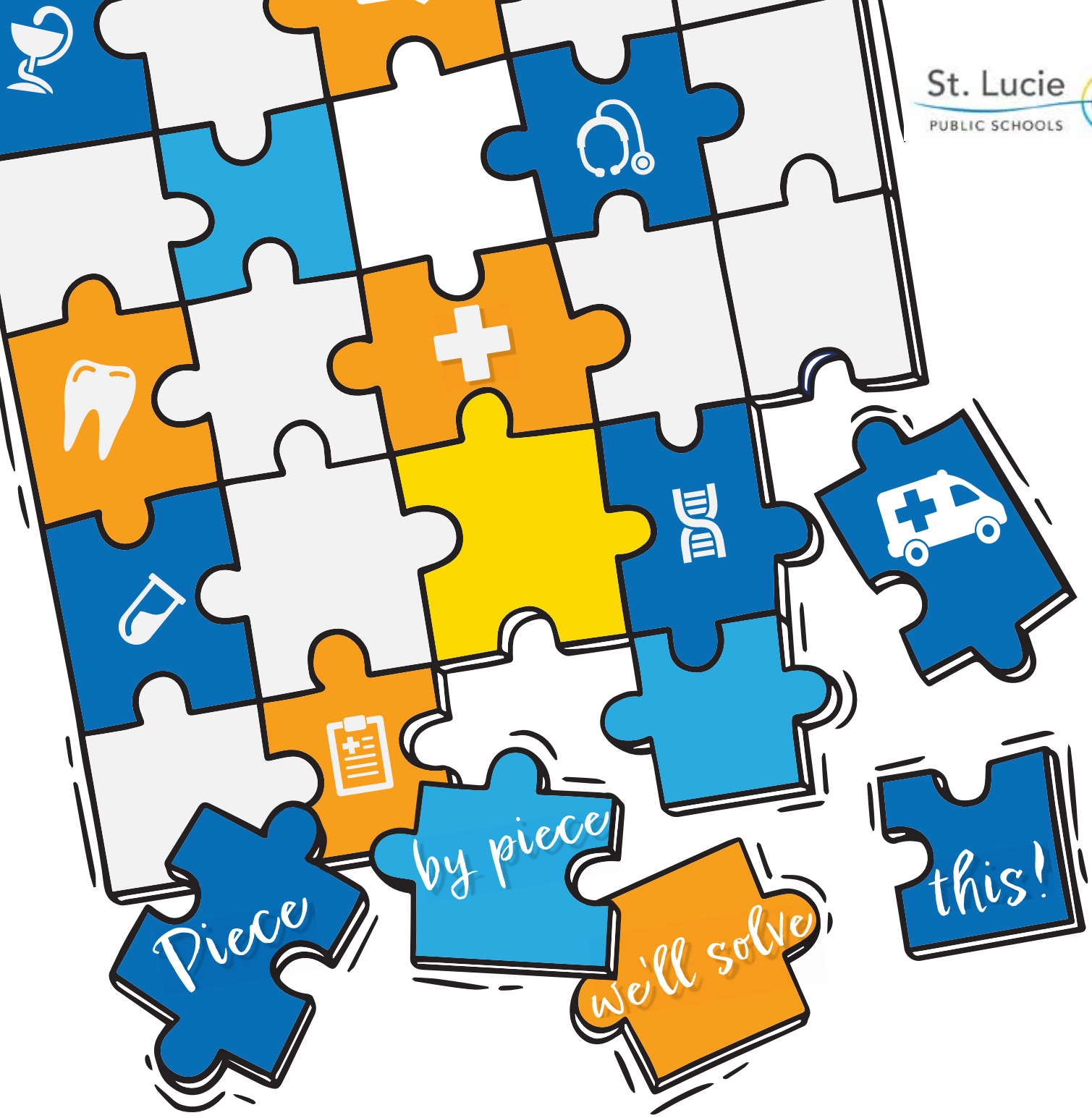


St. Lucie Public Schools

2026 Active Employee Benefit Guide

Table of Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 25 for more details.

What's Happening at SLPS?

St. Lucie PUBLIC SCHOOLS

STAY CONNECTED

For news and happenings across all campuses, visit **stlucie.k12.fl.us** and follow St. Lucie Public Schools (SLPS) on social media.

Connect With Us

Important Dates

- Changes Only Open Enrollment dates: **Oct. 13, 2025 - Oct. 31, 2025**
- Your plan year dates are: **Jan. 1, 2026 - Dec. 31, 2026**
- Trustmark Voluntary Benefits period of coverage: **Feb. 1, 2026 - Jan. 31, 2027**

Key Things to Know

Welcome To Your 2026 SLPS Benefits Open Enrollment!

Open enrollment is your annual opportunity to make changes to your benefit elections. SLPS is committed to providing security for you and your family with its comprehensive benefits program. Your benefits are a valuable part of your employment with SLPS, so be sure you are making the most of them! This year, SLPS supports a new theme of "Happiness is the best benefit." We encourage you not to wait when it comes to your safety, health, and wellness.

Important Notes for 2026

New BlueOptions Medical Plan

- There are five different BlueOptions medical plans, including a new high-deductible BlueOptions 5907 medical plan with lower rates. Be sure to check the plan summary before enrollment. Employees who choose to enroll in the BlueOptions 5172/5173, BlueOptions 05180/05181, or BlueOptions 05192/05193 Plans may add a Health Savings Account (HSA). BlueOptions 5771 and BlueOptions 5907 are non-HSA eligible plans.

New Vision Provider

- EyeMed, your new vision provider, offers lower premiums.

Basic and Voluntary Term Life

Lincoln Financial Group

- You may now enroll in the Voluntary and Basic Life independently of each other.
- The requirement that employees must first enroll in the Basic Life in order to be eligible to enroll in the Voluntary Life has been eliminated. This allows for greater flexibility when selecting the amount coverage that best suits your specific needs.
- In addition, during this year's enrollment all eligible employees are able to enroll in the Life insurance up to the plan maximum amount of $250,000 without having to submit to medical questions.

Short-Term and Long-Term Disability

Lincoln Financial Group

- The Short and Long Term Disability plans are now offered Guarantee Issue without the requirement of medical underwriting.

Dual Spouse

- SLPS offers “dual employee family” health plan coverage. If both you and your spouse are employed by SLPS and have benefit-eligible dependent children, you are defined as a “dual employee family.” One employee is considered “primary” insured and the other spouse becomes a dependent of the primary spouse along with the child(ren). Premiums for “dual employee family” coverage are shared between both employees – with each receiving the employer health plan contribution and each having an equal payroll deduction for the employee-paid portion of the premium.

SLPS $600 HSA Contribution

- For the 2026 plan year, SLPS will make a one-time contribution of $600 to an HSA, and it will be paid in two equal installments. The first installment will be no later than January 5. The second installment paid no later than August 30, 2026

Changes-Only Enrollment

- If you do not make changes during the open enrollment period, your current elected benefits will continue for the 2026 Plan Year.

Note: The HSA employer contribution for each employee in the “dual employee family” will be combined and distributed into the primary spouse’s account only. Health Equity does not have the ability for the secondary employee to be recognized as a member. The secondary employee can only be listed as a dependent. The enrollment process for “dual employee family” is different from the standard procedure. You must enroll in the health plan together with a Benefits Counselor. Please contact the Risk Management Office at **772-429-5521** for more information.

Key Things to Know

What Benefits are Available?

SLPS recognizes that your needs change from year to year. We are providing one-on-one benefits sessions with a Benefits Counselor. Your Benefits Counselor will provide you with guidance on the following valuable benefits:

- **Health** - provides comprehensive medical and pharmacy benefits.
- **Dental** - provides dental benefits with a low or high PPO plan.
- **Vision** - vision plan with in- and out-of-network options.
- **Group Term Life** - provides your beneficiaries with a specified monetary benefit in the event of your death.
- **Disability Income Protection (STD/LTD**) - provides a stable income source to carry you and your family through a temporary or long-term disability.
- **Life Planning Financial and Legal Resources -** with Lincoln group life coverage, you have automatic access to Life Planning, Financial & Legal Resources. This service is provided at no extra cost for employees, spouses and beneficiaries who need help during a terminal illness, or after the loss of a covered employee.
- **World Wide Emergency Travel Assistance -** available to those enrolled in either of the disability plans. Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number! Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Add the number to your cell phone contacts, so it's always close at hand! Just one phone call connects you and your family to medical and other important services 24 hours a day.
- **Medical Bridge Plans** - helps to offset out-of-pocket expenses and deductibles associated with hospital stays. Benefit choices of $1,000 or $2,000 are payable directly to you, so you can use the money as you desire. Individuals covered by Medicare /Medicaid, benefits are automatically paid to Medicare / Medicaid.
- **Healthcare Flexible Spending Accounts** - can help you save tax dollars on qualified, medical expenses and certain over-the-counter drugs and medicines.
- **Dependent Care Flexible Spending Accounts** - can help you save tax dollars for care of your dependents while you are working or actively looking for work.
- **Legal** - provides a wide range of coverage and services to protect your family and better navigate life's legal challenges — with network attorney fees that are 100% paid in full for most covered legal matters.
- **Pet Discount Plans** - offer discounts on medical services provided by in-network veterinarians and wholesale pricing on prescriptions, preventatives and other products.
- **Accident Insurance** - helps pay for unexpected healthcare expenses due to non-occupational covered accidents for initial care, injuries, and follow-up care.
- **Hospital StayPay Plan** - pairs with your medical plan so you can be more confident in your protection. You can get cash benefits for hospital stays due to a covered sickness or accident, normal childbirth or mental wellness/addiction recovery.
- **Critical Illness LifeEvents** - pays benefits for early identification and for later-stage diagnosis of critical illnesses. Earlier benefits help provide funds as quickly as possible to help ensure that treatment or preventive measures may stave off late-stage illness.
- **Universal LifeEvents** - matches your needs throughout your lifetime. Includes accelerated death benefit, built-in long-term care benefit, and optional accidental death benefit, waiver of premium, EZ Value Plan, and children's term benefit.
- **Employee Assistance Program (EAP)** - provides a variety of short-term counseling and informational services. Up to six confidential and free counseling sessions.

Premium Conversion

Premium conversion lets you set aside money from your pretax salary to cover insurance premiums for yourself and your dependents. That way, you don't have to pay taxes on the money you spend on these expenses. The end result? Less taxes paid and more money in your pocket. Your premium conversion applies to:

- Your portion of the School Board-provided major medical premiums;

- AND -

- Medical coverage for your dependents

Appeals Process

If you have an enrollment change request for a mid-plan year election change or a reimbursement claim denied, in full or in part, 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 you may be contacted easily and timely
- Why you believe your variance request should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal
- If your appeal is the result of a denied reimbursement request, you must also include the date of the services for which your request was denied, a copy of the denied request, and the denial letter you received

Send enrollment appeals to:

FBMC Benefits Management, Inc.
Enrollment Appeals
PO Box 1878, Mail Slot 79
Tallahassee, FL 32302-1878
Fax: **1-850-425-6220**

For FSA claims reimbursement:

Inspira Financial
PO Box 3039
Omaha, NE 68103-3039
Fax: **1-855-703-5305**

Eligibility + Coverage

Period of Coverage

Your period of coverage is Jan. 1, 2026, through Dec. 31, 2026 for your "core" benefits. However, during the plan year, your period of coverage will be affected if the following applies:

- If you terminate employment or go on approved unpaid leave, your period of coverage ends on the last day of the month in which you terminate, or your leave of absence without pay begins, unless otherwise provided by law. Refer to the "Who Is Eligible?" section for more information.
- If you are a newly-hired employee, your period of coverage for:
  - The SLPS health plan begins on the first day of the month, following two payroll deductions.
  - The Flexible Benefits Plan begins on the first day of the month, following the submission of an enrollment form.
  - The Trustmark Voluntary benefits begin Feb. 1, 2026 with payroll deductions taken on a post-tax basis.
- Upon certain qualifying events, a covered dependent, spouse and dependents may be eligible to continue their health plan coverage for group health plan continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).
- If you do not enroll within 60 days of hire date or during an annual open enrollment, you must wait until the next plan year or until you experience an event that permits a mid-plan year election change under your employer's plans. Refer to the Changing Your Coverage section for more information on qualifying events.

Who is eligible to participate in the SLPS Group Health and Dental plans?

All full-time employees actively at work on the plan effective date of Jan. 1, 2026 are eligible. For new benefits to be effective, eligible employees must be permanently and actively at work full time (physically capable of performing the functions of your job) on the first day of work concurrent with the plan year effective date. If you are not actively at work, but return to active work status within 10 working days from the plan effective date, your benefits will cover you when you return to work. As required by the Health Insurance Portability and Accountability Act (HIPAA), employees absent due to health reasons are treated as being actively at work for purposes of benefit eligibility.

Who is eligible to participate in the Flexible Benefits Plan?

All full-time employees actively at work on the plan effective date (Jan. 1, 2026) are eligible. For new benefits to be effective, eligible employees must be permanently and actively at work full time (physically capable of performing the functions of your job) on the first day of work concurrent with the plan year effective date. If you are not actively at work, but return to active work status within 10 working days from the plan effective date, your benefits will cover you when you return to work. If you are out on leave and are paying your benefit premiums through the personal pay leave billing, your benefits will remain effective while you are out on leave.

Eligibility + Coverage

Employees on an Approved Workers' Compensation and FMLA Leave

If you are approved for Workers' Compensation or FMLA (Family Medical Leave Act) leave, St. Lucie Public Schools will continue to provide employer contributions toward your benefits. You are required to continue to pay your share of your benefit elections while out on leave. Payments must be paid within 30 days of your first missed deduction or within 30 days of your initial billing notification (whichever is later). For more information on how to make these payments, please contact the Risk Management Department at 772-429-5521.

If you have not returned to active duty when your FMLA leave ends, your benefits will end at the end of that month. You may continue coverage for your eligible insurance benefits by paying the total premium amount under COBRA (Comprehensive Omnibus Budget Reconciliation Act). Upon expiration of benefits, a COBRA notice will be mailed to the home address on record to provide you with an opportunity to elect coverage.

The Human Resources Department determines eligibility for FMLA based on federal regulations.

Employees on an Approved Non-FMLA Leave

St. Lucie Public Schools does not contribute toward your insurance premiums while you're out on non-FMLA leave. In many cases, insurance coverage ends at the end of the month your leave starts (call Risk Management to determine your status). For example, if your leave begins on Sept. 3, your benefits will end on Sept. 30. You may continue your eligible insurance benefits by paying the total premium amount under COBRA. Upon the expiration of benefits, a COBRA notice will be mailed to your home address on record to provide an opportunity to elect coverage.

If your leave extends beyond 30 days, or into a new month, it is each employee's responsibility to re-enroll, by contacting the Risk Management Department. This must occur within 60 days of your return to work. If you do not re-enroll upon your return, you will not be eligible to enroll in coverage until the next open enrollment.

Dependent Eligibility for Group Health and Dental Plans (Pretax):

An individual who meets the eligibility criteria specified below is an eligible dependent and is eligible to apply for coverage:

1. The covered employee's spouse under a legally valid existing marriage;
2. The covered employee's natural, newborn, adopted, foster, or stepchild(ren) (or a child for whom the covered dependent has been court-appointed as legal guardian or legal custodian) who:
   a) has not reached the end of the calendar year in which he or she turns 26
   b) has reached the end of the calendar year in which he or she turns 26, but has not reached the end of the calendar year in which he or she becomes 30 and who:
      i. is unmarried and does not have a dependent;
      ii. is a Florida resident or a full-time or part-time student;
      iii. is not enrolled in any other health coverage policy or plan; and
      iv. is not entitled to benefits under Title XVIII of the Social Security Act unless the child is a disabled dependent child.
   c) in the case of a disabled dependent child, such child is eligible to continue coverage beyond the limiting age of 30 as a covered dependent if the dependent child is:
      i. otherwise eligible for coverage under the Group Master Policy;
      ii. incapable of self-sustaining employment by reason of mental or physical disability; and
      iii. chiefly dependent upon the covered dependent for support and maintenance provided that the symptoms or causes of the child's disability existed prior to the child's 30th birthday. This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a disabled child.

- or -

3. The newborn child of a covered dependent child who has not reached the end of the calendar year in which he or she turns 26. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: If a covered dependent child who has reached the end of the calendar year in which he or she becomes 26 obtains a dependent of their own (e.g., through birth or adoption), such newborn child will not be eligible for this coverage. It is your sole responsibility as the covered dependent to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the child no longer meets the eligibility criteria required to be an eligible dependent.

Eligibility + Coverage

New Employees

New employees are eligible to enroll in the Flexible Benefits Plan and SLPS health plan on the first day of employment. New employees must enroll within 60 days. The effective date for the SLPS health plan and voluntary benefits begins on the first day of the month following two payroll deductions. The effective date of coverage for the Flexible Benefits Plan is on the first day of the month following the submission of an enrollment form.

Dependent Eligibility for Other Plans

Refer to the benefit description pages in this reference guide for information on each benefit. You may cover your eligible dependents under every benefit that shows a premium amount for dependent coverage provided you participate in the same benefit (refer to the rate charts that appear with each benefit description). An eligible dependent is: your legal spouse, an unmarried dependent child of either you or your legal spouse (including a stepchild, legally adopted child, foster child placed and approved for adoption in your home, or a child for whom you have been appointed legal guardian), provided they reside in your household and primarily depend on you for support.

Vision - Coverage will cease at the end of the calendar year in which the child reaches age 19 (or 25 if the child lives in your home and depends on you for support or attends school full or part time.)

Until the following conditions are reached, eligible dependents will be covered from birth, adoption or time of guardianship:

Refer to the specific dependent eligibility criteria on the individual benefit information pages of this reference guide.

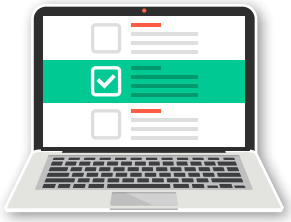
Retiring Employees

A retiree is a former full-time employee of the SLPS who is currently receiving income under the Florida Retirement System (FRS). Unless otherwise provided by law and in accordance with your employer's plans, an employee who retires during the plan year may continue the benefits he or she had while actively at work, with the exception of the Disability Income Protection Plan, Healthcare FSA and Dependent Care FSA. Some plans may be continued at the same premium rates while others require conversion to an individual policy and may have an increase in premium rates. Premiums for continued coverage can be deducted from your Florida Retirement System (FRS) benefit check on a monthly basis, or you can elect to pay via personal check or ACH debit. After you have applied for retirement, you will receive a continuation of benefits application.

How to Enroll

Enroll with a Benefits Counselor and complete a survey for your chance win valuable prizes!

Enroll Online



Employees may choose to enroll online at 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.

Accessing Your Online Benefits

- Log in to 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 your enrollment is complete.
- Print out your confirmation statement containing all benefit elections for you and your family.

Note: You may save your enrollment session progress and return later to complete the enrollment at any point once you've started the benefit elections.

Whether you choose to individually enroll online or meet with a Benefits Counselor, it is your responsibility to carefully review your confirmation statement.

Enrollment changes after Oct. 31, 2025 will not be permitted unless there has been a valid CIS event.

Enroll with a Benefits Counselor

To make an appointment with a Benefits Counselor during Open Enrollment, go to **https://slcps.fbmcbenefits.com/**
Or call: 1-855-582-4348

Bring the following information to your appointment when you see a Benefits Counselor:

- Social Security numbers for your dependents
- Dates of birth for all your dependents and beneficiaries
- Addresses for all your dependents and beneficiaries

Complete your enrollment with the assistance of a Benefits Counselor by Oct. 31, 2025.

Make an Appointment

If you are interested in electing or making a change to your voluntary benefits during Open Enrollment, please make an appointment with a Benefits Counselor by going to **https://slcps.fbmcbenefits.com/** and selecting a virtual or on-site appointment

Enrolling Online

1 How to Enroll Online

To enroll online, go to the FBMC homepage at myFBMC.com and log in with your username and password.

Username and Password

To access your account, you will need to register for a username and password (if you have not already done so). You will need:

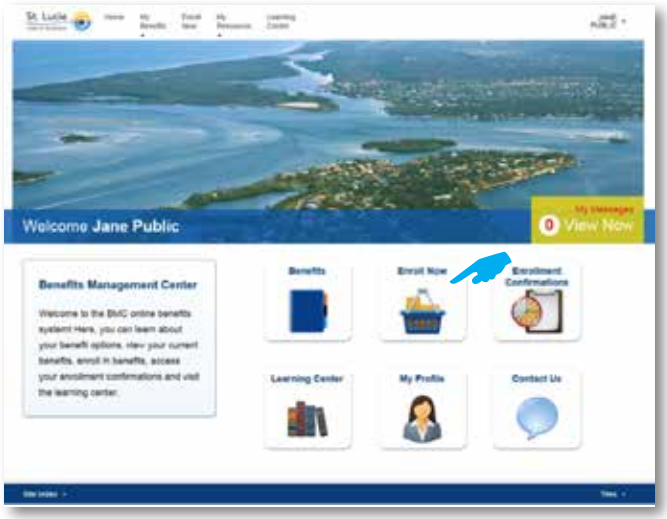
- Your name
- Your mailing ZIP code
- A valid email address
- And one of the following:
  - Your SSN
  - Your Employee ID
  - Your FBMC Member ID

You will use the email address and a password you select to access your enrollment and account information on myFBMC.com.

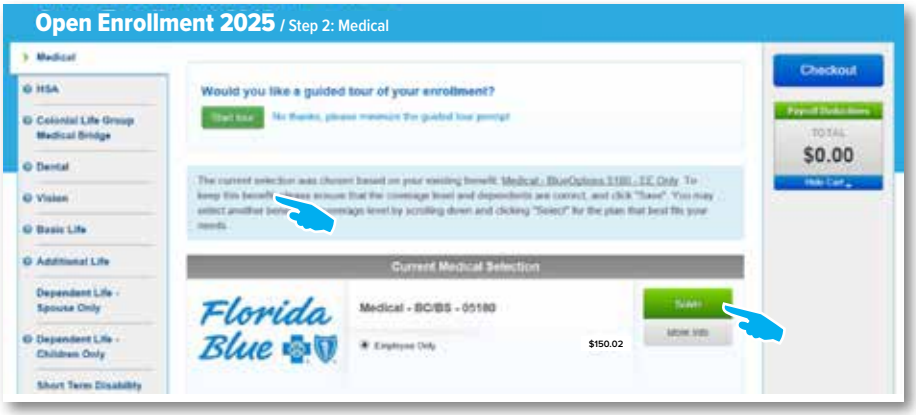
If you forget your password, click the "Forgot your password?" link for help, or you may contact FBMC tech support via email at: techsupport@fbmc.com.

2 Access Your Web Enrollment

After entering your username and password at myFBMC.com, click the "Open Enrollment" link. A second "Open Enrollment 2025" link will then be provided - select this link to access your open enrollment application.



Enrolling Online



3 Begin the Enrollment Process

For each benefit, choose your coverage level or election amounts, click on the Save button, and then go to the next benefit. Continue until enrollment is complete. If you decide to waive a benefit, you must select "waive."

You may save your enrollment session progress and return later to complete the enrollment at any point once you have started the benefit selections.

4 Agreement and Authorization

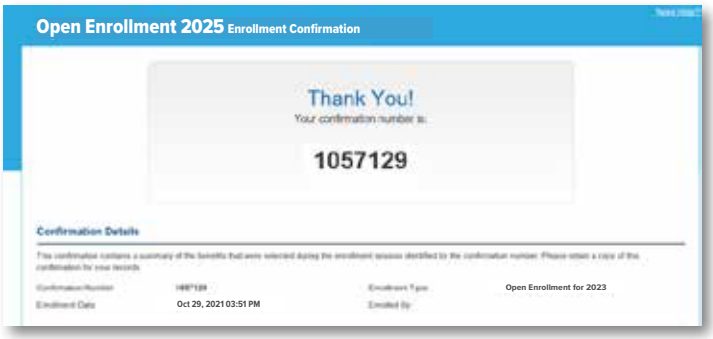
In order to complete your enrollment, you must check the box to agree to the Terms and Conditions, type in the first four digits of your SSN and add your email address.

Adding your email is now mandatory. to receive an enrollment confirmation notification online.

5 Print and Keep Your Confirmation Notice

Once you have completed the enrollment process, you will receive a confirmation number and be able to print a confirmation notice for your records.

You may access the web enrollment 24 hours a day, seven days a week, to make changes to your benefit selections. You have until the end of Open Enrollment period to make any changes to your benefits.



Florida Blue Medical Plans

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), 01/01/2025 - 12/31/2025, unless noted	BlueOptions PPO 05771 (Only Available To Employees Hired Prior to 1/1/14)	BlueOptions PPO HSA - Compatible 05180 | 05181 (Single | Family Coverage)	BlueOptions PPO HSA - Compatible 05192 | 05193 (Single | Family Coverage)
DEDUCTIBLE (DED) (PER PERSON/FAMILY AGGREGATE)			
In-Network	$2,500/$7,500	$2,500 | $5,000	$3,500 | $7,000
Out-of-Network	$7,500/$22,500	$5,000 | $10,000	$7,000 | $14,000
COINSURANCE (BCBSF PAYS / MEMBER PAYS)			
In-Network	75% / 25%	80% / 20%	75% / 25%
Out-of-Network	50% / 50%	50% / 50%	50% / 50%
OUT-OF-POCKET MAXIMUM (PER PERSON/FAMILY AGGREGATE)			
In-Network	$5,500/$11,000	$5,500 | $7,400 / $11,000	$7,250 | $6,900/$14,500
Out-of-Network	$11,000/$22,000	$11,000 | $20,000 / $22,000	$14,500 | $14,500/$27,000
MEDICAL/SURGICAL CARE BY A PHYSICIAN			
Allergy Injections			
In-Network Family Physician	DED+25%	DED + 20%	DED + 25%
In-Network Specialist	DED+25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Telemedicine (BlueVirtualCare)			
In-Network Family Physician	DED+25%	DED + 20%	DED + 25%
In-Network Specialist (Dermatologist)	DED+25%	DED + 20%	DED + 25%
In-Network Mental Health Licensed Therapist	DED +25%	DED + 20%	DED + 25%
In-Network Psychiatrist (initial visit)	DED +25%	DED + 20%	DED + 25%
In-Network Psychiatrist (follow-up visit)	DED +25%	DED + 20%	DED + 25%
Out-of-Network	Not Covered	Not Covered	Not Covered
Office Services			
In-Network Family Physician	DED+25%	DED + 20%	DED + 25%
In-Network Specialist	DED+25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Physician Services at Hospital			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	INN DED + 25%	INN DED + 20%	INN DED + 25%
Convenient Care Center			
In-Network	DED+25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Radiology, Pathology and Anesthesiology Provider Services at Hospital			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	INN DED + 25%	INN DED + 20%	INN DED + 25%
Radiology, Pathology and Anesthesiology Provider Services at ASC			
In-Network	DED+25%	DED + 20%	DED + 25%
Out-of-Network	DED+50%	DED + 50%	DED + 50%
Physician Services at Locations other than Office, Hospital and ER			
In-Network Family Physician	DED+25%	DED + 20%	DED + 25%
In-Network Specialist	DED+25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%

Florida Blue Medical Plans

BlueOptions PPO HSA - Compatible 05172 | 05173 (Single | Family Coverage)	5907 (Single | Family Coverage)
$5,500 | $11,000	$7,500 / $15,000
$11,000 | $22,000	$15,000 / $30,000
70% / 30%	70% / 30%
50% / 50%	50%
$8,000 | $8,000/$16,000	$10,150 / $20,300
$16,000 | $16,000/$32,000	$16,400 / $32,800
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
Not Covered	Not Covered
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
INN DED + 30%	INN DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
INN DED + 30%	INN DED + 30%
DED + 30%	DED + 30%
INN DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%

Florida Blue Medical Plans

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), 01/01/2025 - 12/31/2025, unless noted	BlueOptions PPO 05771 (Only Available To Employees Hired Prior to 1/1/14)	BlueOptions PPO HSA - Compatible 05180 | 05181 (Single | Family Coverage)	BlueOptions PPO HSA - Compatible 05192 | 05193 (Single | Family Coverage)
PREVENTIVE SERVICES-ADULT & CHILD WELLNESS SERVICES			
Office Services			
In-Network Family Physician	$0	$0	$0
In-Network Specialist	$0	$0	$0
Out-of-Network	50% (No DED)	50% (No DED)	50% (No DED)
Independent Clinical Laboratory			
In-Network (Quest Diagnostics)	$0	$0	$0
Out-of-Network	50% (No DED)	50% (No DED)	50% (No DED)
Independent Diagnostic Testing Center			
In-Network	$0	$0	$0
Out-of-Network	50% (No DED)	50% (No DED)	50% (No DED)
Mammograms			
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0
Colonoscopies			
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0
EMERGENCY/URGENT CARE			
Ambulance			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	INN DED + 25%	INN DED + 20%	INN DED + 25%
Emergency Room Facility (per visit)			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	INN DED + 25%	INN DED + 20%	INN DED + 25%
Physician Services at ER			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	INN DED + 25%	INN DED + 20%	INN DED + 25%
Urgent Care Centers (UCC)			
In-Network	DED +25%	DED + 20%	DED + 25%
Out-of-Network	DED + 25%	DED + 20%	DED + 25%
MEDICAL / SURGICAL CARE AT A FACILITY			
Ambulatory Surgical Center			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Inpatient Hospital Facility (per admit)			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	$500 PAD + DED + 50%	DED + 50%	DED + 50%
Outpatient Hospital Facility (per visit)			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%

Florida Blue Medical Plans

BlueOptions PPO HSA - Compatible 05172 | 05173 (Single | Family Coverage)	5907 (Single | Family Coverage)
$0	$0
$0	$0
50% (No DED)	50%
$0	$0
50% (No DED)	50% (No DED)
$0	$0
50% (No DED)	50% (No DED)
$0	$0
$0	$0
$0	$0
$0	$0
DED + 30%	DED + 30%
INN DED + 30%	INN DED + 30%
DED + 30%	DED + 30%
INN DED + 30%	INN DED + 30%
DED + 30%	DED + 30%
INN DED + 30%	INN DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%

Florida Blue Medical Plans

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), 01/01/2025 - 12/31/2025, unless noted	BlueOptions PPO 05771 (Only Available To Employees Hired Prior to 1/1/14)	BlueOptions PPO HSA - Compatible 05180 | 05181 (Single | Family Coverage)	BlueOptions PPO HSA - Compatible 05192 | 05193 (Single | Family Coverage)
DIAGNOSTIC TESTING (E.G., LAB, X-RAY)			
Physician Office			
In-Network Family Physician	DED +25%	DED + 20%	DED + 25%
In-Network Specialist	DED +25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Independent Clinical Laboratory			
In-Network (Quest Diagnostics)	$0	DED	DED
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Independent Diagnostic Testing Facility	**X-Rays and Advanced Imaging**		
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Outpatient Hospital Facility			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
ADVANCED IMAGING (AIS) (MRI, MRA, PET, CT & NUCLEAR MEDICINE)			
Physician Office Visit			
In-Network Family Physician	DED + 25%	DED + 20%	DED + 25%
In-Network Specialist	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Independent Diagnostic Testing Center			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Outpatient Hospital Facility			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
OUTPATIENT THERAPY & SPINAL MANIPULATIONS - PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY IS LIMITED TO 35 VISITS COMBINED SPINAL MANIPULATIONS ARE LIMITED TO 26 VISITS PER BENEFIT PERIOD.			
Physician Office			
Value Choice PCP	DED +25%	DED + 20%	DED + 25%
Value Choice Specialist	DED +25%	DED + 20%	DED + 25%
In-Network Family Physician	DED +25%	DED + 20%	DED + 25%
In-Network Specialist	DED +25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Outpatient Rehabilitation Facility			
In-Network	DED +25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Outpatient Hospital Facility			
In-Network	DED +25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%

Florida Blue Medical Plans

BlueOptions PPO HSA - Compatible 05172 | 05173 (Single | Family Coverage)	5907 (Single | Family Coverage)
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED +30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%

Florida Blue Medical Plans

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), 01/01/2025 - 12/31/2025, unless noted	BlueOptions PPO 05771 (Only Available To Employees Hired Prior to 1/1/14)	BlueOptions PPO HSA - Compatible 05180 | 05181 (Single | Family Coverage)	BlueOptions PPO HSA - Compatible 05192 | 05193 (Single | Family Coverage)
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES			
Virtual Visits			
In-Network Family Physician	DED + 25%	DED + 20%	DED + 25%
In-Network Specialist	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	Not Covered	Not Covered	Not Covered
Physician Office			
In-Network Family Physician	$0	DED + 20%	DED + 25%
In-Network Specialist	$0	DED + 20%	DED + 25%
Out-of-Network	50% (No DED)	DED + 50%	DED + 50%
Inpatient Hospital Facility			
In-Network	$0	DED + 20%	DED + 25%
Out-of-Network	50% (No DED)	DED + 50%	DED + 50%
Outpatient Hospital Facility			
In-Network	$0	DED +20%	DED + 25%
Out-of-Network	50% (No DED)	DED + 50%	DED + 50%
Emergency Room Facility (per visit)			
In-Network	$0	DED + 20%	DED + 25%
Out-of-Network	$0	INN DED + 20%	INN DED + 25%
Physician Services at Hospital			
In-Network	$0	DED + 20%	DED + 25%
Out-of-Network	$0	INN DED +20%	INN DED + 25%
Physician Services at ER			
In-Network	$0	DED + 20%	DED + 25%
Out-of-Network	$0	INN DED + 20%	INN DED + 25%
Physician Services at Locations other than Office, Hospital and ER			
In-Network Family Physician	$0	DED + 20%	DED + 25%
In-Network Specialist	$0	DED + 20%	DED + 25%
Out-of-Network	50% (No DED)	DED + 50%	DED + 50%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
OTHER SPECIAL SERVICES AND LOCATIONS			
Durable Medical Equipment			
In-Network Motorized Wheelchairs	DED + 25%	DED + 20%	DED + 25%
In-Network All Other	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Skilled Nursing Facility			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Home Health Care - 60 Visits per benefit period; 45 visits per benefit period for plan 05907			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Hospice			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%

Florida Blue Medical Plans

BlueOptions PPO HSA - Compatible 05172 | 05173 (Single | Family Coverage)	5907 (Single | Family Coverage)
DED + 30%	DED + 30%
DED + 30%	DED + 30%
Not Covered	Not Covered
DED + 30%	DED + 30%
DED + 25%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
INN DED + 30%	INN DED + 30%
DED + 30%	DED + 30%
INN DED + 30%	$0 Copay
DED + 30%	DED + 30%
INN DED + 30%	INN DED + 30%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED +50%
DED + 50%	DED +50%
DED + 30%	DED + 30%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%

Florida Blue Medical Plans

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), 01/01/2025 - 12/31/2025, unless noted	BlueOptions PPO 05771 (Only Available To Employees Hired Prior to 1/1/14)	BlueOptions PPO HSA - Compatible 05180 | 05181 (Single | Family Coverage)	BlueOptions PPO HSA - Compatible 05192 | 05193 (Single | Family Coverage)
Dialysis Center			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Birthing Center			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
Additional Services			
In-Network	DED + 25%	DED + 20%	DED + 25%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%
PRESCRIPTION DRUGS			
Deductible	N/A	$2500 IN-NETWORK DEDUCTIBLE APPLIES | $5000 IN-NETWORK DEDUCTIBLE APPLIES	$3500 IN-NETWORK DEDUCTIBLE APPLIES | $7000 IN-NETWORK DEDUCTIBLE APPLIES
In-Network			
Retail			
Generic/Brand/Non-Preferred	$10 / $50 / $100	$10 / $50 / $100	$10 / $50 / $100
- Mail Order			
Generic/Brand/Non-Preferred	$20 / $100 / $200	$20 / $100 / $200	$20 / $100 / $200
Condition Care Rx Program, see page 24	N/A	DED IS WAIVED, MEMBERS PAY COPAY ONLY	DED IS WAIVED, MEMBERS PAY COPAY ONLY

The above benefit summary is only a partial description of the many benefits and services covered by Florida Blue. For a complete description of benefits and exclusions, please see your Plan Specific Florida Blue Policy Book and Schedule of Benefits; their terms prevail.

The information contained in this Benefit Book includes changes required as a result of the Patient Protection and Affordable Care Act (PPAACA) otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency.

Florida Blue Medical Plans

BlueOptions PPO HSA - Compatible 05172 | 05173 (Single | Family Coverage)	5907 (Single | Family Coverage)
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
DED + 30%	DED + 30%
DED + 50%	DED + 50%
$5500 IN-NETWORK DEDUCTIBLE APPLIES | $11,000 IN-NETWORK DEDUCTIBLE APPLIES	$7,500 IN-NETWORK DEDUCTIBLE APPLIES | $15,000 IN-NETWORK DEDUCTIBLE APPLIES
$10 / $50 / $100	$10 / 30% / 30%
$20 / $100 / $200	$10 / 30% / 30%
DED IS WAIVED, MEMBERS PAY COPAY ONLY	DED IS WAIVED, MEMBERS PAY COPAY ONLY

BlueVirtualCare

Virtual care when you're not able to see your doctor.

Convenient care from home or on the go!

When life is moving at full speed, unexpected health issues can suddenly slow us down.

When you or a family member on your plan needs medical attention, and you're not able to see your regular health care provider, BlueVirtualCare is here to help you get the care you need.

A virtual visit typically costs less than a trip to urgent care or the ER. Plus, you can use BlueVirtualCare from wherever you are in the U.S. by simply logging in to your member account, on the web, or the Florida Blue app. We're here to help make things easier so you can focus on what matters most — your health and well-being.

BLUE VirtualCare

BlueVirtualCare is here if you need it.

Log in to your member account, on the web, or Florida Blue app, and go to **Find & Get Care**.

Select **Find a Doctor & More**, click on **Find Virtual Care**, then select **BlueVirtualCare**.

It's that easy!

BlueVirtualCare

Care options available through BlueVirtualCare.

General medicine: When your primary care doctor isn't available, get 24/7 virtual care for you and family members covered on your plan. No appointment necessary!

- **Video visit with board-certified doctors** about common conditions, including allergies, bronchitis, cold, flu, migraine, pink eye, sinus infections, stomach ailments, and urinary tract infections.
- **A doctor assesses your symptoms**, provides a treatment plan, and sends prescriptions, if needed, to the in-network pharmacy of your choice.

Behavioral and mental health: When you aren't able to see your mental health provider, or have not found a licensed professional through Florida Blue's mental health care partner Lucet,[1] BlueVirtualCare offers:

- **Talk therapy:** For those age 10 years and older, you can schedule a video appointment with a licensed therapist, all from the comfort and privacy of home. Weekday, evening, and weekend appointments are available.[2]
- **Psychiatry:** For adults age 18 years and older, talk via video with a psychiatrist to manage your mental health condition with ongoing medication management.

Dermatology: Worried about a change in your skin, hair, or nails? Upload a photo, and a board-certified dermatologist will evaluate it and respond within 72 hours — no appointment, video visit, or referral required.

[1]Florida Blue contracts with New Directions Behavioral Health, L.L.C., (d/b/a Lucet), and its affiliates, to provide behavioral health services. Florida Blue and Florida Blue Medicare are Independent Licensees of the Blue Cross and Blue Shield Association.

[2]Children age 10 – 17 years old need parental or guardian consent.

BlueVirtualCare is a telemedicine service provided by American Well Corporation (Amwell®), an independent company contracted by Florida Blue to provide services for eligible members with non-emergent health concerns. Amwell is only available in the U.S.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

For long-term mental health care and ongoing support, Lucet can help Florida Blue members find and schedule a new patient in-person or virtual visit with an in-network mental health professional. To get started, call Lucet at 1-866-287-9569 or log in to your Florida Blue member account, go to Find & Get Care where you can find and schedule a visit with a behavioral or mental health provider.

BlueVirtualCare does not offer a crisis hotline. Appointments must be scheduled.

122532 0825

Condition Care Rx Program

The **Florida Blue Condition Care** Rx Program is a wonderful addition to your health insurance benefits. It was designed to help those of you who are on the District's High Deductible HSA Plan 05180/05181 or 05192/05193 or 05172/05173 to manage the cost of some of your prescriptions.

If your medication is included in the link below for **diabetes**, **cholesterol**, **respiratory issues**, **high blood pressure** and a few other health conditions, you will NOT have to meet your deductible first. It will be WAIVED and you will only pay a copay at the pharmacy instead!

For a complete list of current medications that are included in your Condition Care Rx Program, please click the link below:

Condition Care Rx Drug List

Prescription Drug Program

Did you know that most medical conditions have several drug options? That's why we have a team of pharmacists, doctors and other experts continually working to determine which medicines are clinically effective, safe AND cost less.

To understand how your prescription benefits work, it helps to familiarize yourself with your Prescription Drug program. Log on to our member site, **floridablue.com**, to see your prescription benefits, compare drug prices and more. When you get a prescription, the amount you'll pay at the pharmacy will depend on four things:

1. **Is the drug covered by your prescription plan?**
2. **What Tier is the drug?**
3. **Are there additional requirements, limits, or authorizations needed first?**
4. **Are you using a participating retail, mail-order, or specialty pharmacy?**

1. Covered Drugs

The Medication Guide includes a list of covered drugs called a formulary. Our formulary may be updated up to four times a year after careful review by a team of medical experts. We evaluate how well the drugs work and how they compare to other drugs for the same condition. Clinical effectiveness, safety risks, side effects, and costs are all considered during this review. Using formulary drugs that are proven to work helps you stay well and helps keep costs down for everyone.

2. Drug Tier and Your Cost

Your plan covers Tier 1, 2 and 3 drugs. With most plans, if you choose a brand-name drug when a generic is available, you'll pay your benefit amount plus the difference in the cost between the two drugs. If a brand-name drug is recommended, your doctor must write "medically necessary" on your prescription to avoid paying this difference. Please refer to your benefit materials for more details. Below describes each Benefit Tier and how it affects your cost.

Drug Tier	Prescription Drug Description	Your Cost
Tier 1	Covered **Generic** Medication	$
Tier 2	Covered **Preferred** Brand Medication	$$
Tier 3	Covered **Non-Preferred** Brand Medication	$$$

Prescription Drug Program

3. Coverage Requirements, Limits and Authorizations

With certain medications there are potential safety risks, such as overuse, which can be harmful to your health and costly to your wallet. These medications may be included in one or more of our Responsible Rx programs, such as **Prior Authorization**, **Responsible Steps,** or **Responsible Quantity**. Your **Medication Guide** indicates which drugs are included in these programs. Below is a description of how each program works:

- **Prior Authorization -** This means that your doctor will need to submit medical documentation and an authorization form to request approval for the drug to be covered. If it is not approved, you may purchase the drug at your own expense.
- **Responsible Quantity -** Some drugs have a maximum quantity that is covered for a given time period. For example, if your doctor prescribes a medication that has a 30-day limit of nine tablets, your plan covers nine tablets that month. These safety limits are based on the drug manufacturer's and Food and Drug Administration's dosing guidelines.
- **Responsible Steps (Step Therapy) -** Certain drugs are not covered unless you try another FDA-approved drug first. There may be a lower cost drug that is clinically and cost effective to treat your condition. If an alternate drug is not recommended for you or you had other insurance when you tried the alternate drug, simply ask your doctor to submit an authorization form to request that the drug be covered. You may purchase the drug at your own expense if not approved.

4. Your choice of pharmacy matters

Where you go for your prescriptions will depend on the kind of medication you need. You'll pay less and avoid filing a claim when your prescriptions are filled at a participating pharmacy: retail, mail-order, or specialty.

- **Retail Pharmacy** for up to a 30-day or 90-day supply
- Fill prescriptions for non-specialty generic and brand name drugs at your local participating retail pharmacy, including many national chains, such as: Walgreens, CVS, Publix, Target, and Walmart. To find a participating pharmacy near you, please visit us at **floridablue.com**
- **Home/Mail Order delivery** for up to a 90 day supply. **Amazon Pharmacy** http://www.amazon.com.
- **Specialty Pharmacy** Certain Self-Administered Specialty Drugs, such as: injectable, infused, oral, or inhaled drugs must be purchased from one of our two participating specialty pharmacies, **CVS/CareMark or Accredo**. If your medication is a self-administered specialty drug, simply call **CVS/CareMark toll-free at 866-278-5108 or Accredo at 888-425-5970.**

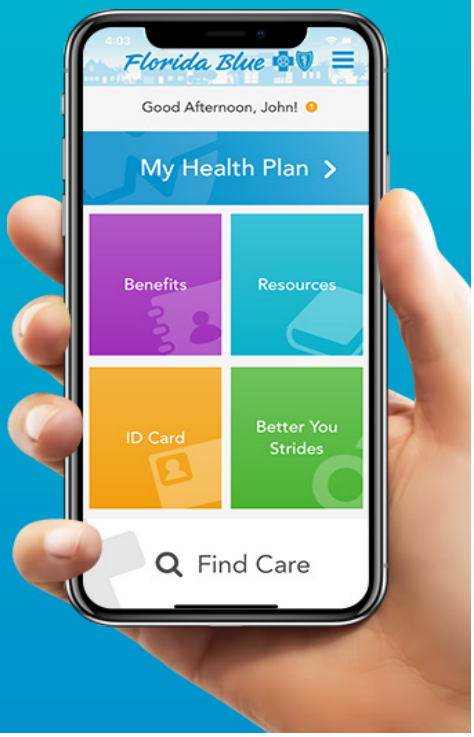
Florida Blue Resources

Questions	Resources	How to Access
What health and dental plan options are available to me?	**Interactive Benefit Portal** Please click on the link to the right to watch a video highlighting many of your benefits.	**2024 Benefits Overview** **Or** Text **Blue 1213** to **258311**
I need my ID number, I have a question about my claim, I don't understand my plan…	**On-Site Customer Service** A Florida Blue Customer Service Representative is available at the District Office to assist members with benefit issues, including plan design questions, claim inquiries and ID cards.	**Toni DiSavino** Located at the District Office in Risk Mgt **(772) 429-7702** **toni.disavino@bcbsfl.com**
How do I order a replacement Health and/or Dental ID card and view my claims?	**www.floridablue.com** **Register online to:** · Review your plan benefits · View your deductible · Find a participating doctor or hospital · View claim activity, status and history · Take a Personal Health Assessment · Understand your upfront medical costs · Order an ID card · Access our exclusive discount program (Blue365)	Go to **www.floridablue.com** and click **"Member login".** All you need to register is a valid email address and your Member Number (located on your Florida Blue Member ID card).
I need help with a claim and I have other questions…	**Customer Service** · Find out what's covered and how much you'll pay · Maximize your health plan benefits to save money. · Find out if an authorization is in place prior to having a procedure or surgery.	**Florida Blue (Health)** 1-800-664-5295 **Florida Combined Life (Dental)** 1-888-223-4892 Mon-Thu 8am-6pm; Friday 9am-6pm
Where can I go to get help afterhours and on weekends?	**Florida Blue Center** The Florida Blue Retail Center located inside the St Lucie West Walmart store, provides great face-to-face customer service.	**772-621-8830** 1675 NW St Lucie West Blvd (Walmart) Port St Lucie, FL 34986 9am-7pm (Mon-Fri) 9am-4pm (Sat)
Will I save money if I use an Urgent Care Center instead of the ER?	**Know Before You Go** Use our online Medical Cost Comparison Tool to shop around for health care services. You can save money and still get the quality care you deserve.	Go to **www.floridablue.com** log into your **Member Account** select **Tools** and **Medical Care Comparison**
I need someone to assist me with a chronic condition such as: Cancer, Diabetes, Asthma, authorizations for procedures and care after surgery…	**Care Consultants** Our team of Care Consultants is standing by to answer questions about your benefits, treatment choices and cost saving options.	Toll Free at **1-888-476-2227** Monday - Friday, 8am to 9pm
I have a question about my health.	**Health Dialog 24-Hour Nurse Line** Questions about your health can come up at any time, including times when doctors' offices are closed. Our 24-hour nurse line can help you make informed health care choices.	Toll Free at **1-877-789-2583**

Florida Blue Resources

Florida Blue
In the pursuit of health®

Download the Florida Blue Mobile App today!



Save Time. Save Money. Stay Healthy.

- Check plan benefits and see the status of your claims
- Find the nearest in-network doctor, Urgent Care Center or pharmacy
- Compare medical costs
- View your member ID card

As Easy as 1, 2, 3…

1. **Download the app –** available through the Apple App Store or Google Play
2. **Get Registered –** log in using your Florida Blue member account User ID and Password
3. **Get Started –** anytime, anywhere with Touch ID*

Stay informed and in control ***24 hours a day, 7 days a week!***

GET IT ON Google Play Download on the App Store

*If available on your mobile device.

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an HMO affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).

90896 0818R

Behavioral Health Services

Your Florida Blue Behavioral Health Services

As a member of Florida Blue, your health insurance plan includes behavioral health benefits like mental health services, substance use treatment and more. Florida Blue has partnered with Lucet to provide behavioral health services. If you have questions about your benefits or want more information call Lucet at 866-287-9569 or visit LucetHealth.com.

What to expect from Lucet

Lucet can help you through their member service phone line, website or by enrolling in one of their programs to:

- Understand your behavioral health needs and benefits.
- Provide information on topics such as depression, anxiety, substance use disorder, autism spectrum disorder and bipolar disorder.
- Locate in-network behavioral health providers, specialty doctors and treatment facilities.
- Connect with people and groups in your community that can support your mental well-being journey.
- Coordinate care with your providers.

Lucet is here for you. They are ready to take your call at 866-287-9569. Licensed clinicians are available when appropriate. Visit LucetHealth.com for articles, videos, guidebooks and more.

The Answer to Behavioral Health's Access Problem

Navigate & Connect is our solution for health plans, combining the industry's largest team of care navigators with technology built on 20+ years of clinical research. Our tech platform connects with in-network providers to allow real-time appointment scheduling for our members – in one phone call. In fact, Navigate & Connect is proven to successfully identify and connect people across the entire acuity spectrum with the right care in less than 5 days on average, and often in as little as 1 day.

✦ Optimize access across your behavioral health ecosystem

Contact us at 866-287-9569 to learn more.

LucetHealth.com

ND-MAR407-20230331

Medical Rates

2026 Employee Payroll Contributions	Blue Options HSA Compatible 05180/05181	Blue Options HSA Compatible 05192/05193	Blue Options HSA Compatible 05172/05173	Blue Options 05771 Only available to employees hired before Jan. 1, 2014.	Blue Options 05907
	PER PAY PERIOD	PER PAY PERIOD	PER PAY PERIOD	PER PAY PERIOD	PER PAY PERIOD
Employee Only	$150.02	$109.35	$86.51	$175.38	$41.59
Employee + 1 Dependent	$731.34	$640.21	$589.02	$788.13	$488.39
Employee + Family	$1,015.45	$899.67	$834.64	$1,088.61	$707.49
Dual Employee + Family	$348.42 Each Employee Per Pay Period	$ 290.53 Each Employee Per Pay Period	$258.01 Each Employee Per Pay Period	$385.00 Each Employee Per Pay Period	$194.44

If both you and your spouse are employed by SLPS and have benefit-eligible dependent children, you are defined as a "dual employee family." One employee is considered "primary" insured and the other spouse becomes a dependent of the primary spouse along with the child(ren). Premiums for "dual employee" family coverage are shared between both employees with each receiving the employer health plan contribution and each having an equal payroll deduction for the employee paid portion of the premium.

Health Savings Account (HSA)

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-free savings account that belongs to you. The account is set up with a qualified HSA trustee (typically a bank or insurance company, or anyone already approved by the IRS to be a trustee). The account is used to pay or reimburse for qualified medical expenses you or your dependents incur. You must meet eligibility requirements to qualify for an HSA.

The Benefits of an HSA are:

- Contributions are excluded from income (pretax)
- Contributions remain in your account from year to year until you use them
- The interest or other earnings on the assets in the account are tax-free
- Distributions are tax-free if used to pay for qualified medical expenses, including Rx, dental and vision
- Spouse/dependent expenses are eligible, even if on another health plan
- HSA funds can be invested once a certain threshold of savings is met
- An HSA is portable; it stays with you if you change employers or leave the workforce

Note: Funds must be deposited into your account before use (works like a checking account).

Qualifying for an HSA (Eligibility):

- You must be covered under a High-Deductible Health Plan (HDHP)
- You cannot have other health coverage, except what's permitted by the IRS (see IRS Publication 969)
- You cannot be enrolled in **Medicare Part A and/or Part B**
- You cannot be claimed as a dependent on someone else's tax return

2026 Maximum HSA Contributions Allowed by the IRS:

The Internal Revenue Service (IRS) issued Revenue Procedure 2020-20, which provides the 2026 inflation-adjusted amounts for health savings accounts (HSAs) as determined under Section 223 of the Internal Revenue Code.

For calendar year 2026, the annual limitation on deductions for an individual with self-only coverage under a High-Deductible Health Plan is $4,400. For calendar year 2026, the annual limitation on deductions for an individual with family coverage under a high deductible health plan is $8,750. Individuals over the age of 55 may contribute up to $1,000 more to their HSA per year until they turn 65 and are enrolled in Medicare.

Health Savings Account (HSA)

Eligible or "Qualified Medical Expenses" Under an HSA:

- Eligible expenses include: medical, prescribed medications, dental, and vision expenses that are not eligible for reimbursement under an insurance plan
- For a current and complete list of eligible expenses go to **irs.gov/publications/p502/index.html**

Use of HSA Funds for Non-Qualified Medical Expenses:

- HSA funds can be used for non-qualified medical expenses; however, if under the age of 65, you'll be taxed on the money you use at your income tax rate and assessed a 20% penalty.
- Once you turn age 65, you'll be taxed for HSA funds used for non-qualified expenses, but won't pay any additional penalty (20%).

How to Fund Your HSA:

- Make pretax contributions through payroll deductions
- Modify payroll contributions anytime after your HSA is open
- Make post-tax contributions directly through the HSA Administrator

Health Equity. Inc. – HSA Administrator for St. Lucie Public Schools Employees

- In partnership with Florida Blue, Health Equity, Inc. is the HSA administrator for those employees enrolled in the high-deductible health plan (HDHP)
- HDHP plan participants will be issued an HSA welcome kit with a debit card
- Online availability and phone support all day, every day
- Online access to account balances, transaction history, claims, and management of your personal information
- Online education and support tools
- FDIC-insured cash deposits
- Competitive interest rates
- Free investment options with no transaction fees

May I Have an HSA and Healthcare FSA?

Yes, individuals may enroll in a Limited-Use Healthcare FSA to pay certain eligible expenses. The Limited-Use Healthcare 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 your healthcare plan. Dependent Care Spending Account eligibility is not affected by your HSA participation. Additionally, you can save money and pay less tax by enrolling in an Limited Use Healthcare FSA, HSA or both. These are pretax benefits that you can take advantage of either independently of each other or together.

Florida Combined Life Dental Plans

BlueDental Choice

Did you know that dental health can have an influence on the development of conditions, such as diabetes, coronary artery disease, and low-birth-weight, premature babies? An undeniable relationship exists between a healthy mouth and overall good health.

BlueDental Choice℠ is a flexible PPO plan designed to encourage regular cleanings and preventive services that lead to good oral health and better overall health.

The dental PPO network consists of a network of quality dentists who have agreed to provide services based on a negotiated fee. When you use a participating dentist in the BlueDental Choice network* for your plan, you'll receive maximum plan benefits and be protected against balance billing (the difference between the BlueDental Choice fee schedule and the dentist's normal charges). You also have the option of visiting a non-participating dentist, although balance billing may occur.

As a BlueDental Choice member, you can look forward to:

- No referrals or authorizations to see a general dentist or specialist
- Access to one of the largest dental networks in Florida
- Access to a vast national network

Maximum Rollover - Maximum Rollover is a BlueDental Choice benefit that rewards you just for visiting the dentist. Each year when you visit the dentist and use less than the yearly claim payment threshold, you'll receive rollover dollars to help cover future unexpected visits or higher, out-of-pocket costs for complex procedures. It's that easy.

Maximum Rollover is applied automatically, as long as:

- You receive at least one covered service during your plan year
- You are an active member of your plan on the last day of the plan year
- You don't exceed the claim payment threshold in your plan year

The following example shows how your Maximum Rollover amount is determined:

If your annual benefit maximum is:	AND your total claims paid for the benefit period do not exceed:	THEN we will roll over:	Accumulated totals will be capped at:
$1,000 - $1,249	$500	$350	$1,000
$1,500 - $1,999	$700	$500	$1,250

Benefits

Orthodontic Discount Program** – When you choose an orthodontist in our orthodontic provider network, you'll receive 20% off your total case fee. This discount is only available to you when orthodontic coverage is not part of your plan.

Cosmetic Dental Discount Program** – You can experience significant savings on cosmetic dentistry procedures by visiting a dentist who participates in our cosmetic dentistry network. As a BlueDental Choice member, you'll receive a 20% savings on the following procedures:

- Cosmetic Contouring
- Laminate Veneer (porcelain or composite)
- Whitening (in office or at-home system)

To see a list of the dentists in our network, visit **FloridaBlueDental.com**.

Don't see your dentist in our network? Send an email to **FCLProvidernomination@FCLife.com** or fax your nomination to **904-866-4846**.

Questions? Need more information? Our Customer Service representatives can help. Just call **888-223-4892** from 8 a.m. to 8 p.m. Monday through Friday.

* Networks are comprised of independent contracted dentists.
** Certain dentists have voluntarily agreed to offer a 20% discount off their usual charge for non-covered cosmetic or orthodontic services. These dentists are identified by an affiliation to either the Cosmetic Dental Discount Program or Orthodontic Discount Program. Because these dentists are neither contractually nor legally bound to offer these discounts, we recommend that you contact the provider to inquire about the continued availability of any discount prior to scheduling an appointment.

Florida Combined Life Dental Plans

2026 Florida Combined Life Dental Benefits for St. Lucie Public Schools Employees

Financial Features	BlueDental Choice PPO Low		BlueDental Choice PPO High	
	In-Network	Out-of-Network	**In-Network**	Out-of-Network
Deductible (Basic & Major Services Only) Per Person Per Plan Year Per Family Per Plan Year *In-Network deductible credits apply to Out-of-Network deductible and Out-of-Network deductible credits apply to In-Network deductible.*	 $50 $150	 $50 $150	 $50 $150	 $50 $150
Coinsurance *	**You Pay**	**You Pay**	**You Pay**	**You Pay**
PREVENTIVE **	**0%**	0%	**0%**	10%
BASIC **	**20%**	20%	**10%**	20%
MAJOR **	**50%**	50%	**40%**	50%
Service Highlights				
Oral Evaluations (Exams) Bitewing X-ray Prophylaxis/Periodontal Cleanings **(4)** – Adult/Child Fluoride Treatment (No age limit) Office Visits X-rays – Intraoral/Complete Series/Panoramic Sealants	Preventive		Preventive	
Amalgam Restorations (Silver Fillings) Resin-Based Restorations (Anterior and Posterior) Extractions Surgical Extractions Root Canal Therapy Periodontal Treatment	Basic		Basic	
Crowns Osseous Surgery Complete Dentures Partial Dentures Fixed Partial Dentures (Bridges) Surgical Placement of Implant Body Implant Supported Porcelain Fused to Metal Crown	Major		Major	
Orthodontia Services ***(children to age 18)*** Orthodontia Lifetime Maximum BlueDental Pays Benefit Waiting Period	 **$500** 50% NONE		 **$1,000** 50% NONE	
Waiting Period: (Major Services)	**NONE**		**NONE**	
Calendar Year Maximum Per Person	**$1,000**		**$1,500**	
Procedures Performed By Specialist	**Covered**		**Covered**	
Dental Rollover	**Yes**		**Yes**	
TYPE OF COVERAGE	**PREMIUM AMOUNT PER PAY PERIOD**			
Employee	**$18.13**		**$22.10**	
Employee Plus 1	**$38.09**		**$46.49**	
Employee Plus 2 or more	**$65.60**		**$81.94**	

The information provided above is a summary of benefits for the group Choice certificate. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as a part of the contract. Possession of this summary in no way implies coverage nor does it guarantee benefits under the plan.

* Percentage of fee schedule

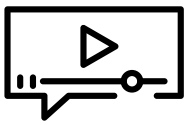
** Some limitations may apply

*** Percentage of fee schedule + balance of any charges; non-par dentists may charge fees in excess of our Fee Schedule and may bill you the difference.

Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

Florida Combined Life Dental Plans



VIDEO LINK

Find the dentist that best meets your needs!

1

Go to www.floridabluedental.com

- Click **Find a Dentist**, found in the navigation bar along the top of the page.
- Go to **Dentist Information** on the second line and choose **Type of Dentist** and enter the Dentist's name.

2

Choose your dental insurance plan

- Choose your dental insurance plan from the drop-down menu under **Insurance Plan Information** (this information is available on your BlueDental ID card.) Selecting your plan ensures that your search will only list providers who are part of your plan's network.

3

Choose your location

- Narrow your search by Zip Code/Distance, Address or County and click **Search**.
- If you'd like to narrow your search even further, click **within** and enter a distance. This feature will allow you to narrow your search for a dentist based on the nearest location to you.

Need help finding a dentist in your area? We can help!
Just call 1-888-223-4892 or visit us online at www.FloridaBlueDental.com.

Vision Plans

NEW VISION PROVIDER!

EyeMed

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering[1]:

- America's largest vision network[2].
- In-network options for buying glasses and contacts online at glasses.com, lenscrafters.com, contactsdirect.com, targetoptical.com, oakley.com, nuanceaudio.com and rayban.com — with benefits applied directly in the shopping cart.
- The right mix of independent eye doctors and national and regional retail providers — so you can go where you want, when you want.
- Separate contact lens fit & follow-up coverage leaving the entire allowance for materials!
- The freedom to choose any ophthalmic frame, lens or contact lens without restrictions at any of our retail providers, independent provider locations or online.
- Complimentary HealthyEyes wellness program keeps the focus on eye health with exam reminders and leading technology.
- Members can use their benefit on Nuance Audio glasses – a breakthrough dual hearing and vision solution.
- Members enjoy exclusive savings on LASIK, including up to $1,000 off at preferred providers or 5% off the in-store promotional price.[3]

Additional Discounts

- 40% off additional pairs of glasses
- 20% off any item not covered by the plan, including non-prescription sunglasses
- 15% off retail price or 5% off promotional price for Lasik or PRK from US Laser Network
- Up to 66% off hearing aids, with an extended warranty and free batteries through Amplifon Hearing Health Care Network
- Members can get exclusive additional discounts and deals that are often stackable with their vision benefits at eyemed.com/member

Tax-Free Vision Rates

	24 PAY PERIODS
Employee Only	$3.55
Employee + One	$8.56
Employee + Family	$12.37

Get the Maximum Value

- Cost transparency with our Know Before You Go cost estimator.
- Digital Tools like online scheduling[4], a mobile app and personalized text alerts.

Contact

EyeMed

Customer Service

Mon - Fri, 8 a.m. to 11 p.m. ET

1-866-939-3633

[1]This document provides highlights of one or more EyeMed plans. Frame allowances may vary by plan. Please consult your EyeMed representative for more information.
[2]Based on the EyeMed Insight network, Spring 2022.
[3]Preferred lasik providers include LasikPlus, TLC Laser Eye Centers and The LASIK Vision Institute
[4]At select locations

Vision Plans

SUMMARY OF BENEFITS		
VISION CARE SERVICES	**IN-NETWORK MEMBER COST**	**OUT-OF-NETWORK MEMBER REIMBURSEMENT**
EXAM SERVICES once every plan year		
Exam	$0 copay	Up to $40
FRAME in lieu of contacts once every plan year		
Frame	$0 copay; 20% off balance over $130 allowance	Up to $65
STANDARD PLASTIC LENSES in lieu of contacts once every plan year		
Single Vision	$0 copay	Up to $30
Bifocal	$0 copay	Up to $50
Trifocal/Lenticular	$0 copay	Up to $70
Progressive – Standard	$65 copay	Up to $50
Progressive – Premium Tier I, II, or III	$85, $95, $110 copay	Up to $50
Progressive – Premium Tier IV	$185 copay	Up to $50
Progressive – Premium Tier V	$225 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating – Standard	$45 copay	Up to $23
Anti Reflective Coating – Premium Tier I, II, or III	$57, $68, or $85 copay	Up to $23
Polycarbonate – Standard < 19 years of age	$0 copay	Up to $20
Scratch Coating – Standard Plastic	$0 copay	Up to $8
Tint - Solid or Gradient	$0 copay	Up to $8
CONTACT LENSES in lieu of frame and lenses once every plan year		
Contacts – Conventional	$0 copay; 15% off balance over $130 allowance	Up to $65
Contacts – Disposable	$0 copay; 100% of balance over $130 allowance	Up to $65
Contacts – Medically Necessary	$0 copay; paid-in-full	Up to $300

ADDITIONAL DISCOUNTS ABOVE THE PROPOSED PLAN BENEFITS	
VISION CARE SERVICES	**IN-NETWORK MEMBER COST**
EXAM SERVICES	
Retinal Imaging	Up to $39
CONTACT LENS FIT/FOLLOW-UP	
Fit and Follow-Up – Standard	Up to $40
Fit and Follow-Up – Premium	10% off retail price
LENS OPTIONS	
Photochromic – Non-Glass	$75
Polycarbonate – Standard	$40
UV Treatment	$15
All Other Lens Options	20% off retail price

Group Medical Bridge Plans

Colonial Life Group Medical Bridge Plans

If you got sick or hurt, would you be able to cover all of your medical expenses?

Even if you have coverage that helps with most of the expenses, you may still have to deal with deductibles, co-payments and co-insurance – not to mention all the other bills you're already paying each month, such as mortgage, groceries, electricity and gasoline.

Colonial Life's Hospital Confinement Indemnity Insurance plan offers added financial protection for those out-of-pocket costs related to a covered accident or a covered sickness.

Group Medical Bridge Plans

Plan Features

This plan is available to all eligible employees regardless of your medical plan choice.

Hospital Confinement Benefit

You will have a choice of $1,000 or $2,000 benefit. Benefit is payable once per covered person per year.

Accident Only Emergency Room Visit Benefit

Provides $150 benefit payable once per covered person per year for treatment in a hospital emergency room for a covered accident.

Benefits may be paid directly to you unless you specify otherwise (See Exclusions and Limitations for more information). Benefits are paid regardless of any other insurance you may have with other insurance companies. Coverage is available for you, your spouse and your eligible dependent children.

What Benefit is included?

A $1,000 or $2,000 hospital confinement benefit can help pay for the costs associated with a hospital stay. Maximum of one benefit per calendar year per covered person.

How are Benefits Paid?

- Benefits are paid directly to you, unless you specify otherwise.
- Your benefits are paid regardless of any other coverage you may have.

Exclusions and Limitations

We will not provide benefits for injuries received in accidents or sicknesses which are caused by: alcoholism, drug addiction, dental procedures, elective procedures, cosmetic surgery, felonies or illegal occupations, pregnancy of a dependent child, psychiatric or psychological conditions, suicide, intentional injuries, war, serving in the armed forces or giving birth within the first nine months after the certificate effective date. We will not pay benefits for hospital confinement of a newborn who is neither injured nor sick. We will not pay benefits for loss due to a pre-existing condition as defined in the certificate unless the pre-existing limitation period stated in the certificate schedule has been satisfied.* **If this claim is for an individual covered by Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.**

Provider

Visit **ColonialLife.com** to learn more about hospital confinement indemnity insurance and how it can help protect what really counts.

Colonial Life insurance products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

Coverage is subject to policy exclusions and limitations that may affect benefits payable. Products may vary by state and may not be available in all states. For cost and complete details, see your Professional Benefits Counselor.

*The pre-existing condition limitation (medical treatment, advice, or medication taken during the six-month period prior to the coverage effective date), has been waived for policies effective Jan. 1, 2021.

Group Medical Bridge Plans

Choice of $1,000 or $2,000 Hospital Confinement Benefit

All rates are based on your age on the effective date of coverage and will continue to be based on the original age for the life of the policy.

Hospital Confinement Benefit Amount: $1,000 BENEFIT AMOUNT Emergency Room Visit: $150 (ACCIDENT ONLY)	
Rates	**24 PAY PERIODS**
	Ages 17-49
Employee	$5.06
EE and Spouse	$9.11
EE and Children*	$8.03
EE and Family**	$12.10
	Ages 50-59
Employee	$6.44
EE and Spouse	$12.82
EE and Children*	$9.42
EE and Family**	$15.80
	Ages 60-64
Employee	$8.92
EE and Spouse	$18.55
EE and Children*	$11.89
EE and Family**	$21.53
	Ages 65+
Employee	$12.46
EE and Spouse	$25.83
EE and Children*	$15.43
EE and Family**	$28.81

Hospital Confinement Benefit Amount: $2,000 BENEFIT AMOUNT Emergency Room Visit: $150 (ACCIDENT ONLY)	
Rates	**24 PAY PERIODS**
	Ages 17-49
Employee	$9.83
EE and Spouse	$17.66
EE and Children*	$14.83
EE and Family**	$22.65
	Ages 50-59
Employee	$12.60
EE and Spouse	$25.07
EE and Children*	$17.59
EE and Family**	$30.07
	Ages 60-64
Employee	$17.55
EE and Spouse	$36.52
EE and Children*	$22.54
EE and Family**	$41.52
	Ages 65+
Employee	$24.63
EE and Spouse	$51.09
EE and Children*	$29.62
EE and Family**	$56.09

*Children includes eligible dependent children only.
**Family includes spouse and eligible dependent children.

Group Life/AD&D Insurance

SLPS is pleased to offer Group Term Life and AD&D Insurance coverage to you and your dependents through Lincoln Financial Group. You are eligible to enroll in the following Term Life Insurance offerings:

Basic Group Term Life Insurance

Seven levels of coverage from $10,000 to a maximum of $50,000. All levels are offered Guarantee Issue so you will not be asked any medical questions to enroll.

Additional Life & AD&D Insurance

Coverage available in multiples of $10,000 (up to $250,000 in Life and matching AD&D insurance coverage) on a Guaranteed Issue Basis during enrollment. If you are currently enrolled in the Additional Life or this is your first time being offered this as a new hire, you may increase your current coverage by any amount up to the Plan maximum of $250,000 on a Guaranteed Issue basis during this enrollment as well as future enrollments.

The Basic Life and Additional Life plans can be enrolled in conjunction with the other or independently. This allows for greater flexibility when selecting the amount of Life Insurance coverage that best suits your specific needs.

Spouse Life/AD&D Insurance

If you enroll, or are currently enrolled in one or both of the Lincoln Life plans available to you, you may also elect Spouse Life/AD&D Insurance in $5,000 increments up to $250,000 in life and matching AD&D insurance coverage. The amount you can purchase for your spouse cannot exceed 100% of your Life/AD&D Insurance amount. Evidence of insurability will be required for amounts exceeding $50,000 and for those outside of their initial eligibility period. Premiums will be based on the Employee's age when they enroll in the benefit.

Dependent Child(ren) Life/AD&D Insurance

You are now able to elect up to $10,000 in life and matching AD&D for all eligible dependent children, regardless of how many up to age 26. Dependent coverage ends on their 26th birthday. The amount you can purchase for your dependent cannot exceed 100% of the Additional Life/AD&D that you have elected for yourself.

Premium Waiver

If you are under the age of 65 and become totally disabled while insured under this plan and you complete a waiting period of 180 days your Basic and Additional Life and your child/spouse life insurance may continue without premium payment, subject to the terms of the group policy. AD&D will not continue while on waiver of premium. If you are on waiver of premium when you reach the age of 70 your Life Insurance coverage will automatically terminate. Call FBMC Service Center at **1-855-LUCIE4-U (1-855-582-4348**) for a waiver of premium application.

Staying Covered

Conversion Privileges at Termination

Portability

If your insurance ends because your employment terminates, you may be eligible to buy portable group term life insurance coverage from Lincoln.

Conversion Privileges at Termination

If your insurance reduces or ends, you may be eligible to convert your existing life insurance to an individual life insurance policy, without submitting proof of good health.

For more information on Portability and Conversion, please refer to your certificate of coverage or contact Lincoln at 877-321-1015.

Retirement

If you retire, you may continue your term life coverage. Call FBMC's Service Center at **1-855-LUCIE4-U (1-855-582-4348)** within the 31-day period before your retirement date to request a Continuation of Benefits Form.

Plan Provider

Lincoln Financial Group insures this plan. Lincoln has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Lincoln has developed a national presence in the employee benefits industry, providing customers with group and individual disability insurance and retirement plans, and group life and dental insurance.

Group Life/AD&D Insurance

There are seven levels of Basic Life that you may purchase for yourself:

	24 PAY PERIODS
Employee Coverage*	Premium Per Pay Period
$10,000	$1.55
$15,000	$2.33
$20,000	$3.10
$25,000	$3.88
$30,000	$4.65
$40,000	$6.20
$50,000	$7.75

*Your benefits decrease to 65% at age 65 and 50% at age 70.

Child Combined Life and AD&D Rates

Employees may purchase Child life in $2,000 increments up to a maximum of $10,000.

Coverage	Rate
$2,000	$0.12
$4,000	$0.23
$6,000	$0.35
$8,000	$0.46
$10,000	$0.58

Additional Life/AD&D Rates (Employee)

Employee Combined Life and AD&D maximum of $250,000. Benefits reduce to 65% at age 65, 50% at age 70.

	24 PAY PERIODS											
Coverage	15-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.33	$0.38	$0.48	$0.53	$0.58	$0.83	$1.28	$2.28	$3.38	$6.43	$12.58	$38.78
$20,000	$0.65	$0.75	$0.95	$1.05	$1.15	$1.65	$2.55	$4.55	$6.75	$12.85	$25.15	$77.55
$30,000	$0.98	$1.13	$1.43	$1.58	$1.73	$2.48	$3.83	$6.83	$10.13	$19.28	$37.73	$116.33
$40,000	$1.30	$1.50	$1.90	$2.10	$2.30	$3.30	$5.10	$9.10	$13.50	$25.70	$50.30	$155.10
$50,000	$1.63	$1.88	$2.38	$2.63	$2.88	$4.13	$6.38	$11.38	$16.88	$32.13	$62.88	$193.88
$60,000	$1.95	$2.25	$2.85	$3.15	$3.45	$4.95	$7.65	$13.65	$20.25	$38.55	$75.45	$232.65
$70,000	$2.28	$2.63	$3.33	$3.68	$4.03	$5.78	$8.93	$15.93	$23.63	$44.98	$88.03	$271.43
$80,000	$2.60	$3.00	$3.80	$4.20	$4.60	$6.60	$10.20	$18.20	$27.00	$51.40	$100.60	$310.20
$90,000	$2.93	$3.38	$4.28	$4.73	$5.18	$7.43	$11.48	$20.48	$30.38	$57.83	$113.18	$348.98
$100,000	$3.25	$3.75	$4.75	$5.25	$5.75	$8.25	$12.75	$22.75	$33.75	$64.25	$125.75	$387.75
$110,000	$3.58	$4.13	$5.23	$5.78	$6.33	$9.08	$14.03	$25.03	$37.13	$70.68	$138.33	$426.53
$120,000	$3.90	$4.50	$5.70	$6.30	$6.90	$9.90	$15.30	$27.30	$40.50	$77.10	$150.90	$465.30
$130,000	$4.23	$4.88	$6.18	$6.83	$7.48	$10.73	$16.58	$29.58	$43.88	$83.53	$163.48	$504.08
$140,000	$4.55	$5.25	$6.65	$7.35	$8.05	$11.55	$17.85	$31.85	$47.25	$89.95	$176.05	$542.85
$150,000	$4.88	$5.63	$7.13	$7.88	$8.63	$12.38	$19.13	$34.13	$50.63	$96.38	$188.63	$581.63
$160,000	$5.20	$6.00	$7.60	$8.40	$9.20	$13.20	$20.40	$36.40	$54.00	$102.80	$201.20	$620.40
$170,000	$5.53	$6.38	$8.08	$8.93	$9.78	$14.03	$21.68	$38.68	$57.38	$109.23	$213.78	$659.18
$180,000	$5.85	$6.75	$8.55	$9.45	$10.35	$14.85	$22.95	$40.95	$60.75	$115.65	$226.35	$697.95
$190,000	$6.18	$7.13	$9.03	$9.98	$10.93	$15.68	$24.23	$43.23	$64.13	$122.08	$238.93	$736.73
$200,000	$6.50	$7.50	$9.50	$10.50	$11.50	$16.50	$25.50	$45.50	$67.50	$128.50	$251.50	$775.50
$210,000	$6.83	$7.88	$9.98	$11.03	$12.08	$17.33	$26.78	$47.78	$70.88	$134.93	$264.08	$814.28
$220,000	$7.15	$8.25	$10.45	$11.55	$12.65	$18.15	$28.05	$50.05	$74.25	$141.35	$276.65	$853.05
$230,000	$7.48	$8.63	$10.93	$12.08	$13.23	$18.98	$29.33	$52.33	$77.63	$147.78	$289.23	$891.83
$240,000	$7.80	$9.00	$11.40	$12.60	$13.80	$19.80	$30.60	$54.60	$81.00	$154.20	$301.80	$930.60
$250,000	$8.13	$9.38	$11.88	$13.13	$14.38	$20.63	$31.88	$56.88	$84.38	$160.63	$314.38	$969.38

Group Life/AD&D Insurance

Additional Life/AD&D Rates (Spouse)

Spouse Combined Life and AD&D maximum is the lesser of 100% of the employee election or $250,000.
Spouse Premiums will be based on the **Employee's** age when they enroll in the benefit.

	24 PAY PERIODS											
Coverage	**15-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75+**
$5,000	$0.16	$0.19	$0.24	$0.26	$0.29	$0.41	$0.64	$1.14	$1.69	$3.21	$6.29	$19.39
$10,000	$0.33	$0.38	$0.48	$0.53	$0.58	$0.83	$1.28	$2.28	$3.38	$6.43	$12.58	$38.78
$15,000	$0.49	$0.56	$0.71	$0.79	$0.86	$1.24	$1.91	$3.41	$5.06	$9.64	$18.86	$58.16
$20,000	$0.65	$0.75	$0.95	$1.05	$1.15	$1.65	$2.55	$4.55	$6.75	$12.85	$25.15	$77.55
$25,000	$0.81	$0.94	$1.19	$1.31	$1.44	$2.06	$3.19	$5.69	$8.44	$16.06	$31.44	$96.94
$30,000	$0.98	$1.13	$1.43	$1.58	$1.73	$2.48	$3.83	$6.83	$10.13	$19.28	$37.73	$116.33
$35,000	$1.14	$1.31	$1.66	$1.84	$2.01	$2.89	$4.46	$7.96	$11.81	$22.49	$44.01	$135.71
$40,000	$1.30	$1.50	$1.90	$2.10	$2.30	$3.30	$5.10	$9.10	$13.50	$25.70	$50.30	$155.10
$45,000	$1.46	$1.69	$2.14	$2.36	$2.59	$3.71	$5.74	$10.24	$15.19	$28.91	$56.59	$174.49
$50,000	$1.63	$1.88	$2.38	$2.63	$2.88	$4.13	$6.38	$11.38	$16.88	$32.13	$62.88	$193.88
$55,000	$1.79	$2.06	$2.61	$2.89	$3.16	$4.54	$7.01	$12.51	$18.56	$35.34	$69.16	$213.26
$60,000	$1.95	$2.25	$2.85	$3.15	$3.45	$4.95	$7.65	$13.65	$20.25	$38.55	$75.45	$232.65
$65,000	$2.11	$2.44	$3.09	$3.41	$3.74	$5.36	$8.29	$14.79	$21.94	$41.76	$81.74	$252.04
$70,000	$2.28	$2.63	$3.33	$3.68	$4.03	$5.78	$8.93	$15.93	$23.63	$44.98	$88.03	$271.43
$75,000	$2.44	$2.81	$3.56	$3.94	$4.31	$6.19	$9.56	$17.06	$25.31	$48.19	$94.31	$290.81
$80,000	$2.60	$3.00	$3.80	$4.20	$4.60	$6.60	$10.20	$18.20	$27.00	$51.40	$100.60	$310.20
$85,000	$2.76	$3.19	$4.04	$4.46	$4.89	$7.01	$10.84	$19.34	$28.69	$54.61	$106.89	$329.59
$90,000	$2.93	$3.38	$4.28	$4.73	$5.18	$7.43	$11.48	$20.48	$30.38	$57.83	$113.18	$348.98
$95,000	$3.09	$3.56	$4.51	$4.99	$5.46	$7.84	$12.11	$21.61	$32.06	$61.04	$119.46	$368.36
$100,000	$3.25	$3.75	$4.75	$5.25	$5.75	$8.25	$12.75	$22.75	$33.75	$64.25	$125.75	$387.75
$105,000	$3.41	$3.94	$4.99	$5.51	$6.04	$8.66	$13.39	$23.89	$35.44	$67.46	$132.04	$407.14
$110,000	$3.58	$4.13	$5.23	$5.78	$6.33	$9.08	$14.03	$25.03	$37.13	$70.68	$138.33	$426.53
$115,000	$3.74	$4.31	$5.46	$6.04	$6.61	$9.49	$14.66	$26.16	$38.81	$73.89	$144.61	$445.91
$120,000	$3.90	$4.50	$5.70	$6.30	$6.90	$9.90	$15.30	$27.30	$40.50	$77.10	$150.90	$465.30
$125,000	$4.06	$4.69	$5.94	$6.56	$7.19	$10.31	$15.94	$28.44	$42.19	$80.31	$157.19	$484.69
$130,000	$4.23	$4.88	$6.18	$6.83	$7.48	$10.73	$16.58	$29.58	$43.88	$83.53	$163.48	$504.08
$135,000	$4.39	$5.06	$6.41	$7.09	$7.76	$11.14	$17.21	$30.71	$45.56	$86.74	$169.76	$523.46
$140,000	$4.55	$5.25	$6.65	$7.35	$8.05	$11.55	$17.85	$31.85	$47.25	$89.95	$176.05	$542.85
$145,000	$4.71	$5.44	$6.89	$7.61	$8.34	$11.96	$18.49	$32.99	$48.94	$93.16	$182.34	$562.24
$150,000	$4.88	$5.63	$7.13	$7.88	$8.63	$12.38	$19.13	$34.13	$50.63	$96.38	$188.63	$581.63
$155,000	$5.04	$5.81	$7.36	$8.14	$8.91	$12.79	$19.76	$35.26	$52.31	$99.59	$194.91	$601.01
$160,000	$5.20	$6.00	$7.60	$8.40	$9.20	$13.20	$20.40	$36.40	$54.00	$102.80	$201.20	$620.40
$165,000	$5.36	$6.19	$7.84	$8.66	$9.49	$13.61	$21.04	$37.54	$55.69	$106.01	$207.49	$639.79
$170,000	$5.53	$6.38	$8.08	$8.93	$9.78	$14.03	$21.68	$38.68	$57.38	$109.23	$213.78	$659.18
$175,000	$5.69	$6.56	$8.31	$9.19	$10.06	$14.44	$22.31	$39.81	$59.06	$112.44	$220.06	$678.56
$180,000	$5.85	$6.75	$8.55	$9.45	$10.35	$14.85	$22.95	$40.95	$60.75	$115.65	$226.35	$697.95
$185,000	$6.01	$6.94	$8.79	$9.71	$10.64	$15.26	$23.59	$42.09	$62.44	$118.86	$232.64	$717.34
$190,000	$6.18	$7.13	$9.03	$9.98	$10.93	$15.68	$24.23	$43.23	$64.13	$122.08	$238.93	$736.73
$195,000	$6.34	$7.31	$9.26	$10.24	$11.21	$16.09	$24.86	$44.36	$65.81	$125.29	$245.21	$756.11
$200,000	$6.50	$7.50	$9.50	$10.50	$11.50	$16.50	$25.50	$45.50	$67.50	$128.50	$251.50	$775.50
$205,000	$6.66	$7.69	$9.74	$10.76	$11.79	$16.91	$26.14	$46.64	$69.19	$131.71	$257.79	$794.89
$210,000	$6.83	$7.88	$9.98	$11.03	$12.08	$17.33	$26.78	$47.78	$70.88	$134.93	$264.08	$814.28
$215,000	$6.99	$8.06	$10.21	$11.29	$12.36	$17.74	$27.41	$48.91	$72.56	$138.14	$270.36	$833.66
$220,000	$7.15	$8.25	$10.45	$11.55	$12.65	$18.15	$28.05	$50.05	$74.25	$141.35	$276.65	$853.05
$225,000	$7.31	$8.44	$10.69	$11.81	$12.94	$18.56	$28.69	$51.19	$75.94	$144.56	$282.94	$872.44
$230,000	$7.48	$8.63	$10.93	$12.08	$13.23	$18.98	$29.33	$52.33	$77.63	$147.78	$289.23	$891.83
$235,000	$7.64	$8.81	$11.16	$12.34	$13.51	$19.39	$29.96	$53.46	$79.31	$150.99	$295.51	$911.21
$240,000	$7.80	$9.00	$11.40	$12.60	$13.80	$19.80	$30.60	$54.60	$81.00	$154.20	$301.80	$930.60
$245,000	$7.96	$9.19	$11.64	$12.86	$14.09	$20.21	$31.24	$55.74	$82.69	$157.41	$308.09	$949.99
$250,000	$8.13	$9.38	$11.88	$13.13	$14.38	$20.63	$31.88	$56.88	$84.38	$160.63	$314.38	$969.38

Short-Term Disability

Short-Term Disability will help to replace a portion of your income when you're unable to work.

If you are unable to work for a few weeks due to a covered injury, illness or even childbirth, Lincoln Short Term Disability Insurance can provide an ongoing benefit to help keep your finances stable.

If you are outside of your initial eligibility period and you choose to enroll in the STD plan you will be asked to submit Evidence of Insurability in order to qualify for coverage.

STD Post-Tax Rates	24 PAY PERIODS
Plan A	$8.63
Plan B	$10.04
Plan C	$11.19
Plan D	$12.86

This insurance plan provides up to 60% of your weekly pay:

- **Plan A** - This insurance plan provides up to 60% of your weekly salary up to a maximum of $300 per week.
- **Plan B** - This insurance plan provides up to 60% of your weekly salary up to a maximum of $500 per week.
- **Plan C** - This insurance plan provides up to 60% of your weekly salary up to a maximum of $600 per week.
- **Plan D** - This insurance plan provides up to 60% of your weekly salary up to a maximum of $750 per week.

Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

What's considered a "disability"?

You are considered disabled if:

- An injury or sickness leaves you unable to perform all the material duties of your regular job and
- After 24 months of receiving monthly benefits, you are unable to perform all the material duties of any job for which you are or may reasonably become qualified based on your education, training or experience.

Eligibility for Coverage

To receive coverage under this plan, you must be an active, full-time employee of the Board who is eligible for the flexible benefits plan.

How do I know which level of coverage to select?

Consider your annual salary when selecting a level of coverage to provide you and your family the most protection.

- If your annual salary is **$26,000** or less, **Plan A** offers the best coverage for your salary.
- If your annual salary is over **$26,000** but no more than **$43,333**, **Plan B** offers the best coverage for your salary.
- If your annual salary is over **$43,333** but no more than **$52,000**, **Plan C** offers the best coverage for your salary.
- If your annual salary is greater than **$52,000**, **Plan D** offers the best coverage for your salary.

Short-Term Disability

How long are my benefits payable?

Once you qualify for benefits under this plan, you will continue to receive them until the end of the 13-week benefit period, or until you no longer qualify for benefits, whichever occurs first.

Benefits payable under this plan will terminate on the earliest of any date indicated below:

- The date we determine you are no longer disabled
- The date you earn from any occupation more than the percentage of your covered earnings – as defined in your definition of disability
- The date the maximum benefit period ends
- The date you cease to get appropriate care
- The date of your death
- The date you fail to cooperate with us in the administration of the claim

What is my benefit waiting period?

Before collecting benefits, you must satisfy an elimination period following your date of disability. For your plan, this period is 14 consecutive days of continuous disability from either accident or sickness.

How will I determine if I am disabled?

Disabled means solely because of a covered injury or sickness, you are unable to perform the material and substantial duties of your regular occupation or you are unable to earn 80% or more of your covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.

Important facts about short-term disability

Work Incentive Benefits – are designed to allow a disabled employee to return to work while considered disabled, and to continue to receive weekly benefits (benefit will be offset if the sum of disability benefit, current earnings and any other income benefits exceeds 100% of weekly covered earnings).

Rehabilitation During Disability – If you are offered a rehabilitation assistance program, we will work with you during the course of your elimination period or while benefits are payable. You are encouraged to cooperate with the implementation of that assistance program in an effort to return to work.

Note: There is a minimum benefit of $25.

What if I have a pre-existing condition?

If your disability results directly or indirectly from a pre-existing sickness or injury for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or consulted a physician within 12 months before the most recent effective date of your insurance, you will receive no weekly benefit for that condition. However, this limitation does not apply to a period of disability that begins more than 12 months after the most recent effective date of your insurance. The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits.

What's not covered?

Benefits are not payable for disability resulting from:

- Suicide, attempted suicide, or whenever you injure yourself on purpose
- War or any act of war, whether or not declared
- Active participation in a riot
- Commission of a felony
- Cosmetic surgery or medically unnecessary surgical procedures (Medically necessary means prescribed by a licensed physician as required treatment for a sickness or injury and appropriate according to conventional medical practice in the locality where it is performed. Benefits are payable if the disability is caused by your donation of an organ in a non-experimental organ transplant procedure.)
- The revocation, restriction or non-renewal of your license, permit or certification necessary for you to perform the duties of your occupation, unless solely due to injury or sickness otherwise covered by the policy

In addition, we will not pay disability benefits for any period of disability during which you are incarcerated in a penal or corrections institution for any reason.

Who is eligible for coverage?

All active, full-time employees of SLPS who are eligible for fringe benefits.

When Coverage Takes Effect

If you meet these eligibility requirements, your coverage takes effect on the latter of the program's effective date, the date you become eligible, the date we receive your completed enrollment form or the date you authorize any necessary payroll deductions.

If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you. If you're not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

Short-Term Disability

Effects of Other Income Benefits

- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf; or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits
- Benefits payable by a Canadian and/or Quebec provincial pension plan
- Amounts payable under the Railroad Retirement Act
- Amounts payable under any local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer
- Employer-paid portion of company retirement plan benefits
- Amounts payable by company-sponsored sick leave or
- salary continuation plan
- Amounts payable by any individual, franchise or group insurance or similar plan
- Benefits payable under work-loss provisions of any mandatory “no fault” auto insurance
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration, or otherwise, where a third party may be liable, regardless of whether liability is determined

Income sources that WILL NOT reduce your benefits under this plan are:

- Benefits paid by personal, individual disability income policies
- Individual deferred compensation agreements
- Employee savings plans, including thrift plans, stock options, or stock bonuses
- Individual retirement funds, such as IRA or 401(k) plans
- Profit-sharing, investment or other retirement or savings plans maintained in addition to an employer-sponsored pension plan

This information is a brief description of the important features of this plan. It is not a contract. Terms and conditions of the short-term disability coverage are set forth in the Group Policy, issued in Florida and subject to its laws. The availability of this offer may change. Please keep this material as a reference, and file it with your certificate, should you become insured.

Submit a Claim:

You can file a claim online by registering for an online account via MyLincolnPortal.com. Our secure web services allow you to download claim forms, access and make changes to your open claims, as well as view updates and available correspondence.

Please provide the following information when filing a short-term disability claim:

- Your name, address, phone number, birth date, date of hire, Social Security number and employer’s name, address, and phone number.
- The date and cause of your disability, as well as your anticipated return-to-work date. If your disability is due to pregnancy, provide the actual or expected date of delivery.
- The name, address, phone number of each doctor you are seeing or have seen for the disability causing your illness or injury.

Plan Provider

Coverage is underwritten by:

Lincoln Financial Group

Client Code - LF1167STL

MyLincolnPortal.com

877-321-1015

Long-Term Disability

With Long-term Disability, you can get payments of up to 60% of your income for a covered accident or serious illness.

You never expect a serious illness or accident to happen, but when it does, it can interrupt your ability to work for months — even years. Long Term Disability Insurance can give you the financial support you need to manage your disability and your household.

If you choose to enroll in the LTD plan and you are outside of your initial eligibility period, you will be asked to submit Evidence of Insurability in order to qualify for coverage.

LTD Post-Tax Rates	24 PAY PERIODS
Plan I	$6.49
Plan II	$8.34
Plan III	$12.61
Plan IV	$14.50
Plan V	$16.19

Plans

Plan I - The monthly maximum benefit is $1,200 or 60% per payroll covered earnings, whichever is less.

Plan II - The monthly maximum benefit is $1,800 or 60% per payroll covered earnings, whichever is less.

Plan III - The monthly maximum benefit is $2,500 or 60% per payroll covered earnings, whichever is less.

Plan IV - The monthly maximum benefit is $3,750 or 60% per payroll covered earnings, whichever is less.

Plan V - The monthly maximum benefit is $5,000 or 60% per payroll covered earnings, whichever is less.

Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

The minimum monthly benefit for all five levels of coverage is $200 or 30% of your monthly benefit, whichever is less, regardless of other income you or your dependents receive during your disability.

How do I know which level of coverage to select?

Consider your annual salary when selecting a level of coverage to provide you and your family the most protection.

- **Plan I** offers the best coverage if your annual salary is less than $24,000.
- **Plan II** offers the best coverage if your annual salary is between $24,000 & $36,000.
- **Plan III** offers the best coverage if your annual salary is between $36,000 & $50,000.
- **Plan IV** offers the best coverage if your annual salary is between $50,000 & $75,000.
- **Plan V** offers the best coverage if your annual salary is greater than $75,000.

Plan Features

- Benefits start after 90 days of continuous disability. A period of disability will be considered even if you return to full-time work in your regular job for up to a total of 30 days during the Benefit Waiting Period. The Benefit Waiting Period will be extended by the number of days you temporarily return to work.
- Benefits are payable monthly up to age 65, if disabled before age 63. If you become disabled between the ages of 63 and 69, benefits are payable on a decreasing scale. A maximum one year benefit is paid for disabilities that begin at age 69 or older.
- Benefits under this plan will be coordinated with Workers' Compensation, Social Security Disability Benefits or any other group benefits to ensure you receive up to 60% of your monthly income.

Long-Term Disability

Effects of Other Income Benefits

Disability insurance is designed to help you meet your financial obligations if you cannot work as a result of a covered injury or sickness. The disability benefit provided by this plan is a total benefit. It will be reduced by any disability benefits payable on behalf of you or your dependents, whether or not you are actually receiving them. Your disability benefits will not be reduced by Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you receive them.

Other income sources that may reduce your benefits under this plan:

- Employer-paid portion of company retirement plan benefits
- Amounts payable under local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer
- Amounts payable under any Workers' Compensation (including temporary or permanent disability benefits), occupational disease, and unemployment compensation. This includes damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted
- Amounts payable by company-sponsored sick leave or
- salary continuation plan
- Amounts payable by any franchise or group insurance or similar plan
- Benefits payable by a Canadian and/or Quebec provincial pension plan
- Amounts payable under the Railroad Retirement Act
- Benefits payable under work-loss provisions of any mandatory "no fault" auto insurance
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined
- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf; or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits

Income sources that WILL NOT reduce your benefits under this plan are:

- Benefits paid by personal, individual disability income policies
- Individual deferred compensation agreements
- Employee savings plans, including thrift plans, stock options or stock bonuses
- Individual retirement funds, such as IRA or 401(k) plans
- Profit sharing, investment or other retirement or savings plans maintained in addition to an employer-sponsored pension plan
- This benefit will **NOT** be dependent on your first utilizing your available sick and/or vacation before you will receive your benefits. However, if time off **IS** used, your benefits will be reduced.

What's considered a "disability"?

You are considered disabled if:

- An injury or sickness that leaves you unable to perform ANY of the material duties of your regular occupationThe insured has a 20% or more loss of indexed monthly earnings due to the same sickness or injury
- After 24 months of receiving monthly benefits, you are unable to perform all the material duties of any occupation for which you are or may reasonably become qualified based on your education, training or experience
- Amounts payable by company-sponsored sick leave or salary continuation plan

How long are my benefits payable?

If you are disabled at or before age 62, your benefits are payable monthly up to age 65, or the date of the 42nd monthly benefit, whichever is later. For disabilities that commence between age 63 and age 69, benefits are payable on a decreasing scale, with a maximum one-year benefit period for disabilities that commence at age 69 or older.

Age Disability Began	Date Monthly Benefits Cease
Age 62 or Under	The latter of: (a) your 65th birthday; or (b) the date the 42nd monthly benefit is payable;
Age 63	The date the 36th monthly benefit is payable;
Age 64	The date the 30th monthly benefit is payable;
Age 65	The date the 24th monthly benefit is payable;
Age 66	The date the 21st monthly benefit is payable;
Age 67	The date the 18th monthly benefit is payable;
Age 68	The date the 15th monthly benefit is payable;
Age 69 or Over	The date the 12th monthly benefit is payable.

Pre-Existing Conditions

If your disability results, directly or indirectly, from a pre-existing sickness or injury for which you incurred expenses, received medical treatment, took prescribed drugs or consulted a physician in the three months before the most recent effective date of your insurance, you will receive no monthly benefits for that condition. However, this limitation does not apply to a total disability that begins more than 12 months after the most recent effective date of your insurance.

If you are currently enrolled in the LTD plan prior to this year's enrollment, you are grandfathered into your existing plan and will not be subject to the Pre-exisiting Condition Limitation.

Note: This information is a brief description of the important features of this plan. It is not a contract. Terms and conditions of the long-term disability coverage are set forth in the Group Policy, issued in Florida and subject to its laws. The availability of this offer may change please keep this material as a reference, and file it with your certificate, should you become insured.

Long-Term Disability

Family Survivor Benefit

The plan also includes a Family Survivor Benefit feature. With this feature, if you die after collecting disability benefits for six or more consecutive months, we pay an amount equal to 100% of the total of your last month's benefit plus any other earnings by which this benefit had been reduced. We continue this benefit for a period of three months.

We pay this benefit directly to your lawful spouse, or to your children (in equal shares), if there is no lawful spouse.

What's Not Covered

No Monthly Benefits will be paid if your disability results, directly or indirectly, from:

- Intentionally self-inflicted injuries while sane or insane
- Any act or hazard of a declared or undeclared war and
- Illnesses or injuries if you are not under the care and supervision of a licensed physician.

Mental Illness, Alcoholism and Drug Abuse Limitation

You can receive payments for a covered disability which does not require hospitalization but results from mental illness, alcoholism or drug abuse for a maximum of 24 months. After 24 months, the benefit will continue only while the disabled employee is institutionalized or hospitalized because of the disabling condition. After being discharged, benefits may continue for up to 90 days.

Monthly benefits will be payable for no more than 24 months during your lifetime for disability or residual disability caused or contributed to by one or more of the following conditions:

- Alcoholism
- Drug addiction or abuse
- Bipolar affective disorder (manic depressive syndrome)
- Schizophrenia
- Delusional (paranoid) disorders
- Psychotic disorders
- Depressive disorders
- Anxiety disorders
- Somatoform disorders (psychosomatic illness)
- Eating disorders
- Mental Illness

Premiums Waived

If your disability entitles you to receive benefits from this plan, your premiums will be waived while you receive benefits.

Conversion Privilege

If you terminate employment or if coverage ends for any reason except non-payment of premium, you can convert this plan to an individual policy by applying for conversion within 31 days of termination. You do not have to submit evidence of good health if you apply within the 31 days. Contact Lincoln's Service Center at **877-321-1015** to request a Conversion Application.

- the date the plan is terminated by the insurer or the employer
- the day after the last date for which premium has been paid by you or the employer
- the date you become eligible for a plan of benefits intended to replace this coverage.

If you are disabled and receiving benefits under this plan, your benefits and coverage will continue until the expiration of your benefit period, or until you no longer qualify for benefits under the plan, whichever occurs first.

Disclaimer

Underwritten by Lincoln Financial Group. This information is not intended to be a complete description of the insurance coverage available. The policy has exclusions and limitations, which many affect any benefits payable. For complete details of coverage and availability, please refer to the group disability contract

To Submit a Claim:

You can file a claim online by registering for an online account via MyLincolnPortal.com. Our secure web services allow you to download claim forms, access and make changes to your open claims, as well as view updates and available correspondence.

Plan Provider

Coverage is underwritten by:

Lincoln Financial Group

Lincoln FuneralPrep

Lincoln Financial Group®

Lincoln FuneralPrep: Help when you need it most

With many details to manage and decisions to make, the funeral planning process can be overwhelming. To help you every step of the way, we've partnered with **FuneralDecisions.com** to provide Lincoln FuneralPrep, a comprehensive planning service.

What is Lincoln FuneralPrep?

An online portal that provides a breadth of resources, Lincoln FuneralPrep can help with at-need planning or pre-planning — 24 hours a day.

At-need planning

When grieving the loss of a loved one, you're dealing with far more than a life insurance claim. Lincoln FuneralPrep helps you reduce the stress and uncertainty of making urgent decisions during an emotional time.

Pre-planning

Being prepared is one of the best things you can do for your family. In addition to providing pre-planning resources, Lincoln FuneralPrep can direct you to funeral professionals who can provide expert guidance and advice.

Lincoln FuneralPrep

How to access Lincoln FuneralPrep

You can access Lincoln FuneralPrep in two ways.

1 Visit the self-service online portal: LincolnFuneralPrep.com/GPLife.

The online portal at LincolnFuneralPrep.com/GPLife includes a wealth of online funeral planning resources and services, including the ability to:

Search for funeral homes
Access an interactive list of funeral homes and cemeteries around the country. You can filter by location, service, and budget.

Access market information
Review price ranges and service options in your selected geographic location.

View guides and checklists
Organize your priorities, consider your options, and make informed decisions based on your preferences with our handy online guides and checklists.

2 Connect with a funeral planning consultant

Work with a funeral planning expert who can guide you through the pre-planning process and:

Help compare options
Get help comparing pre-planning options, even if you don't have a specific funeral home in mind.

Provide personalized service
Work with our experts to ensure your plans reflect your wishes and meet your objectives.

Offer objective guidance
Get guidance on planning options and various funding strategies.

During difficult times, we're here for you and your loved ones.

To learn more, visit LincolnFuneralPrep.com/GPlife.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3795167-092721
ADA 1/23 **Z08**
Order code: LFE-FNPRP-FLI001

Lincoln Financial Group®

Group insurance products and services described herein are issued by The Lincoln National Life Insurance Company.

Not available in New York.

Lincoln EmployeeConnect

Lincoln Financial Group®

Employee Assistance Program

The resources you need to meet life's challenges

EmployeeConnect℠ offers professional, confidential services to help you and your loved ones improve your quality of life.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services any time — online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, and consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit **GuidanceResources.com** or download the **GuidanceNow**℠ mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

EmployeeConnect℠

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
- Parenting
- Addictions
- Emotional
- Legal
- Financial
- Relationships
- Stress

LTD-EAPEE-FLI001_Z03

Lincoln EmployeeConnect

We partner with your employer to offer this service at no additional cost to you!

EmployeeConnect counselors are experienced and credentialed.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills, and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*

For more information about the program, visit **GuidanceResources.com**, download the **GuidanceNow** mobile app, or call **888-628-4824**.

GuidanceResources.com login credentials:

Username: LFGSupport Password: LFGSupport1

LincolnFinancial.com

LCN-4917687-082422
MAP 9/22 **Z04**
Order code: LTD-EAPEE-FLI001

Lincoln Financial Group®

*EmployeeConnect*SM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

To find out more:

- Visit GuidanceResources.com
  username: LFGSupport password: LFGSupport1
- Download the GuidanceNowSM mobile app
- Call 888-628-4824

Lincoln Financial Group® | ComPsych® GuidanceResources® Worldwide

Lincoln LifeKeys

Lincoln Financial Group®

Because life doesn't always go as planned.

No matter how well you plan, unexpected challenges arise. When they do, help and support are nearby—thanks to *LifeKeys*® services from Lincoln Financial Group.

LifeKeys services include:

Discounts on shopping and entertainment

GuidanceResources® includes 24/7 online access to the Working Advantage discount network. You can save up to 60% on a variety of products and services, including electronics, health and fitness, Broadway shows, and much more. Discounts are also available in the GuidanceNow mobile app, available in the Apple App Store and on Google Play.

Help with important life matters

You'll find support tools and advice on a wide range of topics, including legal, financial, family, and career, on GuidanceResources online. Stay in the know on matters that impact your personal and professional life.

Protection against identity theft

Identity theft is widespread, and everyone is vulnerable. *LifeKeys* includes an online resource for information that can help you recognize and prevent identity theft — and restore your good name should your identity be compromised.

Online will preparation

Creating a will allows you to make vital decisions ahead of time, including naming a guardian for your children or designating who will receive your property and assets after you pass away. Without a will, state officials will distribute your estate. *EstateGuidance*® offers a secure, efficient way to create and execute a will so you can rest easy knowing you've planned ahead for your family.

Guidance and support for your beneficiaries

LifeKeys is a comprehensive program that offers resources to help your loved ones address a range of common concerns should they experience a loss. Services include grief counseling, financial and legal advice, and support when coping with the challenges of day-to-day life. Services are detailed on page 2.

Lincoln LifeKeys

Your life and accidental death and dismemberment (AD&D) insurance policies include access to a wide range of services to help you and your loved ones navigate life's most important matters.

Help, guidance, and support for beneficiaries following a loss

The emotional impact of losing a loved one can be deep and long-lasting. All too often, financial or legal issues can add to the stress. *LifeKeys* services can be a welcome resource for your beneficiaries.

Your beneficiaries will have access to six in-person sessions for grief counseling, legal or financial information, and unlimited phone counseling. Services are available for up to one year after a loss.

Grief counseling — advice, information, and referrals on:

- Coping with loss
- Stress, anxiety, and depression
- Memorial planning information
- Concerns about family, including children and teens

Legal support — access to legal information on:

- Estate and probate law
- Real estate transactions
- Social Security survivor and child benefits
- Important documents for beneficiaries

Financial services — online resources and advice from financial specialists on:

- Estate planning
- Budgeting
- Overcoming debt
- Bankruptcy
- Investments

Help with everyday life — comprehensive information on:

- Finding child care or elder care
- Financing a home
- Moving and relocation
- Making major purchases

Access *LifeKeys* services. Visit GuidanceResources.com, download the GuidanceNow mobile app, or call 855-891-3684. First-time users: enter web ID: LifeKeys.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3985132-121521
MAP 1/22 **Z04**
Order code: LFE-LKEYE-FLI001

Lincoln Financial Group®

LifeKeys® services are provided by ComPsych® Corporation, Chicago, IL. ComPsych® is not a Lincoln Financial Group® company. Coverage is subject to actual contract language. Each independent company is solely responsible for its own obligations. GuidanceResources® is a trademark of ComPsych® Corporation.

State limitations apply. Beneficiary grief counseling is the only benefit available to a beneficiary(ies) of policies issued in the state of New York. Online will prep is the only benefit available to insured employee and dependents of policies issued in the state of Washington.

Lincoln TravelConnect

Caring support and assistance when you travel

Lincoln *TravelConnect*® services offer security and reassurance – helping make travel less stressful. If you're enrolled in life and/or accidental death and dismemberment insurance, you and your loved ones can count on *TravelConnect*® services 24 hours a day, 7 days a week.

Services you can count on during an emergency

You'll have dedicated support if you face an emergency when you're 100 or more miles from home. *TravelConnect*® helps with:

- Arranging travel if you're injured and need emergency evacuation to a medical facility
- Managing travel for a companion and/or your dependent children, including transportation expenses and accommodations of a qualified escort
- Planning and paying for a safe evacuation because of a natural disaster or a political or security threat
- Arranging transportation of a deceased traveler
- Securing emergency pet boarding and/or return and vehicle return

Ongoing support when you're far from home

From planning the trip until you're home, these *TravelConnect*® services can help you on your way.

- Medical record requests
- Medication and vaccine delivery
- Medical, dental, and pharmacy referrals
- Corrective lenses and medical device replacement
- Legal consultation
- Recovering lost or stolen documents or luggage
- ID recovery assistance
- Language translation services
- Destination information

TravelConnect®

GLOBAL ASSISTANCE PROGRAM

Provided by On Call International

Medical, security, and travel assistance services for participants traveling 100+ miles from home

Visit MyOnCallPortal.com and enter Group ID: **LFGTravel123** for access to plan documents, international calling instructions, and destination information.

LFE-TRVFE-FLI001

Lincoln TravelConnect

For a complete list of *TravelConnect*® services, go to **MyOnCallPortal.com** and enter Group ID **LFGTravel123.**

TravelConnect® services are provided by On Call International, Salem, NH. On Call International is not a Lincoln Financial Group® company and Lincoln Financial Group does not administer these services. Each independent company is solely responsible for its own obligations. On Call International must coordinate and provide all arrangements in order for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions, and limitations, which can be found in the program description.

The *TravelConnect*® program is not available to insured employees and dependents of policies issued in the states of New York and Washington. Access Only program available to insured employees and dependents of policies issued in the state of Missouri and Texas. Benefits provided under the Access Only program exclude payment for paid services.

Not available in New York and Washington.

LincolnFinancial.com

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Affiliates are separately responsible for their own financial and contractual obligations.

LCN-3885715-102621
MAP 12/21 **Z03**
Order code: LFE-TRVFE-FLI001

Lincoln Financial Group®

If you need medical, security, or travel assistance, regardless of the nature or severity of your situation, contact On Call International 24 hours a day:

Call collect from anywhere in the world:
603-328-1955
Call toll free from U.S. or Canada:
866-525-1955
Email: mail@OnCallInternational.com

Global assistance services must be coordinated and approved by On Call in order to be covered.

See your plan description for full terms and conditions of the services offered in your plan.

On Call International
A member of the **Tokio Marine HCC** group of companies

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) lets you pay for eligible expenses with tax-free money. You contribute to an FSA with pretax money from your paycheck. This, in turn, may help lower your taxable income. There are two types of FSAs – **Healthcare FSA** and **Dependent Care FSA**.

Healthcare FSA

>> Minimum Annual Contribution: $150

>> Maximum Annual Contribution: $3,300

A Healthcare FSA is used to pay for eligible medical expenses which are not covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child, or 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.

Plan for Your FSA Savings

Worksheets will help you 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.

CLICK HERE FOR INSPIRA FINANCIAL SAVINGS CALCULATORS >>

Dependent Care FSA

>> Minimum Annual Contribution: $150

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

You can request reimbursement from your Dependent Care FSA after your dependent receives day care services. Unlike the Healthcare FSA, your full annual contribution is not available at the beginning of the plan year. You can only get reimbursed up to the amount that is available in your account at that time.

The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual contribution is $3,750
- If you are single and head of household, your maximum annual contribution is $7,500.
- If you are married and filing jointly, your maximum annual contribution is $7,500.
- If either you or your spouse earn less than $5,000 a year, your maximum annual contribution is equal to the lower of the two incomes.

Grace Period and Run-Out Period

You have a 90-day run-out period (ending March 30, 2027) after your 2026 plan year ends to submit reimbursement requests for all eligible FSA expenses incurred DURING your plan year.

You may, however, continue using only your Healthcare FSA during the grace period, which is two months and 15 days after the end of your 2026 plan year. Be sure to submit your grace period claims before the end of your 90-day run-out period.

Flexible Spending Accounts (FSA)

FSA Appeals and Managing Your FSA Online

Appeals Process

If you have an FSA reimbursement claim denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to:

Inspira Financial
Flex Department
PO Box 8396
Omaha, NE 68103-8369
- OR -
Fax to **1-855-703-5305**

Your appeal must include:

- The name of your employer
- The date of the services for which your request was denied
- A copy of the denied request
- The denial letter you received
- Why you think your request should not have been denied
- Any additional documents, information or comments you think may have a bearing on your appeal

Your appeal and supporting documentation will be reviewed upon receipt. 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.

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

Use your Inspira Financial Card®, your account debit card

The Inspira Financial debit card is a convenient way to pay for eligible Healthcare expenses. The card knows when the expense is eligible and whether you have funds available. When you use the card, save your Explanation of Benefits, itemized statements and detailed receipts. There may be times when Inspira Financial asks you to provide documentation to verify you used your card for an eligible expense. If you're a new Healthcare FSA member, 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.

Filing a Claim with PayFlex

If you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **inspirafinancial.com** or through the Inspira Financial Mobile® app to pay yourself back for your out of pocket expenses.

Or you can fill out a paper claim form and mail it to Inspira Financial at PO Box 8396, Omaha, NE 68108-0396 or fax it to PayFlex at 1-855-703-5305. This form can be found in the Resource Center at **inspirafinancial.com**.

After you log in to **inspirafinancial.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.

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

- Merchant or service provider name
- Name of patient (if applicable)
- Date of service
- Amount you were required to pay
- Description of item or service

How to Register Online

- Go to **inspirafinancial.com**.
- Click on "Create Your Profile" and follow the online instructions.
- After successfully registering your account, "My Dashboard" will be displayed and you will be able to access your account information.
- To receive electronic account notifications, select "My Settings" at the top of the page and:
  - Select the "Notifications" link
  - Enter your email address and then re-enter to confirm
  - Then select the notifications you wish to receive and click Submit.

Enroll in Direct Deposit

To receive your claim payments quickly, sign up for direct deposit through the Inspira Financial member website. Log in to **inspirafinancial.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.

Limited-Use Healthcare FSA

For HSA Participants Only

Participants enrolled in a Health Savings Account will not be eligible to enroll in a standard Healthcare FSA.

What is a Limited-Use Healthcare FSA?

A Limited-Use Healthcare FSA is designed specifically for employees who wish to take advantage of a Health Savings Account (HSA), while continuing to enjoy the tax savings expected from an FSA. Much like a Healthcare FSA, funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax free. **However, the funds in a Limited-Use Healthcare FSA can only be used for dental, vision and preventive care expenses not covered by your high deductible health plan**. Your HSA is designed to be used for all other medical-related expenses. A partial list of eligible Limited-Use Healthcare FSA expenses can be found on this page.

Aside from these minor differences, a Limited-Use Healthcare FSA follows the same procedures for reimbursement as a Healthcare FSA.

Minimum Annual Deposit:	**$150**
Maximum Annual Deposit:	**$3,300**

Whose expenses are eligible?

Your Limited-Use Healthcare Flexible Spending Account may be used to reimburse eligible expenses incurred by you, your spouse, your qualifying child or your qualifying relative. Please visit **inspirafinancial.com** for more information.

Registering Your Account

Go to **inspirafinancial.com** and click on "Create Your Profile" to get started.

Filing A Claim Online

After you log in, click on the “Financial Center” tab and select your account from the drop-down menu. Click on "File a Spending Account Claim" to get started.

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

- Merchant or service provider name
- Name of patient (if applicable)
- Date of service
- Amount you were required to pay
- Description of item or service

To receive your claim payments quickly, sign up for direct deposit through the Inspira Financial member website. Log in to **inspirafinancial.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.

When are my funds available?

Once you sign up for a Limited-Use Healthcare FSA 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 Jan. 1, 2025.

There is no administrative charge for a Limited-Use Healthcare FSA.

Partial List of Medically Necessary Eligible Expenses*

- Birth control pills and devices for dependent children.
- Contact lenses (corrective)
- Dental fees
- Eyeglasses
- Guide dogs
- LASIK
- Optometrist fees
- Orthodontic treatment

Note: Budget conservatively. No reimbursement or refund of Limited Healthcare FSA funds is available for services that do not occur within your plan year.
* IRS-qualified expenses are subject to federal regulatory change at any time during a tax year.

Legal Insurance Plan

Legal Insurance Plan

UltimateAdvisor®

Legal is everywhere in life. And legal insurance from ARAG® is an affordable, versatile benefit that helps you plan ahead while protecting against the unexpected. You have a nationwide network of attorneys on your side, ready whenever you need help with legal matters or financial issues. For example, you can consult with a network attorney who can help you create a will, fight a traffic ticket or take legal action regarding a dispute with a home contractor. Plus, network attorney fees are 100% paid in full for most covered legal matters.

Here are the kinds of situations where you could use the help of an attorney:

- You realize you need to create or update a will
- There's a charge that's not yours on your credit card bill
- You're thinking of adopting a child
- You want to sell your house and build or buy another one
- You have a legal dispute with a neighbor
- Your child is in trouble with the law

These situations happen every day – to people just like you. But now, with a legal plan, you can protect yourself when faced with legal issues. You'll have peace of mind that comes from having an attorney on your side.

UltimateAdvisor covers almost all of the legal situations you're likely to face. And given that attorneys charge up to *$368 per hour, the plan can protect you from huge legal expenses. Even if you use it only once a year, the plan will likely pay for itself.

* The national average hourly rate for attorneys with 11 to 15 years of experience is $368. "The Survey of Law Firm Economics: 2018 Edition." The National Law Journal and ALM Legal Intelligence, October 2018.

How legal insurance benefits you

- Receive 100% paid-in-full coverage for most covered legal matters when you work with a network attorney.
- Save thousands on average, for each legal matter.*
- Access a nationwide network of more than 14,000 attorneys who average 20 years of experience.
- Quickly address your covered legal situations with a network attorney for legal help and representation.
- Use DIY Docs® to create a variety of legally valid documents, including state-specific templates.

Legal Insurance Premium	24 PAY PERIODS
Premium Includes Eligible Dependents	$11.88

What the Plan Pays

Under the plan, you may choose to receive services from any attorney. However, In-Office Legal Services benefits are paid differently depending on whether you see a network attorney (an attorney who is a member of the plan) or you see a out-of-network attorney:

- If you work with a network attorney, the plan pays those attorney fees in full for most covered legal matters. That means there are no claims for you to file. The network attorney files a claim to be reimbursed directly by ARAG.
- You can view the profiles of network attorneys near you by using the "Find an Attorney" feature on the ARAG Legal app or going to **ARAGlegal.com/myinfo** and entering access code 18197slp. The profiles indicate their area of practice, years of experience and much more. If you need assistance in your search, you can also call ARAG Customer Care at **800-247-4184**.
- **Network Attorney Guarantee** -If you have difficulty connecting with a network attorney contact ARAG for help to receive full plan benefits on covered matters
- If you receive services from a out-of-network attorney, you pay the cost of legal services and then file a claim form along with your attorney's billing statement to ARAG. You will be reimbursed for covered expenses up to the lesser of actual costs or a scheduled amount outlined in your Certificate of Insurance. If you see an out-of-network attorney, you must notify ARAG within 60 days of consulting an out-of-network attorney. In addition, your claim for reimbursement must be received by ARAG within 180 days after you incur a legal expense.

Enrollment in this plan is for the entire calendar year. If you enroll, your cost of coverage per pay period will be paid on a post-tax basis.

For more information on UltimateAdvisor:

- Visit **ARAGlegal.com/myinfo** and type in your Access **Code 18197slp** for detailed information on plan benefits, how to use the plan and FAQs
- Call ARAG Customer Care 7 a.m. – 7 p.m. Central time, Monday to Friday at 800-247-4184
- Contact an ARAG customer care specialist at **service@ARAGlegal.com**

Legal Insurance Plan

Legal Insurance from ARAG

St. Lucie Public Schools

What does legal insurance cover?

An UltimateAdvisor legal insurance plan from ARAG® **covers a wide range of legal needs** like the examples shown below — and many more — to help you address life's legal situations.

Consumer Protection
- ✔ Auto repair
- ✔ Buy or sell a car
- ✔ Consumer fraud
- ✔ Consumer protection for goods or services
- ✔ Home improvement
- ✔ Personal property disputes
- ✔ Small claims court

Criminal Matters
- ✔ Juvenile
- ✔ Parental responsibility

Debt-Related Matters
- ✔ Debt collection
- ✔ Garnishments
- ✔ Personal bankruptcy
- ✔ Student loan debt

Driving Matters
- ✔ License suspension/revocation
- ✔ Traffic tickets

Tax Issues
- ✔ IRS tax audit
- ✔ IRS tax collection

Family
- ✔ Adoption
- ✔ Guardianship/conservatorship
- ✔ Name change
- ✔ Pet-related matters
- ✔ Divorce

Services for Tenants
- ✔ Contracts/lease agreements
- ✔ Eviction
- ✔ Security deposit
- ✔ Disputes with a landlord

Real Estate & Home Ownership
- ✔ Buying a home
- ✔ Deeds
- ✔ Foreclosure
- ✔ Contractor issues
- ✔ Neighbor disputes
- ✔ Promissory notes
- ✔ Real estate disputes
- ✔ Selling a home

Wills & Estate Planning
- ✔ Powers of attorney
- ✔ Trusts
- ✔ Wills

What does it cost?

UltimateAdvisor®

$11.88 biweekly

What is legal insurance?

Legal coverage isn't just for the serious issues, it's for your everyday needs, too. Legal insurance helps you address common situations like creating wills, transferring property, or buying a home.

More details, please!

See the complete list of what your plan covers at:
ARAGlegal.com/myinfo Access Code: **18197slp**

Let's Talk! Call ARAG at 800-247-4184

Legal Insurance Plan

Exclusions

The plan does not cover:

- Matters against us, the policyholder or a member against the interests of the named plan member under the same Certificate
- Legal services arising out of a business interest, investment interests, employment matters or employee benefits,
- Legal services in class actions, punitive damages, personal injury, malpractice, court appeals or post judgments (settlement agreement signed by all parties, final binding arbitration, judgment issued by a court).
- Legal services deemed by us to be frivolous or lacking merit, or in actions where you are the plaintiff and the amount we pay for your legal services exceeds the amount in dispute, or in our reasonable belief you are not actively and reasonably pursuing resolution in your case

The plan services do not include:

1. Matters against us, the named plan member or the plan sponsor.
2. Matters arising out of a business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights.
3. Matters deemed by us to be frivolous or lacking merit.
4. Matters outside the jurisdiction of the United States of America.

Pre-Existing Conditions

Any legal matter which occurs or is initiated prior to your effective date will be considered excluded and no benefits will apply. ARAG defines initiated at the date when the infraction occurs or a document is filed with the court or when an attorney is hired.

Waiver of Premium

Death Benefit - Upon the death of the named insured, coverage for the surviving spouse and the insured dependents continues under the policy for one year, and we waive further premium payments during this time. Coverage shall terminate prior to the end of the one-year period if the policyholder cancels the policy during that time frame, in such case, coverage shall cease as of the date the policyholder cancels the policy.

Military Leave - Should a named insured be deployed for a period of more than thirty (30) consecutive days for the purposes of military service or of responding to a declared national emergency, coverage for the spouse and the insured dependents will continue, without the payment of premium, for the length of the named insured's absence and for so long as the named insured remains eligible for benefits through the policyholder.

Conversion

If members leave employment, they have the option of converting to an ARAG conversion legal insurance plan. You must notify ARAG within 90 days of this disqualifying event to make arrangements for premium payment. Any questions regarding the ARAG conversion plan, please contact ARAG at **800-247-4184**.

Plan Administrator

If you have any questions or concerns, please contact the plan administrator at:

ARAG®
500 Grand Avenue, Suite 100
Des Moines, IA 50309.

Pre-existing and personal legal matters not listed above.

For any legal matters not covered and not excluded, you can still receive at least 25% off the network attorney's normal rates. For additional details regarding your plan's specifically covered services, visit **ARAGlegal.com/myinfo** and enter Access Code **18197slp** or call 800-247-4184.

If you have any questions or want to learn more about how your legal coverage protects you and your family, call ARAG's Customer Care Center at **800-247-4184**, where you can receive more information about navigating your legal issue

Limitations and exclusions apply. Depending upon a state's regulations, ARAG's legal insurance plan may be considered an insurance product or a service product. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa, GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, contact us at **800-247-4184**.

* The national average hourly rate for attorneys with 11 to 15 years of experience is $368. "The Survey of Law Firm Economics: 2018 Edition." The National Law Journal and ALM Legal Intelligence, October 2018.

Pet-Focused Benefits

You may choose any or all of the following pet plans:

Pet Assure Veterinary Discount Plan

Pet Assure is a post-tax employee benefit Veterinary Discount Plan that enables members to receive discounts on all in-house medical services provided by network veterinarians.

Established in 1995, Pet Assure is America's Veterinary Discount Plan. As an alternative or addition to pet insurance, Pet Assure helps pet owners like you save on veterinary care.

Here's what your membership includes:

- 25% off all in-house medical services at every participating veterinarian appointment. With Pet Assure, there are no waiting periods, no claim forms, and no deductibles. Savings are instant - the discount is given at the time of service.
- Coverage for any type of pet. There are no exclusions based on type, breed, age, past medical history, or pre-existing conditions. Do you have one dog, five cats, a lazy iguana, and a donkey? The Pet Assure Unlimited Plan will cover them all.

ThePetTag Lost Pet Recovery Service. Don't worry about your pet getting lost anymore! You'll receive a durable tag for each of your enrolled pets. In the event they go missing, the finder can scan the tag from any smart phone to access all of your contact information instantly.

Pet Assure and PetPlus are brought to you by Pet Benefit Solutions. If you have any questions, please call Pet Benefit Solutions at: 800-891-2565; OR visit www.petbenefits.com/land/stluciepublicschool

PetPlus Product & Prescription Discount Plan

With PetPlus, you receive members-only pricing on all online orders from **PetCareRx.com**. View available products and pricing at **petplusbenefit.com**.

You will get wholesale pricing on:

Members save up to 40% on:

- Prescription Medicine
- Flea & Tick Products
- Vitamins & Supplements
- Heartworm Preventatives
- Food, including Rx diets
- Treats & Supplies

Benefits:

- Free shipping on all online orders
- Same day pickup for most prescriptions at any CareMark® pharmacy nationwide, including Walgreens, Target, and CVS
- 24/7 Pet Help Line powered by AskVet

Pet Assure & PetPlus Rates	24 PAY RATE
Pet Assure Single	$4.00
Pet Assure Unlimited	$5.50
PetPlus Single	$2.25
PetPlus Unlimited	$4.25
Pet Assure Single + PetPlus Single	$6.25
Pet Assure Single + PetPlus Unlimited	$8.25
Pet Assure Unlimited + PetPlus Single	$7.75
Pet Assure Unlimited + PetPlus Unlimited	$9.75

*Unlimited plans covers all pets in your household.

SLPS Employee Pets!

WE LOVE OUR PETS!

SLPS Employee Pets!










2026

Universal LifeEvents

*Only available during open enrollment

Trustmark Universal LifeEvents® Insurance Plan

How does LifeEvents® work?

LifeEvents combines two important benefits into one affordable product. With LifeEvents, your benefits may be paid as a Death Benefit under the Long-Term Care Insurance Rider, or as a combination of both.

Death Benefit

A death benefit puts money in your beneficiaries' hands quickly when they need it most. It's money they may use any way they want to help cover short- and long-term expenses, such as funeral costs, rent or mortgage, debt, tuition and more.

Accelerated Death Benefit for Long-Term Care Services

This benefit makes it easy to accelerate the death benefit to help pay for home healthcare, assisted living, nursing care and adult day care services when you are chronically ill, should you or your covered spouse ever need them.

The LifeEvents® Advantage

LifeEvents is unique. It's designed to match your needs throughout your lifetime, so you have the benefits you need, when you need them most. See for yourself.

Working years — LifeEvents pays a higher death benefit during working years when expenses are high and your family needs maximum protection. Then at age 70, when expenses typically reduce, LifeEvents reduces the death benefit amount to better fit your needs; however, your benefits for the Accelerated Death Benefit for Long-Term Care Services Rider never reduce.*

Throughout retirement — LifeEvents pays a consistent level of benefits during retirement, which is when you may be susceptible to becoming chronically ill and may need long-term care services.

* Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 18 to 64.

This provides a brief description of your benefits under GUL.205 and applicable riders HH/LTC.205.FL, BRR.205. FL, ABR.205.FL, ADB.205/G IL, CT.205/G and WP.205/G IL. This policy contains a provision that guarantees against lapse for a period of 10 years (15 years for Universal LifeEvents) as long as premiums are paid as planned. If you make changes to your coverage during this period, or pay only the minimum premium, you may prevent cash value accumulation or reduce your death benefit amount. If there is negative cash value at the end of the no-lapse period, you must pay enough premium to establish positive cash value. You may also need to maintain your policy with a higher premium than the one you paid to satisfy the no-lapse guarantee or coverage may expire prior to age 100 even if the premium shown is paid as scheduled. An illustration will be delivered with your policy. For applicable disclosures, exclusions and limitations that may apply, please visit https://www.trustmarkbenefits.com/voluntary-benefits/disclosures/ul.

Features You Will Appreciate

- Lifelong protection
- Family coverage
- Accelerated Death Benefit Insurance Rider for Terminal Illness
- Guaranteed renewable — Guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all certificates in your class changes.

Separately priced benefits:

- **Children's Term Life Insurance Rider** - Provides a death benefit for all of your children to age 23. Coverage available to purchase to age 22.
- **EZ Value** - Automatically raises your benefits to keep pace with your increasing needs, without additional underwriting.

Your Policy Contact Information

Trustmark Insurance Co. - Customer Care

Mon. - Thurs., 8 a.m. - 8 p.m. ET
Fri. 8 a.m. - 7 p.m. EST
1-800-918-8877

Trustmark Claims

1-877-201-9373, Option 2
TrustmarkVB.com

How Living Benefits Add Up

Example: $100,000 Death Benefit	Maximum Benefit Amount
Accelerated Death Benefit for Long-Term Care Services** - Pays a monthly benefit equal to 4% of your death benefit for up to 25 months. The Accelerated Death Benefit for Long-Term Care Services Rider accelerates the death benefit and proportionately reduces it.	$100,000
Benefit Restoration Insurance Rider - Restores the death benefit* that is reduced by the Accelerated Death Benefit for Long-Term Care Services, so your beneficiaries may receive the full death benefit amount when they need it most.	$100,000
Total Maximum Benefit - Living Benefits may double the value of your life insurance.	$200,000

** The Long-Term Care (LTC) Insurance Accelerated Death Benefit Rider is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services, and to qualify for benefits you must be chronically ill. Pre-existing condition limitation may apply. Please consult your certificate for complete details.

Hospital StayPay

Trustmark Hospital StayPay®

Helps you cover unexpected hospital bills.

Hospital stays can be really expensive, and health insurance might not cover everything. You may have copays, deductibles and other surprise expenses. Trustmark helps you keep a hospital trip affordable. It's designed to pair with your medical plan so you can be more confident in your protection. You can get cash benefits for hospital stays due to a covered sickness or accident, normal childbirth or mental wellness/addiction recovery. You also have flexibility to adjust your benefit as your needs change.

Hospital StayPay also features a Claim Free Return benefit. A $100 payment will be automatically sent to you every two years that you don't have to claim – no action needed!

Trustmark Insurance Company Hospital StayPay

Semi-Monthly Premium Rates

Rates	$700 Benefit	$1,400 Benefit	$1,800 Benefit
	Ages 18-49		
Employee	$6.25	$9.16	$10.83
EE and Spouse	$9.25	$15.17	$18.55
EE and Children*	$9.77	$16.21	$19.89
EE and Family**	$12.78	$22.22	$27.62
	Ages 50-59		
Employee	$7.78	$12.22	$14.76
EE and Spouse	$12.32	$21.31	$26.45
EE and Children*	$11.30	$19.27	$23.82
EE and Family**	$15.85	$28.36	$35.51
	Ages 60-64		
Employee	$10.19	$17.05	$20.98
EE and Spouse	$17.23	$31.13	$39.07
EE and Children*	$13.72	$24.10	$30.04
EE and Family**	$20.76	$38.18	$48.14
	Ages 65-70		
Employee	$13.19	$23.04	$28.67
EE and Spouse	$23.24	$43.14	$54.52
EE and Children*	$16.71	$30.09	$37.73
EE and Family**	$26.76	$50.19	$63.58

Sample weekly rates are shown for illustrative purposes only and are not a guarantee. An application for insurance must be completed to obtain coverage.

Plan form HII 119 is underwritten by Trustmark Insurance Company, Lake Forest, Illinois. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Benefits, availability, exclusions and limitations may vary by state and may be named differently. Your policy/certificate will contain complete information. Trustmark® is a registered trademark of Trustmark Insurance Company. Trustmark Hospital StayPay® is a trademark of Trustmark Insurance Company.

Accident Insurance

Trustmark Accident insurance helps pay for unexpected healthcare expenses due to non-occupational accidents that occur every day. Accident insurance provides benefits due to covered accidents for initial care, injuries and follow-up care. Benefits are paid directly to the employee, in addition to any other coverage they have.

Who is Eligible?

- **Employees** – Ages 18 to 80, actively working full-time
- **Spouses** – Ages 18 to 80, who are not disabled
- **Children** – Birth through age 25, who are unmarried and a dependent

For the 2024 open enrollment, the accident plan effective date will be Feb. 1, 2024 as long as you are an active employee.

Plan Features

- Coverage for non-occupational injuries
- Guaranteed issue – No medical questions
- Level premiums – Rates do not increase with age
- No limitations for pre-existing conditions
- Guaranteed renewable – Coverage remains in force for life, as long as premiums are paid
- Portable coverage – Employees can continue coverage if they leave or retire

Accident Insurance Rates

	24 PAY PERIOD
	Post-Tax
Employee Only	$9.44
Employee & Spouse	$16.17
Employee & Children	$24.01
Employee & Family	$30.74

* Actual payroll deduction amount may vary based on rounding calculations.

VIDEO LINK

Accident Insurance

Wellness Benefit

The Wellness Benefit promotes good health among employees and their families by providing them a $100 benefit to offset the cost of going to the doctor for routine physicals, immunizations and health screening tests, regardless of other coverage. The benefit provides a maximum of two visits per person, annually. File a wellness claim directly through Trustmark.

Eligible tests include:

- Low-dose mammography
- Pap smear for women over age 18
- Flexible sigmoidoscopy
- Hemoccult stool specimen
- Colonoscopy
- Prostate-specific antigen (PSA) test for prostate cancer
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Bone marrow testing
- Serum cholesterol test to determine HDL and LDL levels
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Serum protein electrophoresis (blood test for myeloma)
- Immunizations
- Themograph

Accidental Death Benefit

- Provides an additional lump-sum benefit for an accidental death that occurs within 90 days of a covered accident:
  - Pays $100,000 for the insured, $50,000 for spouse and $25,000 for a child.
  - The benefit doubles if the accidental death is due to a common carrier.

Catastrophic Accident Benefit

Provides an additional lump-sum benefit for catastrophic loss after fulfilling a 90-day elimination period.

Definitions

Covered Accident - An accident causing injury, which:

- Occurs after the effective date;
- Occurs while the certificate is in force; and
- Is not excluded by name or specific description in the certificate.

Elimination Period - The period of time after the date of a covered accident for which catastrophic accident benefits are not payable.

Injury or Injuries - An accidental bodily injury that resulted from a covered accident. It does not include sickness, disease or bodily infirmity. Overuses syndromes, typically due to repetitive or recurrent activities, such as osteoarthritis, carpal tunnel syndrome or tendonitis, are considered to be a sickness and not an injury.

Maximum Benefit Period - The longest period of time for which hospital benefits will be paid.

Non-Occupational Injury - An injury that did not result from a person's work or occupation; applicable to non-occupational coverage only.

Waiting Period - The period of time following the effective date of the certificate during which wellness benefits are not payable.

This is a brief description of benefits under A-607 and applicable riders WB-607, HS-12000R, and LCWP-5/01. This is an accident only policy with limited benefits and does not pay benefits for diseases, sickness, or for loss from sickness. This is not a workers' compensation policy or a substitute for medical expense insurance, major medical insurance or a health benefit plan alternative. It is also not a Medicare Supplement policy. Please refer to your policy/group certificate and outline of coverage, if applicable, for complete information. Limitations on pre-existing conditions may apply. For costs and coverage detail, including exclusions, limitations and terms, see your agent or write the company. Underwriting conditions may vary and determine eligibility for the offer of insurance.

Plan Form A-607 is underwritten by Trustmark Insurance Company, Lake Forest, Illinois.

Accident Insurance

Schedule of Benefits[1]

Effective 8/1/2012

Accident Insurance Provides Non-Occupational Coverage

Benefit	Amount
Initial Care	
Hospital Benefits	
Admission Benefit (per admission)	$3,200
Confinement Benefit (per day up to 365 days)	$500
ICU Benefit (per day up to 15 days)	$1,000
Emergency Room Treatment	$150
Ambulance	
Ground	$600
Air	$2,500
Initial Doctor's Office Visit	$200
Lodging (per night up to 30 days per accident)	$200
Surgery Benefit	
Open, abdominal, thoracic	$2,000
Exploratory	$200
Blood, Plasma and Platelets	$600
Emergency Dental Benefit	
Extraction	$150
Crown	$450
Follow-Up Care	
Accident Follow-Up Treatment	$200
Physical Therapy	
Up to six visits per person per accident	$100
Appliance	$250
Transportation	
100+ miles, up to three trips	$600
Prosthetic Device or Artificial Limb	
More than one	$2,000
One	$1,000
Skin Grafts	25% of burn benefit
Accidental Death	
Employee	$100,000
Spouse[4]	$50,000
Child	$25,000
Accidental Death – Common Carrier	
Employee	$200,000
Spouse[4]	$100,000
Child	$50,000

Benefit	Amount
Injuries	
Fractures	
Open reduction	up to $15,000
Closed reduction	up to $7,500
Chips	25% of closed amount
Dislocations	
Open reduction	up to $12,000
Closed reduction	up to $6,000
Laceration	$50-$1,000
Burns	
Flat amount for:	
Third-degree 35 or more sq. in.	$25,000
Third-degree 9-34 sq. in.	$4,000
Second-degree for 36% or more of body	$2,000
Concussion	$200
Eye Injury	
Requires surgery or removal of foreign body	$400
Ruptured Disc	$1,000
Loss of Finger, Toe, Hand, Foot or Sight	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	$40,000
Loss of one hand, foot or sight of one eye	$20,000
Loss of two or more fingers, toes or any combination of two or more losses	$4,000
Loss of one finger or one toe	$2,000
Tendon/Ligament/Rotator Cuff Injury	
Repair of more than one	$1,500
Repair of one	$1,000
Exploratory surgery without repair	$200
Torn Knee Cartilage	$1,250
Exploratory surgery	$250
Wellness Benefit	
Two per person annually	
Routine physicals, immunizations and health screening tests. 60-day waiting period applies.	
Catastrophic Accident	
Employee	$150,000
Spouse	$75,000
Child	$75,000

[1]Benefits are payable only as the result of a covered accident. Benefits may vary by state and additional benefits may be available in some states. Most benefits are paid once per person per covered accident unless otherwise noted. [4]In some states, spouse, domestic partner or civil union partner.

Critical HealthEvents®

Critical HealthEvents® Insurance

Trustmark's Critical HealthEvents was designed to focus on the many ways critical illness touches your life. Benefits are payable for early identification as well as for later-stage diagnosis. Earlier benefits help provide funds as quickly as possible to help ensure that treatment or preventive measures may stave off late-stage illness. A replenishing annual benefit helps you deal with a new or recurring covered condition. You can use the benefit any way you wish, whether it's for treatment, changes to your home or someone to watch your kids.

How does Critical HealthEvents work?

Critical HealthEvents is designed to help manage critical illness the way it is experienced by those closest to it. Early diagnosis of a major illness can be a lifesaver, yet successful treatment may be expensive, and a critical illness can sometimes come back again. Critical HealthEvents protection provides continual assistance when covered critical illnesses come into your life:

- Your benefit replenishes each calendar year to help you deal with a new or recurring covered condition.
- Benefits are payable for early identification of a condition as well as for later-stage diagnosis. These can help with early treatment that may stave off serious late-stage illness.
- The policy focuses on the conditions that are most likely to occur. This helps keep coverage affordable.
- Events that trigger a benefit are simple and easy to understand.
- Benefits can be used to pay for whatever you and/or your family need most.
- Choose a personalized benefit amount at time of enrollment: your maximum available for benefit payouts each calendar year.

How are benefits paid?

Critical HealthEvents pays a benefit when there's a new diagnosis of a covered critical illness. Depending on the diagnosis you receive, your benefit payment may be 100%, 50% or 10% of your selected benefit amount.

The following conditions are covered with no lifetime maximum on the number of payouts:

- Cancer
- Coronary Artery Disease/Heart Attack
- Cerebral Vascular Disease/Stroke

Features that work for you

- Healthy Living Rider – Provides coverage annually for one $50 routine service for early detection and prevention. Also pays for certain follow-up diagnostic tests; your policy will contain complete details.
- Specified Illness Rider – Provides a benefit at 10%, 50%, or 100%, once per lifetime per condition, for additional covered conditions, including: permanent blindness, occupational HIV, paralysis due to sickness, renal or other organ failure, stem cell/bone marrow transplant, central nervous conditions, or complications of diabetes.

A 30-day waiting period may apply before benefits are payable. Please consult your policy/group certificate for specific covered illnesses and details.

Benefits you'll appreciate

- **Access to Medical Experts** – Receive one-on-one support through Best Doctors®, a leader in connecting you to medical information you may need for a wide range of medical conditions.
- **Guaranteed Renewable** – Guaranteed active coverage for life, as long as premiums are paid. Your premium may change if the premium for all policies in your class changes.
- **Level Premiums & Coverage** – Rates will not increase and benefits will not decrease due to age.
- **Family coverage** – Apply for your spouse, children, and dependent grandchildren.
- **Portability** – Take your coverage with you and pay the same premium even if you change jobs or retire.
- **Convenient Payroll Deduction** – No checks to write. A direct bill option is available if you change jobs or retire.

Pre-Existing Condition Limitation: No benefit will be paid for any condition caused by or resulting from a pre-existing condition.

Benefits are restored each year.
Example:

YEAR 1 *(January 1st)*
100% benefit available each and every year for any covered illness.

YEAR 1
Early identification–
10% benefit paid,
90% benefit remains

YEAR 1
Early stage diagnosis–
50% benefit paid,
40% benefit remains.

YEAR 2 *(January 1st)*
Benefit well is restored.
100% benefit is again available.

Wellness Program

Wellness Program Offerings for Everyone

Sam Gaines Academy and other schools throughout the district are showing support for Heart Health Month in "Wear Red Day"

Living Better, Together.
St. Lucie Public Schools Wellness Program

If you have Florida Blue medical insurance through the District, earn incentive points ($$) throughout the year for completing certain activities such as exercising, participating in a health fair, or a tobacco cessation program.

Florida Blue also offers:

- HALT Diabetes Program
- Healthy Addition Prenatal Program
- Tivity Health Fitness Your Way Program and Active and Fit Direct.

- Wellness Wednesday emails
- Wellness Website - access everything related to your Wellness program on the SLPS Wellness Website
- Wellness bulletin board at your location
- Health Fair, COVID Booster at your worksite
- Full access to the Employee Assistance Program (EAP) - free and confidential counseling, legal and financial services, will preparation, etc.
- Walking paths at your workplace
- District-wide wellness challenges and competition
- Vaccines at work
- Tobacco Cessation workshops
- Exercise at work - Peloton App, Zumba and Yoga
- Staff Sports - soccer, kickball, volleyball & more
- Lunch n' Learns, webinars, lectures, and cooking classes
- Free Nutrition Consultations
- "Simple" Lymphatic Drainage Massage

Mark Dionisio
Wellness Manager - Risk Management
Mark.Dionisio@stlucieschools.org
Phone: 772-429-3974
https://www.stlucie.k12.fl.us/health-wellness/

Sam Gaines Academy vs Forest Grove in the May Staff Kickball League

Wellness Program

Wellness Activities and Associated Points for Employees with Florida Blue Health Insurance through the District

Earn up to 200 incentive points ($200) for participating in various wellness activities if you have Florida Blue medical insurance through the District between June 1, 2025 - April 30, 2026. You will receive the money you earn on your HSA card or paycheck on June 30, 2026. (9, 10, and 11 month employees may differ.) To receive the payout; **You must be an active employee at the end of the current school year and be currently enrolled in one of our health plans. You must receive the last payroll check of the fiscal year in June**.

50 points:

- Attend a Health Fair - Complete a Personal health Assessment and Biometric Screening (or have bloodwork done at Quest Diagnostics and complete a PHA online through FloridaBlue.com)
- Participate in a Tobacco Cessation Program

30 points:

- Annual Physical from your Primary Care Physician
- Annual Physical from your Gynecologist

20 points:

- Exercise at least 12 times per month for at least 30 minutes total/day. Must complete Exercise Tracking Logo or hand in gym attendance printout
- Participate in Florida Blue Healthy Addition Prenatal Program
- Track a minimum of 15 Mindfulness Activities per month

15 points:

- Cancer Screening(s) - prostate, skin, breast,colon, cervical, etc.
- Attend a health lecture
- Submit a Wellness Success Story - 1/2 page minimum
- Participate in a webinar from the Employee Assistance Program, Florida Blue, or from your Wellness manager - Up to five times per year
- Participate in a 5k/10k/Triathlon/Half marathon - up to four times per year
- Complete 15 mindfulness activities per month

10 points:

- Dental Cleaning (Prophylaxis) - up to two times per year
- Annual Vision/Glaucoma Screening
- Blood Donation - up to five times per year

5 points:

- Immunizations - Flu, Pneumonia, Shingles, COVID Booster
- Participate in a District-wide Wellness Challenge - up to four times per year
- Chiropractic Adjustments - up to 5 per year

3 points:

- Enroll in and maintain active membership in HALT Diabetes Program offered through the Florida Department of Health (FDOH).

You must provide documentation to the Wellness Manager in order to receive points ($).

Visit our Website to see all schedule health events. www.stlucie.k12.fl.us/health-wellness/.

Employee Assistance Program

Anytime Support - Resources for Living

Resources For Living is an employer sponsored program, available at no cost to you and all members of your household. That includes dependent children up to age 26, whether or not they live at home.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional well-being support

You can access counseling sessions per issue each year. You can also call us 24 hours a day for in-the-moment emotional well-being support.

Counseling sessions are available face to face or online with televideo. Services are free and confidential. We're always here to help with a wide range of issues including:

- Relationship support
- Stress management
- Work/life balance
- Substance misuse & more
- Self-esteem & personal development
- Family issues
- Grief and loss
- Depression
- Anxiety

Legal services*

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal law
- Divorce
- Elder law & estate planning
- Wills & document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25 percent discount.

* Services must be related to the employee and eligible household members. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

** Services must be for financial matters related to the employee and eligible household members.

Online Resources

Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

myStrength

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain.

Financial services**

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Credit/debt issues
- College funding
- Retirement/other financial planning
- Mortgages/refinancing
- Tax and IRS questions/preparation

You can also get a 25 percent discount on tax preparation services.

Other Services

- **Identity theft services** — One hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.
- **MindCheck** online tools make it easy to improve your emotional well-being. Measure your mindset and get feedback and resources to maintain a positive outlook.

Changing Your Coverage

Qualifying Events

Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, such as adding or dropping dependents, depending on whether or not you experience an "eligible" qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125.

Within 60 days of a qualifying event, please contact Risk Management so they may assist you with filing your election change request. Upon the approval of your election change request, your existing elections may be stopped or modified (as appropriate). However, if your election change request is denied, you will have 60 days from the date you receive the denial to file an appeal with SLPS. For more information, refer to the "Appeal Process" section of this Benefits Reference Guide. Visit **myFBMC.com** for information on rules governing periods of coverage and IRS Special Consistency Rules.

TYPE OF CHANGES	DESCRIPTION	SUPPORTING DOCUMENT
Marital Status *(Marriage or Divorce)* **Plans that may be affected**: Medical, Dental, Vision, Healthcare FSA, DEP FSA, Group Life Insurance, Short Term Disability, Long Term Disability	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in Florida).	• Marriage Certificate and recent IRS 1040 Tax Return (Tax Return required if married prior to current calendar year); • Divorce Decree; • Death Certificate.
Change in Number of Employee's Dependents *(Birth, Adoption or Legal Custody)* **Plans that may be affected:** Medical, Dental, Vision, Healthcare FSA, DEP FSA, Group Life Insurance, Short Term Disability, Long Term Disability	A change in number of dependents includes the following: birth, adoption and placement for adoption. **Note:** You can add your other eligible dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid CIS event.	**One of the following:** • Birth Certificate or Hospital Certificate with Foot Prints; • Adoption papers or placement for adoption papers; • Legal Custody papers
Change in Employment Status **Plans that may be affected:** **Gain of Employment** - Medical, Dental, Vision, DEP FSA, Group Life Insurance, Short Term Disability and Long Term Disability **Loss of Employment** - Medical, Dental, Vision, Healthcare FSA, DEP FSA, Group Life Insurance, Short Term Disability and Long Term Disability **Note:** Change can only be made for individual involved	Change in employment status of the employee, employee's spouse or employee's dependent that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.	**One of the following:** • Letter from employer showing employment and insurance termination date • Letter from employer showing employment and insurance effective date. **Note:** Letter must be on the company's letterhead
Gain or Loss of Dependents' Eligibility Status *(Death, Dependent no longer meets eligibility requirements)* **Plans that may be affected:** Medical, Dental, Vision, Healthcare FSA, DEP FSA, Group Life Insurance, Short-Term Disability and Long-Term Disability **Note:** Change can only be made for individual involved	An event that causes an employee's dependent to satisfy or cease to satisfy dependent eligibility coverage requirements which may include change in age, student status, death, marriage, disabled/disabled, employment or tax dependent status.	**One of the following:** • Death certificate of dependent child; • Letter from employee indicating child is dependent/non-dependent on them for support; • Letter from employer indicating the child no longer meets their eligibility requirements with the effective date. **Note:** Physician certification is required for disabled or disabled dependent children who are over the maximum age of 26.

Changing Your Coverage

TYPE OF CHANGES	DESCRIPTION	SUPPORTING DOCUMENT
Coverage and Cost Changes **Plans affected:** Dependent FSA **Note:** Does not apply to Healthcare FSA	Change is permitted when you switch dependent care providers. **Note**: 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.	**One of the following:** • A letter from the daycare which outlines the type of change and effective date. This change can be an increase in cost, decrease in costs or provider no longer provides services. • Letter from employee indicating the child has reached the maximum age limit of 13.
Open enrollment Under Other Employer's Plan **Plans affected:** Medical, Dental, Vision, Dependent FSA, Group Life Insurance, Short Term Disability, Long Term Disability **Note:** Does not apply to Healthcare Expense FSA	Employee may make an election change when their 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.	Open enrollment election form with the company's name on it or a letter on letterhead from the employer indicating the open enrollment period and effective date of coverage.
Judgment/Decree/Order **Plans affected:** Medical, Dental, Vision, Healthcare FSA **Note:** Does not apply to a Dependent Care FSA	If a judgment, decree or order from a divorce, 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.	Legal Court documentation that outlines the judges orders: • Divorce papers • Court orders
Medicare/Medicaid **Plans affected:** Medical, Dental, Vision, Healthcare FSA **Note:** Does not apply to a Dependent Care FSA	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.	**One of the following:** • Medicaid approval or disapproval letter; • Medicaid ID card with effective date; • Medicare approval or disapproval letter; • Medicare ID card with effective date
Family and Medical Leave Act (FMLA) **Leave of Absence** **Plans affected:** All plans	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave.	Must be placed on approved FMLA leave by HR Department.
Revoking Election of Coverage **Plans affected:** *Medical*	Your plan permits a mid-year election change in employer-sponsored health coverage in order to purchase other coverage. You may prospectively revoke an election of coverage under a group health plan that is not a health FSA under the following circumstances. You have a reduction in average weekly hours of service to less than 30 hr. per week and you and your spouse and dependents you currently cover enroll in another plan that provides minimum essential coverage that becomes effective no later than the first day of the second month following the date of termination of your employer's plan. You are eligible to enroll in a State Exchange during open enrollment of the Exchange; or through a Special Enrollment Right and you and your spouse and dependents you currently cover enroll in a State Exchange that is effective no later than the day immediately following the last day of coverage of your employer's plan.	Your employer will let you know of any requirements needed to demonstrate proof that you have enrolled in or will enroll in other Qualified Health Plan coverage.

Benefits Directory

St. Lucie Public Schools
Risk Management Department
1-772-429-5521

Toni Di Savino
Florida Blue On-Site Group Service Rep. Health/Dental
1-772-429-7702
1-772-343-1193 (fax)
toni.disavino@bcbsfl.com

FBMC Benefits Management, Inc.
(Contract Administrator)
FBMC Service Center
Mon. - Fri., 8 a.m. - 5 p.m. ET
1-855-582-4348
FBMC.com

Florida Blue
(Medical)
Customer Service
Mon - Fri, 8 a.m. - 6 p.m. ET
1-800-664-5295
floridablue.com

Florida Combined Life
(Dental)
Customer Service
1-888-223-4892
Mon - Fri, 8 a.m. - 5 p.m.
FloridaBlueDental.com

Lucet
(Mental Health Benefits)
1-866-287-9569
lucethealth.com

Health Equity
(Health Savings Account/Bank)
1-866-346-5800
healthequity.com

EyeMed
(Vision)
Customer Service
Mon - Fri, 8 a.m. to 11 p.m. ET
1-866-939-3633

Lincoln Financial Group
(Long and Short-Term Disability (Group Life & AD&D Insurance)
877-321-1015
Monday - Friday, 8 a.m. - 8 p.m. ET
MyLincolnPortal.com

Trustmark
(Accident Insurance, Critical Illness, LifeEvents Universal LifeEvents, Trustmark, Hospital StayPay, Critical HealthEvents)
Customer Service
Mon - Thurs, 8 a.m. - 7 p.m. ET
Fri, 8 a.m. - 7 p.m. ET
1-800-918-8877
Wellness Fax Claim #: **1-508-853-2867**
TrustmarkVB.com

Transamerica
(Existing Universal Life and Long-Term Care Policies)
Universal Life: **1-800-322-0426**
Long-Term Care: **1-800-227-3740**

Inspira Financial
(FSA - Flexible Spending Accounts)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
Sat, 10 a.m. - 3 p.m. ET
1-800-284-4885
Inspira Financial Toll-Free Claims Fax:
1-855-703-5305
inspirafinancial.com

Resources for Living
(EAP - Employee Assistance Program)
Customer Service - 24 hours a day
1-800-272-3626, TTY: **711**
resourcesforliving.com
Username: **St Lucie School Board**
Password: **8002723626**

ARAG®
(Legal Insurance)
500 Grand Avenue
Suite 100
Des Moines, IA 50309
1-800-247-4184
Access Code: **18197slp**
ARAGlegal.com/myinfo

Colonial Life
(Group Medical Bridge Plans)
Customer Service
Mon. - Fri., 7 a.m. - 7 p.m. CT
1-800-325-4368
ColonialLife.com

Pet Benefits
Customer Service
Mon. - Fri., 8 a.m. - 6 p.m. ET
1-800-891-2565
customercare@petbenefits.com
Mon. - Fri., 9 a.m. - 4 p.m. ET

FBMC BENEFITS MANAGEMENT

PO Box 1878
Tallahassee, FL 32302-1878
FBMC.com
1-855-582-4348

Appendix

Available notices are on the following pages for your convenience:

SLPS Benefits Program

Participation in the St. Lucie Public Schools Benefit Program

Be aware that when you participate in the SLPS Benefit Program, you are automatically making the following affirmations:

1. You authorize the St. Lucie Public Schools (SLPS) to deduct premiums for the benefits rolled over or elected for the plan year.
2. You certify that the information you supplied on the online enrollment website is true and complete to the best of your knowledge.
3. You understand that health, dental, vision and flexible spending account(s), will be deducted pretax to the extent possible and that your income subject to federal income tax and Social Security withholding (FICA) will be reduced, and that this may slightly affect your Social Security benefits in the future.
4. You acknowledge that you cannot stop or change benefits paid for on a pretax basis during the plan year unless you experience a relevant qualifying event.
5. All benefits are subject to change. All benefits are subject to the provisions and exclusions of the master contract.
6. You understand that a Section 125 Flexible Spending Account (Healthcare Expense and Dependent Care) can be used only to reimburse payment of eligible expenses incurred during the plan year while participating in the plan and that any amount remaining in either spending account, that is not used during the plan year, will be forfeited. Funds in one spending account cannot be used to reimburse expenses covered by another account. Expenses for which you are reimbursed cannot be claimed.
7. You understand and agree that SLPS and the Third Party Administrator (TPA) will not incur any liability resulting from failure to read all rules pertaining to benefit enrollment; to enroll online accurately or to submit elections; or in the administration of your flexible spending accounts. You also understand that elections for benefits on a pretax basis are irrevocable and cannot be changed after the established deadline date. Subsequent changes can only be made upon experiencing a relevant qualifying event.
8. You agree for yourself and covered members of your family and others covered under SLPS insurance plans to be bound by the benefits, deductibles, copayments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements and plan documents for the plans in which you enroll.
9. Chapter 207-251 Laws of Florida requires agencies to notify individuals of the purpose(s) that requires the collection of Social Security numbers (SSNs). SLPS collects SSNs of employee and dependents for enrollment in health insurance, life insurance, and other miscellaneous insurances. The SSNs of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
10. Your contributions to the Flexible Benefits Plan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS. Any salary directed to your Flexible Benefit Plan is included in the compensation reported to the FRS.
11. Social Security consists of two components: FICA and Medicare. A separate maximum wage to which the tax is assessed applies to both tax components. The maximum taxable annual wage for FICA varies from year to year. There is no maximum taxable annual wage for Medicare. 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.

Notices

Cobra Q&A

Overview

COBRA is a continuation of Plan coverage when it would otherwise end because of a life event, also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the SLPS.

Options Besides COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **healthcare.gov**.

More Information

This COBRA Q&A 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.

Keep Address Updated

To protect your family's rights, let your Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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 pretax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pretax and post-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 Healthcare expenses you incur, if these premiums were paid with pretax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

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 a cafeteria plan may generally outweigh the Social Security reduction. Call FBMC's Service Center at **1-855-LUCIE4-U (1-855-582-4348)** for an approximation.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plans

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.

Notices

Notice Of FBMC'S Capacity

FBMC Benefits Management, Inc. (FBMC) has been authorized by your employer to provide certain administrative services for some the insurance plans offered within your employer's benefit program. Importantly, FBMC is not the policyholder or an insurance company. The policyholder is the entity to whom the insurance policy has been issued; the employer is the policyholder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate. The insurance companies noted in this guide have been selected by your employer and are liable for the funds to pay your insurance claims.

Women's Health And Cancer Rights Act Of 1998 (WHCRA) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Call your Plan Administrator for more information.

Newborn And Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.

Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

HIPAA Privacy

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Plan Administrator.

Wellness Program Notice Of Reasonable Alternative

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at **stlucie.k12.fl.us/health-wellness/** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice Regarding Wellness Program

St. Lucie Public School's Wellness Program, **Living Better, Together** is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

As part of the Wellness Program for St. Lucie Public School Florida Blue members, employees have the opportunity to complete a voluntary Health Risk Assessment or "HRA." The HRA consists of a biometric screening and brief health questionnaire. The health questionnaire is a series of questions about health-related activities and behaviors and personal history of certain medical conditions (e.g., cancer, diabetes, or heart disease). The biometric screening includes a blood finger stick to obtain a sample of blood to test Total Cholesterol, HDL, Total Cholesterol to HDL Ratio, and Blood Glucose. You are not required to complete the HRA or participate in the blood test or other medical examinations. Employees who complete the HRA will receive a $50 incentive.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as participating in a Tobacco Cessation or Better You program, getting involved in on-site exercise or making an appointment with your primary care physician. You also are encouraged to share your results or concerns with your own doctor.

St. Lucie Public School Florida Blue members who choose to participate in voluntary aspects of the wellness program will receive an incentive of up to $200 per school year. These voluntary health activities include participating in a race, having an Annual Physical by a Primary Care Physician, attending a health lecture, having dental cleanings and much more. If you are unable to participate in any of the health-related activities to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by emailing **wellness@stlucieschools.org** or calling **772-429-3974**.

Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - -Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - -Cover emergency services by out-of-network providers.
  - -Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - -Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the federal phone number for information and complaints is: 1-800-985-3059. Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Notices

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in Florida, you may be eligible for assistance paying your employer health plan premiums.
If you reside outside of Florida, view the entire CHIP Model Notice online at:
https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.doc

Contact your state for more information on eligibility.

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

To locate the list of states, current as of July 31, 2025, or to view states that have recently added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice from St. Lucie Public Schools
About Your Prescription Drug Coverage and Medicare

Please note that this notice only pertains to you if:

You are Medicare eligible (over age 65 or considered disabled by the Social Security Administration) and currently covered or eligible for coverage under the health plan sponsored by St. Lucie Public Schools for retired employees, or
You have a dependent spouse/domestic partner or child who is covered by Medicare or Medicaid and who is currently covered or eligible for coverage under the health plan sponsored by St. Lucie Public Schools for employees and retired employees.

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

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

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

St. Lucie Public Schools has determined that the prescription drug coverage offered by the St. Lucie Public Schools Prescription Drug Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare

Creditable Coverage Notice

While you have Creditable Coverage, you can decline coverage under Medicare Part D and if you decide to enroll in Medicare Part D in the future, you will not be assessed a late payment charge by the Center for Medicare and Medicaid Services (CMS). This letter serves as your "Notice of Creditable Coverage." If you are covered under the St. Lucie Public Schools Prescription Drug Plan, you have Creditable Coverage.

Enrollment for Medicare Part D for the 2024 calendar year begins October 15, 2023 and runs through December 7, 2023. If you elect the St. Lucie Public Schools Prescription Drug Plan for 2024, you will have Creditable Coverage and you can choose to delay enrollment in Medicare Part D without paying a Medicare Part D late enrollment penalty. As long as you maintain Creditable Coverage, you will not be assessed a late enrollment penalty if you choose to enroll in Medicare Part D at a later date. Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare. If you leave employment during the year, you may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

If you enroll or your dependent enrolls in Medicare Part D for the 2024 calendar year, you or your dependent cannot maintain coverage in the St. Lucie Public Schools Prescription Drug Plan. If you or one of your dependents enrolls in Medicare Part D, you must disenroll them from the St. Lucie Public Schools Prescription Drug Plan. To disenroll yourself or your dependent from prescription coverage, please call Risk Management. You will be able to re-enroll in the St. Lucie Public Schools Prescription Drug Plan in the future during each annual open enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with St. Lucie Public Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	09/15/2023
Name of Entity/Sender:	St. Lucie Public Schools
Contact–Position/Office:	Risk Management
Address:	9461 Brandywine Lane Port St. Lucie, FL 34986
Phone Number:	(772) 429-5521

Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

As a result of the Affordable Care Act, starting in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace starts November 1, 2023, and ends January 15, 2024, in most states.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. For plan years beginning in calendar year 2025, if the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.02% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Risk Management at 772-429-3600

.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Notices

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name St. Lucie County School Board		4. Employer Identification Number (EIN) 59-6000832
5. Employer address 9461 Brandywine Lane		6. Employer phone number (772) 429-3600
7. City Port St. Lucie	8. State FL	9. ZIP code 34986
10. Who can we contact about employee health coverage at this job? Risk Management Department		
11. Phone number (if different from above)	12. Email address marcy.deweese@stlucieschools.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☒ All employees. Eligible employees are:

Full time employees working 21+ hours per week

☐ Some employees. Eligible employees are:

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Your current Legal Spouse;
Children from birth to age 26 who are your natural child, stepchild, legally adopted child or child for whom you are appointed legal guardian;
Eligible children from 26 to 30 who are unmarried, have no dependents of their own, a Florida resident or a full-time or part-time student, are otherwise uninsured, and not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Notices

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☒ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $ $41.24
b. How often? ☐ Weekly ☐ Every 2 weeks ☒ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

FBMC
BENEFITS MANAGEMENT

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