Health is on the Way

St. Lucie PUBLIC SCHOOLS

Plan Year 2022

Retiree|COBRA Benefits Guide

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PayFlex – FBMC's COBRA Outsource Provider

COBRA benefits communication is being supported by FBMC Benefits Management's outsource provider, PayFlex Systems USA, Inc. Please note that all PayFlex correspondence you receive is approved for distribution by the St. Lucie Public Schools and FBMC Benefits Management, Inc.

For COBRA questions about your benefits open enrollment and throughout the year, please contact PayFlex at **1-855-LUCIE4-U (1-855-582-4348)**.

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 36 for more details.

Key Things to Know

COBRA Participants

- At open enrollment, a Qualified Beneficiary under COBRA will be given the same opportunity as similarly situated active participants and beneficiaries to change his or her group health plans, to drop dependents, or to add eligible dependents who are not already covered under COBRA.
- FBMC Benefits Management, Inc. contracts with PayFlex Systems USA, Inc. to administer COBRA services as required by law.
- If you're currently enrolled in medical, dental, or vision plans only and you wish to continue your existing benefits, no action is required. Your current benefits will roll over for the 2022 plan year. Please refer to the information contained on your current benefit statement and in this book when making your COBRA selections for the 2022 plan year. You can cover your dependents under every benefit that shows a premium amount for dependent coverage (refer to the rates in this book) if you participate in the same benefit.
- If you are making changes to your benefits, you must fully complete, sign, and return the enclosed enrollment form postmarked by **Nov. 26, 2021** to:

  PayFlex Systems USA, Inc.
  Benefits Billing Department
  PO Box 953374
  St. Louis, MO 63195-3374

  Forms may be faxed to **1-402-231-4302** or emailed to **cobramail@payflex.com**. You may also call PayFlex Systems at **1-855-LUCIE4-U (1-855-582-4348)**.

- If you choose to make changes and complete an enrollment form, make sure you mark all of the benefits you wish to keep in the new plan year. Any benefits on your current Benefit Statement will be terminated as of **Dec. 31, 2021** if they are not included on the enrollment form. Late forms will not be accepted. For more information, contact FBMC Service Center at **1-855-LUCIE4-U (1-855-582-4348)**, Monday - Friday, 7 a.m. - 7 p.m. ET.

Retiree Participants

- At open enrollment, a retiree may continue, cancel, or decrease coverage. A retiree may not add or increase coverage, or add or increase dependent coverage. Once a type of coverage is canceled, it may not be reinstated or added at a later date.
- If you currently do not have your premiums deducted from your Florida Retirement System (FRS) monthly benefit check and would like to, please complete the enclosed FRS Deduction Authorization Form and return it with your enrollment form. Your deductions will start as soon as possible. Please be aware that you must make your payments via personal check or money order until the FRS deductions begin.
- If you are making changes to your benefits, you must complete and mail an FBMC Retiree Enrollment Form postmarked by **Nov. 26, 2021** to:

  FBMC Benefits Management, Inc.
  Retiree and Direct Bill Department
  PO Box 10789, Mail Slot 32
  Tallahassee, FL 32302-2789

Key Things to Know

- If you are Medicare-eligible and you elect to enroll in BlueMedicare Group PPO plan, you must also complete and mail a Florida Blue BlueMedicare enrollment form to:

  Florida Blue
  PO Box 45296
  Jacksonville, FL 32232-5296

- Any changes to your retiree benefits will require your written authorization. Premium changes required because of such written authorization will be initiated as soon as possible after receipt of your written request. If you are having FRS deductions for premium payments, any required refunds will be completed as soon as it has been verified that FRS changed your deduction.
- **Retirees are encouraged to submit their enrollment form(s) early during open enrollment to ensure that deductions are made by FRS in a timely manner**.
- Please ensure you have noted all benefits you want to continue in the new plan year. Late forms will not be accepted. For more information, contact FBMC Service Center at **1-855-LUCIE4-U (1-855-582-4348)**, Monday - Friday, 7 a.m. - 7 p.m. ET.

What benefits are available to continue as a retiree?

- **Health** - provides comprehensive medical and pharmacy benefits.
- **Dental** - provides valuable dental benefits with a low or high PPO plan.
- **Vision** - vision plan with in- and out-of-network options and a **New Rate Tier of Participant + 1 has been added**.
- **Group Term Life** - Starting in Plan Year 2021, UNUM will be providing the Group Term Life benefits. During Open Enrollment, you may continue your policy, decrease or cancel coverage. Your plan rate and benefit level will remain the same.

Eligibility + Coverage

Medicare Advantage Plans

SLPS offers two Medicare Advantage Plans for eligible retirees who are age 65 or older and are eligible for Medicare. If you are currently eligible for Medicare and would like to enroll in either plan, please complete the enclosed application along with the Florida Blue BlueMedicare enrollment form. The effective date of your Medicare Advantage Plan will be Jan. 1, 2022.

If you will become eligible for Medicare during the 2022 Plan Year and would like to participate in the Medicare Advantage Plan, please contact St. Lucie Public Schools Risk Management Office to request an application. The effective date of your Medicare Advantage Plan can be the same date your Medicare becomes effective.

Retiree Benefits Coverage

Under section 112.0801, Florida Statutes, your FRS employer is required to offer you or your eligible dependents the option of continued participation in any employer-sponsored group insurance plans in which you were participating at your retirement or at your DROP termination date.

As a retiree, your premium cost for health and hospitalization insurance coverage may not exceed the total employee and employer premium cost applicable to active employees. You may lose your eligibility to participate if you choose not to continue participating in your employer's group plan at retirement, initially choose to continue but subsequently stop participating, defer your retirement to a future date, or otherwise do not meet your employer's group plan requirements. Before you terminate employment, contact your FRS employer about continuing your employer-sponsored group insurance coverage. The division has no authority over or responsibility for employer group health and hospitalization plans.

Income Taxes on Your Retirement Benefit

Each year at the end of January, the division provides you an IRS Form 1099-R. Your annual taxable income is shown in the taxable amount box (Box 2a). You should use this form when you file your income tax return.

Dependent eligibility for Group Health and Dental Plans:

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

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 becomes 26
   b) has reached the end of the calendar year in which he or she becomes 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 becomes 26. Coverage for such newborn child will automatically terminate 18 months after the birth of 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

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.

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

- **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).
- **Term Life** - coverage will cease at the end of the calendar year in which the child reaches age 20 (or 25 if the child lives in your home and depends on you for support or attends school full or part time.)

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

COBRA Coverage

A Qualified Beneficiary's (QB) period of coverage is Jan. 1, 2022, through Dec. 31, 2022, unless a QB's scheduled COBRA expiration date is sooner. QBs who have elected to continue eligible group health plans under COBRA will be given the same opportunity to change their coverage options or add or drop eligible dependents at open enrollment as similarly situated active employees and beneficiaries.

A QB's Medical Expense FSA coverage will not be continued beyond the Plan Year in which the qualifying COBRA event occurs.

HIPAA's special enrollment rights may apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add dependents if such person acquires a new dependent, or if an eligible dependent declines coverage because of alternative coverage and later loses such coverage due to certain qualifying reasons. Spouses or dependents who are added under this law do not become Qualified Beneficiaries — and their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

If there's a loss of coverage for a group health plan, due to one of the triggering events below, then COBRA rights may have been created:

For Covered Employees upon:

- Termination of employment (other than for gross misconduct), including retirement, or
- A reduction in hours of employment

For Spouses or Dependent Child(ren) upon:

- A covered employee's termination of employment (other than for gross misconduct), including retirement
- A covered employee's reduction in hours of employment
- A covered employee's death
- A divorce or legal separation (if recognized by state law) of a spouse from a covered employee
- A covered employee's entitlement to Medicare, or
- A child's loss of dependent status

Benefits Payment Requirements

A COBRA participant's initial payment, including all back premiums, is due within 45 days of COBRA continuation election. Subsequent monthly premium payments are due on the first of every month. COBRA law allows for a 30-day grace period after the due date for monthly payments. If a full premium payment is not received from a COBRA Participant by 30 days after the due date, COBRA coverage will be canceled retroactive to the first day of the month for which the full premium payment is due. A cancellation notice will be sent to the COBRA participant if his or her full premium payment is not received.

Florida Blue Group Health Premiums

2022 COBRA Participant and Retiree Monthly Rates		
BLUE OPTIONS - PLAN 05180 (SINGLE)/05181 (FAMILY)	**RETIREE**	**COBRA**
Participant Only	$698.42	$712.39
Split Plan Spouse	$866.36	N/A
Participant & 1 Dependent	$1,564.78	$1,596.08
Participant & Family	$1,988.21	$2,027.98
BLUE OPTIONS - PLAN 05192 (SINGLE)/05193 (FAMILY)	**RETIREE**	**COBRA**
Participant Only	$632.31	$644.97
Split Plan Spouse	$784.33	N/A
Participant & 1 Dependent	$1,416.64	$1,444.97
Participant & Family	$1,800.00	$1,836.00
BLUE OPTIONS - PLAN 05771	**RETIREE**	**COBRA**
Participant Only	$793.32	$809.19
Split Plan Spouse	$984.04	N/A
Participant & 1 Dependent	$1,777.36	$1,812.91
Participant & Family	$2,259.91	$2,305.12

Premiums for Medicare Eligible Retirees and Medicare-Eligible Dependents (age 65 and older)		
BLUEMEDICARE GROUP PPO ELITE	**RETIREE**	**COBRA**
Retiree Only	$281.31	N/A
Retiree & Spouse	$562.62	N/A
BLUEMEDICARE GROUP PPO ADVANCED	**RETIREE**	**COBRA**
Retiree Only	$214.96	N/A
Retiree & Spouse	$429.92	N/A

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), unless noted	BlueOptions HSA - Compatible 05180 (Single Coverage)	BlueOptions HSA - Compatible 05181 (Family Coverage)
DEDUCTIBLE (DED)		
In-Network (Per Person/Family Aggregate)	$2,000	$4,000
Out-of-Network (Per Person/Family Aggregate)	$4,000	$8,000
COINSURANCE (MEMBER RESPONSIBILITY)		
In-Network	15%	15%
Out-of-Network (OON)	50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES	50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES
OUT-OF-POCKET MAXIMUM (INCLUDES DED, COINSURANCE, & COPAYS)		
In-Network (Per Person/Family Aggregate)	$5,000	$6,900 / $10,000
Out-of-Network (Per Person/Family Aggregate)	$10,000	$20,000
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections		
In-Network Primary/Family Care Physician	DED + 15%	DED + 15%
In-Network Specialist	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
TELADOC and E-Office Services		
In-Network Primary/Family Care Physician	DED ($42) + 15%	DED ($42) + 15%
In-Network Specialist	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Office Services		
In-Network Primary/Family Care Physician	DED + 15%	DED + 15%
In-Network Specialist	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Provider Services at Hospital and ER		
In-Network Primary/Family Care Physician	DED + 15%	DED + 15%
In-Network Specialist	DED + 15%	DED + 15%
Out-of-Network	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%
Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center		
In-Network Specialist	DED + 15%	DED + 15%
Out-of-Network	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%
PREVENTIVE CARE		
Adult/Child Wellness Office Services		
In-Network Primary/Family Care Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	50% (NO DED)	50% (NO DED)
Colonoscopies (Routine - 1 every 10 years) Age 50+ then Frequency Schedule Applies		
In-Network Specialist	$0	$0
Out-of-Network	$0	$0

Florida Blue Medical Plans

BlueOptions HSA - Compatible 05192 (Single Coverage)	BlueOptions HSA - Compatible 05193 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
$3,000	$6,000	$1,750 / $5,250
$6,000	$12,000	$5,250 / $15,750
20%	20%	20%
50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES	50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES	50% OF ALLOWED AMOUNT + SUBJECT TO BALANCE BILLING CHARGES
$6,750	$6,900 / $13,500	$5,000 / $10,000
$13,500	$13,500 / $27,000	$10,000 / $20,000
DED + 20%	DED + 20%	$10
DED + 20%	DED + 20%	$10
DED + 50%	DED + 50%	DED + 50%
DED ($42) + 20%	DED ($42) + 20%	$10
DED + 20%	DED + 20%	$10
DED + 50%	DED + 50%	DED + 50%
DED + 20%	DED + 20%	$40
DED + 20%	DED + 20%	$65
DED + 50%	DED + 50%	DED + 50%
DED + 20%	DED + 20%	DED + 20%
DED + 20%	DED + 20%	DED + 20%
IN-NETWORK DED + 20%	IN-NETWORK DED + 20%	IN-NETWORK DED + 20%
DED + 20%	DED + 20%	ASC: $65, HOSPITAL: DED + 20%
IN-NETWORK DED + 20%	IN-NETWORK DED + 20%	ASC: $65, HOSPITAL: IN-NET DED + 20%
$0	$0	$0
$0	$0	$0
50% (NO DED)	50% (NO DED)	50% (NO DED)
$0	$0	$0
$0	$0	$0

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), unless noted	BlueOptions HSA - Compatible 05180 (Single Coverage)	BlueOptions HSA - Compatible 05181 (Family Coverage)
Mammograms (Routine)		
In-Network	$0	$0
Out-of-Network (OON)	$0	$0
EMERGENCY/URGENT CARE		
Ambulance Maximum (per day)	**NO MAXIMUM**	**NO MAXIMUM**
In-Network	DED + 15%	DED + 15%
Out-of-Network	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network	DED + 15%	DED + 15%
Out-of-Network	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%
Urgent Care Centers (UCC)		
In-Network	DED + 15%	DED + 15%
Out-of-Network	OON DED + 15%	OON DED + 15%
FACILITY SERVICES – HOSPITAL/SURGICAL/ICL/IDTF*		
Ambulatory Surgical Center		
In-Network	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Independent Clinical Lab		
In-Network (Quest Diagnostics)	DED	DED
Out-of-Network	DED + 50%	DED + 50%
Independent Diagnostic Testing Facility (IDTF) - X-Rays and AIS (Includes Physician Services)		
In-Network - Advanced Imaging Services (AIS)	DED + 15%	DED + 15%
In-Network - Other Diagnostic Services	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Inpatient Hospital (per admit)		
In-Network	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 15% OPTION 2 - DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Outpatient Hospital (per visit)		
In-Network	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 15% OPTION 2 - DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Therapy at Outpatient Hospital		
In-Network	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 15% OPTION 2 - DED + 15%
Out-of-Network	DED + 50%	DED + 50%
OTHER SPECIAL SERVICES AND LOCATIONS		
Durable Medical Equipment (DME), Prosthetics, Orthotics	**NO MAXIMUM**	**NO MAXIMUM**
In-Network (CareCentrix)	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%

* Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.

Florida Blue Medical Plans

BlueOptions HSA - Compatible 05192 (Single Coverage)	BlueOptions HSA - Compatible 05193 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
$0	$0	$0
$0	$0	$0
NO MAXIMUM	**NO MAXIMUM**	**NO MAXIMUM**
DED + 20%	DED + 20%	DED + 20%
IN-NETWORK DED + 20%	IN-NETWORK DED + 20%	IN-NETWORK DED + 20%
DED + 20%	DED + 20%	DED + 20%
IN-NETWORK DED + 20%	IN-NETWORK DED + 20%	IN-NETWORK DED + 20%
DED + 20%	DED + 20%	$80
OON DED + 20%	OON DED + 20%	OON DED + $80
DED + 20%	DED + 20%	DED + 20%
DED + 50%	DED + 50%	DED + 50%
DED	DED	$0
DED + 50%	DED + 50%	DED + 50%
DED + 20%	DED + 20%	DED + 20%
DED + 20%	DED + 20%	DED + 20%
DED + 50%	DED + 50%	DED + 50%
OPTION 1 - DED + 20% OPTION 2 - DED + 20%	OPTION 1 - DED + 20% OPTION 2 - DED + 20%	OPTION 1 - DED + 20% OPTION 2 - DED + 20%
DED + 50%	DED + 50%	$500 PAD + DED + 50%
OPTION 1 - DED + 20% OPTION 2 - DED + 20%	OPTION 1 - DED + 20% OPTION 2 - DED + 20%	OPTION 1 - DED + 20% OPTION 2 - DED + 20%
DED + 50%	DED + 50%	DED + 50%
OPTION 1 - DED + 20% OPTION 2 - DED + 20%	OPTION 1 - DED + 20% OPTION 2 - DED + 20%	OPTION 1 - $65 OPTION 2 - $85
DED + 50%	DED + 50%	DED + 50%
NO MAXIMUM	**NO MAXIMUM**	**NO MAXIMUM**
DED + 20%	DED + 20%	DED + 20%
DED + 50%	DED + 50%	DED + 50%

COST SHARING Maximums shown refer to the Per Benefit Period (BPM), unless noted	BlueOptions HSA - Compatible 05180 (Single Coverage)	BlueOptions HSA - Compatible 05181 (Family Coverage)
Home Healthcare (BPM)	**20 VISITS**	**20 VISITS**
Home Healthcare In-Network (CareCentrix)	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Hospice	**NO MAXIMUM**	**NO MAXIMUM**
In-Network	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Skilled Nursing Facility BPM	**60 DAYS**	**60 DAYS**
In-Network	DED + 15%	DED + 15%
Out-of-Network	DED + 50%	DED + 50%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Physician Office Visit		
In-Network Family Physician or Specialist	DED + 15%	DED + 15%
Out-of-Network Provider	DED + 50%	DED + 50%
Inpatient/Outpatient Hospitalization - Facility		
In-Network	OPTION 1 - DED + 15% OPTION 2 - DED + 15%	OPTION 1 - DED + 15% OPTION 2 - DED + 15%
Out-of-Network	DED + 50%	DED + 50%
Emergency Room Facility Services (per visit)		
In-Network	DED + 15%	DED + 15%
Out-of-Network	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%
Provider Services at Hospital and ER		
In-Network Family Physician or Specialist	DED + 15%	DED + 15%
Out-of-Network Provider	IN-NETWORK DED + 15%	IN-NETWORK DED + 15%
PRESCRIPTION DRUGS		
Deductible	$2,000 IN-NETWORK DEDUCTIBLE APPLIES	$4,000 IN-NETWORK DEDUCTIBLE APPLIES
In-Network (Mandatory Generic Program)		
Retail (30 days) Generic / Preferred Brand / Non-Preferred	$10 / $50 / $75	$10 / $50 / $75
Mail Order/Retail (90 days) Generic / Preferred Brand / Non-Preferred	$20 / $100 / $150	$20 / $100 / $150
	CONDITION CARE RX PROGRAM - AVAILABLE FOR HSA PLANS ONLY 05180/05181, IN-NETWORK DEDUCTIBLE IS WAIVED/COPAY ONLY, **"CLICK HERE TO SEE COVERED MEDICATIONS"**	

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.

The information contained in this proposal includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), 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. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary.

Additionally, Interim rules released by the Federal Government February 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE). Benefits and rates reflected in the proposal are subject to change based on the outcomes of the test.

Florida Blue Medical Plans

BlueOptions HSA - Compatible 05192 (Single Coverage)	BlueOptions HSA - Compatible 05193 (Family Coverage)	BlueOptions 05771 (Only Available To Employees Hired Prior to 1/1/14)
20 VISITS	**20 VISITS**	**20 VISITS**
DED + 20%	DED + 20%	DED + 20%
DED + 50%	DED + 50%	DED + 50%
NO MAXIMUM	**NO MAXIMUM**	**NO MAXIMUM**
DED + 20%	DED + 20%	DED + 20%
DED + 50%	DED + 50%	DED + 50%
60 DAYS	**60 DAYS**	**60 DAYS**
DED + 20%	DED + 20%	DED + 20%
DED + 50%	DED + 50%	DED + 50%
DED + 20%	DED + 20%	$0
DED + 50%	DED + 50%	50% (NO DED)
OPTION 1: DED + 20% OPTION 2: DED + 20%	OPTION 1: DED + 20% OPTION 2: DED + 20%	OPTION 1: $0 OPTION 2: $0
DED + 50%	DED + 50%	50% (NO DED)
DED + 20%	DED + 20%	$0
IN-NETWORK DED + 20%	IN-NETWORK DED + 20%	$0
DED + 20%	DED + 20%	$0
IN-NETWORK DED + 20%	IN-NETWORK DED + 20%	$0
$3,000 IN-NETWORK PLAN DEDUCTIBLE APPLIES	$6,000 IN-NETWORK PLAN DEDUCTIBLE APPLIES	$0
$10 / $50 / $100	$10 / $50 / $100	$10 / $50 / $75
$20 / $100 / $200	$20 / $100 / $200	$20 / $100 / $150
CONDITION CARE RX PROGRAM - AVAILABLE FOR HSA PLANS ONLY 05192/05193, IN-NETWORK DEDUCTIBLE IS WAIVED/COPAY ONLY "**CLICK HERE TO SEE COVERED MEDICATIONS**"		N/A

Florida Blue BlueMedicare Group PPO - Elite

Monthly Premium, Deductible and Limits

Monthly Plan Premium	▪ **$281.31 for Elite PPO** You must continue to pay your Medicare Part B premium.
Deductible	▪ **$1,000** per year for Out-of-Network health care services ▪ **$0** per year for Part D prescription drugs
Maximum Out-of-Pocket Responsibility	▪ **$1,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$3,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in- and out-of-network providers.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Care ◊ (Authorization applies to in-network services only.)	▪ **$200** copay per day, days 1-5 ▪ **$0** copay per day, after day 5	▪ **20**% of the Medicare-allowed amount after $1,000 out-of-network deductible
Outpatient Hospital Care	▪ **$75** copay per visit for Medicare-covered observation services ▪ **$200** copay for all other services ◊	▪ **20**% of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulatory Surgical Center	▪ **$150** copay for surgery services provided at an Ambulatory Surgery Center ◊	▪ **20**% of the Medicare-allowed amount after $1,000 out-of-network deductible
Doctor's Office Visits	▪ **$10** copay per primary care visit ▪ **$25** copay per specialist visit	▪ **20**% of the Medicare-allowed amount after $1,000 out-of-network deductible
Preventive Care	**$0** copay ▪ Abdominal aortic aneurysm screening ▪ Annual wellness visit ▪ Bone mass measurement ▪ Breast cancer screening (mammograms) ▪ Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) ▪ Cardiovascular disease testing ▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screening ▪ Depression screening ▪ Diabetes screening	▪ **20%** of the Medicare-allowed amount

	In-Network	Out-of-Network
	▪ Diabetes self-management training, diabetic services and supplies ▪ Health and wellness education programs ▪ Hepatitis C Screening ▪ HIV screening ▪ Immunizations ▪ Medical nutrition therapy ▪ Medicare Diabetes Prevention Program (MDPP) ▪ Obesity screening and therapy to promote sustained weight loss ▪ Prostate cancer screening exams ▪ Screening and counseling to reduce alcohol misuse ▪ Screening for lung cancer with low dose computed tomography (LDCT) ▪ Screening for sexually transmitted infections (STIs) and counseling to prevent STIs ▪ Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) ▪ Vision care: Glaucoma screening ▪ "Welcome to Medicare" preventive visit	
Emergency Care	**Medicare Covered Emergency Care** ▪ **$75** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$75** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	

Florida Blue BlueMedicare Group PPO - Elite

	In-Network	Out-of-Network
Urgently Needed Services	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$25** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$25** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$75** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	
Diagnostic Services/ Labs/Imaging ◊ (Authorization applies to in-network services only.)	**Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$15** copay at an outpatient hospital facility **X-Rays** ▪ **$25** copay at a physician's office and at an Independent Diagnostic Testing Facility (IDTF) ▪ **$100** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$50** copay at a physician's office ▪ **$75** copay at an IDTF ▪ **$100** copay at an outpatient hospital facility **Radiation Therapy** ▪ **20%** of the Medicare-allowed amount	▪ **20**% of the Medicare-allowed amount after $1,000 out-of-network deductible
Hearing Services	**Medicare-Covered Hearing Services** ▪ **$25** copay for specialist exams to diagnose and treat hearing and balance issues	**Medicare-Covered Hearing Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Dental Services	**Medicare-Covered Dental Services** ◊ ▪ **$25** copay for specialist non-routine dental care	**Medicare-Covered Dental Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for non-routine dental

Florida Blue BlueMedicare Group PPO - Elite

	In-Network	Out-of-Network
Vision Services	**Medicare-Covered Vision Services** ▪ **$25** copay for specialist to diagnose and treat eye diseases and conditions ▪ **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) ▪ **$0** copay for one diabetic retinal exam per year ▪ **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery	**Medicare-Covered Vision Services** ▪ **20%** of the Medicare-allowed amount for glaucoma screening ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for Medicare-covered specialist services to diagnose and treat diseases and conditions of the eye and diabetic retinal exams ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible for eyeglasses or contact lenses after cataract surgery
Mental Health Services ◊ (Authorization applies to in-network services only)	**Inpatient Mental Health Services** ▪ **$200** copay per day, days 1-7 ▪ **$0** copay per day, days 8-90 190-day lifetime benefit maximum in a psychiatric hospital. **Outpatient Mental Health Services** ▪ **$30** copay	**Inpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible 190-day lifetime benefit maximum in a psychiatric hospital. **Outpatient Mental Health Services** ▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Skilled Nursing Facility (SNF) ◊ (Authorization applies to in-network services only.)	▪ **$0** copay per day, days 1-20 ▪ **$100** copay per day, days 21-100 Our plan covers up to 100 days in a SNF per benefit period.	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Physical Therapy	▪ **$25** copay per visit ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Ambulance	▪ **$150** copay for each Medicare-covered trip (one-way) ◊	▪ **$150** copay for each Medicare-covered trip (one-way)
Transportation	▪ Not covered	▪ Not covered
Medicare Part B Drugs	▪ **$5** copay for allergy injections ▪ **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

Part D Prescription Drug Benefits

Deductible Stage

$0 per year for Part D prescription drugs.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **$4,430**. You may get your drugs at network retail pharmacies and mail-order pharmacies.

	Preferred Retail/LTC (31-day supply)	Standard Retail (31-day supply)	Mail Order (90-day supply)
Tier 1 - Preferred Generic	**$0** copay	**$8** copay	**$0** copay
Tier 2 - Generic	**$3** copay	**$15** copay	**$9** copay
Tier 3 - Preferred Brand	**$30** copay	**$40** copay	**$90** copay
Tier 4 - Non-Preferred Drug	**$60** copay	**$70** copay	**$120** copay
Tier 5 - Specialty Tier	**33%** of the cost	**33%** of the cost	**N/A**

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including total drug costs paid by you *and* any Part D plan) reaches **$4,430**.

You stay in this stage until your year-to-date “out-of-pocket” costs reach a total of **$7,050**.

During the Coverage Gap Stage:

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs throughout the Coverage Gap.

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050** you pay the *greater* of:

- **$3.95** copay for generic drugs in all tiers (including brand drugs treated as generic) and an **$9.85** copay for all other drugs in all tiers, or **5%** of the cost

Additional Drug Coverage

- Please call us or see the plan's "Evidence of Coverage" on our website (**www.floridablue.com/medicare**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 (Non-Preferred Drug) cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug.

Additional Benefits

	In-Network	Out-of-Network
Diabetic Supplies	▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips **Important Note: Insulin, insulin syringes and needles for self-administration in the home are obtained from a retail or mail-order pharmacy and are covered under your Medicare Part D pharmacy benefit.** Applicable Part D co-pays and deductibles apply.	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medicare Diabetes Prevention Program	▪ **$0** copay for Medicare-covered services	▪ **20%** of the Medicare-allowed amount
Podiatry	▪ **$25** copay for each Medicare-covered podiatry visit	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Chiropractic	▪ **$20** copay for each Medicare-covered chiropractic service	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Medical Equipment and Supplies ◊ (Authorization applies to in-network services only.)	▪ **20%** of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible
Occupational and Speech Therapy	▪ **$25** copay per visit ◊	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

Florida Blue BlueMedicare Group PPO - Elite

	In-Network	Out-of-Network
Telehealth ◊ (Authorization applies to in-network services only)	▪ **$25** copay for Urgently Needed Services ▪ **$10** copay for Primary Care Services ▪ **$25** copay for Occupational Therapy/Physical Therapy/Speech Therapy at all locations ▪ **$25** copay for Dermatology Services ▪ **$30** copay for individual sessions for outpatient Mental Health Specialty Services ▪ **$30** copay for individual sessions for outpatient Psychiatry Specialty Services ▪ **$30** copay for Opioid Treatment Program Services ▪ **$30** copay for individual sessions for outpatient Substance Abuse Specialty Services ▪ **$0** copay for Diabetes Self-Management Training ▪ **$0** copay for Dietician Services	▪ **20%** of the Medicare-allowed amount after $1,000 out-of-network deductible

You Get More with BlueMedicare

Health Education	In- and Out-of-Network meQuilibrium's digital coaching platform delivers clinically validated and highly personalized resilience solutions to help people improve their ability to manage stress and successfully cope with life's challenges. To get started go to FloridaBlue.com/Medicare log in, click on My Health and select HealthyBlue Rewards.
Healthy Blue Rewards	▪ Your BlueMedicare plan rewards you for taking care of your health. Redeem gift card rewards for completing and reporting preventive care and screenings.
SilverSneakers® Fitness Program	▪ Gym membership and classes available at fitness locations across the country, including national chains and local gyms ▪ Access to exercise equipment and other amenities, classes for all levels and abilities, social events, and more

Florida Blue BlueMedicare Group PPO - Advanced

Monthly Premium, Deductible and Limits

Monthly Plan Premium	▪ **$214.96 for Advanced PPO** You must continue to pay your Medicare Part B premium.
Deductible	▪ **$0** per year for In-Network health care services ▪ **$2,000** per year for Out-of-Network health care services ▪ **$100** per year for Part D prescription drugs (applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) only)
Maximum Out-of-Pocket Responsibility	▪ **$1,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services from in-network providers for the year. ▪ **$3,000** is the most you pay for copays, coinsurance and other costs for Medicare-covered medical services you receive from in and out-of-network providers combined.

Medical and Hospital Benefits

	In-Network	Out-of-Network
Inpatient Hospital Care ◊ (Authorization applies to in-network services only.)	▪ **$200** copay per day, days 1-7 ▪ **$0** copay per day, after day 7	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Outpatient Hospital Care	▪ **$75** copay per visit for Medicare-covered observation services ▪ **$250** copay for all other services ◊	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Ambulatory Surgical Center	▪ **$200** copay for surgery services provided at an Ambulatory Surgery Center ◊	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Doctor's Office Visits	▪ **$25** copay per primary care visit ▪ **$45** copay per specialist visit	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Preventive Care	**$0** copay ▪ Abdominal aortic aneurysm screening ▪ Annual wellness visit ▪ Bone mass measurement ▪ Breast cancer screening (mammograms) ▪ Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) ▪ Cardiovascular disease testing	▪ **40%** of the Medicare-allowed amount

	In-Network	Out-of-Network
	▪ Cervical and vaginal cancer screening ▪ Colorectal cancer screening ▪ Depression screening ▪ Diabetes screening ▪ Diabetes self-management training, diabetic services and supplies ▪ Health and wellness education programs ▪ Hepatitis C Screening ▪ HIV screening ▪ Immunizations ▪ Medical nutrition therapy ▪ Medicare Diabetes Prevention Program (MDPP) ▪ Obesity screening and therapy to promote sustained weight loss ▪ Prostate cancer screening exams ▪ Screening and counseling to reduce alcohol misuse ▪ Screening for lung cancer with low dose computed tomography (LDCT) ▪ Screening for sexually transmitted infections (STIs) and counseling to prevent STIs ▪ Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) ▪ Vision care: Glaucoma screening ▪ "Welcome to Medicare" preventive visit	
Emergency Care	**Medicare Covered Emergency Care** ▪ **$75** copay per visit, in- or out-of-network This copay is waived if you are admitted to the hospital within 48 hours of an emergency room visit. **Worldwide Emergency Care Services** ▪ **$75** copay for Worldwide Emergency Care ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	

Florida Blue BlueMedicare Group PPO - Advanced

	In-Network	Out-of-Network
Urgently Needed Services	**Medicare Covered Urgently Needed Services** Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention. ▪ **$30** copay at an Urgent Care Center, in- or out-of-network Convenient Care Services are outpatient services for non-emergency injuries and illnesses that need treatment when most family physician offices are closed. ▪ **$30** copay at a Convenient Care Center, in- or out-of-network **Worldwide Urgently Needed Services** ▪ **$75** copay for Worldwide Urgently Needed Services ▪ **$25,000** combined yearly limit for Worldwide Emergency Care and Worldwide Urgently Needed Services Does not include emergency transportation.	
Diagnostic Services/ Labs/Imaging ◊ (Authorization applies to in-network services only.)	**Laboratory Services** ▪ **$0** copay at an Independent Clinical Laboratory ▪ **$30** copay at an outpatient hospital facility **X-Rays** ▪ **$50** copay at a physician's office and at an Independent Diagnostic Testing Facility (IDTF) ▪ **$150** copay at an outpatient hospital facility **Advanced Imaging Services** Includes services such as Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Computer Tomography (CT) Scan ▪ **$75** copay at a physician's office ▪ **$100** copay at an IDTF ▪ **$150** copay at an outpatient hospital facility **Radiation Therapy** ▪ **20%** of the Medicare-allowed amount	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Hearing Services	**Medicare-Covered Hearing Services** ▪ **$45** copay for specialist exams to diagnose and treat hearing and balance issues	**Medicare-Covered Hearing Services** ▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Dental Services	**Medicare-Covered Dental Services** ◊ ▪ **$45** copay for specialist non-routine dental care	**Medicare-Covered Dental Services** ▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible for non-routine dental

	In-Network	Out-of-Network
Vision Services	**Medicare-Covered Vision Services** ▪ **$45** copay for specialist to diagnose and treat eye diseases and conditions ▪ **$0** copay for glaucoma screening (once per year for members at high risk of glaucoma) ▪ **$0** copay for one diabetic retinal exam per year ▪ **$0** copay for one pair of eyeglasses or contact lenses after each cataract surgery	**Medicare-Covered Vision Services** ▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Mental Health Services ◊ (Authorization applies to in-network services only)	**Inpatient Mental Health Services** ▪ **$200** copay per day, days 1-7 ▪ **$0** copay per day, after day 7 190-day lifetime benefit maximum in a psychiatric hospital. **Outpatient Mental Health Services** ▪ **$40** copay	**Inpatient Mental Health Services** ▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible 190-day lifetime benefit maximum in a psychiatric hospital. **Outpatient Mental Health Services** ▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Skilled Nursing Facility (SNF) ◊ (Authorization applies to in-network services only.)	▪ **$0** copay per day, days 1-20 ▪ **$100** copay per day, days 21-100 Our plan covers up to 100 days in a SNF per benefit period.	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Physical Therapy	▪ **$35** copay per visit ◊	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Ambulance	▪ **$200** copay for each Medicare-covered trip (one-way) ◊	▪ **$200** copay for each Medicare-covered trip (one-way)
Transportation	▪ Not covered	▪ Not covered
Medicare Part B Drugs	▪ **$5** copay for allergy injections ▪ **20%** of the Medicare-allowed amount for chemotherapy drugs and other Medicare Part B-covered drugs ◊	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible

Part D Prescription Drug Benefits

Deductible Stage

This plan has a **$100** deductible. The deductible applies to Tier 3 (Preferred Brand), Tier 4 (Non-Preferred Drug), and Tier 5 (Specialty Tier) only.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **$4,430**. You may get your drugs at network retail pharmacies and mail order pharmacies.

	Preferred Retail/LTC (31-day supply)	Standard Retail (31-day supply)	Mail Order (90-day supply)
Tier 1 - Preferred Generic	**$8** copay	**$15** copay	**$24** copay
Tier 2 - Generic	**$10** copay	**$15** copay	**$30** copay
Tier 3 - Preferred Brand	**$35** copay	**$45** copay	**$105** copay
Tier 4 - Non-Preferred Drug	**$78** copay	**$85** copay	**$234** copay
Tier 5 - Specialty Tier	**31%** of the cost	**31%** of the cost	**N/A**

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including total drug costs paid by you *and* any Part D plan) reaches **$4,430**.

You stay in this stage until your year-to-date “out-of-pocket” costs reach a total of **$7,050**.

<u>During the Coverage Gap Stage:</u>

- You pay the same copays that you paid in the Initial Coverage Stage for drugs in Tier 1 (Preferred Generic) and Tier 2 (Generic) – or **25%** of the cost, whichever is lower.
- For generic drugs in all other tiers, you pay **25%** of the cost.
- For brand-name drugs, you pay **25%** of the cost (plus a portion of the dispensing fee).

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$7,050**, you pay the *greater* of:

- **$3.95** copay for generic drugs in all tiers (including brand drugs treated as generic) and an **$9.85** copay for all other drugs in all tiers, or **5%** of the cost

Additional Drug Coverage

- Please call us or see the plan's "Evidence of Coverage" on our website (**www.floridablue.com/medicare**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 [Non-Preferred Drug] cost-sharing.
- Your cost-sharing may be different if you use a Long-Term Care (LTC) pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug

Additional Benefits

	In-Network	Out-of-Network
Diabetic Supplies	▪ **$0** copay at your network retail or mail-order pharmacy for Diabetic Supplies such as: • Lifescan (One Touch®) Glucose Meters • Lancets • Test Strips **Important Note: Insulin, insulin syringes and needles for self-administration in the home are obtained from a retail or mail order pharmacy and are covered under your Medicare Part D pharmacy benefit.** Applicable Part D co-pays and deductibles apply.	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Medicare Diabetes Prevention Program	▪ **$0** copay for Medicare-covered services	▪ **40%** of the Medicare-allowed amount
Podiatry	▪ **$45** copay for each Medicare-covered podiatry visit	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Chiropractic	▪ **$20** copay for each Medicare-covered chiropractic service	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Medical Equipment and Supplies ◊ (Authorization applies to in-network services only.)	▪ **20%** of the Medicare-allowed amount for all plan approved, Medicare-covered motorized wheelchairs and electric scooters ▪ **0%** of the Medicare-allowed amount for all other plan approved, Medicare-covered durable medical equipment	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible
Occupational and Speech Therapy	▪ **$35** copay per visit ◊	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible

	In-Network	Out-of-Network
Telehealth ◊ (Authorization applies to in-network services only)	▪ **$30** copay for Urgently Needed Services ▪ **$25** copay for Primary Care Services ▪ **$35** copay for Occupational Therapy/Physical Therapy/Speech Therapy at all locations ▪ **$45** copay for Dermatology Services ▪ **$40** copay for individual sessions for outpatient Mental Health Specialty Services ▪ **$40** copay for individual sessions for outpatient Psychiatry Specialty Services ▪ **$40** copay for Opioid Treatment Program Services ▪ **$40** copay for individual sessions for outpatient Substance Abuse Specialty Services in an office setting ▪ **$0** copay for Diabetes Self-Management Training ▪ **$0** copay for Dietician Services	▪ **40%** of the Medicare-allowed amount after $2,000 out-of-network deductible

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 or 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 quality dentists who provide services based on a negotiated fee. When you use a participating dentist in the BlueDental Choice network*, 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 rollover:	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.

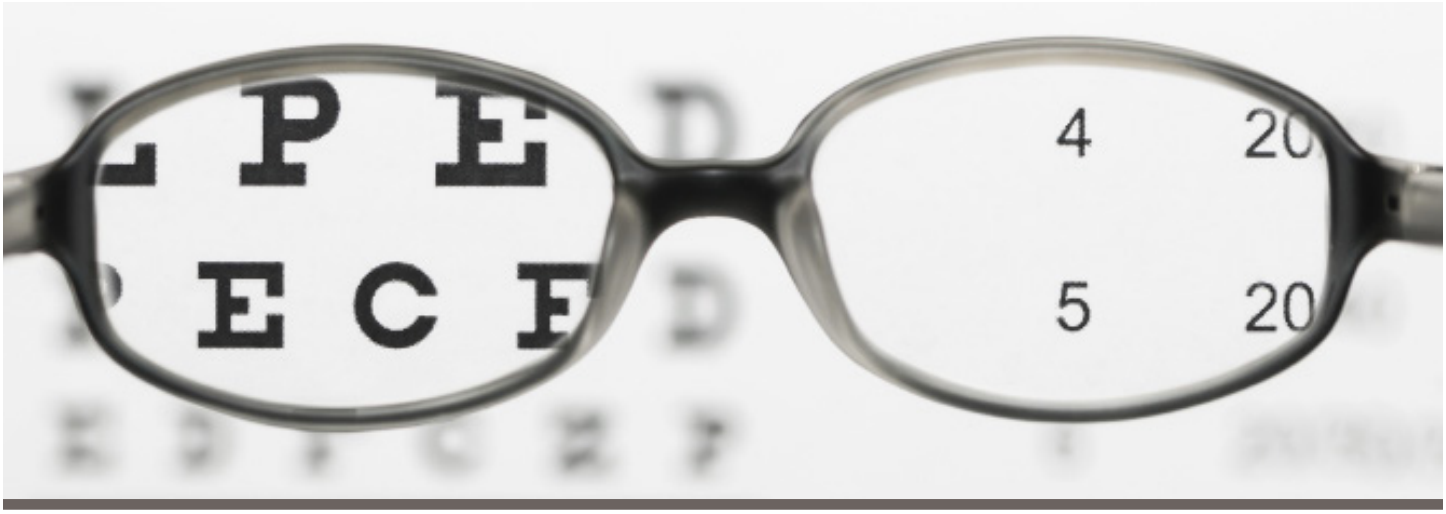
2022 Florida Combined Life Dental Benefits
*St. Lucie Public Schools - **Retirees and COBRA***

	BlueDental Choice PPO Low		BlueDental Choice PPO High	
Financial Features	**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 19)* 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	**MONTHLY PREMIUM**			
	RETIREE	**COBRA**	**RETIREE**	**COBRA**
Employee	**$35.20**	**$35.90**	**$42.90**	**$43.76**
Employee Plus 1	**$73.95**	**$75.43**	**$90.26**	**$92.07**
Employee Plus 2 or more	**$127.37**	**$129.92**	**$159.10**	**$162.28**

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.

Vision Plan



See How Davis Vision Plan Expands Your Vision Plan Features!

Davis Vision Plan

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:

- Paid in full eye examinations, eyeglasses and contacts!
- Frame Collection - Your plan includes a selection of designer, name-brand frames that are covered in full.*
- Contact Lens Collection - Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.*
- One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

*Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Value for Davis Vision Members

A comprehensive benefit ensuring low, out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features

Replacement contacts through Davis Vision contact lens replacement service – saving both time and money.

The Exclusive Collection

The Exclusive Collection of frames is available at close to 9,000 locations across the U.S. Log in to your account to browse frames and find an Exclusive Collection near you.

COVERAGE	Retiree	COBRA
Participant Only	$6.60	$6.73
Participant + 1	$15.92	$16.27
Participant + Family	$23.01	$23.47

Free Breakage Warranty

Your glasses are covered with our FREE, one-year breakage warranty. Some limitations apply.

Find A Network Provider

Just log on to the open enrollment section of our Member site at **davisvision.com/member** and click "Find a Provider" to locate a provider near you, including: Visionworks

1. Contact lens coverage varies by product selection.
2. Visually-required contacts are covered in full with prior approval.
3. Some limitations apply to additional discounts. Discounts are not applicable at all in-network providers.
4. The Exclusive Collection of Contact Lenses evaluation, fitting and follow-up care is covered in full.

Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

For more details about the plan, just log on to the open enrollment section of our member site at **davisvision.com/member** or call 877-923-2847 and enter Client Code **8165**.

Vision Plan

In-Network Benefits	Plan Design Options
Frequency – Once Every:	Designer
Eye Examination Inclusive of Dilation (when professionally indicated)	12 Months
Spectacle Lenses	12 Months
Frame	12 Months
Contact Lens Evaluation, Fitting & Follow-Up Care (in lieu of eyeglasses)	12 Months
Contact Lenses (in lieu of eyeglasses)	12 Months
Copayments	
Eye Examination	$0
Spectacle Lenses	$0
Contact Lens Evaluation, Fitting & Follow-Up Care	$0[1]
Eyeglass Benefit – Frame	
Frame Allowance (Retail):	Up to $130 Plus a 20% discount on any overage[2]
Davis Vision Exclusive Collection[3] (in lieu of Allowance)	
Fashion / Designer / Premier - member charge (if applicable)	$0 / $0 / $25
Eyeglass Benefit - Spectacle Lenses	Member Charges
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any size or Rx)	Covered
Tinting of Plastic Lenses	Covered
Scratch-Resistant Coating	Covered
Polycarbonate Lenses (Children[4] / Adults)	$0 / $30
Ultraviolet Coating	$12
Anti-Reflective (AR) Coating (Standard / Premium / Ultra)	$35 / $48 / $60
Progressive Lenses (Standard / Premium / Ultra)	$50 / $90 / $140
High-Index Lenses	$55
Polarized Lenses	$75
Plastic Photochromic Lenses	$65
Scratch Protection Plan: Single Vision / Multifocal Lenses	$20 / $40
Contact Lens Benefit (in lieu of eyeglasses)	
Contact Lens Materials Allowance	Up to $130 Plus a 15% discount on any overage[2]
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types	Covered
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types	Up to $60 allowance Plus a 15% discount on any overage[2]
Exclusive Collection Contact Lenses[3] (in lieu of Allowance): Materials: Disposable DR Planned Replacement: up to	4 OR 2 boxes
- Evaluation, Fitting & Follow-up Care	Covered
Medically Necessary Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care	Covered
Additional Savings	
Retinal Imaging – member charge	$39
Additional Pairs of Eyeglasses	30% discount[2]

Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $35	Single Vision Lenses: $25	Trifocal Lenses: $60	Elective Contact Lenses: $85
Frame: $30	Bifocal/Progressive Lenses: $40	Lenticular Lenses: $100	Medically Necessary CL: $210

[1] Copayment applies to Collection Contact Lenses only.

[2] Additional discounts and applicable at Walmart, Sam's Club, or Costco locations or where limited by law or manufacturer restrictions.

[3] Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select frame and manufacturers.

[4] Polycarbonate lenses are covered for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

Vision Plan

COPAYS FOR OPTIONS AND UPGRADED LENS OPTIONS	
Service	**Amount**
Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any Rx)	$0
Oversized Lenses	$0
Plastic Lenses	$0
Polycarbonate Lenses **- Children** **- Adults**	 $0 $30
High-Index Lenses	$55
Polarized Lenses	$75
Progressive Lenses (Standard/Premium/ Ultra)	$50/$90/$140
Anti-Reflective (AR Coating Standard/Premium/Ultra)	$35/$48/$60
Ultraviolet Coating	$12
Tinting of Plastic Lenses (Solid/Gradient)	$0
Plastic Photochromic Lenses (Transitions® Signature™)	$65
Scratch-Resistant Coating	$0
Scratch-Protection Plan (Single-Vision/ Multifocal)	$20/$40
Additional Pairs of Eyeglasses	30% discount

ADDITIONAL SAVINGS	
Service	**Amount**
Retinal Imaging (Member Charge)	$39
Additional Pairs of Eyeglasses	30% discount

Out-Of-Network Benefits

You will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. However, you may also receive service from an out-of-network provider. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
PO Box 1525
Latham, NY 12110

Group Medical Bridge Plans

Only available to those retirees who are currently retired and enrolled in the group medical bridge plan.

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. 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 preexisting condition as defined in the certificate unless the preexisting limitation period stated in the certificate schedule has been satisfied.*

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, 2020**.

Group Medical Bridge Plans

For Retiree Participants Only

Group Medical Bridge Plans
Choice of $1,000 or $2,000 Hospital Confinement Benefit

All rates are dependent upon your age on the effective date of coverage.

Hospital Confinement Benefit Amount: **$1,000 BENEFIT AMOUNT** Emergency Room Visit: **$150 (ACCIDENT ONLY)**	MONTHLY RATE
	Ages 17-49
Participant	$10.11
EE and Spouse	$18.22
EE and Children*	$16.06
EE and Family**	$24.19
	Ages 50-59
Participant	$12.88
EE and Spouse	$25.64
EE and Children*	$18.83
EE and Family**	$31.60
	Ages 60-64
Participant	$17.83
EE and Spouse	$37.09
EE and Children*	$23.78
EE and Family**	$43.05
	Ages 65+
Participant	$24.91
EE and Spouse	$51.65
EE and Children*	$30.86
EE and Family**	$57.62

Hospital Confinement Benefit Amount: **$2,000 BENEFIT AMOUNT** Emergency Room Visit: **$150 (ACCIDENT ONLY)**	MONTHLY RATE
	Ages 17-49
Participant	$19.66
EE and Spouse	$35.31
EE and Children*	$29.65
EE and Family**	$45.30
	Ages 50-59
Participant	$25.19
EE and Spouse	$50.14
EE and Children*	$35.18
EE and Family**	$60.13
	Ages 60-64
Participant	$35.09
EE and Spouse	$73.04
EE and Children*	$45.08
EE and Family**	$83.03
	Ages 65+
Participant	$49.26
EE and Spouse	$102.17
EE and Children*	$59.24
EE and Family**	$112.17

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.

* Children includes eligible dependent children only.

** Family includes spouse and eligible dependent children.

Group Term Life Insurance

For Retiree Participants Only

If you're like most people, you want to make sure that your loved ones are adequately provided for if something happens to you.

Levels of Group Term Life Insurance:

- $10,000
- $15,000
- $20,000
- $25,000
- $30,000
- $35,000
- $40,000
- $45,000
- $50,000

You may either continue the level of Basic Term Life you had in force at the time of your retirement, or elect a lower amount from the options listed above. During annual enrollment, you may decrease or cancel your retiree life insurance. You may not increase your level of coverage.

Coverage Level at Ages 65 and 70

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

Plan Provider

Unum Life Insurance Company of America insures this plan. Unum has earned a solid reputation for its quality products, superior customer service, expert resources, steady growth, innovation and strong financial performance. Founded in 1848, Unum 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.

Retirees Under 65 Rates

	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64
$10,000	$4.35	$4.35	$4.35	$4.35	$4.35	$4.35	$4.35	$4.35
$15,000	$5.12	$5.26	$5.54	$6.45	$7.72	$9.75	$12.42	$16.06
$20,000	$5.61	$6.17	$6.73	$8.56	$11.08	$15.15	$20.48	$27.78
$25,000	$6.66	$7.09	$7.93	$10.66	$14.45	$20.55	$28.55	$39.49
$30,000	$7.44	$8.00	$9.12	$12.77	$17.82	$25.96	$36.62	$51.21
$35,000	$8.21	$8.91	$10.31	$14.87	$21.19	$31.36	$44.69	$62.92
$40,000	$8.98	$9.82	$11.50	$16.98	$24.55	$36.76	$52.75	$74.64
$45,000	$9.75	$10.73	$12.70	$19.08	$27.92	$42.16	$60.82	$86.35
$50,000	$10.52	$11.64	$13.89	$21.19	$31.29	$47.56	$68.89	$98.07

Retirees Age 65 - 69* Rates

Coverage Amount	Premium
$6,500	$2.83
$9,750	$4.24
$13,000	$14.70
$16,250	$25.93
$19,500	$37.14
$22,750	$48.36
$26,000	$59.57
$29,250	$70.80
$32,500	$82.01

Retirees Age +70* Rates

Coverage Amount	Premium
$5,000	$2.17
$7,500	$3.25
$10,000	$11.31
$12,500	$19.95
$15,000	$28.57
$17,500	$37.21
$20,000	$45.82
$22,500	$54.46
$25,000	$63.08

* Age as of Jan. 1, 2021

Retired members 70 or older on Jan 1, 2018 and who retired prior to Jan 1, 2018	Coverage Amount	70+
	$3,000	$1.30

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:

1. 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.
2. 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 Drug Plan?

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 2022 calendar year begins October 15, 2021 and runs through December 7, 2021. If you elect the St. Lucie Public Schools Prescription Drug Plan for 2022, 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 2022 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 This Notice Or Your Current Prescription Drug Coverage...
Contact the Risk Management Department for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through St. Lucie Public Schools changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For 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: 09/13/21
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) 429-5520

Notices

COBRA OVERVIEW

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage 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.

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 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.

Notes

Benefits Directory

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

Melissa Rusignuolo
Florida Blue On-Site Group Service Rep. Health/Dental
1-772-429-7702
1-772-343-1193 (fax)
melissa.rusignuolo@FloridaBlue.com

Florida Blue
Customer Service
Monday - Friday, 8 a.m. - 6 p.m. ET
1-800-664-5295
FloridaBlue.com

Florida Blue BlueMedicare Group PPO Plans Elite & Advanced
Medical
Customer Service
Monday - Friday, 8 a.m. - 9 p.m. ET
1-800-926-6565
www.bluemedicarefl.com

Florida Combined Life
Dental
Customer Service
1-888-223-4892
Monday - Friday, 8 a.m. - 5 p.m.
FloridaBluedental.com

Davis Vision
Vision
Customer Service
Monday - Friday, 8 a.m. to 11 p.m. ET
1-800-999-5431 - Client Code: 8165
davisvision.com

PayFlex Systems USA, Inc.
COBRA Services
P.O. Box 953374
St. Louis, MO 63195-3374
1-855-LUCIE4-U (1-855-582-4348)
Fax: 1-402-231-4302
Email: **cobramail@payflex.com**
www.healthhub.com

FBMC Benefits Management, Inc.
Contract Administrator
Retiree and Direct Bill Department
PO Box 10789
Tallahassee, FL 32302-2789
Service Center 1-855-LUCIE4-U (1-855-582-4348)
Monday - Friday, 7 a.m. - 7 p.m. ET
Direct Bill Fax: 1-866-836-9943

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

Transamerica
Existing Universal Life and Long-term Care policies
Universal Life: 1-800-322-0426
Long-term Care: 1-800-227-3740

Trustmark
Existing Accident, Critical Illness, Life Events and Universal Life policies
Customer Service
Monday - Thurs, 8 a.m. - 8 p.m. ET
Friday, 8 a.m. - 7 p.m. ET
1-800-918-8877
www.trustmarksolutions.com

Colonial Life
Group Medical Bridge Plans
Customer Service
Monday - Friday, 7 a.m. - 7 p.m. CT
1-800-325-4368
www.ColonialLife.com

Unum Life Insurance Company of America
Group Term Life Insurance
Unum.com
1-800-858-6843
www.unum.com/lifebalance

FBMC BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
PO Box 1878 • Tallahassee, Florida 32302-1878
FBMC Service Center 1-855-5MY-DCPS (1-855-569-3277)
Mon. - Fri,, 7 a.m. - 7 p.m. ET
www.myFBMC.com

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.