2026-27



LEGAL AID SOCIETY
OF PALM BEACH COUNTY

Employee Benefits Guide

2026-2027 Benefits Overview

Welcome to the

BENEFITS OPEN ENROLLMENT

It's that time of year again! Legal Aid Society of Palm Beach County's annual insurance open enrollment period is about to begin.

Your Benefit Plans run 10/01/2026 – 09/30/2027

We know that benefits are an integral part of the overall compensation package provided to all of our eligible employees, which is why we take great care to review all available benefits options on an annual basis. During this year's review, 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 ONLINE AT
WWW.EMPLOYEENAVIGATOR.COM/BENEFITS/ACCOUNT



IMPORTANT DATES

Open enrollment runs
September 10th – 23rd

NOT SURE HOW TO GET STARTED?

DON'T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions by email.

Until then, now is the perfect time to prepare by doing the following:

- Review the benefits in which you are currently enrolled,
- Take a look at the changes, and
- Get a sneak peek at the plans being offered for the coming year.

Consider this booklet your open enrollment survival guide. Inside, you'll find everything you need to make informed benefits decisions, including in-depth information regarding your plan options, our policies and more.

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

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

UPDATES AT A GLANCE

- Medical plan premiums and deductibles have been updated for the new plan year.
- Telehealth services are included in all medical plans through BlueVirtualCare.
- Mental Health coverage under some plans now follows the medical cost structure.
- Health Savings Account (HSA) annual contribution limits increase for 2027 - $4,500 Single, $9,000 Family and $1,000 catch-up contribution for those age 55+
- Dental PA Xrays have moved from Preventive to Basic Care on PPO

Table of Contents

Welcome	2
Contact Information & Table of Contents	3
Understanding Medical Plan Options	4
Care Options	5
Medical Insurance Plan Options	6
TeleHealth	8
Mental Health	9
Health Savings Account (HSAs)	11
Flexible Spending Accounts (FSAs)	13
Dental Insurance	14
Vision Insurance	16
Basic Life and AD&D	17
Disability Insurance	18
Pet Insurance	19
Retirement/401(k)	20
How to Enroll	21
Video Resources	23
Glossary of Terms	24
Important Notices	25

Want to learn more?

Throughout this guide, you'll find clickable video and link icons that will take you to resources that provide additional info on your available benefits.



Contact Information

If you have any questions regarding your benefits, please contact the insurance company, your LASPBC Human Resources Representative, or our CBIZ representatives listed here.

Benefits are governed by the certificates of coverage and carrier plan documents, which are available upon request.

MEDICAL INSURANCE
Florida Blue
floridablue.com
See the back of your ID Card for contact information

DENTAL INSURANCE
Guardian
Guardiananytime.com
(800) 541-7846

VISION INSURANCE
eyemed.com
(866) 939-3633

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

HEALTH SAVINGS ACCOUNTS
Optum Bank
www.optum.com

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

Noelle Smith
nsmith@legalaidpbc.com
(561) 822-9764

CBIZ REPRESENTATIVES
Wendy Ciacciarelli
wciacciarelli@cbiz.com

Kelly Sundermeier
ksundermeier@cbiz.com

Paige Rhymes
prhymes@cbiz.com

Medical Insurance Options

YOUR HEALTH PLAN OPTIONS

As a benefits eligible employee of Legal Aid Society of Palm Beach County, you can choose among several medical plan options for your coverage.

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

While some plans give you the option of using out-of-network providers, you can save money by using in-network providers because Florida Blue 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 Florida Blue UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

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

HOW TO GET STARTED

SELECT YOUR MEDICAL PLAN

Option 1:
BlueCare HMO 59
OFFERS SEVERAL BENEFITS:

- Lower premium
- Routine preventive exams are covered at 100%

Option 2:
BlueCare HMO 56
MAY BE FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You would rather pay more in monthly premiums and less on medical expenses when they occur
- Routine preventive exams covered at 100%

Option 3:
BlueOptions PPO 3768
MAY BE FOR YOU IF THE FOLLOWING IS TRUE

- You want access to a national network of in-network doctors and facilities
- Routine preventive exams covered at 100%

Option 4:
BlueOptions PPO HDHP 5190/5191
MAY BE FOR YOU IF ANY OF THE FOLLOWING IS TRUE:

- You want a national network of in-network doctors and facilities
- Routine preventive exams covered at 100%
- You want a Health Savings Account (HSA)

FREQUENTLY ASKED QUESTIONS

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

You must be a full-time employee working a minimum of 25 hours per week on a regular basis.

Q. **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.

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

A calendar year basis.

Q. **How long can I cover my dependent children?**

Dependent children are eligible until the end of the month in which they turn age 26. For coverage to age 30, certain restrictions apply to be eligible.

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

Your medical insurance benefit will begin on the 1st of the month following thirty (30) days of employment for regular full-time employees.

Medical Plan FAQs

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 best — and already has access to your medical records. You'll also likely pay the least amount out-of-pocket.

TELEHEALTH

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

Telehealth, or a "virtual visit," lets you talk to a doctor anytime, anywhere from your mobile device or computer — no appointment necessary.

Florida Blue offers BlueVirtualCare 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 & Vaccines
- Pregnancy tests
- Rashes
- Screenings

If you're unable to get to your doctor's office and your condition is not urgent/an emergency, these providers serve as a good alternative.

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 & Strains
- Small cuts
- 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) that you believe may result in serious injury or death without immediate medical care.

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
	Employee Cost Per Paycheck	**Employee Cost Per Paycheck**
Employee	$38.44	$62.98
Employee + Spouse	$793.49	$851.87
Employee + Child(ren)	$290.11	$337.22
Employee + Family	$990.43	$1068.93
	In-Network	**In-Network**
Network Name	BlueCare (Florida Only)	BlueCare (Florida Only)
Deductible (1)		
Individual / Family	$500 / $1,000	None
Coinsurance (Member Pays)	10%	10%
Out-of-Pocket Maximum (2)		
Individual / Family	$3,500 / $7,000 Embedded	$2,500 / $7,500 Embedded
Office Visits		
Preventive Care (subject to limits)	Covered at 100%	Covered at 100%
Primary Care Physician Required?	Yes	Yes
Referral Required?	Only to Ophthalmologist	Only to Ophthalmologist
Primary Care Physician/Specialist	$15 / $35 Copay	$15 / $35 Copay
Diagnostic Lab	No Copay Quest	No Copay Quest
Urgent Care	$35 Copay	$35 Copay
Hospital Visits		
Inpatient Care	$500 Copay	$200 Copay Per Day, up to $1,000
Outpatient Surgery	$350 Copay	$150 Copay
Ambulatory Surgical Center	$250 Copay	$100 Copay
Major Diagnostics at Hospital	Additional cost share	Additional cost share
Major Diagnostics at Standalone Facility	$175 Copay Per Scan	$100 Copay Per Scan
Emergency Room	$100 Copay	$100 Copay
Mental Health & Substance Use		
Outpatient Services	No Charge	No Charge
Inpatient Services	No Charge	No Charge
Prescription Drug		
Deductible	Does Not Apply	Does Not Apply
Tier 1	$10	$10
Tier 2	$30	$30
Tier 3	$50	$50
Mail Order (90-day supply)	2.5x Retail Copay	2.5x Retail Copay
	Out-Of-Network (3)	Out-Of-Network (3)
Deductible		
Individual / Family		
Coinsurance (Member Pays)	No Out-Of-Network Benefits	No Out-Of-Network Benefits
Out-of-Pocket Maximum		
Individual / Family		

(1) Family deductible is embedded; an individual covered in a family will not exceed the individual deductible

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

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

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Medical Insurance

Florida Blue	**Option 3:** BlueOptions PPO Plan 3768	**Option 4:** BlueOptions PPO HDHP 5190/5191
	Employee Cost Per Paycheck	**Employee Cost Per Paycheck**
Employee	$112.88	$38.44
Employee + Spouse	$970.64	$700.76
Employee + Child(ren)	$433.03	$259.21
Employee + Family	$1228.64	$857.47
	In-Network	**In-Network**
Network Name	BlueOptions (National PPO)	BlueOptions (National PPO)
Deductible (1)		
Individual / Family	$250 / $750	$1,700 / $3,400
Coinsurance (Member Pays)	0%	20%
Out-of-Pocket Maximum (2)		
Individual / Family	$3,000 / $6,000 Embedded	$4,800 / $7,050 / $9,200 Non-Embedded DED/Emb OOP
Office Visits		
Preventive Care (subject to limits)	Covered at 100%	Covered at 100%
Primary Care Physician Required?	No	No
Primary Care Physician/Specialist	$20 / $45 Copay	Deductible then 20%
Diagnostic Lab	No Copay Quest	Deductible then 20%
Urgent Care	$50 Copay	Deductible then 20%
Hospital Visits		
Inpatient Care	$700 Copay Per Admission	Deductible then 20%
Outpatient Surgery	$300 Copay	Deductible then 20%
Ambulatory Surgical Center	$200 Copay	Deductible then 20%
Major Diagnostics at Hospital	Additional cost share	Deductible then 20%
Major Diagnostics at Standalone Facility	$200 Copay Per Scan	Deductible then 20%
Emergency Room	$200 Copay	Deductible then 20%
Mental Health & Substance Use		
Outpatient Services	Virtual: $0 / Office: $20 / $300 Copay	Deductible then 20%
Inpatient Services	$700 Copay	Deductible then 20%
Prescription Drug		
Deductible	Does Not Apply	Deductible Applies
Tier 1	$10	Deductible applies, then $10
Tier 2	$30	Deductible applies, then $50
Tier 3	$50	Deductible applies, then $80
Mail Order (90-day supply)	2.5x Retail Copay	Deductible applies ;2.5x Retail Copay
	Out-Of-Network (3)	Out-Of-Network (3)
Deductible		
Individual / Family	$1,000 / $3,000	$3,400 / $6,800
Coinsurance (Member Pays)	50%	40%
Out-of-Pocket Maximum		
Individual / Family	$6,000 / $12,000	$9,600 / $18,400

(1) Family deductible is embedded; an individual covered in a family will not exceed the individual deductible

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

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

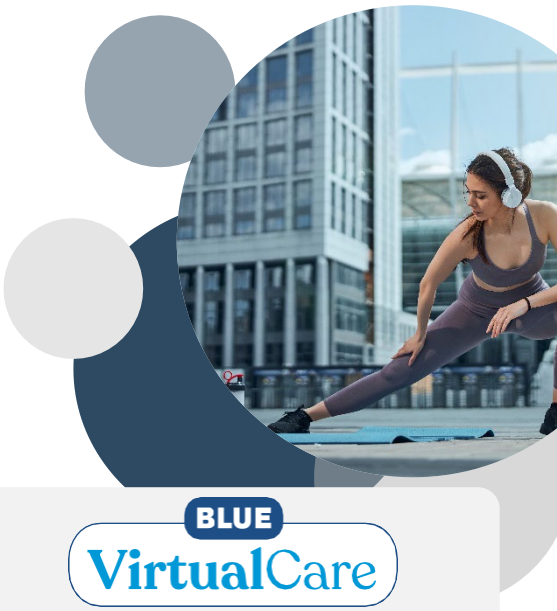
Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Telehealth

Telehealth Savings

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 has BlueVirtualCare to bring you care from the comfort and convenience of your home or wherever you are.

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 BlueVirtualCare

Step 1: Download the FloridaBlue Mobile App

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

Step 2: Enroll

Create an account either online or through the mobile app. Be sure to include your insurance information when creating your account.

Step 3: Choose Find a Doctor & More

Step 4: Click on Find Virtual Care

Step 5: Select BlueVirtualCare

BLUE VirtualCare

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

Care options available through BlueVirtualCare

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

- **Video visit with board-certified doctors**
- **A doctor assesses your symptoms**, provides a treatment plan, and sends prescriptions, if needed, to the in-network pharmacy of your choice.

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

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

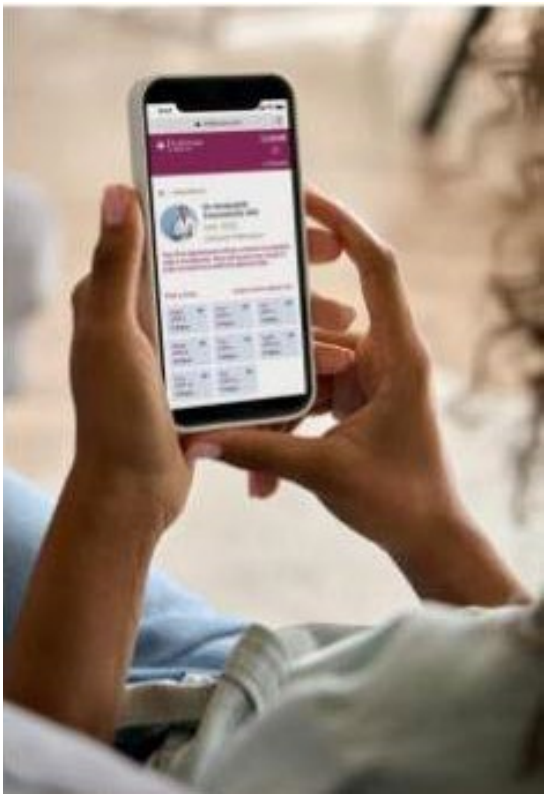
Dermatology: Worried about a change in your skin, hair, or nails? Upload a photo, and a board-certified dermatologist will evaluate it and respond within 72 hours — no appointment, video visit, or referral required.

Mental Health Resources

Skip the phone calls and wait times
with online mental health booking

Find a mental health provider and directly schedule into in-network care using Lucet's online booking tool. The tool guides you step-by-step to help you navigate your mental health journey with confidence, find the care that is right for you, and book an appointment with an available provider — anytime, anywhere.

- **Instant access**
  Browse available providers and appointment slots in real time.
- **Convenient 24/7 scheduling**
  Browse and book appointments anytime, even when the provider office is closed.
- **Quick and easy**
  Follow the prompts that guide you through booking to find the provider and time that works best for you.
- **24/7 support**
  Lucet's team is available 24/7 if you need help or have questions along the way.



Connect Now!
ssoportal.bcbsfl.com/sso/saml2/Member/Lucet

Let's connect you to mental health care, today.

Lucet's team of behavioral health professionals are here to help you navigate your mental health journey with confidence. Whether you are looking for immediate care or do not know where to start, we will guide you through every step.

**Lucet manages behavioral health benefits and services on behalf of Florida Blue.*

Mental Health Resources

How to Access Online Booking

1. Log in to Lucet's Online Booking through the Florida Blue member portal.
2. Answer a few questions to help you find providers who can meet your needs.
3. Browse the list of providers and their availability — use the filter options to narrow your search.
4. Pick a provider and time slot that suits you best.
5. Review your selection and confirm your appointment.

Frequently Asked Questions

What type of providers can I find and book appointments with?

You can find and book appointments with a variety of mental health providers, including therapists, psychologists, psychiatrists and counselors. Each provider's profile indicates their specialty, qualifications and areas of focus.

What kind of assessment questions will I have to answer?

You will be asked a few questions about your needs, preferences and overall wellbeing. This helps match you with the most suitable providers. Lucet prioritizes your privacy and ensures all personal information and health data is secure and protected.

Are there any costs associated with using Lucet's Online Booking?

No, there are no additional costs for using the online booking tool. Lucet manages behavioral health benefits and services on behalf of Florida Blue.

Scan to learn more at
LucetHealth.com



Florida Blue contracts with New Directions Behavioral Health, L.L.C. (d/b/a Lucet), and its affiliates, to provide behavioral health services. Florida Blue is an independent licensee of the Blue Cross and Blue Shield Association.

Health Savings Account (HSA)

Understanding a HSA – Available with Blue Options 5190/5191 HDHP Only

Your Employer contributes the following to your HSA Account each month:

$134.35 Employee, $134.35 EE + Spouse, $196.18 EE + Children, $196.18 EE + Family

There are two (2) ways you can put money into your HSA:

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

What is an HSA?

An HSA is exactly what it sounds like — 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.

Your HSA can also be an investment opportunity.

Depending upon your HSA 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.

HSA Funds can be used by your family.

Your HSA doesn't just benefit you. You can use the funds for your spouse and tax dependents for their eligible expenses, too — even if they're not covered by your medical plan.

Your funds can carry over and even grow over time.

The money in your HSA always belongs to you, and we mean always. Even if you leave the company or you don't use a lot of health services now, your funds will carry over from year to year and will always be there if you need them in the future — even after retirement.

Contribute up to:
$4,400 Single, or $8,750 Family in 2026 and $4,500 Single, or $9,000 Family in 2027

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.
- You cannot set up an HSA if you have insurance coverage under another plan, such as 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 2026 are $4,400 for Single and $8,750 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 health care expenses are more than your HSA balance, you need to pay the remaining cost another way. Save your receipts in case you are ever audited! You can request reimbursement later, after you have accumulated more money in your account.

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**.

As a health savings 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 are 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.
- You are enrolled in the HDHP.

What is a Health Savings Account?

Important Information:

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.

Frequently Asked Questions

Q. **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.

Q. **What will I pay at the physician's office with the HSA qualified plan?**

You'll provide your ID card at the time of your visit and the physician's office will submit the claim to Florida Blue. You will not owe anything at the time of your 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.

Q. **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.

Flexible Spending Accounts (FSA) Renews Jan.1, 2027

Select Your FSA Accounts

- *Health Care Flexible Spending Account*
- *Dependent Care Expense Account*

The FSA and DCA renew January 1, 2027

Health Care Flexible Spending Account

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing your chance of incurring a large out-of-pocket expense early in the plan year. **Be aware — any unused portion of the account at the end of the plan year is forfeited.**

Eligible Expenses Examples

- Coinsurance & copayments
- Contraceptives
- Crutches
- Dental expenses
- Dentures
- Diagnostic expenses
- Eyeglasses, including exam fee
- Handicapped care & support
- Nutrition counseling
- Hearing devices & batteries
- Hospital bills
- Deductible amounts
- Laboratory fees
- Licensed practical nurses
- Orthodontia
- Orthopedic shoes
- Oxygen
- Prescription drugs
- Psychiatric care
- Routine physical
- Psychologist expenses
- Seeing-eye dog expenses
- Prescribed vitamin supplements (medically necessary)

How The Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to LASPBC. Reimbursement is issued to you through direct deposit into your bank account, or by check.

2026 Maximum Contributions	
Health Care Flexible Spending Account	$2,500 max
Dependent Care Expense Account	$5,000 max

Dependent Care Expense Account

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13.

Qualified care centers include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a childcare tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. **Any unused portion of your account balance at the end of the plan year is forfeited.**

Contact Information

Request a full statement of your accounts at any time by calling 1-855-410-2249 or log on to:

https://myplans.cbiz.com to review your FSA balance.

The address to mail claims to is – 110 Franklin Rd. SE, Suite 300, Roanoke, VA 24011

On the member website you can:

- *View account information and activity*
- *File claims*
- *Manage your profile*
- *View notifications*
- *Access forms*

Full list of Health Care FSA Eligible Expenses

What is a Dependent Care FSA?

What is a Flexible Spending Account?

Dental Insurance

Review Your Dental Plans

Guardian is the Dental Carrier For 2026-27.

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 age 26.

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 standards and balance billing is possible.

Dental Insurance Plan Options and Costs

Guardian

	Employee Cost Per Paycheck	Employee Cost Per Paycheck
Employee	$0.00	$0.00
Employee + Spouse	$6.38	$27.73
Employee + Child(ren)	$3.94	$16.14
Employee + Family	$10.32	$43.87

	In-Network	Out-of-Network	In-Network	Out-of-Network	
Plan/Network	Managed Dental Care (Florida Only)		PPO: DentalGuard Preferred		
Deductible Individual / Family	n/a	No out-of-Network Coverage	$50 / $150	$50 / $150	Applies to Basic & Major Services
Annual Maximum	n/a		$1,500 + Rollover		Applies to Preventive, Basic & Major Services

	You Pay	You Pay		
Diagnostic / Preventive Services	**See the Carrier Materials for more procedures. Common Treatments:** Office Visit: $0.00 Copay Prophylaxis (cleaning): $0.00 Copay X-Rays Intraoral: $0.00 Copay Sealant: $0.00 Copay	0%	0% Subject to Balance Billing	▪ Oral Evaluations ▪ Cleanings ▪ Fluoride Treatments ▪ Sealants
Basic Services	**See the Carrier Materials for more procedures. Common Treatments:** Fillings: $0-$75 Copay Root Canals: $120 - $270 Copay	Deductible then 0%	Deductible then 20% Subject to Balance Billing	▪ Fillings ▪ Endodontics/Periodontics ▪ Simple & Surgical Extractions ▪ General Anesthesia ▪ PA X-Rays
Major Services	**See the Carrier Materials for more procedures.**	Deductible then 40%	Deductible then 50% Subject to Balance Billing	▪ Single Crowns ▪ Inlays/Onlays ▪ Bridges & Dentures ▪ Prosthodontics
Orthodontia Services	$2,500 Copay for Children $2,800 Copay for Adults	50% up to a lifetime benefit of $1,500; Orthodontia appliance must be placed prior to the age limit		▪ Diagnostics & Treatment (for dependents up to age 19)

To find a Guardian Dental Provider in your area, visit the website at https://www.guardianantytime.com/

- Click on "Find a dental or vision provider"
- Select your Plan Type: "Managed Dental Care" or "PPO: DentalGuard Preferred"
- Type in your ZIP code then click the blue search button
- Select a provider from the list

What is Dental Insurance?

Dental Insurance

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

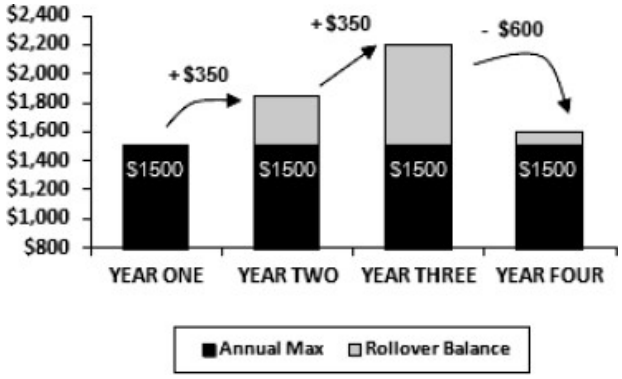
Here's how the benefits work:

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 $1,600 ($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 2026-27.

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.

In addition, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers. To find a participating provider, go to www.eyemed.com.

What is Vision Insurance?

Vision Insurance Plan Options and Costs

EyeMed	Employee Cost Per Paycheck	
Employee	$3.12	
Employee + Spouse	$5.92	
Employee + Child(ren)	$6.23	
Employee + Family	$9.16	
	In-Network	**Out-of-Network**
Examination Copay (Refractive Exam)	$10 copay	**Reimbursement** Up to $30
Frequency of Service		
Exam	Every 12 months	
Lenses/Contacts	Every 12 months	
Frames	Every 24 months	
Lenses (Standard plastic lenses)		**Reimbursement**
Single	$25 copay ; 100% covered	Up to $25
Bifocal	$25 copay ; 100% covered	Up to $40
Trifocal	$25 copay ; 100% covered	Up to $60
Lenticular	$25 copay ; 100% covered	Up to $60
Frames *	$130 allowance, 20% off balance over $130	**Reimbursement** Up to $65
Conventional Contacts *	$130 allowance, 15% off balance over $130	**Reimbursement** Up to $104
Medically Necessary Contacts	$0 copay; paid-in-full	**Reimbursement** Up to $200

* Frames and contact lenses allowance cannot be used in the same eligibility period

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

- Click "Find an Eye Doctor"
- Choose the network: Select
  Type in your ZIP Code, then click the green "Search" button
- EyeMed can be reached at 1-866-299-1358
- Help is also available on their mobile app

Life Insurance and AD&D

Review Your Life Insurance Policy

- *Add Your Spouse*
- *Add your dependents*
- *Increase Your Coverage*

Basic Life and AD&D

LASPBC provides 2x your annual earnings + $15,000, to a maximum of $150,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance.

This coverage is offered through Mutual of Omaha at no cost to you. Note: Age reduction schedule applies beginning at age 65.

Voluntary Life and Dependent Life

You can purchase additional Life Coverage beyond what LASPBC provides. Mutual of Omaha guarantees issued coverage during your initial enrollment period — which means you can't be turned down for coverage based on medical history.

- **Voluntary Employee Life :** You may elect to be insured for an amount of life insurance from $10,000 to $300,000 in increments of $10,000. Guarantee issue amount is $100,000 (New Hires Only).
- **Voluntary Spouse Life :** You may elect to have your Spouse insured for an amount of life insurance from $5,000 to $150,000 provided the amount does not exceed 100% of the employee's amount of life insurance. Guarantee issue amount is $25.000.
- **Voluntary Child Life :** You may elect $10,000 of coverage starting at 14 days old, up to age 21 (25 if a full-time student). Guarantee issue $10,000.

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 approved by Mutual of Omaha before you're able to get coverage in the future.

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



If you elect Voluntary Life for yourself and/or your dependents, **Voluntary AD&D** is an automatic election based on the voluntary life insurance amount.

Did you know?

LASPBC provides you Basic Life and AD&D AT NO CHARGE.

Disability Insurance

Review Your Disability Insurance

- *Short-Term Disability*
- *Long-Term Disability*

Short-term Disability Insurance

Short-Term Disability insurance is offered through Mutual of Omaha. LASPBC pays 100% of the premium cost. The plan benefit is $66^{2}/_{3}$% of basic weekly earnings up to a maximum of $1,000 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)

What is Short-term Disability?

Long-term Disability Insurance

Long-Term Disability insurance is offered through Mutual of Omaha. LASPBC pays 100% of the premium cost. The plan benefit is 70% of 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.

Note: preexisting condition limitations apply. The plan benefit duration varies based on the age of disability.

There are offsets for other sources of income when out on claim – see the LTD certificate for details.

What is Long-term Disability?

Why Should You Consider Disability Insurance?

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

Here are the actual odds:

Winning Mega Millions	.0000004%
Being struck by lightning	.02%
Being audited by the IRS	1%
Having twins	3%
Becoming Disabled	25%

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 (6) months or more of their expenses.

Nearly **70%**

of workers that apply for Social Security Disability Insurance **are denied.**

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

What is Disability Insurance?

Pet Insurance Coverage

spot pet insurance



America's Favorite Pet Insurance!

Help Get Peace Of Mind With Our Pet Coverage

Accidents

Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries.

Illnesses

Spot plans cover exams for qualified illnesses and related treatment, including things like surgeries & medications.

Wellness

Spots optional Preventive Care plans focus on routine care and regular check-ups to help ensure their routine wellbeing.

Spot Plans Help Cover Vet Bills for:

- Vet Exam Fees
- Behavioral Issues
- Dental Illnesses
- Surgery
- Microchip Implantation
- Unexpected Emergencies
- Hereditary Conditions
- Prescription Medications
- Diagnostics
- X-rays & Tests
- Cancer & Growths
- And Much More...

Flexible Plans For Any Budget

Customize your annual limit, annual deductible and reimbursement rate to make your pet and wallet happy.

Simple & Easy Claims Process

1. Visit Any Vet in the U.S or Canada
2. Submit Your Claim Online
3. Get Cash Back for Covered Vet Bills!

Unleash More with Spot

spotperks+

Special discounts on pet products and services from your favorite brands.

24/7 Pet Telehealth Helpline

Get unlimited 24/7 virtual pet care from vet experts for your pet.

LEGAL AID SOCIETY OF PALM BEACH COUNTY

Get Up to 20% Off With Your Special Discount*

spotpet.link/legalaidpbc

*10% group discount available on every pet. Not available in HI or TN. Plus an additional 10% multi-pet discount on 2nd+ pets. For all terms visit Subheading. Insurance plans are underwritten by either Independence American Insurance Company (NAIC #26581) or United States Fire Insurance Company (NAIC #21113), and are produced by Spot Pet Insurance Services, LLC. (NPN # 19246385, CA License #6000188). Premiums are based on and may increase or decrease due to the age of your pet, the species or breed of your pet, and your home address.

Retirement

Elect Your 401(k) Contribution

Our 401(k) plan is managed by **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. When Participation Starts If you are an eligible employee, then you can begin contributing Elective Contributions to the Plan on the first day of the quarter of the plan year coincident with or next following the date such participation requirements are satisfied. This date is known as your entry date.

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 5% 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).

Contact the Plan Administrator if you have any questions regarding the Retirement Plan:

Michael Spillane
mspillane@legalaidpbc.com

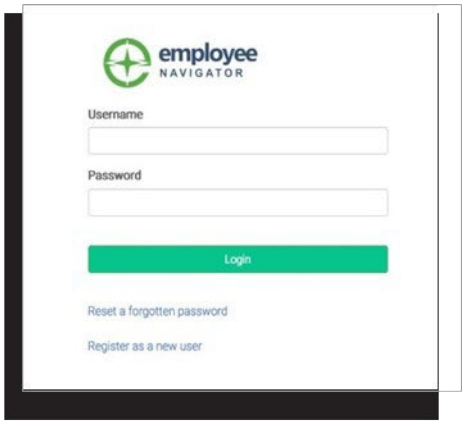
This information is intended as a Summary of Benefits provided under your Certificate of Coverage. Please remember that this is just a summary of your benefits. Certain limitations may apply. Please refer to the certificate of Coverage for the actual benefits provided.

What is a 401(k) Retirement Plan?

LASPBC
will make a competitive matching contribution (100% of the first 5% of the amount you save).

How to Enroll

ENROLL IN YOUR BENEFITS: ONE STEP AT A TIME



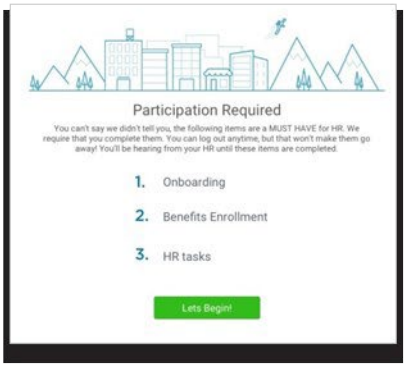
Step 1: Log In

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.

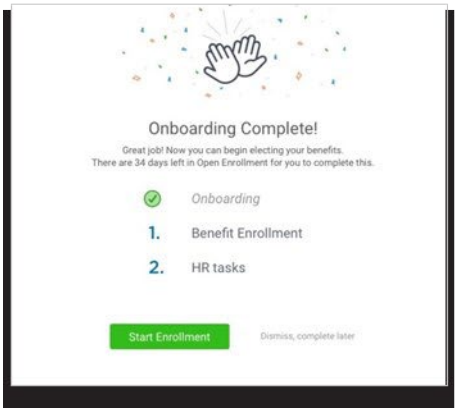
NOTE: In order to register, you will need to enter your first and last name, your PIN (the last 4 digits of your SSN), your birth date, and the company identifier. Your company identifier is: **LASOPBCI**



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



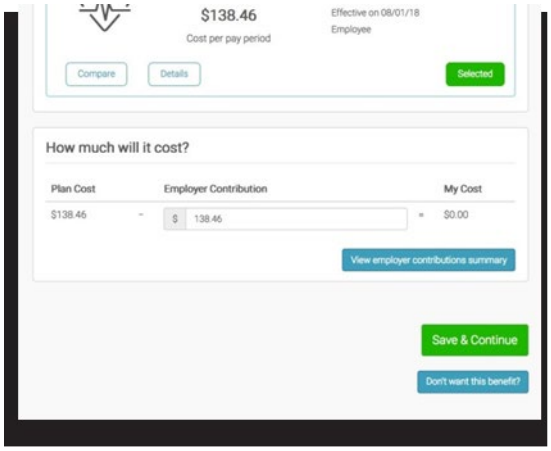
Step 5: Benefit Elections

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.

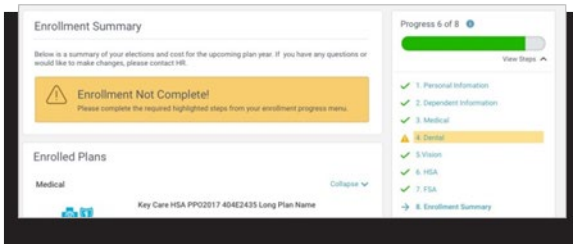


Step 6: Forms

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 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

wciacciarelli@cbiz.com

prhymes@cbiz.com

Video Library

Medical Plans

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview
- HDHP vs. PPO
- HDHP with HSA 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 a Flexible Spending Account?
- What is a 401(k) Retirement Plan?
- What is a Dependent Care FSA?

Ancillary Benefits

- What is Dental Insurance?
- What is Vision Insurance?
- What is Life and AD&D Insurance?
- What is Disability 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 out-of-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to doctor's office visits, as well as urgent care and 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.

> ***Embedded Deductible–** The single team member deductible is *embedded* into the family deductible, meaning no one person covered under the plan can contribute more than the single amount toward the family deductible.

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 (also known as Prior Authorization (PA)—A process conducted 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.

Important Notices

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Florida Blue 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 LASPBC 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.

Florida Blue has determined that the prescription drug coverage offered by the LASPBC health 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?

If you decide to join a Medicare drug plan, your current Florida Blue 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 Florida Blue medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

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 LASPBC 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 Florida Blue changes. You also may request a copy of this notice at any time.

Contact: Human Resources (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, 2026
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

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: Noelle Smith, Human Resources, Legal Aid Society of Palm Beach County, 423 Fern Street, Suite 200, West Palm Beach, FL 33401, (561) 822-9764, nsmith@legalaidpbc.com

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.

Important Notices

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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, Human Resources, Legal Aid Society of Palm Beach County, 423 Fern Street, Suite 200, West Palm Beach, FL 33401, (561) 822-9764, nsmith@legalaidpbc.com

Important Notices

WOMEN'S HEALTH AND 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. If you would like more information on WHCRA benefits, call your Plan Administrator, Noelle Smith, at (561) 822-9764 or nsmith@legalaidpbc.com.

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 Noelle Smith in Human Resources at (561) 822-9764 or nsmith@legalaidpbc.com.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

We have access to a Summary of Benefits and Coverage (SBC). This document includes key provisions, limitations, cost-sharing and examples explaining how your health plan works. The SBC is available by contacting Noelle Smith in Human Resources at (561) 822-9764 or nsmith@legalaidpbc.com.

SUMMARY PLAN DESCRIPTION (SPD)

This guide is designed to provide an overview of the coverages available. It is not a Summary Plan Description (SPD). Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail.

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, 2026. Contact your State for more information on eligibility –

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

To access CHIP benefits for all states, scan the QR code with your phone for a complete listing.

To see if any other states have added a premium assistance program since July 31, 2026, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 5/31/2029)

Notes

Notes



© Copyright 2026. CBIZ, Inc. NYSE Listed: CBZ. All rights reserved.

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.

The formats and templates used by CBIZ to create this document are the intellectual property of CBIZ under the copyright laws of the United States. Use of CBIZ material is subject to license. Unauthorized use of CBIZ material is not permitted. No material supplied by CBIZ and licensed to the client may be reused without prior authorization and proper attribution.