<th>Then Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS</td>
<td>CIGNA</td>
</tr>
<tr>
<td>HMO</td>
<td>OAP-IN</td>
</tr>
<tr>
<td>PPO</td>
<td>OAP</td>
</tr>
<tr>
<td>HSA</td>
<td>CHOICE FUND HSA</td>
</tr>
</tbody>
</table>

OPEN ACCESS PLUS – IN NETWORK PLAN (OAP-IN)

If you choose the OAP-IN plan, you are not required to choose a PCP, but you must choose doctors within the CIGNA network. You generally pay a-per-visit co-pay when you visit an OAP-IN provider or are hospitalized, without having to meet a deductible, pay coinsurance or file a claim. A per-visit co-pay of $20 for PCP and $35 for a specialist is charged. CIGNA determines which providers are considered PCP and which are specialist. For hospitalization, the plan will pay the full cost after a $300 per day, per admission up to a five-day maximum and a $300 co-pay per outpatient surgery admission. There is no coverage for out-of-network services.

OPEN ACCESS PLUS PLAN (OAP)

With CIGNA HealthCare Open Access Plus OAP, you can visit any provider you choose, in or out-of-network. You are not required to choose a PCP, nor do you need a referral for a specialist. You generally pay a-per-visit co-pay when you visit an OAP provider or are hospitalized, without having to meet a deductible, pay coinsurance or file a claim. A per-visit co-pay of $20 for PCP and $35 for a specialist is charged. Deductibles and coinsurance must be met. For hospitalization, the plan will pay the full cost after a $600 per admission and a $300 co-pay per outpatient surgery admission.

While you are not required to see doctors in the CIGNA network, if you choose to see providers outside of the CIGNA network, you will pay higher out-of-pocket costs and your care will be covered at the out-of-network benefits level.
CHOICE FUND HSA
In addition to the OAP and OAP-IN plans, you will also be offered a High Deductible Health Plan with a Health Savings Account plan option.

Health Savings Accounts (HSAs) are tax exempt accounts where funds grow to pay for medical expenses. They were created to help give control back to consumers and lower health care costs. HSAs provide a financial incentive for consumers to select a High Deductible Health Plan (HDHP), which has lower monthly premiums than traditional plans. The HSA/HDHP combination provides consumers with more incentive to shop carefully for health care services.

The HSA is your account. If you switch jobs, the HSA goes with you. Your money rolls over every year. There is no “use it or lose it” requirement.

FEATURES OF THE HSA PLAN
HCC will contribute up to $625 to each employee’s HSA account. You may add tax free contributions to your HSA account up to a maximum of $3,050, or $6,150 for family, which includes the $625 from HCC.

RETIREMENT SAVINGS
You can treat your HSA as a pure retirement account -- like an IRA or a 401k. You can make HSA deposits to age 65, withdraw no funds and generate tax-deferred investment income to be disbursed in your retirement years. However, a more financially sensible approach is to use some HSA funds for current health care expenses. It’s a matter of paying bills with pre-tax income, as opposed to paying with after-tax income.

Use your HSA to save, but spend when appropriate. For most people, the HSA functions both as a tax-deferred retirement account AND as a tax-advantaged health care funding tool.

DISTRIBUTIONS
Here are some key points about distributions:
• You can use your money tax-free at any time for eligible medical expenses.
• When you turn 65, you can use the money for non-eligible medical expenses. The money is subject to income tax, and there are no IRS penalties.
• If you are under age 65 and use your money for non-eligible medical expenses, you will be subject to income tax and a tax penalty.

IRS REQUIREMENTS FOR 2010

<table>
<thead>
<tr>
<th>Plan</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution Limit</td>
<td>$3,050</td>
<td>$6,150</td>
</tr>
<tr>
<td>Catch-Up Contribution*</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

* If a spouse is also 55 or older, a second HSA must be established and a second contribution of $1,000 could be made to that account.
MEDICAL BENEFITS - CIGNA

CIGNA WEBSITE
www.mycigna.com

www.mycigna.com is your personalized web-site that provides you with access to details about your health benefits, tips on first-aid and healthy living from WebMD, and tools to help you better understand your benefits and manage your overall health and well-being.

With www.mycigna.com, you have the ability to:

• View your own claims and benefits
• Complete a brief questionnaire with the University of Michigan’s Health Risk Assessment. Get recommendations based on your health profile to help enhance your health and well-being, as well as links to other interactive tools, including on-line coaching programs designed to help you manage your weight, sleep better, have more energy, and reduce your stress level.
• Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through Healthwise, an interactive library.
• Use the pharmacy tools to: Check your prescription drug costs, listed by specific pharmacy and location. Click Drug Compare to look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.
• Learn how the hospitals rank by number of procedures performed, patients’ average length of stay, and cost all in one convenient tool, Select Quality Care. Get information on more than 170 surgical and medical procedures through a personalized report. You can also visit our online Provider Directory to find hospitals that achieve the highest scores for certain procedures and conditions.

THE CIGNA HEALTHCARE WELL AWARE PROGRAM

Your CIGNA HealthCare plan includes the CIGNA HealthCare Well Aware Program for better health. It offers valuable, confidential support for you and your covered family members with specific medical conditions. The CIGNA HealthCare Well Aware Program provides educational materials that help you learn more about your health condition, regular reminders of important checkups and tests and helpful information that keeps your doctor advised of the latest care and treatment techniques.

The CIGNA HealthCare Well Aware Program helps you and your doctor follow your condition more closely and treat it more effectively.

The following programs are available:
Asthma
Chronic Obstructive Pulmonary Disease (COPD)
Low Back Pain
Diabetes
Heart Disease
Depression
Weight Complication
Some Other Targeted Conditions

To learn more, call the toll-free number on your CIGNA HealthCare ID card, 1.800.CIGNA24 (1.800.244.6224).

Once enrolled in the Well Aware program, you will be provided with:
• Access to registered nurses who specialize in your condition.
• Information and resources that include assistance with self-care materials and services; and informative topic sheets on a variety of condition related topics.
• Reminders of self-care routines, exams and doctor appointments and other important topics.
CIGNA HEALTHCARE HEALTHY PREGNANCIES, HEALTHY BABIES

The CIGNA HealthCare Healthy Preganacies, Healthy Babies program provides education and support for covered mothers-to-be along with special attention for high-risk pregnancies.

The program includes:

• Enroll in your first or second trimester and receive an incentive award.
• Access to a valuable toll-free information line staffed by experienced registered nurses.
• Educational materials from a recognized source of information on pregnancy and babies.
• Post-delivery support and services.

Please call CIGNA HealthCare at the toll-free number on your CIGNA HealthCare ID card, 1-800-CIGNA24 (1-800-244-6224) for more information or to enroll in the Healthy Preganacies, Healthy Babies program.

THE CIGNA HEALTHCARE 24-HOUR HEALTH INFORMATION LINE℠

No matter where you are in the U.S., you can call the CIGNA HealthCare 24-Hour Health Information Line, toll-free at 1-800-CIGNA24 (1-800-244-6224).

• You can speak to a registered nurse for answers to your health questions, assistance in locating nearby medical facilities, assistance with emergency care, and helpful self-care tips.
• You can listen to informative, recorded audio tapes on hundreds of health topics.
• This service is available around the clock, 24-hours a day, seven days a week.

CIGNA HEALTHY REWARDS PROGRAM

Healthy Rewards is a discount program offered to CIGNA members. Healthy Rewards offers discounts for acupuncture, laser vision correction, hearing aids, cosmetic dentistry, smoking cessation, fitness club memberships, herbal supplements and a variety of other services and programs. There are no claims to file. Members use their CIGNA medical plan ID card for identification. Discounts apply only with Healthy Rewards participating providers. Members can find a list of providers and services by calling 1-800-870-3470 or by visiting www.cigna.com/healthyrewards.

Healthy Rewards discounts can’t be applied to any copayments or coinsurance for services already covered by your medical plan.

CIGNA HEALTHCARE ID CARD

Carry it with you at all times and present it whenever you access medical care. This will help ensure that your claim is handled properly.

CUSTOMER SERVICE

CIGNA Customer Service:

• The toll-free number is 1-800-CIGNA24 (1-800-244-6224). Please have your CIGNA HealthCare ID card ready when you call.
• Se habla Espanol - and more than 140 other languages. CIGNA provides bi-lingual representatives in Spanish-speaking areas; for other non-English speaking members, CIGNA also offers a Language Line service that can translate virtually any language.
## MEDICAL PLAN COMPARISON CHART

<table>
<thead>
<tr>
<th>Benefit/Feature</th>
<th>OPEN ACCESS PLUS - IN NETWORK PLAN</th>
<th>OPEN ACCESS PLUS PLAN</th>
<th>CHOICE FUND HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td>Network to Use</td>
<td>CIGNA OAP-IN</td>
<td>CIGNA OAP</td>
<td>CIGNA HSA</td>
</tr>
<tr>
<td>Calendar Year Deductible:</td>
<td>N/A</td>
<td>$500/1500</td>
<td>$1,250/2,500</td>
</tr>
<tr>
<td>Single/Family</td>
<td></td>
<td>Combined w/ In-Network</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>N/A</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Office Visit – Primary</td>
<td>$20</td>
<td>$25</td>
<td>CYD + Coinsurance</td>
</tr>
<tr>
<td>Office Visit – Specialist</td>
<td>$35</td>
<td>$35</td>
<td>CYD + Coinsurance</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$35</td>
<td>$40</td>
<td>CYD + Coinsurance</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150</td>
<td>$150</td>
<td>CYD + Coinsurance</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>$300/Day 5 Day Max)</td>
<td>$600</td>
<td>CYD = 20% / 25%</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>$5</td>
<td>$10</td>
<td>CYD + Coinsurance</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>$5,000,000</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Out of Pocket Maximum: Single/Family</td>
<td>$2000/4000</td>
<td>$2,500/5,000</td>
<td>$5,000/10,000</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>$0</td>
<td>CYD + In-Network Coinsurance</td>
<td>CYD + In-Network Coinsurance</td>
</tr>
</tbody>
</table>

Go to www.mycigna.com to:
- Find a CIGNA network provider
- Check if your doctor is in the CIGNA network (Networks listed in chart below)
- Health and Wellness information
- 3-Tier Preferred Medication Guide
PRESCRIPTION BENEFITS

OAP-IN and OAP PROGRAM
If you enroll in the OAP-IN or OAP medical plan options, you automatically received prescription drug coverage without paying an additional premium or making a separate election. You may fill your prescription at participating pharmacies for a copay and fill longer-term maintenance medication through the Tele-Drug mail order program.

FINDING PARTICIPATING PHARMACIES
Keep in mind that you only receive benefits for prescriptions drugs at participating pharmacies. Most major chains participate in the CIGNA Pharmacy Network. To find a list of participating pharmacies, visit the CIGNA website.

PRESCRIPTION DRUG BENEFITS

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>OAP-IN</th>
<th>OAP-In</th>
<th>Mail Order Pharmacy</th>
<th>Mail Order Pharmacy</th>
<th>CHOICE FUND HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$15</td>
<td>$15</td>
<td>$15</td>
<td>$15</td>
<td>30%</td>
</tr>
<tr>
<td>Brand Formulary</td>
<td>$25</td>
<td>$25</td>
<td>$30</td>
<td>$60</td>
<td>40%</td>
</tr>
<tr>
<td>Non-Formulary</td>
<td>$40</td>
<td>$50</td>
<td>$50</td>
<td>$100</td>
<td>50%</td>
</tr>
</tbody>
</table>

As you can see, you can save by purchasing generic drugs or brand-name drugs on the formulary. Before you fill your prescription, ask your doctor or your pharmacist if a generic drug or brand-name drug is listed on the formulary is appropriate for your condition. If both the generic and brand-name prescriptions are available on the formulary and you choose a brand-name, you will be required to pay the brand-name copay plus the difference between the cost of the generic drug and the cost of the brand-name drug.

OTHER HELPFUL INFORMATION
- Always take a copy of your formulary to your appointments where a medication might be prescribed.
- For most chronic diseases, there are several drugs from which to choose. Many of these drugs are considered by experts to be very similar in terms of their side effects and benefits. If you are prescribed a branded medication, ask your doctor regularly whether there is a similar drug that might be as effective and which would be available generically.

MAIL ORDER PROGRAM
Through the Tele-Drug Mail Order Pharmacy Program, you can obtain a 3-month supply of maintenance medications for the same cost that you would pay for a 2-month supply at a retail pharmacy. To take full advantage of this benefit, you should encourage your doctor to prescribe a 3-month supply where appropriate. You may request mail order forms directly from CIGNA or you may contact CIGNA and inquire about the “Quick Switch” program.

Using the “Quick Switch” program, you provide CIGNA with the name of your medication, the name and telephone number of your prescribing provider, and a credit card number. CIGNA will then contact your provider to make all the arrangements to have you switched over to the mail order program.

Prior to sending for a mail order supply, check to make sure that the medication is one that will be using long term, the drug is working effectively and you tolerate it, and your doctor has obtained prior authorization if the medication requires prior authorization or another exception.
### DENTAL OPTIONS

HCC will provide two dental options for employees to choose from. The Humana Dental DHMO and PPO include providers that have agreed to accept Humana Dental’s allowance as payment in full.

### HUMANA DHMO

You and each of your dependents must select a dentist who participates in the Humana Dental Prepaid/DHMO Network. This primary care dentist will take care of your dental needs.

The plan will not cover services, except emergency care, from a dentist who does not participate in the Network.

When you visit your primary care dentist, simply present your Humana Dental identification card. You may be required to pay a co-payment for some services. If the dental services received are not covered by the dental insurance plan, the dentist will bill you for the charges. You pay your dentist directly, if applicable.

The chart on the right is for illustrative purposes only. Benefits may be subject to limitation, exclusions and governing administrative policies of the plan. Please refer to Schedule of Benefits for more detailed information.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Features/Procedures</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Annual Deductible</td>
<td>None</td>
</tr>
<tr>
<td>N/A</td>
<td>Annual Maximum</td>
<td>Unlimited</td>
</tr>
<tr>
<td>9430</td>
<td>Office Visit</td>
<td>$5</td>
</tr>
<tr>
<td>0120</td>
<td>Periodic oral Evaluation</td>
<td>$0</td>
</tr>
<tr>
<td>0140</td>
<td>Limited oral evaluation – problem focused</td>
<td>$0</td>
</tr>
<tr>
<td>0180</td>
<td>Comprehensive periodontal exam</td>
<td>$10</td>
</tr>
<tr>
<td>0210</td>
<td>X-Rays-full mouth series</td>
<td>$0</td>
</tr>
<tr>
<td>2140</td>
<td>Amalgam/filing</td>
<td>$0</td>
</tr>
<tr>
<td>3310</td>
<td>Root Canal (anterior)</td>
<td>$100</td>
</tr>
<tr>
<td>3330</td>
<td>Root Canal (molar)</td>
<td>$250</td>
</tr>
<tr>
<td>4261</td>
<td>Periodontal Osseous surgery (gum treatment)</td>
<td>$350</td>
</tr>
<tr>
<td>2752</td>
<td>Crown (porcelain/noble)</td>
<td>$280</td>
</tr>
<tr>
<td>2740</td>
<td>Crown (porcelain/ceramic)</td>
<td>$280 + Lab</td>
</tr>
<tr>
<td>5110/5120</td>
<td>Complete denture – upper and lower</td>
<td>$300 + Lab</td>
</tr>
<tr>
<td>7111</td>
<td>Extraction – deciduous tooth</td>
<td>$0</td>
</tr>
<tr>
<td>7220</td>
<td>Extraction – impaction soft tissue</td>
<td>$50</td>
</tr>
<tr>
<td>8070</td>
<td>Comprehensive orthodontia treatment</td>
<td>$2,085</td>
</tr>
</tbody>
</table>
HUMANA DENTAL PPO
Under the Humana PPO Plan, you and your covered dependents may go to any dentist you choose, however, for maximum benefits at the lowest cost you should visit a participating network dentist. If your dentist is not in the network you still receive benefits, but you will pay higher out-of-pocket costs for the dental services. Prior to receiving services, review your plan document for important plan information, such as deductibles or required waiting periods.

When you visit a dentist, simply present your Humana Dental identification card. The dentist will submit the claim on your behalf. Humana Dental will review the claim and reimburse the dentist for eligible charges. Humana Dental will mail an Explanation of Benefits (EOB) to your home. Your dentist will bill you for your portion of the charges. If you visit a participating PPO network dentist, your dentist cannot bill you for amounts over the negotiated fees, ensuring lower out-of-pocket costs for you. You pay your dentist directly, if applicable.

### AVERAGE COST OF SERVICES WITHOUT INSURANCE
Crown: $900 • Root Canal: $900 • Total Cost: $1,800

### In-Network Out-of-Network
<table>
<thead>
<tr>
<th>Annual Deductible</th>
<th>$25/$75</th>
<th>$50/$150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventative Oral exams, X-rays, Cleanings</td>
<td>100%, no deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong> - Oral Surgery (extraction including surgical removal of teeth), Basic Restorative, Periodontal Cleanings, Root Canal, General Anesthesia</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Major Services</strong> - Crowns, Bridges, Dentures</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Dental Services Calendar Year Maximum</td>
<td>$1,500 combined, in/out of network</td>
<td></td>
</tr>
<tr>
<td>Orthodontics Bands/Appliances</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Orthodontics Lifetime Maximum</td>
<td>$1,000</td>
<td></td>
</tr>
</tbody>
</table>

Benefits may be subject to limitation, exclusions, and governing administrative policies of the plan. Please refer to Schedule of Benefits for more detailed information.

### EXAMPLE:
Nancy needs to have a root canal (molar) and then have her tooth crowned. How much will it cost if she used the Humana Dental DHMO, PPO in network, and PPO out-of-network?

<table>
<thead>
<tr>
<th>DHMO</th>
<th>PPO</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown</td>
<td>copay</td>
<td>60%</td>
<td>50% of U&amp;C</td>
</tr>
<tr>
<td>Root Canal</td>
<td>copay</td>
<td>90%</td>
<td>80% of U&amp;C</td>
</tr>
</tbody>
</table>

**Benefit Coverage – What the Plan Pays**

<table>
<thead>
<tr>
<th></th>
<th>DHMO</th>
<th>PPO</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown</td>
<td>$620</td>
<td>$540</td>
<td>$450</td>
<td></td>
</tr>
<tr>
<td>Root Canal</td>
<td>$650</td>
<td>$810</td>
<td>$720</td>
<td></td>
</tr>
</tbody>
</table>

Nancy pays the remaining amount. Nancy must pay the difference between the plan allowance and the actual cost if she receives services out-of-network.

<table>
<thead>
<tr>
<th></th>
<th>DHMO</th>
<th>PPO</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crown</td>
<td>$280</td>
<td>$360</td>
<td>$450</td>
<td></td>
</tr>
<tr>
<td>Root Canal</td>
<td>$250</td>
<td>$90</td>
<td>$180</td>
<td></td>
</tr>
</tbody>
</table>

Total Nancy pays $530 $450 $630

This example is for illustrative purposes only and assumes that no calendar year maximum or deductible applies.
VISION BENEFITS

Vision benefits are provided through Humana. Humana covers services including annual eye exams, and contact lenses. Frames are covered every other year. To maintain a high standard of care, Humana only contracts with highly qualified private practice optometrists and ophthalmologists. For this reason, there are no retail chains included in their network. Private practitioners using that network providers are to treat employees as patients with the highest quality health care. This also allows providers to create doctor-patient relationships rather that the doctor-customer relationships that are created by some retail chains.

Humana’s Vision Care Plan also includes LASIK benefits to plan participants and their covered family members. Human currently offers more than 100 LASIK locations.

How Do I Access My Humana Vision Benefits?
You do not need any claim forms to access your Humana benefits. Simply:
• Visit www.humanavisioncare.com or call member services to contact at 1-866-537-0229 or number on the back of your ID card.
• After you locate a Humana provider, call and make an appointment. The participating provider contacts Humana Vision Care Plan to obtain a Vision Pass Form (eligibility verification). At the time of your visit, you receive your treatment and pay any applicable copayments; the providers does the rest.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exam</td>
<td>$10 Copay</td>
<td>$35 Allowance</td>
</tr>
<tr>
<td>Once every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>100%, Includes Single, Bifocal 9FT-23, FT-28, Round, Trifocal (7x25, 7x28), Lenticular, UV Protection, SV Poly Carbonates for members 18 or under</td>
<td>$25 Allowance - Single Vision $40 Allowance - Bifocal $60 Allowance - Trifocal $100 Lenticular</td>
</tr>
<tr>
<td>Once every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$135 Allowance</td>
<td>$135 Allowance</td>
</tr>
<tr>
<td>Once every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>$50 Wholesale Allowance (approximately $100-150 retail value)</td>
<td>$45 Retail Allowance</td>
</tr>
<tr>
<td>Once every 24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lasik Vision Service*</td>
<td>$895 per eye Conventional $1,295 per eye Custom $1,895 per eye Custom Lasik w/ IntraLase</td>
<td>No Benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*TLC Vision Lasik Advantage Center
LIFE AND AD&D BENEFITS

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Life and accident insurance ensures that you and your family are financially protected in the event of death or accidental injury. HCC provides you with basic coverage, as well as the opportunity to purchase additional coverage.

HCC’s Benefit Program provides Basic Life and Accident Coverage at no cost to regular full-time employees, as listed below:

- **Life Insurance**
  1X eligible earnings at a minimum of $25,000 up to $250,000.

- **AD&D Insurance**
  1X eligible earnings at a minimum of $25,000 up to $250,000. (Refer to your full AD&D schedule in your certificate booklet.)

You may add to your coverage by purchasing Supplemental Life Insurance for you, your spouse/domestic partner and your children.

LIFE AND EVIDENCE OF INSURABILITY

The combined limit for the Basic Life and Supplemental Life Insurance plan is $900,000. However, you may be required to provide Evidence of Insurability (EOI) for certain levels of coverage. This means that during your initial enrollment period, you will need to submit evidence of good health to Hartford if you elect to purchase coverage equal to an amount in excess of three times eligible earnings or $525,000, whichever is less. If you are approved, your coverage will become effective on the date The Hartford approves your application.

You may also be required to provide EOI if you wish to increase the level of your coverage or elect supplemental life after your initial eligibility period.

BENEFICIARIES

You purchase life insurance to ensure that your family is financially protected in the event of your death. It is equally important to make sure that those you want to receive your Life Insurance benefits can do so without incurring expensive legal fees. To do this, specify beneficiaries for the Life Insurance plan you elect. You may change your beneficiaries at any time during the year by contacting your Benefits Department.

BENEFIT REDUCTIONS

Your coverage amounts may be reduced based on your age as follows, if you remain employed at HCC:

<table>
<thead>
<tr>
<th>At Age</th>
<th>Reduced By</th>
</tr>
</thead>
<tbody>
<tr>
<td>70</td>
<td>33%</td>
</tr>
<tr>
<td>75</td>
<td>50%</td>
</tr>
</tbody>
</table>

CONVERSION

If you reduce your hours or leave employment with HCC before you reach the Social Security definition of retirement (age 65 or older, based on your year of birth), conversion allows you to continue your Life Insurance coverage, if you wish. You also are allowed to continue your Supplemental Life Insurance coverage, assuming you apply for this coverage and pay the premiums within 31 days of your date of termination or reduction in hours. You are not required to provide proof of good health to continue your coverage.
LIFE AND AD&D BENEFITS

LIFE INSURANCE AND AD&D PLAN SUMMARY

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Options</th>
<th>Who Is Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Insurance</td>
<td>• 1 X eligible earnings&lt;br&gt;• Minimum of $25,000&lt;br&gt;• Maximum of $250,000</td>
<td>Employee</td>
</tr>
<tr>
<td>Employee Supplemental Life Insurance</td>
<td>• 1, 2, 3, 4, or 5 X eligible earnings&lt;br&gt;• Maximum of $650,000&lt;br&gt;• Evidence of insurability required for coverage in excess of 3 x eligible earnings or $525,000, whichever is less&lt;br&gt;• Combined maximum for Basic and Supplemental Life is $900,000</td>
<td>Employee</td>
</tr>
<tr>
<td>Spouse Life Insurance</td>
<td>$25,000</td>
<td>Spouse/Domestic Partner</td>
</tr>
<tr>
<td>Child Life Insurance</td>
<td>$5,000</td>
<td>Child(ren)</td>
</tr>
<tr>
<td>Basic Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</td>
<td>• 1 X eligible earnings&lt;br&gt;• Minimum of $25,000&lt;br&gt;• Maximum of $250,000&lt;br&gt;Refer to your full AD&amp;D schedule in your certificate booklet</td>
<td>Employee</td>
</tr>
</tbody>
</table>

ADDED VALUE BENEFITS
Hartford offers three unique programs at no additional cost to you, as part of their Life Insurance Coverage.

ESTATE GUIDANCE
This service helps you create a simple legal will quickly and conveniently online, with the support of licensed attorneys if needed.

BENEFICIARY ASSIST PROGRAM
This program is provided to your beneficiaries to help cope with the emotional, financial, and legal issues that can arise after a loss.

EMPLOYEE TRAVEL ASSISTANCE PROGRAM
This program provides three kinds of services for your business or vacation travels:
• **Pre-Trip information** - provides helpful informational services before you leave to help ensure your trip is as smooth as possible.
• **Emergency Medical Assistance** – provides medical referrals, medical monitoring and medical evacuation.
• **Emergency Personal Services** – will relay emergency messages to your family, make or change airline, hotel or car reservations due to emergency, advances funds and much more.
**DISABILITY BENEFITS**

**SHORT-TERM DISABILITY**
Short-Term Disability (STD) insurance coverage provides you with weekly income protection of 60% of your eligible earnings, up to a maximum weekly benefit of $1,000, if you become disabled and are unable to work. Benefits begin on the 8th day for a disability due to an accident and on the 15th day for a disability due to sickness. The benefit duration is 90 days. You can purchase this coverage to be insured the first of the month following your date of hire.

**LONG-TERM DISABILITY**
Long-Term Disability (LTD) insurance coverage provides you with a percentage of monthly income protection if you become totally disabled and are unable to work. In some circumstances, you may also be eligible for LTD benefits if you are disabled and only able to work part-time as a result of your disability. You are automatically insured for LTD on the first of the month following your date of hire.

**BASIC BENEFIT AMOUNT**
HCC provides you with a basic benefit amount at no cost to you. Your basic benefit amount is equal to 50% of your base annual earnings up to a maximum monthly benefit of $6,000. These benefits are income taxable and may be reduced by the amount of other income you receive, such as Social Security Disability Income.

**ELIMINATION PERIOD**
Benefits begin when you have been disabled for 90 days, provided you are disabled as determined by The Hartford and the terms of the plan.

**DURATION OF BENEFITS**
Benefits are paid while you are disabled according to the below schedule. Unless you are hospitalized, benefits for mental illness, substance abuse, and alcoholism are limited to 24 months for disability periods during your lifetime.

<table>
<thead>
<tr>
<th>Age Disabled</th>
<th>Months Benefits are Payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to 63</td>
<td>To normal retirement age or 48</td>
</tr>
<tr>
<td>63</td>
<td>To normal retirement age or 42</td>
</tr>
<tr>
<td>64</td>
<td>36</td>
</tr>
<tr>
<td>65</td>
<td>30</td>
</tr>
<tr>
<td>66</td>
<td>27</td>
</tr>
<tr>
<td>67</td>
<td>24</td>
</tr>
<tr>
<td>68</td>
<td>21</td>
</tr>
<tr>
<td>69 and over</td>
<td>18</td>
</tr>
</tbody>
</table>

**SUPPLEMENTAL LONG-TERM DISABILITY BENEFITS**
In addition to HCC providing you with a basic 50% income replacement benefit and a $6,000 monthly maximum benefit, you have the option to purchase extra coverage to increase the benefit to 60% with a monthly maximum benefit of $8,000. Your employee contributions for Supplemental LTD coverage are paid on an after-tax basis, so if you receive LTD benefits, that portion of your supplemental benefit would not be taxable income.

**HOW MUCH LTD COVERAGE DO YOU NEED?**
- How much replacement income would your family need if you were disabled and not able to work?
- Do you have other sources of income?
- Consider that Basic LTD benefits are income taxable for you and Supplemental Disability benefits are not.
FLEXIBLE SPENDING ACCOUNTS

HCC FLEXIBLE SPENDING ACCOUNT (FSA)
Flexible spending accounts (FSAs) are designed to help you save taxes on eligible health care expenses through one account and/or eligible dependent care expenses through another. HCC offers you the opportunity to participate in one or both of the accounts – the FSA Health Care Account and the FSA Dependant Care Account. HCC’s FSA administrator is Custom Benefits Services.

FSA – HEALTH CARE
The FSA-Health Care allows you to set aside money each year on a pre-tax basis to reimburse you and your dependents for medical, dental, and vision care expenses not covered by your benefit plans. This means that you will not pay Federal taxes or FICA on the fund you contribute to your FSA – Health Care. You may only use the FSA – Health Care to reimburse yourself for eligible health care expenses. It cannot be used for day care expenses.

SOME ELIGIBLE HEALTH CARE EXPENSES
Eligible health care expenses (which are not covered by insurance) include:
• Acupuncture
• Alcohol & drug rehabilitation (inpatient)
• Ambulance service
• Blood pressure monitoring devices
• Birth control pills, condoms, spermicide
• Chiropractic care
• Coinsurance and deductible
• Contact lenses (corrective)*
• Crutches
• Dental treatment, dentures
• Diagnostic tests
• Doctors’ fees
• Drug addiction/ alcoholism treatment
• Drugs*
• Experimental medical treatment
• Eye exams, glasses
• Fertility enhancement
• Flu shots
• Guide dogs
• Hearing aids & exams
• Injections and vaccinations
• In vitro fertilization
• Lasik surgery**
• Lamaze classes related to childbirth
• Medical alert bracelet, necklace
• Nursing services
• Optometrist fees
• Orthodontic treatment*
• Oxygen
• Reconstructive surgery after mastectomy**
• Smoking cessation programs/treatments
• Surgery**
• Transportation for local medical care
• Weight loss programs (if medically necessary)
• Wheelchairs
• X-rays

IRS Publication 502, Medical and Dental Expenses, contains a list of eligible expenses. Go to www.IRS.gov for complete copy of the list.
* To be eligible for reimbursement, some treatments, prescription drugs or services deemed cosmetic in nature require written proof of medical necessity from your health care provider.
** Unused funds designated for Health Care FSAs cannot be refunded to you. Please verify with your health care provider (prior to the commencement of the upcoming plan year) that you are a suitable candidate for any surgical procedure before committing the money to your FSA.
FLEXIBLE SPENDING ACCOUNT

WHEN CAN I USE IT?
Once you sign up for a Health Care Expense FSA and decide how much to contribute, that total amount is available to you at anytime during your period of coverage. It’s like a cash advance because you don’t have to wait for the cash to accumulate in your account before you can use it to pay for your uninsured, eligible health care expenses. Your money is tax-free and interest free!

SOME INELIGIBLE HEALTH CARE EXPENSES
- Vision warranties, service contracts
- Health / fitness club membership fees
- Cosmetic surgery not deemed medically necessary
- Teeth whitening
- Non-prescription herbs, vitamins

HOW TO REQUEST REIMBURSEMENT:
You have two options on how you can receive your medical reimbursement.

1. You may sign up for the Visa Flex Benefit Card which is the easiest way to access your Flexible Spending Benefit Account. When you swipe your flex benefit card, to pay for qualified plan expenses, the money is taken directly from your flexible spending account(s). No need to pay for qualified plan expenses with a personal check, cash or credit card and then submit a claim to get reimbursed from your plan account. It’s that simple!
   - Swipe your flex care when you’re ready to pay for your purchases. Note: Your card has no PIN #, so select CREDIT instead of DEBIT.
   - Remember to save all itemized receipts for your tax records, or for the purchase verification – you may be occasionally asked to provide receipts for certain purchases.

2. You may also obtain reimbursement from your FSA by completing a claim form and attach all itemized receipts from the service provider. Receipts must include:
   - Name of employee or dependent
   - Dates of service
   - Name of service provider
   - Charges incurred
   - Explanation of Benefits (EOB) or itemized statement

After you incur your medical expenses, you simply file a claim form along with your documentation for reimbursement of your eligible expenses. You can access claims online at www.ezflexplan.com/cbs.
FLEXIBLE SPENDING ACCOUNT

FSA – DEPENDENT CARE
The FSA-Dependent Care allows you to use pre-tax dollars to pay for dependent day care expenses so that you can work and your spouse (if married) can work or attend school full-time. You may contribute up to $5,000. You may only use an FSA – Dependent Care to reimburse yourself for dependent day care expenses for eligible dependents; it cannot be used for health care expenses.

Remember, the FSA – Dependent Care cannot be used to covered expenses for your domestic partner or your domestic partner’s children.

Eligible dependents must live in your home at least eight hours every day and may include: Children under age 13 who meet the IRS definition of a qualifying individual. A spouse or legal dependent of any age that is physically or mentally incapable of self-care. Example of eligible dependent day care expenses include fees charged by a:
- Child or adult care center that complies with the State and Local regulations (not including nursing homes)
- Sitter inside or outside the home
- Day care during school vacation, provided it is not primarily for education purposes
- Nursery school, even if the school provides educational services
- Relative who care for eligible dependents, as long as that relative is not your dependent and is age 19 or older (if related to your child)

IRS Publication 503, Child and Dependent Care Expenses, contains a list of eligible expenses. Go to www.irs.gov for complete copy of list.

<table>
<thead>
<tr>
<th></th>
<th>FSA Health Care</th>
<th></th>
<th>FSA – Dependent Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With Account</td>
<td>Without Account</td>
<td>With Account</td>
<td>Without Account</td>
</tr>
<tr>
<td>Annual Salary</td>
<td>$50,000</td>
<td>$50,000</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Pre-tax FSA Contribution</td>
<td>-$1,000</td>
<td>$0</td>
<td>-$5,000</td>
<td>$0</td>
</tr>
<tr>
<td>Taxable Income</td>
<td>$49,000</td>
<td>$50,000</td>
<td>$45,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Estimated Taxes (30%)</td>
<td>$14,700</td>
<td>$15,000</td>
<td>$13,500</td>
<td>$15,000</td>
</tr>
<tr>
<td>After-tax Expenses</td>
<td>$0</td>
<td>-$1,000</td>
<td>$0</td>
<td>-$5,000</td>
</tr>
<tr>
<td>Net Income</td>
<td>$35,300</td>
<td>$35,000</td>
<td>$36,500</td>
<td>$35,000</td>
</tr>
<tr>
<td>Annual Tax Savings</td>
<td>$300</td>
<td>$0</td>
<td>$1,500</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Assumes a combined total 30% tax rate for Federal and FICA taxes.
HOW TO REQUEST REIMBURSEMENT

To obtain reimbursement from your Dependent Care Account, you must complete and submit a claim form and attach itemized receipts that include:

- The dependent’s name
- The period during which the services were rendered
- The name, address and taxpayer ID or social security number of the individual or organization providing services
- A description of the service provided
- Alternatively, if the above information is documented on the reimbursement form, you may have the provider sign the reimbursement form in lieu of a receipt.

Canceled checks, bankcard receipts, credit card receipts and credit card statements are not acceptable forms of documentation. You are responsible for paying your expenses directly.

If the care is provided outside your home, your dependents must spend at least eight hours each day in your home. You will have to report the Social Security number of the caregiver on your federal income tax return. If you use a child- or adult-care center, you will have to report the center’s taxpayer identification number. The amount of your Dependent Care FSA contribution will automatically be reported on your W-2 form.

BEFORE YOU ENROLL

Be certain you can obtain the information needed to request reimbursement before you enroll in a Dependent Care FSA. A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check promptly.

USE IT OR LOSE IT

The IRS’s “use or lose” rule states that you will lose any money left in your account at the end of the plan year. There is, however, a short time period (called a “run-out” period) after the plan year ends. During the runout period, you can still submit claims for expenses incurred during the plan year. HCC also allows a short overlap period.

IF YOU TERMINATE EMPLOYMENT

If you terminate employment during the plan year, you may have a period of time after termination (a run-out period) to submit claims for reimbursement. Services rendered for health care expenses must be incurred prior to the termination date unless you continue contributing to your medical FSA account through COBRA. You will have until the completion of the plan year run-out period to submit your dependent care expenses incurred during the entire plan year as long as you were working or seeking work during that time.
Hillsborough Community College recognizes that employees are unique individuals with a variety of need and person concerns. Life is a series of happy, complicated, and challenging events – job responsibility mixed with personal obligations, such as finding a good daycare center or dealing with a financial concern. To help manage all of your commitments and reduce stress that may come with them, HCC has partnered with Corporate Care Works to offer an Employee Assistance Program to you and your family. This innovative program provides resources and expertise you need to deal with everything from the demands of everyday life to major life events, so you can enjoy balanced living.

**HOW IT WORKS**

When you contact Corporate Care Works, a licensed counselor will assess your needs and advise you of available alternatives. You will be provided with information and support as well as directed to additional resources as necessary. EAP follow-up is offered on an ongoing basis in the event that further assistance is needed.

Corporate Care Works maintains an extensive network of referral sources. Some of the services available through the Employee Assistance Program include helping you to:

- Locate an available childcare facility near your home
- Find housing or care-giving options for an aging parent
- Answer a legal question or obtain financial advice
- Locate short-term counseling to manage stress and anxiety
- Get help for a substance abuse problem
- Health & Wellness Assessment tools
- Discounts to over hundreds of retailers

Any eligible individual may contact the program directly. In addition, a supervisor or manager may refer an employee when there are concerns about the employee’s work performance.

**COST**

Six (6) free sessions of EAP assessment, referral, and follow-up services are provided to you and your family.

**CONFIDENTIALITY**

Your right to privacy is one of the most crucial aspects of this program. Confidentiality is maintained to the full extent permitted by law. Participation in the EAP will not jeopardize job security or opportunity for promotion. In fact, since the EAP helps you resolve personal problems that may be affecting your work performance, job security and career development may be enhanced. To find out more, Simply call 800-327-9757 or visit [www.corporatetecareworks.com](http://www.corporatetecareworks.com) for more information.
ADDITIONAL BENEFITS

LEGAL AND IDENTITY THEFT BENEFITS
Pre-Paid Legal Plan provides a wide range of legal advice and fully covered legal services as well as identify theft shield for you and your eligible dependents. This voluntary, low cost, and convenient plan can help protect you financially.

COSTS
Your premiums are paid through payroll deduction for the entire coverage period. You may not drop coverage during the year. There are no deductible, copays, waiting period, or limits when you use the plan.

For more information on Pre-Paid Legal Services or Identity Theft Services, go to www.prepaidlegal.com or contact Don Thompson at 239-699-2983 or Don Thompson@prepaidlegal.com.

SERVICES COVERED

PRE-PAID LEGAL
• Preventive Legal Services
• Motor Vehicle Legal Expenses Services
• Trial Defense Services
• IRS Audit Legal Services
• Discount on other Legal Services (up to 25% on standard hourly rate)

IDENTITY THEFT SHIELD
• Credit Report
• Continuous Credit Monitoring
• Identify Restoration
• Restoration Reimbursement

LEGAL PLAN

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Plan Only</td>
<td>$14.95</td>
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<tr>
<td>I.D. Theft Only</td>
<td>$12.95</td>
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<tr>
<td>Legal &amp; I.D. Theft Plans</td>
<td>$25.90</td>
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</tbody>
</table>

CANCER INSURANCE
With improved technology, chances of surviving cancer and other critical diseases have improved dramatically. However, this new age of medical technology means higher costs for the life saving treatments. Even the best group health insurance may not cover 100% of the treatment costs.

There are also costs, such as travel expenses, associated with treatments that are rarely, if ever, covered. The cancer plan helps ease the financial burden and lets the member concentrate their energy and efforts into getting well.

Cancer plans have many options from which to choose. The plan should be customized to fit your personal needs. For more information about the Cancer Insurance, call 800-809-8161.

HOSPITAL INDEMNITY PLAN
Cash paid directly to you to offset the rising cost of a hospital stay.

FEATURES:
• Guaranteed Issue - No Health Questions
• No Pre-existing condition (except pregnancy)

BENEFITS INCLUDE:
• Doctors Visits (6 visits per year at $50 each)
• Daily Hospital Benefit ($200 per day-max 30 days)
• Hospital Admission Benefit ($250 per admission)
• Hospital Intensive Care ($250 per day-max 30 days)
• Wellness Benefit ($50 per calendar year)
• Medical Fees ($300/Accident) Limited Benefit Plan for expenses due to injury or sickness
• Well Baby Care (4 visits per year at $50 each)

HOSPITAL INDEMNITY PLAN

<table>
<thead>
<tr>
<th>Plan</th>
<th>Monthly Premium</th>
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</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$16.05</td>
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<tr>
<td>Employee &amp; Spouse</td>
<td>$31.30</td>
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<tr>
<td>Employee &amp; Child(ren)</td>
<td>$28.09</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>$43.34</td>
</tr>
</tbody>
</table>
LONG-TERM CARE
Can you afford to pay for extended long-term care? Would you like the freedom to choose the type of care you receive? Do you have the financial resources to protect your spouse’s lifestyle?

The John Hancock Long-Term Care plan provides benefits for home health care, assisted living and nursing home care. Benefits are available for employees, spouses, parents and in-laws. The decisions we make today are the decisions we have to live with tomorrow.

If you are interested in learning more about Long-Term Care Insurance, contact the Employee Benefits Office or John Hancock at 813-287-8800.

PET INSURANCE
Chances are an accident or serious illness will strike your pet at some point in its lifetime. The odds don’t improve for pets that stay indoors. The reality is that pets are as apt to need the same professional medical services as any other family member. From ear and bladder infections to broken bones, cancer and heart disease, today’s veterinarian can diagnose and treat many of the same ailments that affect you and your family. And, though veterinary services often cost less than comparable procedures from a physician, quality pet care can add up to hundreds… even thousands of dollars.

Veterinary Pet Insurance (VPI) is the number one pet insurance plan licensed and regulated in the US and is recommended by veterinarians and their staff. Exclusively endorsed by the American Humane Association, Veterinary Pet Insurance provides these comprehensive features:

• Use any veterinarian worldwide with no pre-authorization required;
• The policy pays for prescriptions, lab fees, x-rays, surgery, hospitalization, treatment and even office calls for any covered medical problem;
• Average claims turnaround is approximately one week;
• No physical exam is required;
• Pet ID tag with Lost & Found Registry to reunite you with your pet; and
• Protection costs 25¢ to 62¢ per day for any pet aged eight years or younger.

For more information about the Veterinary Pet Insurance plan, visit www.petinsurance.com/eb or call 800-872-7387.
The following chart provides an overview of the basic benefits and optional coverage offered to you and your eligible dependents.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Your Options</th>
<th>Coverage Levels</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>OAP-IN, OAP, Choice Fund HSA</td>
<td>Employee, Employee + Spouse or Domestic Partner, Employee + Children Family</td>
<td>HCC pays 100% of employee only OAP-IN, OAP and Choice Fund HSA premiums</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>DHMO and PPO</td>
<td>Employee, Employee + Spouse or Domestic Partner, Employee + Children Family</td>
<td>HCC pays 100% of employee only DMO and PPO premiums</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>PPO Vision</td>
<td>Employee, Employee + Spouse or Domestic Partner, Employee + Children Family</td>
<td>Employee Paid</td>
</tr>
<tr>
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<tr>
<td>FSA-Health Care</td>
<td>Up to $5,000 per plan year</td>
<td>Employee and eligible dependents</td>
<td>Employee Paid</td>
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<tr>
<td></td>
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<tr>
<td>FSA-Dependent Care</td>
<td>Up to $5,000 per plan year</td>
<td>Employee and eligible dependents</td>
<td>Employee Paid</td>
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<tr>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>1 x eligible earnings up to a maximum of $250,000</td>
<td>Employee</td>
<td>HCC pays 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental Life Insurance</td>
<td>1, 2, 3, 4, or 5 times eligible earnings up to a maximum of $650,000</td>
<td>Employee</td>
<td>Employee Paid</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Spouse Life Insurance</td>
<td>$25,000</td>
<td>Spouse</td>
<td>Employee Paid</td>
</tr>
<tr>
<td>Child Life Insurance</td>
<td>$5,000</td>
<td>Child</td>
<td>Employee Paid</td>
</tr>
<tr>
<td>Basic Accidental Death &amp; Dismemberment (AD&amp;D)</td>
<td>1 x eligible earnings up to a maximum of $250,000</td>
<td>Employee</td>
<td>HCC pays 100%</td>
</tr>
<tr>
<td>Short-Term Disability</td>
<td>60% of eligible earnings up to $1,000 maximum weekly benefit</td>
<td>Employee</td>
<td>Employee Paid</td>
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<tr>
<td>Basic Long-Term Disability (LTD)</td>
<td>50% of eligible earnings up to $6,000 per month</td>
<td>Employee</td>
<td>HCC pays 100%</td>
</tr>
<tr>
<td>Supplemental LTD</td>
<td>Additional 10% of eligible earnings for a total of 60% up to $8,000 per month</td>
<td>Employee</td>
<td>Employee Paid</td>
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<tr>
<td>Legal Benefits</td>
<td>Legal advice and representation</td>
<td>Employee and eligible dependents</td>
<td>Employee Paid</td>
</tr>
<tr>
<td>Pet Insurance</td>
<td>Veterinarian Services</td>
<td>Pets</td>
<td>Employee Paid</td>
</tr>
<tr>
<td>Cancer Insurance</td>
<td>Cancer-only policy</td>
<td>Employee and spouse</td>
<td>Employee Paid</td>
</tr>
<tr>
<td>Hospital Indemnity</td>
<td>Hospital only policy</td>
<td>Employee and Eligible dependents</td>
<td>Employee Paid</td>
</tr>
</tbody>
</table>
ADDITIONAL BENEFITS

TUITION ASSISTANCE
TUITION REIMBURSEMENT

After six (6) months of employment in a full-time regular (non-temporary or non-grant) position, an employee has the following tuition assistance benefits. **Tuition Reimbursement** is for an employee seeking an undergraduate or graduate degree. Both **Undergraduate** and **Graduate** courses will be reimbursed at the rate of six (6) semester hours each academic term.

Annual funding is limited and early application is recommended. Funding of this program is subject to FUSA and SEIU contract negotiations.

Applications will be accepted on a first come, first serve basis following the below schedule:

- **June 1 through July 1** – for classes commencing August through December (fall semester)
- **November 1 through December 1** – for classes commencing January through May (spring semester)

The employee must maintain a:

- **2.0 (“C”) grade point average or better on a 4.0 grade scale for each undergraduate course, or a**
- **3.0 (“B”) grade point average or better on a 4.0 grade scale for each graduate course.**

TUITION FEE WAIVER

After six months of employment in a full-time regular (non-temporary or non-grant) status assigned to a full-time regular position may participate in HCC’s tuition fee waiver program. The employee and their immediate family members may enroll in HCC regular classes at no charge or fee. Tuition Waiver Fee forms are available at the bursar’s office on each campus.

RETIREMENT PROGRAMS
FLORIDA RETIREMENT SYSTEM — EMPLOYER CONTRIBUTION

HCC makes a monthly contribution for Florida Retirement System (FRS) eligible employees. It is a percentage of the employee’s salary. The percentage of contribution is determined by the Florida legislation every July. Employees have two FRS plans from which to choose:

1. A defined benefit plan, called the **Pension** plan provides a retiree with a guaranteed monthly retirement benefit for the rest of their life. There is a six (6) year vesting period required.
2. A defined contribution plan, called the **Investment** plan allows the employee to invest their retirement account the way they see fit. The retirement benefit is not guaranteed and will provide a monthly benefit as determined by the retiree. There is a one (1) year vesting period required.

OPTING OUT OF THE FLORIDA RETIREMENT SYSTEM

Administrators and full-time faculty have a third option of opting out of FRS and electing contribution be sent to a Board approved 401(a) financial institute. This define contribution plan alternative is called CCorp.

Employee-contributed Retirement Plan 403(b) & 457

FRS + Social Security + Your Retirement Plan = A Financial Secure Retirement

Your FRS retirement and Social Security may not provide you with enough money to live in the manner in which you do now. You should save for your own retirement too! Voluntary, pre-tax, tax-deferred retirement accounts are available through IRS approved 403(b) and 457 plans. Contact the Benefits Office for more information regarding enrollment into these plans.
The following is a brief description of the various types of leaves of absence available to eligible employees. Please refer to the appropriate Administrative Procedure for complete information.

**VACATION LEAVE**

Full-time administrative and career employees receive one (1) day of vacation leave per month to the fifth (5th) year of service. Employees earn one and one-quarter (1.25) days per month from the sixth (6th) to the tenth (10th) year of service. Beginning the eleventh (11th) year of service, one and one-half (1.50) days are earned each month. The maximum accrual is 44 days. Maximum reimbursement for unused vacation leave at separation is 30 days.

**SICK LEAVE**

Full-time employees earn one (1) day per month for sick leave. Upon employment, all employees are advanced the first nine (9) days of sick leave. An employee may elect to transfer sick leave from another Florida educational institution on a day-for-day earned basis. Reimbursement for unused sick leave will not be issued at the time of termination based on College policy. Sick Leave hours are used for bereavement leave.

**PERSONAL LEAVE**

Full-time employees are entitled to four (4) days per fiscal year (July 1 - June 30) for personal leave. This leave is deducted from accrued sick leave and is not cumulative.

**SICK LEAVE POOL**

A sick leave pool is available to provide participating members with secondary source of sick leave days. Members may make application to draw from the pool after exhausting their earned paid time off. After one (1) year of employment and attainment of twelve (12) days of accumulated sick leave, full-time employees may join the sick leave pool. Approved membership requires contribution of two (2) days of sick leave to the pool for staff and four (4) days for faculty.

**SICK LEAVE DONATION**

Active employees may donate accrued sick leave to other HCC employees who are on a medical leave of absence and have exhausted all sick, annual, compensatory, and sick-leave-pool time. The medical leave of absence must be due to the employee’s personal serious medical condition (except for natural childbirth) and not due to the medical condition of a family member.

**ON-THE-JOB-INJURY**

The employee is required to notify his/her supervisor, the Safety and Security Department for accident incident reports, and the Workers’ Compensation office in Human Resources for medical referrals. Eligible full-time employees will be paid his/her regular salary for the first seven (7) calendar days of such leave. If the employee is subsequently paid for the first seven (7) calendar days by Workers’ Compensation, the employee will endorse those payments to the College.

**SABBATICAL LEAVE**

After six (6) academic years of continuous employment, full-time faculty members, administrators and managerial professionals may request a maximum of one (1) year of sabbatical leave at three-quarters (.75) of the employee’s normal salary.
EMPLOYEE LEAVE

PROFESSIONAL LEAVE
Full-time employees may request a maximum of one (1) year leave without pay for professional development that will benefit both the individual and the College. Call the Employee Benefits Office for continuation of benefits information.

DUTY LEAVE
The College President may grant a full-time faculty member a temporary absence from regular duty for other educational services.

MILITARY LEAVE
Full-time employees who are military reserve members may receive their normal salary for the first 17 days of military leave. A copy of the military orders is required.

JURY/COURT LEAVE
Employees who are summoned to jury duty or subpoenaed as a witness may be entitled to administrative leave. A copy of the summons/subpoena is required.

PERSONAL LEAVE WITHOUT PAY
Full-time employees may request a maximum of one (1) year for personal illness, disability, educational pursuits, parental responsibilities, or personal obligations. The Campus President, the College President and the Board of Trustees must approve all such leaves.

FAMILY AND MEDICAL LEAVE
Eligible employees may take up to 12 weeks of unpaid leave during a 12-month rolling year for one or more of the following reasons:

- The birth and care of the newborn child of the employee
- The placement with the employee of a son or daughter for adoption or foster care
- To care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- To take medical leave when the employee is unable to work because of a serious health condition.
- Up to 12 weeks of leave for certain qualifying exigencies arising out of a covered military member's active duty status, or notification of an impending call or order to active duty status, in support of a contingency operation, and
- Up to 26 weeks of leave in a single 12-month period to care for a covered service member recovering from a serious injury or illness incurred in the line of duty on active duty. Eligible employees are entitled to a combined total of up to 26 weeks of all types of FMLA leave during the single 12-month period. Contact the Benefits Office for more detailed information.

HOLIDAYS
HCC offers numerous holidays each year. To qualify for holiday pay, the employee must be in an active work status or on an approved leave of absence with pay the day before and the day after the holiday.

- New Year’s Day
- Dr. Martin Luther King Jr. Day
- President’s Day (Brandon, Dale Mabry, Ybor, District and SouthShore only)
- Strawberry Festival (Plant City only)
- Spring Day
- Spring Break
- Memorial Day
- Independence Day
- Labor Day
- Veteran’s Day
- Thanksgiving
- Day after Thanksgiving
- Winter Break
- Christmas
Newborn & Mothers’ Laws & Notices
Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse, midwife or physician’s assistant) after consultation with the mother, discharge the mother or newborn earlier. Plans and issuers may not select the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorably to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers of facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

Women’s Health & Cancer Rights Act
On October 21, 1988, the Women’s Health and Cancer Rights Act became effective. This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies.

As the Act requires, we have included this notification to inform you about the law’s provisions. The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

Children’s Health Insurance Program Reauthorization Act
The Children’s Health Insurance Program Reauthorization Act was recently signed into law. If your child loses Medicaid coverage, you have 60 days from the date of loss of coverage to enroll your child on the HCC Health Plan.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)
HIPAA requires that you be informed of your Special Enrollment rights when you and/or your eligible dependents decline health care coverage during the initial enrollment period.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in a HCC medical plan provided that you request coverage within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or a court order, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption or the court order.

If you are declining health coverage for yourself or your dependents (including your spouse) and you are not currently covered under a medical plan, you will be considered a late applicant.

HIPAA allows a late applicant to enter a medical plan only during an open enrollment period.
YOUR BENEFITS TEAM!

(From left to right)

Zach Dawson - Benefits Technician
Ronkel Williams - Benefits Officer
Lekiva Judge - Benefits Technician
<table>
<thead>
<tr>
<th>BENEFIT PROVIDER</th>
<th>BENEFIT PLAN</th>
<th>PHONE NUMBER</th>
<th>WEBSITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIGNA</td>
<td>OAP-IN</td>
<td>800-244-6224</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>CIGNA</td>
<td>OAP</td>
<td>800-244-6224</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
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<td>CIGNA</td>
<td>Choice Fund HSA</td>
<td>800-244-6224</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
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<tr>
<td>CIGNA</td>
<td>Lifestyle Management</td>
<td>866-417-7848</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
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<tr>
<td>Humana</td>
<td>DHMO</td>
<td>800-979-4760</td>
<td><a href="http://www.humanadental.com">www.humanadental.com</a></td>
</tr>
<tr>
<td>Humana</td>
<td>PPO</td>
<td>800-979-4760</td>
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<tr>
<td>Humana</td>
<td>Vision</td>
<td>866-537-0229</td>
<td><a href="http://www.humanavisioncare.com">www.humanavisioncare.com</a></td>
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<tr>
<td>The Hartford</td>
<td>Life &amp; AD&amp;D</td>
<td>888-563-1124</td>
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<tr>
<td>The Hartford</td>
<td>Short-Term Disability</td>
<td>800-445-9057</td>
<td><a href="http://www.thehartfordatwork.com">www.thehartfordatwork.com</a></td>
</tr>
<tr>
<td>The Hartford</td>
<td>Long-Term Disability</td>
<td>800-445-9057</td>
<td></td>
</tr>
<tr>
<td>Corporate Care Works</td>
<td>Employee Assistance Program</td>
<td>800-327-9757</td>
<td><a href="http://www.corporatecareworks.com">www.corporatecareworks.com</a></td>
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<tr>
<td>Custom Benefits Services</td>
<td>FSA</td>
<td>800-809-8161</td>
<td><a href="http://www.ezflexplan.com/cbs">www.ezflexplan.com/cbs</a></td>
</tr>
<tr>
<td>John Hancock</td>
<td>Long-Term Care</td>
<td>800-521-3535</td>
<td></td>
</tr>
<tr>
<td>American Heritage</td>
<td>Cancer</td>
<td>800-809-8161</td>
<td></td>
</tr>
<tr>
<td>Pre Paid Legal Services</td>
<td>Legal/Theft</td>
<td>800-654-7757</td>
<td><a href="http://www.prepaidlegal.com">www.prepaidlegal.com</a></td>
</tr>
<tr>
<td>Florida Retirement System</td>
<td>Pension/Investment Benefits</td>
<td>888-738-2252</td>
<td><a href="http://www.myfrs.com">www.myfrs.com</a></td>
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<tr>
<td>TSA Consulting Group</td>
<td>403(b) Transactions</td>
<td>888-796-3786</td>
<td><a href="http://www.tsacg.com">www.tsacg.com</a></td>
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<tr>
<td>AIG Retirement</td>
<td>403(b)/457(b)</td>
<td>813-269-3362</td>
<td><a href="http://www.aigretirement.com">www.aigretirement.com</a></td>
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<td>AXA Equitable</td>
<td>403(b)/457(b)</td>
<td>800-628-6673</td>
<td><a href="http://www.axa-equitable.com">www.axa-equitable.com</a></td>
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<tr>
<td>Lincoln Investment</td>
<td>403(b)</td>
<td>800-242-1421</td>
<td><a href="http://www.lincolninvestment.com">www.lincolninvestment.com</a></td>
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<tr>
<td>MetLife</td>
<td>403(b)</td>
<td>800-492-3553</td>
<td><a href="http://www.metlife.com">www.metlife.com</a></td>
</tr>
<tr>
<td>Suncoast Schools FCU</td>
<td>403(b)/457(b)</td>
<td>800-999-5887</td>
<td><a href="http://www.suncoastfcu.org">www.suncoastfcu.org</a></td>
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<tr>
<td>TIAA-CREF</td>
<td>403(b)/457(b)</td>
<td>800-842-2888</td>
<td><a href="http://www.tiaa-cref.org">www.tiaa-cref.org</a></td>
</tr>
</tbody>
</table>

**HCC BENEFITS CONTACTS**

- Zach Dawson  
  Benefits Technician  
  Phone: 813-259-6004  
  Email: zdawson@hccfl.edu

- Lekiva Judge  
  Benefits Technician  
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  Email: ljudge@hccfl.edu

- Ronkel Williams  
  Benefits Officer  
  Phone: 813-253-7573  
  Email: rwilliams92@hccfl.edu

www.hccfl.edu