2023–2024

LEGAL AID SOCIETY OF PALM BEACH COUNTY, INC.

EMPLOYEE BENEFITS GUIDE

LEGAL AID SOCIETY
OF PALM BEACH COUNTY

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2023-2024 BENEFITS

WELCOME TO THE 2023 BENEFITS OPEN ENROLLMENT

LASPBC's annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

ENROLL ON LINE AT

WWW.EMPLOYEENAVIGATOR.COM/BENEFITS/ACCOUNT

NOT SURE HOW TO GET STARTED? DON'T WORRY!

Now is the perfect time to prepare by doing the following:

- ✔ Review the benefits in which you are currently enrolled,
- ✔ Check out the plans being offered for the coming year.

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the LASPBC family and look forward to a healthy and safe 2023-2024.

TIP

REMEMBER! Open enrollment is the one time of year you can make any adjustments you'd like for the upcoming plan year.

2023-2024 HIGHLIGHTS

- No Changes to Medical Benefits
- No Changes to Dental Benefits
- No Change to Vision Benefit
- No Changes to Mutual of Omaha Optional Life (If you've moved into a new age bracket, you will see a premium change)
- No Changes to Mutual of Omaha Disability Benefits

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CONTACT INFORMATION

If you have any questions regarding your benefits, please contact the Insurance Carrier, your LASPBC Administrator, or our CBIZ representative(s) listed below.

MEDICAL INSURANCE
Florida Blue
www.floridablue.com
See the # on the back of your ID Card

DENTAL INSURANCE
Guardian
www.guardiananytime.com
(800) 541-7846

VISION INSURANCE
www.eyemed.com
(866) 939-3633

BASIC LIFE/AD&D INSURANCE, VOLUNTARY LIFE AND DISABILITY
Mutual of Omaha
www.mutualofomaha.com
(800) 775-6000

YOUR BENEFITS TEAM
Legal Aid Society
Michael Spillane
mspillane@legalaidpbc.org
(561) 822-9755

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Throughout this guide you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

YOUR HEALTH PLAN OPTIONS

As a full-time employee of LASPBC you have the choice between four medical plans. Two PPO options and two HMO options.

For each, your deductible will run from JANUARY 1 – DECEMBER 31.

These the two PPO plans give you the option of using out-of-network providers, you can save money by using in-network providers because Blue Cross has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and Blue Cross UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

Be sure to register for your Florida Blue member portal and member app to explore your plan benefits as well as complimentary member discount programs such as gym discounts.

TIP Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

? How many hours do I need to work to be eligible for insurance benefits?

The Legal Aid Society offers insurance coverage to all regular employees that work at least 25 hours per week.

? Will I receive a new Medical ID card?

You will receive an ID card in the mail if you are electing medical coverage for the first time or changing plans. Note, BCBS does not list out dependents on their ID cards.

? Does the deductible run on a calendar year or policy year basis?

A calendar year basis.

? How long can I cover my dependent children?

Dependent children are eligible until the end of the calendar year in which they turn age 26. For coverage over the age of 26 to 30, certain restrictions apply to be eligible; see Administration for more information.

? I just got hired. When will my benefits become effective?

Your insurance benefits will begin on the 1st of the month following 30 days of employment for regular full-time employees.

HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

- **OPTION 1: BLUECARE 59**
- **OPTION 2: BLUECARE 56**
- **OPTION 3: BLUEOPTIONS PPO 3768**
- **OPTION 4: BLUEOPTIONS HDHP 5190/5191**

BlueCare Plans Include:

- Routine preventive exams are covered at 100%; certain restrictions apply
- Teladoc Services
- Network Access in Florida Only
- No referrals for specialists except at participating Ophthalmologists
- Set Copays for the majority of services
- PCP Selection Required

BlueOptions Plans Include:

- Routine preventive exams are covered at 100%; certain restrictions apply
- Teladoc Services
- National Network of providers and facilities for the PPO plans only
- No referrals for specialists

To find a participating provider visit: www.floridablue.com; Network Selections: BlueCare or Blue Options

CARE OPTIONS & WHEN TO USE THEM

YOUR CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.floridablue.com

PRIMARY CARE

- Routine, primary/preventive care
- Non-urgent treatment
- Chronic disease management

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus problems

Telehealth, or a "virtual visit," lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! Florida Blue partners with Teladoc to bring you care from the comfort and convenience of your home or wherever you are.

CONVENIENCE CARE

- Common infections (ear infections, pink eye, strep throat & bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

These providers are a good alternative when you are not able to get to your doctor's office and your condition is not urgent or an emergency. They are often located in malls or retail stores (such as CVS, Walgreens, Wal-Mart and Target), and generally serve patients 18 months of age or older without an appointment. Services may be provided at a lower out-of-pocket cost than an urgent care center.

URGENT CARE

- Sprains
- Small cuts
- Strains
- Minor infections
- Sore throats
- Mild asthma attacks
- Back pain or strains

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary. During office hours, you may be able to go to your doctor's office. Outside regular office hours — or if you can't be seen by your doctor immediately — you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening. Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 9-1-1, even if your symptoms are not described here.

Primary Care vs. Urgent Care vs. ER

MEDICAL INSURANCE

Florida Blue	Option 1: BlueCare Plan HMO 59	Option 2: BlueCare Plan HMO 56	Option 3: BlueOptions PPO Plan 3768	Option 4: BlueOptions PPO HDHP 5190/5191
	Employee Cost Per Paycheck	**Employee Cost Per Paycheck**	**Employee Cost Per Paycheck**	**Employee Cost Per Paycheck**
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$31.68 $653.85 $239.06 $816.16	$51.89 $701.96 $277.88 $880.84	$93.01 $799.84 $356.84 $1,012.44	$31.67 $577.45 $213.60 $706.59
	In-Network	**In-Network**	**In-Network**	**In-Network**
Network Name	BlueCare *(Florida Only)*	BlueCare *(Florida Only)*	BlueOptions (National PPO)	BlueOptions (National PPO)
Deductible (1) Individual / Family	$500 / $1,000	$0 / $0	$250 / $750	$1,500 / $3,000
Coinsurance (Member Pays Tier 1 / Tier 2))	10%	10%	0%	20% / 25%
Out-of-Pocket Maximum (2) Individual / Family Embedded or Non-Embedded	$3,500 / $7,000 Embedded	$2,500 / $7,500 Embedded	$3,000 / $6,000 Embedded	$4,500/$6,850/$9,000 Non-Embed DED/Emb OOP
Office Visits Preventative Care (subject to limits) Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% $15 / $35 Copay No Copay at Quest $35 Copay	Covered at 100% $15 / $35 Copay No Copay at Quest $35 Copay	Covered at 100% $20 / $45 Copay No Copay at Quest $50 Copay	Covered at 100% 20% after Deductible 20% after Deductible 20% after Deductible
Hospital Visits Inpatient Care (4) Outpatient Surgery (4) Major Diagnostics & Imaging (5) Emergency Room	$500 Copay $350 Copay $175 Copay per scan $100 Copay	$200/Day; $1,000 Max $150 Copay $100 Copay per scan $100 Copay	$700 Tier 1/$1,000 Tier 2 $300 Tier 1/$600 Tier 2 $200 Copay per scan $200 Copay	20%/25% after Deductible 20%/25% after Deductible 20% after Deductible 20% after Deductible
Prescription Drug Deductible Retail Tier 1 / 2 / 3 Mail Order (90-day supply)	Does Not Apply $10 / $30 / $50 2.5x Retail Copay	Does Not Apply $10 / $30 / $50 2.5x Retail Copay	Does Not Apply $10 / $30 / $50 2.5x Retail Copay	Deductible then: $10 / $50 / $80 2.5x Retail Copay
	Out-of-Network	**Out-of-Network**	**Out-of-Network (3)**	**Out-of-Network (3)**
Deductible Individual / Family	No Out of Network Benefits	No Out of Network Benefits	$1,000 / $3,000	$3,000 / $6,000
Coinsurance (Member Pays)			50%	40%
Out-of-Pocket Maximum Individual / Family			$6,000 / $12,000	$9,000 / $18,000

(1) Family deductible for Plan 5190/5191 is considered non-embedded; if enrolled with any dependents, the overall family deductible must be met before the plan begins to pay. (The individual deductible does NOT apply).

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays for covered services. Excluded services do not accumulate to the out of pocket. The out of pocket for plan 5190/91; the single out of pocket maximum does not apply if you are enrolled with dependents, you are subject to the $6,850 per person within the family, not to exceed $9,000 in total.

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

(4) BCBS categorizes their hospitals as Tier 1 or Tier 2. See the BCBS provider site for details related to the hospital tiers (All in-network hospitals outside the state of Florida are tier 2 facilities).

(5) Reflected benefit applies at the Independent Advanced Imaging Facilities. Services at the hospital will have a different cost share.

(6) Additional member share applies for physician services (ie: Emergency Room Doctor)

FLORIDA BLUE MEMBER RESOURCES

Staying healthy just got less expensive

Great discounts and valuable information that can be used all year long—Blue365®

You can save BIG on a wide variety of healthy products and services through our members-only discount program—Blue365[1]. Take advantage of exclusive discounts at select local companies and leading, national brands for everyday health and wellness or family care. Save up to 60% on fitness clubs, exercise equipment, contact lenses or glasses, nutrition and weight management programs and so much more! All available to you as part of your Florida Blue membership. We're dedicated to your pursuit of health.

Fitness

BodyMedia®

Get 15% off wearable body monitors plus receive a 3-month subscription to easily track more than 5,000 data points including everything from calorie expenditure to step count to sleep quality.

Snap Fitness®

Get 50% off the current enrollment fee, 10% off personal training sessions, a complimentary 1-month online nutrition and meal planning membership, and more.

Healthways™

Members will have access to *Healthways Fitness Your Way*, which includes a fitness membership with access to over 8,000 participating fitness locations for just $25 a month and a network of 40,000 health and well-being specialists. Plus save up to 30% off health and wellness related products and services.

Polar

Save up to 25% on a selection of heart rate monitors that will allow you to track your progress, plus get recommendations on choosing a type of exercise, access training programs tailored to individual level and goals, and much more.

Reebok

- Make a purchase of footwear and apparel from the online Reebok store and receive a 20% discount and free shipping on the entire order (enter Promo Code REEBOK365 at checkout on reebok.com).
- At Reebok outlet stores when you use one of the online coupons you'll receive 15% off the entire purchase.
- Plus, each quarter there are additional specials just for our members, including Reebok Friends and Family events at 30% off and free shipping at Reebok.com, and 40% off at Reebok Outlets.

Healthy Eating

Children's Nutrition Education

Nutritional information is available for your children through the SuperKids program from Dole Food Company, Inc. The program offers unique Superkids recipes, games, and comics, and, where available, printable coupons for in-store promotions.

[1] Blue365 offers access to savings on items that members may purchase directly from independent vendors. Blue365 does not include items covered under your policies with Florida Blue or any applicable federal health care program. To find out what is covered under your policies, call Florida Blue. Blue Cross and Blue Shield Association (BCBSA) and local Blue companies may receive payments from Blue365 vendors. Neither BCBSA nor any local Blue company recommends, endorses, warrants or guarantees any specific Blue365 vendor or item. For more information about Blue365, go to floridablue.com.

See next page...

Florida Blue

In the pursuit of health®

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Florida Blue

Florida Blue Cares

We make managing your ongoing health condition easier.

Make the most of your healthcare benefits. Connect with your Florida Blue Care Team to receive one-on-one support for managing your medical condition or complex care needs.

Your Florida Blue Care Team works hand-in-hand with your physician, so you can have peace of mind knowing Florida Blue cares.

Your nurse is waiting to hear from you. Call us at **844-730-2583 (844-730-BLUE)** *to get in touch.*

Your Florida Blue plan includes these services at no extra cost:

Dedicated nurses and other clinical professionals focused on helping you reach your health goals

Access to community resources that help with transportation, food, finances and more

Here's what members are saying:

"I'm so glad Florida Blue has people who take the time to call and assist me with my care. I didn't know insurance companies did things like this. Thank you!"

"My experience with the Florida Blue Care Team has been incredible. Their care, support and availability during my treatments, surgery and recovery was amazing."

"My case manager helped me in so many ways, even if it was just listening to all my grief. She went well over and above the call of duty."

FLORIDA BLUE WELLNESS GUIDELINES

Adult (age 19+) Wellness Schedule

Be sure to review your plan benefits to determine your costs for these services

Routine Health Guide	
Annual Wellness and Routine Check-up	Annually: Discuss related screening with your doctor.
Obesity Screening: Diet/Physical Activity/BMI Counseling	Annually.
Vision and Dental Exam (These services may not be covered by your medical benefits plan. Check your plan documents.).	Annually: Discuss with your doctor
Recommended Diagnostic Checkups and Screenings for At-Risk Patients	
Abdominal Aortic Aneurysm (AAA) Check	One-time screening for ages 65 to 75 who have ever smoked or have a family history of AAA
Bone Mineral Density Screening and prescribed medication for Osteoporosis	Women beginning at age 65 or older; and in younger women who have an increased risk
Cholesterol Screening	Age 35+; Age 20-35 at risk Annually: All Men; Age 45+; Age 20-45 at risk Annually: All Women
Colorectal Cancer Screening and Counseling	Age 45-75; Colonoscopy or fecal occult blood test or sigmoidoscopy
Mammogram	Women should have a baseline mammogram age 35-40. Thereafter, every two years age 40-50; every year age 50+. At any age if recommended by physician based on risk factors.
Pap Test/Pelvic Exam	Women age 21-29 should have a Pap Test every 3 years. Women age 30-65 should have a Pap Test alone every 3 years or combined with HPV testing every 5 years. Women ages 65+ should discuss with their doctor.
HIV and other Sexually Transmitted Infections (STIs) Screening and Counseling	As indicated by history and/or symptoms. Discuss with your doctor behavioral risks.
Lung Cancer Screening and Counseling	Ages 50-80; 20 pack smoker history, current smoker/quit within past 15 years
Prostate Cancer Screening	Discuss with your doctor
Skin Cancer Screening	Discuss with your doctor
Guidance	
Screen/Counseling: Depression, Obesity, Tobacco, Alcohol, Substance Abuse and Pregnancy	Every visit, or as indicated by your doctor
Fall Risk/Unintentional Injury/Domestic Violence Prevention/Seat Belt Use	Discuss exercise and home safety with your doctor
Medication List (including over-the-counter and vitamins) for potential interactions	Every visit, or as indicated by your doctor
Advance Directives/Living Will	Annually
Immunizations* (Routine Recommendations)	
Tetanus, Diphtheria, Pertussis (Td/Tdap)	Ages 19+: Tdap vaccine once, then a Td booster every 10 years
Flu (Influenza)	Annually during flu season
Pneumococcal PCV13 and PPSV23	Ages 19-64: if risk factors are present; Ages 65+: 1-2 doses (per CDC); Ages 50+:1 dose (Florida Blue Benefits)
Shingles (Zoster)	Ages 50+: 2 doses Shingrix
Haemophilus Influenzae Type b (HIB) Hepatitis A, Hepatitis B, Meningococcal	Ages 19+: if risk factors are present
Human Papillomavirus (HPV), Measles/Mumps/Rubella (MMR), Varicella (Chickenpox) & Hepatitis C (HCV) Infection Screening	Physician recommendation based on past immunization or medical history
COVID-19	Recommended for adults ages 19 and older within the scope of the authorization/approval for the particular vaccine.

Florida Blue
Your local Blue Cross Blue Shield

Live a Healthy Lifestyle

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

FLORIDA BLUE WELLNESS GUIDELINES

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

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

Immunizations*	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4 - 6 years	11 - 12 years	13 - 14 years	15 years	16 - 18 years
Hepatitis A						2 dose series, 12-23 months								
Hepatitis B	1st dose	2nd dose			3rd dose									
Diphtheria, Tetanus, Pertussis (DTaP)			1st dose	2nd dose	3rd dose		4th dose			5th dose				
Tetanus, Diphtheria, Pertussis (Tdap)											1st dose			
Haemophilus Influenzae Type b (Hib)			1st dose	2nd dose	3rd or 4th dose**									
Inactivated Poliovirus			1st dose	2nd dose	3rd dose					4th dose				
Measles, Mumps, Rubella (MMR)***						1st dose				2nd dose				
Varicela						1st dose				2nd dose				
Pneumococcal PCV13 and PPSV23			1st dose	2nd dose	3rd dose	4th dose								
Flu (Influenza)					6 months through 8 years 1 or 2 doses; 9 years and older 1 dose only									
Rotavirus			1st dose	2nd dose	3rd dose**									
Meningococcal											1st dose			booster
Human Papillomavirus (HPV)											3 dose series			
Covid 19											12 and older per CDC guidelines for specific vaccine			

Are your children up-to-date with vaccinations?

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

Tdap Vaccine

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

Meningococcal Vaccine

(MCV4) Two doses beginning at 11 or 12 years, with a booster dose at age 16. (MenB) Two doses beginning at ages 16-18. Protects against meningitis, sepsis (a blood infection) and other meningococcal diseases. Children with higher risk factors may need additional doses.

Human Papillomavirus

(HPV) Vaccine two or three doses over six months, beginning at ages 11–12. (Two doses if started before 15th birthday or three if started on or after 15). Protects boys and girls against HPV, which can lead to cancers and genital warts.

Flu Vaccine

Every year after six months of age. Protects individuals from getting the influenza virus.

COVID-19 Vaccine

The American Academy of Pediatrics (AAP) recommends the COVID-19 vaccination for all children and adolescents 12 years of age and older who do not have contraindications using a COVID-19 vaccine authorized for use for their age. Any authorized COVID-19 vaccine appropriate by age and health status can be used for COVID-19 vaccination in children and adolescents.

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

TELEHEALTH

TELEHEALTH SAVINGS

TELADOC

Retail Telehealth, or a "virtual visit," lets you see and talk to a doctor from your mobile device or computer without an appointment. Florida Blue partners with Teladoc to bring you care from the comfort and convenience of your home or wherever you are.

Conditions commonly treated through a virtual visit:

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/ headaches
- Pink eye
- Rash
- Sinus problems
- Sore throat

Most visits take about 10-15 minutes, and your doctor can write a prescription, if needed, that you can pick up at your local pharmacy.

GET STARTED TODAY WITH TELADOC

STEP 1: Download the Teladoc Mobile App

The Teladoc app can be downloaded directly to your smart phone or tablet. Or, if you prefer the web, visit www.Teladoc.com.

STEP 2: Enroll

Create an account in a few simple steps. Be sure to include your Florida Blue insurance information when creating your account. Your information is stored securely.

STEP 3: Choose a doctor

View a list of available doctors, their experience and ratings, and select one.

STEP 4: Visit

Engage in a secure live video visit directly from the web or your mobile device in high-quality streaming video.

FLORIDA BLUE MOBILE APP

DOWNLOAD THE FLORIDA BLUE MOBILE APP

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…

Download the app – available through the Apple App Store or Google Play

Get Registered – log in using your Florida Blue member account User ID and Password

Get Started – anytime, anywhere with Touch ID

HEALTH SAVINGS ACCOUNT (HSA)

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

THERE ARE TWO WAYS YOU CAN PUT MONEY INTO YOUR HSA:

- Regular payroll deductions on a pre-tax basis, and
- Lump-sum contributions of any amount, anytime, up to the maximum limit.

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep — the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds — or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you leave the company, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future — even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses — even if they're not covered by your medical plan.

WHO ADMINISTERS THE HSA

HSAs are opened and maintained at an HSA qualified bank or financial institution. LASPBC utilizes Optum. Interest or other earnings on the assets are tax free.

What Is A Health Savings Account?

Legal Aid Society will contribute on a per pay period basis for HSA eligible and active employees
See Employee Navigator for details.

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA.
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or TRICARE due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2023 are $3,850 for Single and $7,750 for Family coverage. If you're age 55 or older, you are allowed to make an extra $1,000 contribution each year.
- The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the -counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. But save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.
- The LASPBC contribution is a tax free benefit for those enrolled in the company sponsored health plan that is compatible with the HSA. The total contribution between both yourself and your employer cannot exceed the annual IRS limit.

HEALTH SAVINGS ACCOUNT (HSA)

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications (such as allergy medicine, cold and flu, pain relievers, and feminine hygiene)
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at irs.gov.

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

THIS MAY BE THE BEST PLAN OPTION FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You do not incur a lot of medical and prescription medication expenses.
- You would like money in a savings account to pay for Qualified Expenses permitted under Federal Law.
- You would like the opportunity to contribute pre-tax income to a Health Savings Account.

FREQUENTLY ASKED QUESTIONS

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to Florida Blue
You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from Florida Blue that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to www.floridablue.com

DENTAL INSURANCE

GUARDIAN IS THE DENTAL CARRIER FOR 2023—2024

You have option of selecting between a dental DHMO or a PPO plan. The DHMO plan offers services In-Network Only. All services must be performed by your In-Network Dentist and are subject to a fixed copay. Below is a list of the most commonly used services, for the full copay schedule visit www.guardianantytime.com. Limited to Florida Only.

Dependent children are eligible until the end of the month in which they turn 20. Dependent children are eligible up to the end of the month they turn age 26 if they meet a certain criteria. Dependent verification forms are required.

What Is Dental Insurance?

REVIEW YOUR DENTAL PLAN

FIND A DENTIST

To find a Guardian provider in your area, visit the website at www.Guardianantytime.com

- Click on Find a Provider
- Select the Network: Managed Dental Care
- Limited to Florida Only.

COVERAGE TIERS	Employee Cost Per Paycheck
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$0.00 $6.38 $3.94 $10.32
	In-Network Only
Network Name	**Managed Dental Care**
Procedure	**Patient Copay**
Office Visit fee (Per patient, per office visit in addition to any other applicable patient charges)	**$0.00**
Comprehensive periodontal evaluation New or established patient	**$0.00**
Prophylaxis (Cleaning) (Limit 2 per calendar year/ 1x every 6 months)	**$0.00**
X-rays intraoral Complete series of radiographic images *(limit* 1 every 3 years) Code: D0210	**$0.00**
Sealant - Per tooth Code: D1351	**$0.00**
Root Canals Minor procedure Code: D3310 - D3330	**$120 - $270**
Fillings Amalgam & Resin Based Codes: D2140 - D2394 Resin Based Composite Crown, anterior Code: D2390	**$0.00** **$75.00**
Orthodontia 24 month treatment fee Code: D8080/8090	**Children up to age 19 - $2,500** **Adults - $2,800**

DENTAL INSURANCE

GUARDIAN IS THE DENTAL CARRIER FOR 2023—2024

The dental plan PPO offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Guardian's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the month in which they turn 20. Dependent children are eligible up to the end of the month they turn age 26 if they meet a certain criteria. Dependent verification forms are required.

REVIEW YOUR DENTAL PLAN

FIND A DENTIST

To find a Guardian provider in your area, visit the website at www.Guardiananytime.com

- Click on Find a Provider
- Select the Network: PPO

What Is Dental Insurance?

DENTAL INSURANCE PLAN OPTIONS AND COSTS

Guardian	Employee Cost Per Paycheck		
Employee Employee & Spouse Employee & Child(ren) Employee & Family	$0.00 $27.73 $16.14 $43.87		
Plan Name/Network	**PPO**		
PPO	**In-Network**	**Out-of-Network**	
Deductible	$50/$150	$50/$150	
Annual Maximum	$1,500 + Rollover		Applied to Type Preventive, Basic & Major Services
Orthodontic Lifetime Maximum	Covered at 50% up to $1,500 Lifetime maximum *(children only)*		Ortho Only
You Pay			
Diagnostic/Preventive Services	0%	0%	■ Office Visit ■ Routine Oral Exams—1x every 6 months ■ Routine Cleanings—1x every 3 months ■ X-rays
Basic Services	Deductible then, 0%	Deductible then, 20%	■ Anesthesia ■ Fillings ■ Perio Surgery/Maintenance ■ Root Canal ■ Scaling & Root Planing (per quadrant) ■ Simple Extractions ■ Surgical Extractions
Major Services	Deductible then, 40%	Deductible then, 50%	■ Bridges & Dentures ■ Single Crowns ■ Inlays/Onlays
Orthodontia Services Adult & Child(ren)	50% up to a lifetime benefit of $1500; children only up to age 19 Orthodontia appliance must be placed prior to the age limit		■ Diagnostics and treatment

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary (UCR) standards and balance billing is possible.

DENTAL MAXIMUM ROLLOVER

GUARDIAN'S DENTAL MAXIMUM ROLLOVER

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Plan Annual Max	Threshold	Maximum Rollover Amount	In-Network Rollover Amount	Maximum Rollover Amount Limit
$1,500	$700	$350	$500	$1,250
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $2,750 in total

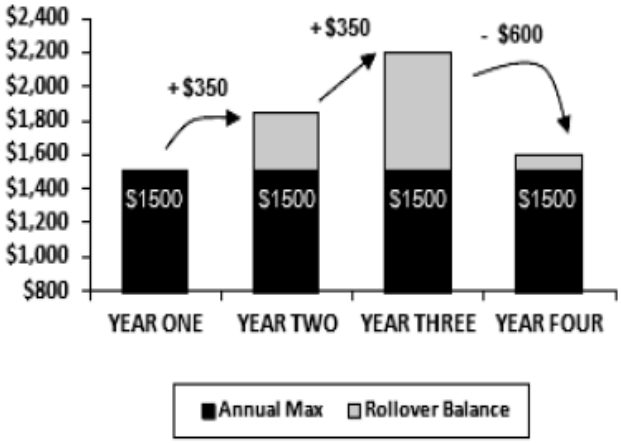
Here's how the benefits work:

YEAR ONE: Jane starts with a $1,500 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $700 Threshold, she receives a $350 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,850. This year, she submits $50 in claims and receives an additional $350 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $2,200. This year, she submits $2,100 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $1,6000 ($1,500 Plan Annual Maximum + $100 remaining in her Maximum Rollover Account).



Note: You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

VISION INSURANCE

REVIEW YOUR VISION PLAN

EYEMED IS THE VISION CARRIER FOR 2023—2024

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

What Is Vision Insurance?

VISION INSURANCE PLAN OPTIONS AND COSTS

EyeMed	Employee Cost Per Paycheck	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$3.12 $5.92 $6.23 $9.16	
	In-Network	Out-of-Network
Examination Copay (Refractive Exam)	$10 copay	Reimbursement Up to $30
Frequency of Service (from date of service) Exam Lenses Contact Lenses (*you may obtain eyeglasses or contact lenses but not both per 12 month period) Frames	Once Every 12 months Once Every 12 months Once Every 12 months * Once Every 24 months	
Lenses - (Covers Standard Plastic Lenses; upgrade options available at an additional member cost) Single Bifocal Trifocal Lenticular	 $25 copay; 100% covered $25 copay; 100% covered $25 copay; 100% covered $25 copay; 100% covered	 Reimbursement Up to $25 Up to $40 Up to $60 Up to $60
Frames	Up to $130 allowance, then 20% off balance	Reimbursement Up to $65
Conventional Contacts	Up $130 allowance, 15% off balance over $130	Reimbursement Up to $104
Medically Necessary Contacts	$0 copay	Reimbursement Up to $200

FIND A VISION PROVIDER

To find a EyeMed Vision Provider in your area, visit the website at www.eyemed.com

Network: Select

1-866-299-1358

Download the app for Android or Apple devices

LIFE INSURANCE AND AD&D

REVIEW YOUR LIFE INSURANCE POLICY

- UPDATE YOUR BENEFICIARY

BASIC LIFE AND AD&D

LASPBC offers basic life insurance coverage to full-time active employees. The basic life coverage provides each eligible employee a benefit amount of 2x your basic annual earnings Plus $15,000 to a maximum of $150,000 with a matching Accidental Death and Dismemberment (AD&D) benefit. This benefit is provided to you at no cost.

This benefit provides for an accelerated life benefit subject to certain conditions. ***(Note: Age reduction schedule applies beginning at age 65 years; benefits reduce)***.

Benefits will reduce to:
At Age 65 reduce to 65% of original amount
At Age 70+ reduce to 50% of original amount

A couple of things to remember. First, keep your beneficiary information updated. As your life changes—get married, have kids or get divorced your beneficiary may need to be changed. To do so, get with Human Resources to update your records.

Next, if you leave LASPBC, you have the option to port your life and AD&D policy. To begin the porting process contact Mutual of Omaha directly. Certain restrictions will apply.

For more policy details refer to the Mutual of Omaha certificate of coverage (COC) available on logging on mutualofomaha.com

What Is Life And AD&D Insurance?

DID YOU KNOW? LASPBC provides you Basic Life and AD&D AT NO CHARGE.

VALUE ADDS:

Worldwide Travel Assistance:

- Pre-Trip Assistance
- Emergency Travel Support Services
- Immediate Attention for Emergencies While Traveling
- Medical Assistance
- ID Theft Issue Assistance
- Education & Prevention Related to ID Theft While Traveling
- Recovery Information Related to Credit Card and Check Fraud while Traveling

Employee Assistance Program:
Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

EAP Benefits:

- Unlimited telephone access, 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents

***EAP CONSULTATION CONTACT INFORMATION*:**
1-800-316-2796 OR MUTUALOFOMAHA.COM/EAP

VOLUNTARY LIFE INSURANCE

VOLUNTARY LIFE AND DEPENDENT LIFE

We offer Voluntary Life Insurance Coverage for yourself, spouse, and your children through Mutual of Omaha.

- **Voluntary Employee Life:** you may elect insurance in increments of $10,000, not to exceed the lesser of 5x earnings up $300,000. Your Guarantee issue is 5x Your Annual Earnings or $100,000 whichever is less. (Applies to New Hires only)
- **Optional Spouse Life:** you may elect insurance in increments of $5,000 up to $150,000 (not to exceed 50% of the employee life benefit). Guarantee issue is 100% of your elected amount up to $25,000. (Applies to New Hires Only). Spouse rate is based on Employee's Age.
- **Optional Child Life:** You may elect optional life for your child(ren) in the amount of $10,000. Children include those 14 days old, up to age 21 (25 if a full-time student).

Benefits will reduce for you and your spouse at:
To 65% at age 65;
To 40% at age 70;
To 25% at age 75
(Spouse benefit terminates at Age 70).

EVIDENCE OF INSURABLITY

If you don't enroll in the Voluntary Life plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form and be reviewed by Mutual of Omaha before you're able to be considered for coverage in the future.

You must be enrolled in voluntary life coverage in order for your spouse, and/or eligible dependent children to enroll.

REVIEW YOUR LIFE INSURANCE POLICY

- ADD YOUR SPOUSE
- ADD YOUR DEPENDENTS
- INCREASE YOUR COVERAGE

VOLUNTARY LIFE AND DEPENDENT LIFE OPTIONS AND COSTS PER MONTH

VOL LIFE / Mutual of Omaha	Rates per $1,000 of coverage		
	Age	Employee	Spouse
Voluntary Life	<25	$0.05	$0.05
	25-29	$0.06	$0.06
	30-34	$0.07	$0.07
	35-39	$0.08	$0.08
	40-44	$0.12	$0.12
	45-49	$0.20	$0.20
	50-54	$0.34	$0.34
	55-59	$0.53	$0.53
	60-64	$0.79	$0.79
	65-69	$1.41	$1.41
	70-74	$2.53	$2.53
	75—79	$4.18	$4.18
	80+	$8.46	$8.46
	Child(ren)	$.020 per $1,000 of benefit	

DISABILITY INSURANCE

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is offered through Mutual of Omaha at no cost to you. The plan benefit is 66 2/3% of basic weekly earnings up to a maximum of $600 per week.

Benefits are paid after a waiting period and will begin (if approved) on the 1st day for an injury and on the 8th day for sickness. Benefits can continue for up to 13 weeks. Not all conditions are eligible for the max duration. (Maternity Duration is a 6-8 week period)

LONG-TERM DISABILITY INSURANCE

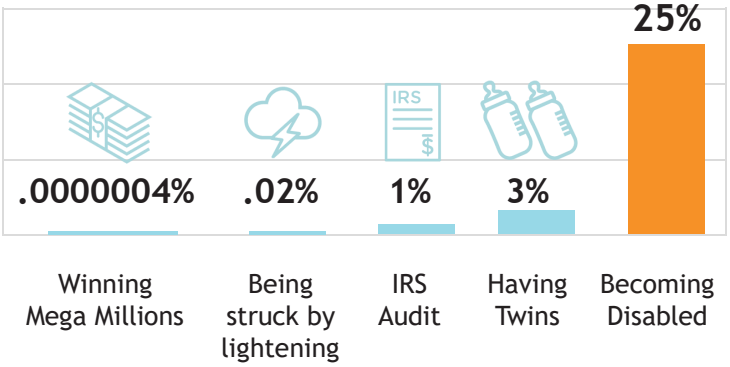
Long-Term Disability insurance is offered through Mutual of Omaha at no cost to you. The plan benefit is 70% of your basic monthly earnings up to a maximum of $7,000 per month. Basic earnings is the average of your gross monthly income for the year immediately prior to the onset of disability and excludes commissions, bonuses, overtime pay, shift differential pay, or any other earnings.

The benefits begin after a 90 day waiting period.

Please note, preexisting condition limitations apply. The plan benefit duration varies based on the age of disability.

WHAT'S MORE LIKELY?

Many workers think these events are more likely than becoming disabled during their careers. But here are the actual odds:



In fact, nearly **40 million** American adults live with a disability.

What Is Disability Insurance?

REVIEW YOUR DISABILITY COVERAGE

- SHORT-TERM DISABILITY
- LONG-TERM DISABILITY

COULD YOU PAY THE BILLS IF YOU WEREN'T WORKING?

Less than **1/4** of U.S. consumers have enough emergency savings to cover six months or more of their expenses.

Nearly **70%** of workers that apply to Social Security Disability Insurance **are denied.**

FLEXIBLE SPENDING ACCOUNTS (FSA)
CBIZ— *JANUARY 1ST THRU DECEMBER 31ST*

LASPBC offers its employees a variety of ways to save and plan for out-of-pocket qualified medical, dental and vision care expenses in addition to dependent care expenses. A Flexible Spending Account (FSA) is a tax-advantaged way for you to pay for your predictable medical, dental, vision and daycare expenses using pre-tax dollars. An FSA lowers your taxes and results in more take home pay.

Healthcare Spending Account

The MEDICAL EXPENSE REIMBURSEMENT ACCOUNT allows employees to pay for medical expenses (not covered by insurance) with pre-tax dollars. Examples of FSA eligible expenses include: Deductibles, co-pays, coinsurance amounts, Vision Care, Dental Care (not cosmetic), acupuncture, over-the-counter medications, first aid supplies, smoking cessation aids, LASIK eye surgery, etc.

You decide how much money to put into your FSA Account with a maximum contribution of $1,500 per plan year

- Contributions to the plan are made through payroll deduction.
- This deduction is taken out of each paycheck before taxes
- Annual contribution is available on the first day of plan year
- "The Use It or Lose It Rule" – Applies if you do not use up all of the money in your account that you have chosen to put into your FSA by the end of the plan year, your balance will be forfeited and cannot be returned to you (IRS regulations).

FSA DEPENDENT CARE EXPENSE REIMBURSEMENT ACCOUNT

This plan allows employees to pay for most child/dependent care expenses with pre-tax dollars. In most cases, there is substantially more tax savings with this plan than there is with the "tax credit" that you get when doing your tax return

- Maximum contribution - $5,000 ($2,500 if married and filing a separate tax return)
- Child must be under the age of 13, or
- Child, spouse or other dependent who is physically or mentally incapable of self -care and spends at least 8 hours a day in your household

Qualified expenses for reimbursement include: Licensed & registered facilities with tax #I.D. Adult and child daycare centers, preschool and before/after school care, au Pair expenses, summer day camp expenses, etc.

If you are enrolled in the HDHP Plan and have a Health Savings Account (HSA), you may not participate in the Flexible Spending Account.

Note: If you are currently enrolled in the FSA, our plan has an extended grace period; if you have questions related to how this impacts you and your claims; please contact CBIZ FLEX team directly at 800-815-3023.

RETIREMENT PLAN BENEFITS
ABA RETIREMENT PROGRAM 401(K)

ABA Retirement Funds

Eligibility:

As an employee, you will become eligible for the Plan on the date you meet the Participation Requirements. However, you do not actually become a Participant in the Plan until the first "Entry Date" after you become eligible. The Participation Requirements for our Plan and the Entry Dates are discussed below.

Participation Requirements:

You are eligible to participate in the Plan when you meet the Participation Requirements indicated in the Plan Summary. You must also have completed 12 month(s) of service in order to be eligible to contribute Elective Contributions to the Plan. The first twelve month period starts on your first day of employment, and subsequent twelve month periods start on successive anniversaries of that day. Whenever the term "work" is used, it means any time for which you are paid or are entitled to be paid, such as vacation, sickness or holidays.

Limits on Contributions:

Current federal tax law limits the maximum amount that may be contributed to the Plan on your behalf each year in several ways. For example, your Elective Contributions (and any other pre-tax or designated Roth contributions you make under another employer's 401(k) plan) in any calendar year cannot exceed the limit for that year prescribed by federal income tax law.

Employer Contributions:

Matching Contributions are measured as a percentage of Elective Contributions. For each plan year, the Employer will make a Matching Contribution in an amount equal to 100% of your Elective Contributions up to 3% of your compensation.

Loans and Withdrawals:

Withdrawals: Although the Plan is designed primarily for retirement, you can withdraw a portion of the vested balance in your account while you are employed by the Employer. The Employer, as Plan Administrator, must approve all Plan withdrawals in accordance with the terms of the Plan. Contact the Employer for more information about how to apply for a withdrawal.

Withdrawals at Age 59½: You may withdraw any or all of your vested accounts upon attaining age 59½.

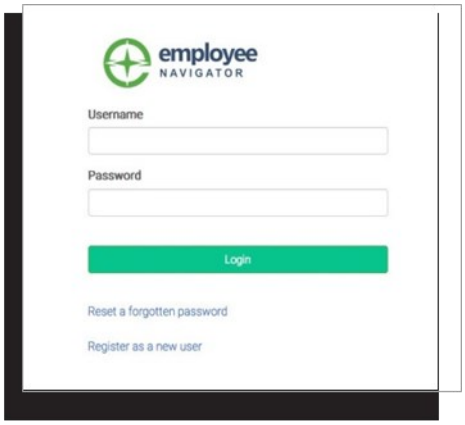
Loans: The Plan includes provisions that give you access to your Account while you are employed by the Employer. Please see your 401(k) packet to obtain the rules applying to Plan loans.

Hardship Withdrawals: If you incur a financial hardship, you may apply for a hardship withdrawal from your Matching Contribution Account and Employer Account (if applicable).

This information is intended as a Summary of Benefits provided under your Certificate of Coverage. Please remember that this is just a summary of your benefits. Certain limitations may apply. Please refer to the certificate of Coverage for the actual benefits provided.

HOW TO ENROLL

ENROLL IN YOUR BENEFITS: ONE STEP AT A TIME



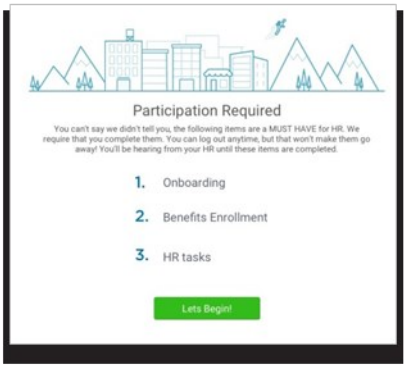
Step 1: Log In

Go to www.employeenavigator.com/benefits/Account

First time users: Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password.

Returning users: Log in with the username and password you selected.

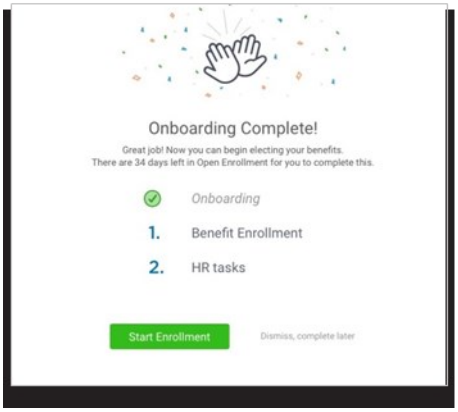
NOTE: In order to register, you will need to enter your first and last name, your PIN (the last 4 digits of your SSN), your birth date, and the company identifier. Your company identifier is: **LASOPBCI**



Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

Step 3: Onboarding (For first time users, if applicable) Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click Start Enrollment to begin your enrollments.



Step 4: Start Enrollments

TIP

if you hit "**Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **"Start Enrollments"**

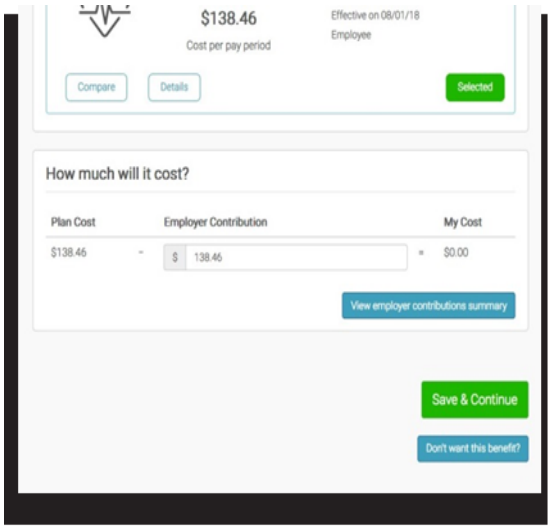
After clicking Start Enrollment, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

HOW TO ENROLL

ENROLL IN YOUR BENEFITS: ONE STEP AT A TIME



Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling**?

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

Click **Save & Continue** at the bottom of each screen to save your elections.

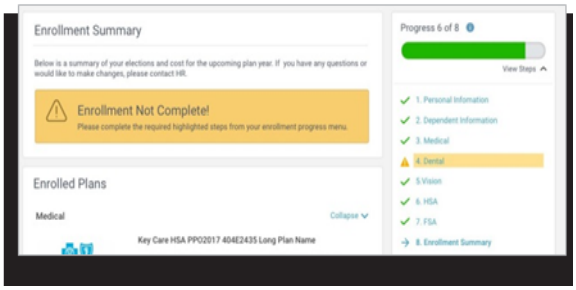
If you do not want a benefit, click **Don't want this benefit**? at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click Sign & Agree to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.



TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.

For Technical Support with Employee Navigator Contact CBIZ at:

ksundermeier@cbiz.com

Rose.adams@cbizwc.com

wciacciarelli@cbiz.com

VIDEO RESOURCES

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- HDHP vs. PPO
- HDHP With HSA Overview
- HMO Overview

INSURANCE 101

- Benefits Key Terms Explained
- How To Read An EOB
- What Is A Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What Is A Health Savings Account?
- What Is An H S A vs an FSA?

ANCILLARY BENEFITS

- What Is Dental Insurance?
- What Is Vision Insurance?
- What Is Life And AD&D Insurance?

GLOSSARY OF MEDICAL TERMS

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Legal Aid Society of Palm Beach County, Inc. about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Legal Aid Society of Palm Beach County, Inc. 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.

Legal Aid Society of Palm Beach County, Inc. has determined that the prescription drug coverage offered by the Florida Blue plans are, 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?

If you decide to join a Medicare drug plan, your current Legal Aid Society of Palm Beach County, Inc's coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Legal Aid Society of Palm Beach County, Inc.'s medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

This notice is a summary. For a full description of all of Legal Aid Society of Palm Beach County Inc.'s Benefit plans, please refer to the Summary Plan Descriptions, by contacting Legal Aid Society's Administrator.

IMPORTANT NOTICES

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 Legal Aid Society of Palm Beach County, Inc. 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 person listed below 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 Legal Aid Society of Palm Beach County, Inc changes. You also may request a copy of this notice at any time.

Contact: Noelle Smith, LASPBC Administration at 561-822-9764

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 http://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 http://www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2023
Name of Entity/Sender: Legal Aid Society of Palm Beach County, Inc.
Contact--Position/Office: Noelle Smith, Administration
Address: 423 Fern Street, Suite 200, West Palm Beach, FL 33401
Phone Number: 561-822-9764

IMPORTANT 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 www.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 www.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 www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

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

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

IMPORTANT NOTICES

WOMEN'S HEALTH & CANCER RIGHTS ACT OF 1998

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, contact Administration.

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event.

If you or your dependents become ineligible for Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

If you or your dependents become eligible for premium assistance from Medicaid or CHIP, you may be able to enroll yourself and your dependents in the plan. You must request enrollment within 60 days.

To request special enrollment or obtain more information, contact Administration.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Legal Aid Society of Palm Beach County, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, the health plan will never disclose any of your personal health information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are health professionals in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Administration.

IMPORTANT NOTICES

INITIAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. 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 pay 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 continuation coverage 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;

- 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: Administration

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage -

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. 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.

If you have questions -

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes -

To protect your family's rights, let the 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.

Plan contact information -

Noelle Smith

561-822-9764

nsmith@legalaidpbc.org

This notice is intended as a brief outline; please see HR for more information.

MARKETPLACE COVERAGE OPTIONS

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 begins in October 2013 for coverage starting as early as January 1, 2014.

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. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12 % 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 Legal Aid Society’s HR department.

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.

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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% of such costs.

MARKETPLACE COVERAGE OPTIONS (CONT.)

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.

Employer Name: Legal Aid Society of Palm Beach County, Inc.	**Employer Identification Number (EIN):** 59-6046994
Employer Address: 423 Fern Street, Suite 200 West Palm Beach, FL 33401	**Employer Phone Number:** 561-655-8944
Who can we contact about employee health coverage at this job? Noelle Smith	**Phone Number:** 561-822-9764 **Email Address:** nsmith@legalaidpbc.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 a minimum 30 hours per week on a regular basis. Employees will be effective following their new hire waiting period (See Administration for details).

☐ Some employees. Eligible employees are:

■ With respect to dependents:

✔ We do offer coverage. Eligible dependents are: Your legal spouse, Your child, as defined as: a child who is yours by birth or legal adoption; your spouse's child by birth or legal adoption; one whose medical care is the legal obligation of you or your spouse as per a court order or court approved requirement

☐ 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.

LEGAL AID SOCIETY
OF PALM BEACH COUNTY

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.