2024

EMPLOYEE BENEFITS

BENEFITS YOUR WELLNESS CHOICE

Brevard Public Schools

Agenda

- Open Enrollment
- Medical/Rx
  - Marathon Health Well-Care Centers
  - Hinge Health & Surgery Plus
- Dental
- Vision
- Life and AD&D
- Disability
- Flexible Spending Accounts (FSA)
- Employee Assistance Program (EAP)
- Supplemental Health Benefits
- Next Steps

Open Enrollment

Open Enrollment: 10/16 – 10/31/2023

- Open Enrollment is your **ONLY** opportunity during the year to add, drop, or change coverage *unless* you experience a qualified life event, e.g., marriage, divorce, birth/adoption of a child
- During Open Enrollment, employees MUST:
  - Complete the online Medical Plan Affidavit which
    - Asks about tobacco use by employee, and spouse if applicable, and
    - If covering a spouse, asks about spouse's employment status and eligibility for employer health care. NOT completing the affidavit results in *automatic* application of the $250/month Spousal Surcharge*
  - Complete the Over-age Dependent (age 26 – 30 non-disabled) Affidavit[1]
    - Failure to do so results in that dependent being dropped from 2024 coverage
  - Enroll in a Flexible Spending Account (Health care and/or Dependent care), if desired
    - FSA elections do not roll over to new plan year
  - Meet the 10/31 deadline to provide eligibility documents for *newly* added dependents.
    - Marriage certificate for spouse; birth certificate/adoption paperwork for child(ren)

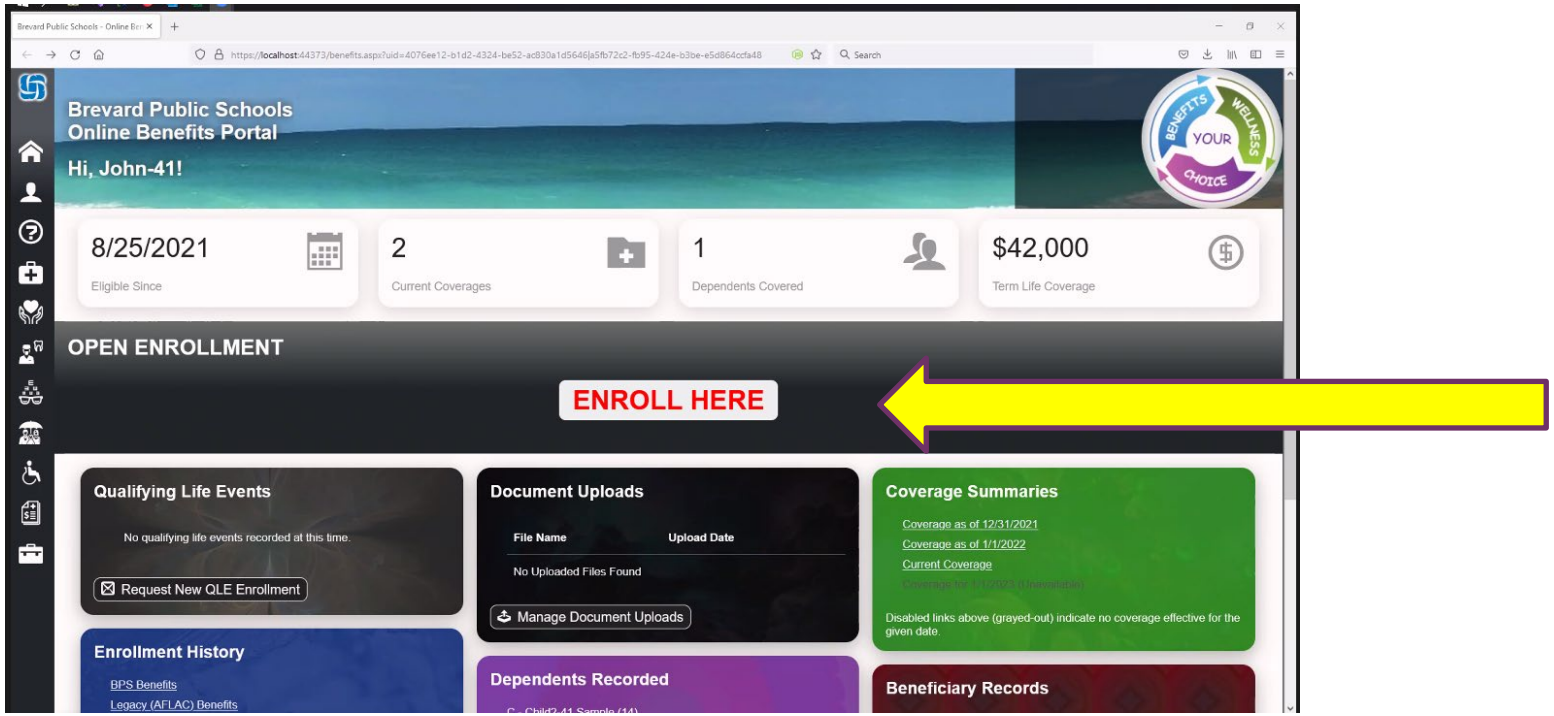
* ***Depending on responses, noted surcharge could be waived***

[1] ***Affidavit to be completed online; eligibility for Over-age dependent coverage is determined by answers given on affidavit***

Enrollment is completed online at http://bps.primebenefits.io.

- To log-in, use your *BPS* network log-in credentials as indicated on this login screen:

- Once you're logged in, click "Enroll Here" to start the enrollment process.



After you've selected your benefits, click the **"Submit"** button at the end of the enrollment process. Then **be sure to print and review a confirmation statement each time** you visit your enrollment page to ensure no unintended changes were made.

If you ***do nothing*** during Open Enrollment:

- **You will be penalized with a $250/month Spousal Surcharge**
  - Not completing the Medical Plan Affidavit results in an *automatic* application of the surcharge.
- **Your Over-age dependent (non-disabled) will lose coverage**
  - Not completing the Over-age Dependent (not disabled) Affidavit results in automatic cancellation of that dependent's coverage for the new plan year
- **You will not have a Flexible Spending Account**
  - The IRS requires re-enrollment each year

However, your medical, dental, vision, life, and disability elections, and currently enrolled dependents (except Over-age non-disabled) will carry forward to the 2024 plan year and the related payroll deductions will apply.

BPS offers a Benefits Education & Call Center to help with your employee benefit related questions. Benefit Counselors are available by phone to speak with employees one-on-one to explain and review the BPS benefits offered. Benefit Counselors will also be able to capture your elections over the phone.

Benefits Education & Call Center

(321) 800-4490

Monday - Friday, 9am to 9pm EST

Website: **https://pesenroll.com/bps/**

Email: **BPS@pesenroll.com** with any benefit questions

To schedule a call with a Benefit Counselor during the enrollment period, visit the link below or scan the QR code:

www.qrco.de/bcOBS5

Tobacco-use Surcharge

- Use of <u>any</u> tobacco product is subject to the $50/month surcharge. This includes, but isn't limited to, cigarettes, pipes, cigars, smokeless tobacco, and all Electronic Nicotine Delivery Systems, e.g., vape and hookah pens, vaporizers and e-cigarettes.

- Employees enrolled/enrolling in the BPS Health Plan **<u>must complete the *online* Medical Plan Affidavit</u>** which asks about their own tobacco use, and their spouse's if applicable. Employees affirming tobacco use on the Affidavit will be subject to the surcharge*. The surcharge will be refunded IF the tobacco user(s):
  - Complete Cigna's Tobacco Cessation Program by **September 30, 2024**, with either:
    - A Cigna telephonic coach: 1-800-244-6224 OR
    - Cigna's onsite health coach, Joni Deblecourt-Whelen. Contact her by email (**Joni.deblecourt-whelen@cigna.com**), or call/text: 321-338-5955.

Both coaching options have a similar average of 6 sessions and include Nicotine Replacement Therapy.

** If both the employee and covered spouse use tobacco, only one surcharge will apply. However, <u>both</u> must complete the cessation program in order to have the surcharge refunded.*

Tobacco-use Surcharge

- **If an individual completes the coaching sessions by the deadline, any applied surcharge will be refunded by January 1st of the following calendar year.**

- Employees and covered spouses must be **tobacco free as of April 1, 2023 in order** to NOT be considered a tobacco user.

- You are required to complete the *online* Medical Plan Affidavit during Open Enrollment which is **October 16 to October 31, 2023.**

Important Dates to Remember

October 16 through October 31, 2023

- For all benefit-eligible employees, this is the **Open Enrollment period** to elect 2024 plan year benefits.
- Enroll via the BPS benefits portal https://bps.primebenefits.io/
- No changes can be made once the enrollment period closes.

January 1* through January 31, 2024

For employees **electing medical coverage for the first time during this Open Enrollment**, this is the timeframe to complete both wellness activities – an Annual Physical and a Health Assessment – for a reduced 2024 medical plan deductible.

*You must wait until your benefits are in effect, i.e., 1/1/24, before you can complete these activities.

Important Dates to Remember (cont.)

August 31, 2024

For employees and spouses currently enrolled in a medical plan, this is the deadline to complete an *Annual Physical AND* a *Health Assessment to earn a reduced 202**5** In-network medical plan deductible.*

- **Annual Physical** (do this first)
  - Performed free at any BPS Well-Care Center (WCC)
  - Performed free with your In-network primary care physician

- **Cigna Health Assessment** (HA)
  - Visit www.MyCigna.com, register for an account (if you don't already have one), then click the Wellness link to access the HA

Employees who *currently* have BPS medical coverage may complete their Annual Physical and Health Assessment anytime from 9/1/23 to 8/31/24.

2024 Benefits Overview

Product	Carrier	2024 Highlights
Medical and Rx	Cigna	Two plans offered: Silver & Gold. No change to current plan designs or employee contributions
Flexible Spending Accounts	TASC	Health Care and Dependent Care
Dental	Humana	Four plans offered: two DPPO and two DHMO. No change to current plans or contributions
Vision	Humana	Two plans offered: Basic & Enhanced. No change to current plans or contributions
Life and Voluntary Life	The Standard	No change to current plans or contributions. EOI (health questionnaire) may be required for some elections
Short- and Long-Term Disability	The Standard	No change to current plans or contributions. EOI (health questionnaire) will be required
Supplemental Health Benefits *(Accident, Hospital Indemnity and Critical Illness)*	The Standard	No change to current plans or contributions.
Employee Assistance Program	CN Associates	No change to current plan including unlimited counseling by phone or video

Medical/Rx
&
Marathon Health
Well-Care Centers

Medical/Rx – Cigna

- **Two plans offered:** Silver and Gold **No change to plan designs or networks**
- **No Change in Employee Payroll Deductions** for 2024 (BPS picks up full increase)
- **Reminder:** In-network preventive care, virtual-care services with Cigna's contracted partners, and care from the BPS employee Well-Care Centers are covered by the plans at 100%.

Silver	Gold
There are two different Pricing Schedules within the Silver plan to choose from. • **Schedule 1: Lower cost to you for using Parrish & Steward hospital systems and their affiliates plus independent physicians in Brevard County and Cigna's ancillary providers, e.g., labs. PCP and Specialist care for a copay** • **Schedule 2: Higher cost to you for using Health First and other Cigna network providers *excluding Schedule 1 providers,* plus Out-of-network providers.**	• **Open Access Plus network** • **This plan offers In-network care, including Health First PCPs and Specialists, for a copay.** • **Save money by using *Tier 1* health care providers which have lower PCP and Specialist copays** • **Tier 1 providers, identified as providing quality, cost-effective care, may be found on myCigna.com.**

GOLD Medical/Rx Plan

Medical	Gold Plan Cigna's Open Access Plan	
	In-network	Out-of-network
Annual Deductible		
Wellness Deductible (Individual/Family)	$1,500 / $3,000	$3,000 / $6,000
1/2 Wellness Deductible (Individual/Family)	$2,000 / $4,000	$4,000 / $8,000
Annual deductible (Individual/Family)	$2,500 / $5,000	$5,000 / $10,000
Annual Out-of-Pocket Maximum		
Medical Out-of-pocket maximum (Individual/Family)*	$5,500 / $11,000	$12,500 / $25,000
Pharmacy Out-of-pocket maximum (Individual/Family)*	$2,200 / $4,400	N/A
Preventive care	No Charge	50% AD
Primary physician office visit	Tier 1**: $30 Non-Tier 1**: $45	50% AD
Specialist office visit	Tier 1**: $50 Non-Tier 1**: $75	50% AD
Virtual Care: Urgent Care	No Charge	Not Covered
Inpatient hospital services	$900 copay, then 20% AD	50% AD
Outpatient hospital services (lab, x-ray, diagnostic)	20% AD	50% AD
Advanced diagnostics	20% AD	50% AD
Urgent care	$75 copay	$75 copay
Preferred Health Center	$30 copay	Not covered
Emergency room care	$450 copay, plus 20% AD	$450 copay, plus 20% AD
Prescription drugs		
Retail (30-day supply)		
Generic	$20	N/A
Brand preferred	$50	N/A
Brand non-preferred	$150	N/A
Retail (90-day supply)		
Generic	$60	N/A
Brand preferred	$150	N/A
Brand non-preferred	$450	N/A
Mail order (90-day supply)		
Generic	$40	N/A
Brand preferred	$100	N/A
Brand non-preferred	$300	N/A

Contact the Benefits Education & Call Center for more information

SILVER Medical/Rx Plan

Medical	Silver Plan	
	Parrish & Steward Hospital Systems & their Affiliates plus Independent Physicians in Brevard County and Cigna Ancillary1 providers.	Health First & other Cigna network providers excluding Schedule 1 providers, plus Out-of-network Providers
Annual Deductible	**Schedule 1**	**Schedule 2**
Wellness Deductible (Individual/Family)	$750 / $1,500	$1,250 / $2,500
1/2 Wellness Deductible (Individual/Family)	$1,250 / $2,500	$2,250 / $4,500
Annual deductible (Individual/Family)	$1,750 / $3,500	$3,250 / $6,500
Annual Out-of-Pocket Maximum		
Medical Out-of-pocket maximum (Individual/Family)*	$4,500 / $9,000	$6,500 / $13,000
Pharmacy Out-of-pocket maximum (Individual/Family)*	$2,200 / $4,400	N/A
Preventive care	No Charge	60% AD
Primary physician office visit	$30 copay	40% AD
Specialist office visit	$50 copay	40% AD
Virtual Care: Urgent Care	No Charge	No Charge
Inpatient hospital services	$600 copay, then 20% AD	40% AD
Outpatient hospital services (lab, x-ray, diagnostic)	20% AD	40% AD
Advanced diagnostics	20% AD	40% AD
Urgent care	$50 copay	$50 copay
Preferred Health Center	$30 copay	Not covered
Emergency room care	$300 copay, plus 20% AD	$300 copay, plus 20% AD
Prescription drugs		
Retail (30-day supply)		
Generic	$20	N/A
Brand preferred	$50	N/A
Brand non-preferred	$150	N/A
Retail (90-day supply)		
Generic	$60	N/A
Brand preferred	$150	N/A
Brand non-preferred	$450	N/A
Mail order (90-day supply)		
Generic	$40	N/A
Brand preferred	$100	N/A
Brand non-preferred	$300	N/A

Contact the Benefits Education & Call Center for more information

Pharmacy Information

- Visit *Cigna.com* to find an in-network pharmacy or to use the drug cost estimator tool; or call 1-800-285-4812.

- Discount sites like GoodRx and WellRx can help you instantly save. (Please note that prescriptions acquired under these plans do not go through your insurance).

- Ask if a generic/mail order is available. Generic contraceptives are covered and available at no cost.

- See if your drug has a Patient Assistance Program.

- Enroll in SaveonSP and save!
  If you're filling an eligible medication, a representative from SaveonSP will call you about enrolling in the program.
  - If you choose to participate, you'll pay $0 for your medication.
  - If you choose not to participate, you'll pay higher copays when you fill your medication.
  - Conditions supported by SaveonSP include, but are not limited to: Hepatitis C, Multiple Sclerosis, Psoriasis, Inflammatory Bowel Disease, Rheumatoid Arthritis, and Oncology.

Contact the Benefits Education & Call Center for more information

SaveonSP Example

John's taking a specialty medication that's eligible for the SaveonSP program. His copay is currently $70. His new copay will be $1,000.

- **If he participates in SaveonSP, he won't pay anything ($0) out-of-pocket**. His full copay will be paid through a manufacturer copay assistance program, and the copay won't count toward his deductible or out-of-pocket maximum.

- **If he decides not to participate in SaveonSP, he'll pay his full copay of $1,000 out-of-pocket.** And the copay John pays won't count toward his deductible or out-of-pocket maximum.

Contact the Benefits Education & Call Center for more information.

Marathon Health Well-Care Centers

- Employees and their dependents (age 6+) enrolled in a BPS medical plan can schedule appointments at any of the three Well-Care Centers.
- To make an appointment, call or logon to the Marathon eHealth Portal. Same-day appointments *may* be available. Please be reminded: these are not *walk-in* clinics.
- Appointments typically last 20-30 minutes.
- Please bring your insurance card and photo ID to your appointment.
- There is **no charge** for healthcare services provided, however, some lab tests may require additional payment. Contact a Well-Care Center for questions about costs.

Central
ESF Overflow Parking Lot
2694 Judge Fran Jamieson Way Melbourne, FL 32940
(321) 252 – 1169

Mon/Tues: 6:30a.m. – 5:00p.m.

Wed/Thurs: 6:30a.m. – 7:00p.m.

Fri: 7:00a.m. – 7:00p.m.

Saturday: 8:00a.m. – 1:30p.m.

South
Central Middle School
2550 Wingate Blvd.
West Melbourne, FL 32904
(321) 369 – 9514

Mon/Tues: 9:00a.m. – 6:00p.m.

Wed/Thur: 6:30a.m. – 5:30p.m.

Fri: 10:00a.m. – 2:00p.m.

North
Jackson Middle School
1505 Knox McRae Drive
Titusville, FL 32780
(321) 222 – 9070

Mon/ Thurs: 6:30a.m. – 5:00p.m.

Tue/Wed/Fri: 7:00a.m. – 7:00p.m.

Saturday: 8:00a.m. – 1:30p.m

Contact the Benefits Education & Call Center for more information

Marathon Health Well-Care Centers

- BPS offers employees and their families enrolled in the BPS health plan access to receive medical care at one of three Well-Care Centers. A medical doctor or nurse practitioner and a certified medical assistant staff most centers. **All treatment rendered at a center is at no cost, including commonly-prescribed drugs dispensed on site by the center's physician.**

- A Well-Care Center can be the first stop for eligible employees and retirees before seeing a specialist for minor injuries and common health concerns, including skin conditions, joint pains, common illnesses, headaches, and digestive issues.

- Medications can be dispensed during your *subsequent* appointments after diagnosis is reaffirmed, refilled through a pharmacy, or by mail-order. If you use a pharmacy or mail-order, your usual copayment will apply.

- Marathon Health protects your health information in compliance with state and federal privacy laws.

Log in and explore all the resources available to you at:
my.marathon-health.com

Contact the Benefits Education & Call Center for more information

Did you know you can save…

$1,000 on an Individual deductible or $2,000 on a Family deductible?

Here's how:

- **For employees currently enrolled in a medical plan**

  Complete BOTH an Annual Physical (1st) and a Health Assessment (2nd) in order and by the designated **deadline of August 31, 2024.** This deadline is **for employees currently enrolled** in a medical plan.

- **For employees enrolling in a medical plan for the first time during Open Enrollment**

  Complete an Annual Physical first, then a Health Assessment from **1/1/24 through 1/31/24**.

Annual Physicals can be completed at any of the three Marathon Health Well-Care Centers and are free. You can log-in to schedule an annual physical appointment at my.marathon-health.com or call one of the locations.

- You may also have an annual physical performed by your own primary care doctor. Annual physicals with IN-network doctors are free.

Cigna Health Assessments can be completed via mycigna.com if you are currently enrolled for medical coverage.

- If you are newly enrolling for medical coverage, then beginning 1/1/24 you may complete your Health Assessment via mycigna.com. Please note that you'll need to first register with Cigna before you are able to complete the Health Assessment.

Contact the Benefits Education & Call Center for more information

Hinge Health
&
SurgeryPlus

Hinge Health

- The Hinge Health benefit is free to medical plan participants
- This program helps you conquer back and joint pain, recover from injuries, avoid surgery, or stay healthy and pain free. Best of all, Hinge Health's programs are **provided at *no cost to you* or your eligible dependents enrolled in a BPS medical plan**.
- Hinge Health provides all the tools you need to get moving again from the comfort of your home. Here are some of the ways your treatment plan could be tailored to you:
  - Get a personal-care team, including a physical therapist and health coach
  - Schedule as many personal physical therapy sessions as needed
  - Receive wearable sensors that give live feedback on your form in the app
  - Get a second opinion on your recommended surgery and treatment plan

Apply at www.hingehealth.com/mybrevard

If you have any questions, please feel free to email hello@hingehealth.com or call 855.902.2777

Surgery Plus

- The SurgeryPlus™ benefit is **free to medical plan participants**
- This program is a supplemental benefit offered by BPS for planned, non-emergency surgeries which provides a personalized concierge experience through a dedicated Care Advocate plus access to quality care through a network of credentialed health care providers.
- When you call SurgeryPlus™, a Care Advocate will help you find a surgeon that meets the rigorous SurgeryPlus™ credentialing standards, schedule your appointments, coordinate logistics such as medical record transfers and any necessary travel arrangements, and ensure you have access to the best information as you make decisions about your care.
- Covered procedure categories include, but are not limited to:
    - orthopedics, spine, general surgery, gynecology, ear nose and throat, GI, cardiac, and pain management.

For more information and for the full list of available surgeries offered under the SurgeryPlus benefit, visit brevardschools.surgeryplus.com or call 833.709.2441 to speak with a Care Advocate.

Flexible Spending Accounts

What is a Flexible Spending Account (FSA)?

- A Health Care FSA is an account that helps you pay for qualified health care expenses, e.g., copays/coinsurance and deductibles for medical, Rx, dental and vision, with pre-tax dollars deducted from your paychecks.
- Certain dependent care expenses are also covered in a Dependent Care FSA.
- For 2024, the annual maximum contribution is $3,050 for a Health Care FSA and $5,000 for a Dependent Care FSA.
- The BPS FSA program is administered by TASC.

Calculate your anticipated out-of-pocket expenses for next year carefully because:

- Once you enroll, you can only change your election during the year **if** you experience a Qualifying Event/Change in Status.
- Plans generally do not allow rollover of unused funds to the next Plan Year. The only exception is for the **Health Care FSA**, which permits up to $610 to carry over to the next plan year's Health Care FSA.
- Contribution balances greater than $610 at end of the year will be forfeited to the Plan.

What is a Flexible Spending Account (FSA)? (cont.)

- If you are a new FSA participant, after enrolling, you will receive a debit card in the mail from TASC that can be used at the point of sale.
- If you already have a TASC card, check the expiration date and that will determine if you can continue to use that card or if a new one will be mailed to you.
- **Health Care FSA** participants will have access to 100% of their full annualized election on January 1st while per pay period deductions will continue throughout the year per your calculated contributions.
- Keep your receipts for your records and substantiation.

Please be aware that if your card/funds are used for an unauthorized purchase, you'll be required to repay those funds to your account for use on *allowable* expenses.

What is a Dependent Care Spending Account?

- Allows pre-tax dollars deducted from your paychecks to be used for qualified dependent care expenses such as daycare for children under age 13, elder care for parents or care for disabled spouses.
- Your Dependent Care FSA funds are only available as they are deposited, and you must provide documentation that all expenses are qualified.
- For 2024, the Annual Maximum is $5,000 (or $2,500 if married and filing separate).
- Any unused funds do not carry over to next year, so plan carefully.

Contact the Benefits Education & Call Center for more information.

Dental
Vision
Life and AD&D
Disability
Employee Assistance Program
Supplemental Health Benefits

Dental HMO: Humana

	Low DHMO Plan	High DHMO Plan
	Member Pays	
	In-network	In-network
Calendar Year Deductible	None	None
Calendar Year Maximum/Member	None	None
Office Visit Copay - **charged even if preventative services visit itself is at No Charge**	$15	$10
Preventative Services	**See Schedule**	**See Schedule**
Cleanings	No Charge	No Charge
Cleaning Frequency	Twice in any 12 calendar months	Twice in any 12 calendar months
Oral Exams	No Charge	No Charge
Sealants (age restrictions)	$20 copay, up to age 16	$15 copay, up to age 16
Fluoride	No Charge, for child up to age 16 (limited to twice in any 12 calendar months)	No Charge, for child up to age 16 (limited to twice in any 12 calendar months)
Bitewing – four images	No Charge (limited to twice in any 12 calendar months)	No Charge (limited to twice in any 12 calendar months)
Basic services	**See Schedule**	**See Schedule**
Fillings (one surface)	$45	$35
Space Maintainers	$95	$75
Extractions	$60	$55
Crown	$410	$350
Root Canal	$390	$310
Major services	**See Schedule**	**See Schedule**
Bridges	$410	$350
Dentures	$550	$475
Inlay (two surface)	$380	$320
Onlay (two surface)	$395	$335
Implants	Not Covered	Not Covered
Orthodontia services	**See Schedule**	**See Schedule**
Orthodontia (Child/Adult)	Orthodontic Treatment $1,900	Orthodontic Treatment $1,900

Dental HMO

- You will receive a letter from Humana informing you that a Primary Care Dentist (PCD) needs to be assigned. Your member ID card will indicate "unassigned" until you select a PCD.
- Any Primary Care Dentist requests received from a member who has never selected a facility, will be given an effective date of the first of the current month.
- If you select a Primary Care Dentist, but choose to change it, it must be changed prior to the 15th of the month to be effective 1st of the following month.
- If you change the Primary Care Dentist *after* the 15th of the month, your new Primary Dentist selected will go into effect the 1st of the following next month.
- New ID cards are sent to members when adding or changing Primary Care Dentists

NOTE: On the DHMO plans, Office Visit copays of $10 (Low plan) or $15 (High plan) will apply even if the service(s) you receive are listed as *No Charge*.

Contact the Benefits Education & Call Center for more information.

Dental HMO (cont.)

How to find a Primary Care Dentist?

Go to www.humana.com

1. Choose "Shop for Plans" and click "Find a Dentist" from the drop-down menu.
2. Click "Find a Dentist"
3. Enter your Zip Code
4. Choose "Look up by Coverage Type". For the PPO, select PPO/Traditional Preferred. For the Low DMO, select HD215 DHMO/Prepaid Network. For the High DHMO, select HS210 DHMO/Prepaid Network.
5. Search by Name or Specialty Dentist and the system will provide a list of dentists near you who are part of the network.

Pro-Tip: Be sure to select a Dentist who is accepting new patients!

Contact the Benefits Education & Call Center for more information.

Dental PPO: Humana

	Low PPO Plan		High PPO Plan	
	Member Pays			
	In-network	Out-of-network*	In-network	Out-of-network*
Annual deductible (Individual/Family)	$50 / $150	$50 / $150	$50 / $150	$50 / $150
Annual maximum (per person)	$750	$750	$1,250	$1,250
Diagnostic and preventive care Includes cleanings, fluoride treatments, sealants and x-rays	0%	0%	0%	0%
Basic services Includes fillings, periodontics, scaling and root planning, and oral surgery	30% AD	30% AD	20% AD	20% AD
Major services Includes crowns, bridges and full and partial dentures	60% AD	60% AD	50% AD	50% AD
Orthodontia	60% AD	60% AD	50% AD	50% AD
Orthodontia Lifetime maximum	$1,000	$1,000	$1,000	$1,000
Non-network reimbursement	N/A	UCR 90th (Preventive)/ UCR 80-85th (Basic and Major)	N/A	Maximum Allowable Fee

Contact the Benefits Education & Call Center for more information

Dental PPO

Plan Features:

- 4 cleanings per year
- 4 periodontal cleanings per year covered 100%
- Extended maximum: If you meet your dental plan maximum and you need additional dental services within the plan year, you will receive a discount rather than paying 100% out of pocket.

Vision: Humana

	Basic Plan		Enhanced Plan	
	In-network	Out-of-network	In-network	Out-of-network
Examination (every 12 months)	100% after $0 copay	up to $35	100% after $0 copay	up to $35
Lenses	**Every 24 months**		**Every 12 months**	
Single	100% after $0 copay	$20	100% after $0 copay	$20
Bifocal		$40		$40
Trifocal		$60		$60
Frames	**Every 24 months**		**Every 12 months**	
New frames	$120 allowance	$30	$120 allowance	$30
Contact lenses	**Every 24 months**		**Every 12 months**	
Elective	$100 allowance	$100	$100 allowance	$100
Medically necessary*	Covered 100%	$150	Covered 100%	$150

** Medically necessary (prior authorization required) is defined as 1) following cataract surgery w/o intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/ or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life*

Contact the Benefits Education & Call Center for more information.

Life and AD&D: The Standard

- BPS provides benefit-eligible employees with Basic Life insurance in the amount of one times their annual pay at **no cost to them**!
- If you would like *additional* coverage, Voluntary Life and AD&D insurance is available for you, your spouse, and your dependent child(ren).
- You must enroll in coverage for yourself in order to cover your spouse or children. (Dependents covered to age 26.)
- If you are not currently enrolled in Voluntary Life, or elect an amount over the Guaranteed Issue, *you will be required to complete an Evidence of Insurability (EOI) form* for The Standard's review and adjudication.

Contact the Benefits Education & Call Center for more information.

Life and AD&D: The Standard

Basic Life is 100% paid for by BPS!

Insurance coverage	Coverage Options
Basic Life	1x annual earnings to a maximum of $1,000,000. Guarantee Issue: $1,000,000
Additional Life	**Minimum Benefit:** Choice of 1-4x annual earnings, in increments of 1x. **Maximum Benefit:** $1,000,000. Guarantee Issue: $1,000,000
Dependent Life	Employees may choose from the following Options: 1. Spouse: $5,000/Child: $2,500 2. Spouse: $10,000/Child: $2,500 3. Spouse: $25,000/Child: $2,500 4. Spouse: $5,000/Child: $5,000 5. Spouse: $10,000/Child: $5,000 6. Spouse: $25,000/Child: $5,000
Accidental Death and Dismemberment (AD&D)	**Employee** 1-4x base annual earnings Maximum of $500,000 **Family Plan** Spouse (with children): 40% Spouse (no children): 50% Each child (with spouse): 10% Each child (no spouse): 15%

Disability Insurance: The Standard

Short-term (STD) and Long-term disability (LTD) insurance plans give you income protection in the event you are ill or injured in a non-work-related accident and can't work.

Short-Term Disability Benefits		Long-Term Disability Benefits	
Short-Term Disability Income (STD) coverage replaces a portion of your lost income if you have a sickness or injury and are unable to work.		Long-Term Disability Income (LTD) coverage replaces a portion of your lost income if you have a sickness or injury and are unable to work. LTD coverage provides financial support for an extended period of disability. **Pre-Existing Condition Limitation:** For LTD, benefits will not be paid for any period of disability caused or contributed to by, or resulting from, a Pre-Existing Condition. For more information, please refer to the plan benefit summary.	
Elimination period	14 days	Elimination period	180 days
Weekly benefit	60% of weekly earnings	Monthly benefit	60% of monthly earnings
Maximum weekly benefit	$1,500	Maximum monthly benefit	$6,500
Maximum benefit period	26 weeks	Maximum benefit period	to SSNRA

Contact the Benefits Education & Call Center for more information.

Employee Assistance Program (EAP)

- BPS is pleased to offer an Employee Assistance Program at ***no cost to ALL employees and their dependents**** to assist you and your family through difficult times.

You'll have:

- Unlimited access to an experienced, certified counselor by phone 24/7 to help with:
  - stress, depression, anxiety, relationship issues, divorce, job stress, work conflicts, family and parenting problems, anger, grief and loss, addiction, eating disorders, mental illness
- Up to **6** face-to-face visits with an experienced, certified counselor at no cost.
- Access to an experienced, certified counselor for help with balancing work and life issues. Just call and one of their Work/Life Specialists can answer your questions as well as put you in touch with resources for the following areas:
  - childcare services, elder care services, legal services, and financial services.
- Unlimited access to helpful tools and resources online
- Access to referrals

Charles Nechtem Associates
1.800.531.0200 / English/Spanish
www.charlesnechtem.com

*** Even if not enrolled in a BPS health plan. Dependents must be at least 18 years old.**

Contact the Benefits Education & Call Center for more information.

Supplemental Health Benefits: The Standard

- The BPS medical plans provide great coverage, but everyone's needs are different. That's where supplemental health benefits come in!

- These benefits are designed to protect your family's finances in case of an unforeseen injury or illness.

- You can enroll, drop, or change your Supplemental Health Benefits via the BPS benefits portal or by calling the Benefits Education & Call Center.

Contact the Benefits Education & Call Center for more information.

Supplemental Health Benefits (cont.)

Accident

Pays cash benefits directly to you to help pay costs associated with injuries caused by a covered accident.

Critical Illness

Helps protect your income and personal assets if you are diagnosed with a specified illness. This plan covers conditions like heart attack, stroke, end stage renal failure, invasive cancer, and more.

Hospital Indemnity

The plan pays benefits when you have a hospital stay for an illness, injury, surgery or having a baby. The plan pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

Next Steps

- Review the Brevard Public Schools *2024 Benefits Guide* for information on all options available to you and their costs

- Login to the BPS benefits portal at https://bps.primebenefits.io. or contact the Benefits Education & Call Center to take the actions noted earlier and **enroll in or waive coverage by October 31.**

  Remember, doing nothing can lead to surcharges being added to your medical plan cost and your Over-age dependent's coverage being canceled.

- Complete your annual enrollment in the BPS benefits portal if you wish or need to make any changes. **Be sure to print and review a confirmation statement after each visit to your enrollment page**.

- By 10/31/23, provide eligibility documents for **newly**-enrolled dependents. Documents are marriage certificate for a spouse and birth certificate/adoption paperwork for child(ren). These can be uploaded into your benefit portal account or faxed to the Employee Benefits Office at (321) 735-9786.

- Notify your medical, dental and vision providers of any changes in your insurance information effective January 1, 2024

For more information and/or assistance with enrollment, please contact the Benefits Education & Call Center at:

(321) 800-4490

Monday - Friday, 9am to 9pm EST

Website: https://pesenroll.com/bps/

Email: BPS@pesenroll.com