2024 Employee Benefits

BENEFITS YOUR WELLNESS CHOICE

Brevard Public Schools

Here's where to find...

WELCOME TO YOUR ANNUAL ENROLLMENT!

Brevard Public Schools appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefits plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Any time you have questions about benefits or the enrollment process, you can contact your BPS Office of Employee Benefits representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please visit the BPS benefits website at **https://www.brevardschools.org/Page/18898**

GREETINGS! Welcome to BPS's Annual Benefits Enrollment for plan year 2024!

The Brevard Public Schools Benefit Plan Year begins January 1 and ends December 31. For the 2024 plan year, we're pleased to announce that we will continue our partnerships with Surgery Plus and Hinge Health, as well as with Marathon Health for the employee Well-Care Centers. Employees will continue to have a choice between two medical plans: Gold and Silver.

The district will also continue its commitment to helping and supporting our employees and their families towards good health. As such, tobacco-use cessation coaching will again be offered, as will numerous wellness activities and events throughout the year. Further, completing two specific wellness activities — an Annual Physical and a Health Assessment at **myCigna.com** — will result in substantial reductions to in-network medical plan deductibles. You can have an Annual Physical performed at any of our Well-Care Centers at no cost to you. For most employees, the time frame to complete these two activities is from September 1, 2023 to August 31, 2024 for a reduced deductible in 2025. However, please see page 21 for some important exceptions.

Benefits education will continue to be available throughout the new plan year:

- The interactive flip-book format of the Employee Benefits Guide will offer a simple one-stop benefits resource where information will be at your fingertips.
- If you need assistance, email us at: **BPSBenefitsWellnessAndChoice@brevardschools.org**. This email box is continuously monitored by the benefits team. Whenever you see this as a "sender name" in your email inbox, you'll know the message contains information related to your benefits. You can also email questions to the Benefits Education Center at **BPS@PESENROLL.COM**.
- Cigna (our medical and Rx plan administrator) may at times reach out to you by U.S. mail, e-mail, or phone to offer cost-effective services and programs available to you as a plan member. In many instances, the information will be *customized just for you*. We encourage you to engage in their outreach efforts; you may be pleasantly surprised at what you learn.

This guide highlights many options available to you as a benefit-eligible employee and provides information to help you make well-informed decisions about your healthcare benefits. When you make healthy lifestyle choices and seek care, you can reduce your out-of-pocket costs and improve your health. We encourage you to read the information contained in this guide, engage in all benefit communications and educational opportunities, and take time to learn about your options to determine which benefit choices best suit you and your family's needs.

We extend our gratitude for all you do in serving the students of Brevard County. Thank you!

Your Employee Benefits & Risk Management Team

WHO IS ELIGIBLE?

All full-time, regular employees who are in a benefits-eligible position as determine by the District. Full-time is defined as working in **excess of 25 hours per week**. Part-time employees may be covered as authorized by the applicable collective bargaining agreement or administrative regulation (or if such employees satisfy the requirements of the Summary Plan Description).

Benefit Eligibility Date for Employees, Retirees, and Dependents

Insurance coverage for an Employee, Retiree, and/or Dependent will not become effective unless a written request is made for all such coverage on **an application form or through any other designated enrollment process** established by Employer, and the Employee or Retiree consents therein to pay any applicable premium. The BPS Health Plan may not limit eligibility or delay participation due to individual confinement to a hospital or other health institution.

Dependent Eligibility Verification

All employees who become Benefits Eligible and wish to enroll dependents for coverage must **provide proof** of eligibility for those individuals.

Proof of dependent eligibility can be a copy of a(n):

- Marriage Certificate
- Birth Certificate
- Adoption Certificate or Decree
- Legal Guardianship Decree

If proof of dependent eligibility is not provided by your benefits effective date, your dependent(s) will **not** have coverage.

Benefits Effective Date for New Employees

Elected insurance coverage for full-time, benefit-eligible employees will be effective on the 14th day following date of hire. However, variable employees must satisfy the PPACA* hours requirement for full-time status during an applicable subsequent measurement period to receive an offer of coverage under the BPS Health Plan for an applicable stability period.

Status Change/ Qualifying Events

Once your benefit elections become effective, they remain in effect until the end of the calendar year. However, qualifying events during the calendar year may permit you to make changes to your benefits. To be eligible, you **MUST** notify the Office of Employee Benefits **within 30 days** of the qualifying event. If you fail to report the event within 30 days, you will not be permitted to add/change coverage until the following Open Enrollment period.

Qualifying events include, but are not limited to:

- Change in **marital status** (marriage, death of spouse, divorce, or annulment)
- Change in **number of dependents** (including birth, adoption, placement for adoption or death)

For further information on eligible qualifying events, see next page, refer to the Summary Plan Description, or contact your local Benefit Contact (school secretary).

*Patient Protection and Affordable Care Act

HOW TO ENROLL

To sign up for benefits, visit **https://bps.primebenefits.io** before the end of your enrollment period.

MAKING CHANGES

You may only make changes to your elections during open enrollment each year or during the year if you experience a qualifying event. Qualifying events include, but are not limited to:

- Birth, legal adoption, or placement for adoption.
- Marital status.
- Dependent child reaches age 26.
- Spouse gains or loses employment or eligibility with current employer.
- Death of a covered dependent.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or CHIP.
- Change in residence that changes eligibility for coverage.
- Court-ordered change.

IMPORTANT:

- Changes to your coverage due to a qualifying life event must be made within 30 days of that life event. Proof of the qualifying life event is required (marriage certificate, divorce decree, birth certificate, or loss of coverage letter).
- Any change you make to your coverage must be consistent with the change in status.

ENROLLMENT DEADLINES

Type of Employee/dependent	Enrollment opportunity	Coverage effective date
Current Employee	Annually during the enrollment period	Start of new plan year: January 1
New hire	Must enroll within 10 days of hire	The 14th day following date of hire.
Qualified life event	Changes must be made within 30 days of life event	Qualified life events require documented proof of the event, e.g., birth/marriage certificate, divorce decree, within 30 days from the event. The effective date of your coverage change(s) will depend on the type of Qualifying Event, and follow the guidelines as stated in the SPD.




MONTHLY EMPLOYEE PAYROLL CONTRIBUTIONS

Medical/Rx

Gold Plan	Total Cost	Employer Contribution	Employee Contribution
Employee	$857.19	$707.93	$149.26
Employee + spouse	$1,921.07	$1,314.64	$606.43
Employee + child(ren)	$1,549.14	$1,190.83	$358.31
Family	$2,592.91	$1,850.72	$742.19

Silver Plan	Total Cost	Employer Contribution	Employee Contribution
Employee	$822.28	$711.75	$110.53
Employee + spouse	$1,813.65	$1,289.88	$523.77
Employee + child(ren)	$1,482.01	$1,174.73	$307.28
Family	$2,472.06	$1,830.73	$641.33

NOTE: There is a spousal surcharge of $250 per month added for a spouse who has access to a medical plan through his or her employer yet is enrolled in the BPS Health Plan as the primary coverage. For more information, see page 38.

What is a Tobacco-use surcharge and a Medical Plan Affidavit?

In 2024, BPS will continue the Tobacco-use Surcharge Program. Use of any tobacco product by employees and spouses enrolled in a BPS medical plan will result in the $50/month surcharge being added to the medical premium.

As part of the program, you are required to complete the online Medical Plan Affidavit during Open Enrollment. If both you and your covered spouse use tobacco, only one surcharge will apply. However, both of you must complete the coaching in order to have the surcharge refunded. Please see page 7 for full details.

Dental

	Low PPO Plan	High PPO Plan
Employee	$23.82	$30.34
Employee + 1	$48.17	$61.24
Employee + 2 or more	$71.25	$90.44

	Low DHMO Plan	High DHMO Plan
Employee	$6.39	$10.48
Employee + 1	$12.65	$20.74
Employee + 2 or more	$22.48	$36.88

Vision

	Basic Plan	Enhanced Plan
Employee	$3.92	$5.91
Employee + 1	$9.75	$14.69
Employee + 2 or more	$16.72	$25.19

Note: Additional rate information can be found in your enrollment portal.

KEY THINGS TO KNOW

Tobacco-Use Surcharge!

As part of our important initiative to support and promote employee and family good health, BPS has a Tobacco-use Surcharge Program. Use of all tobacco products 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 must complete a **Medical Plan Affidavit** 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**:
  - A Cigna telephonic coach: 1.800.244.6224 OR
  - Cigna's onsite health coach, Joni Deblecourt-Whelen. Contact her by email (Josephina.deBlecourt-Whelen@evernorth.com) or call or text to 1.321.338.5955.
- Both coaching options have a similar average of 6 sessions and include Nicotine Replacement Therapy.

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

You are required to complete the Affidavit during Open Enrollment each year and if you have a mid-year qualifying life event, e.g., marriage, and elect medical coverage for yourself/spouse.

** If both the employee and covered spouse use tobacco, only one surcharge will apply. However, both must complete the coaching in order to have the surcharge refund.*

The Cigna Lifestyle Management Tobacco Cessation Program uses two key strategies to increase chances of success:

- Counseling and social support to address the emotional addiction.
- Nicotine replacement therapies to address the physical addiction.

Visit https://bit.ly/2EUpLAa for a short video on this program.

If you have any questions, please contact **Cigna** or the Employee Benefits Office.

YOUR BENEFITS, YOUR CHOICE

One of the most important decisions you'll make this year involves benefits. At Brevard Public Schools, we want to help you make the most of your health plan decisions. This benefits guide is a valuable source of information and highlights the main features of the many benefit plans sponsored by Brevard Public Schools. It will help you determine the best benefit options for you and your family.

BPS' HEALTH PLAN IS SELF-INSURED: What Does That Mean?

Rather than pay premiums to "some giant insurance company" to cover our claims (medical + Rx), BPS' health plan claims are actually paid by enrolled employees, retirees, and the School Board. You see, each of these groups contributes to a pool of funds (called the Trust Fund) and it's from this Fund that health plan claims are paid. Therefore, our "insurer" is really us and we use a Third Party Administrator (TPA) that gives us access to a nationwide network of health care providers (with negotiated pricing), and processes all our claims. Currently, our TPA is Cigna. Because the BPS Trust Fund (our money) pays the claims for thousands of health plan members, it's important that each member:

- Is a wise consumer of health care services and thinks about spending health care dollars as if they were their own – because, really, they are.
- Strives to achieve and maintain good health.

The bottom line is that every dollar saved on health care spending is a dollar that can be spent elsewhere in the District, such as in classrooms or for salary increases or additional benefits.

Two medical plans are available for the 2024 plan year (Gold and Silver).

The Gold Plan

The Gold plan is staying the same with no changes to the plan design or network (Open Access Plus) for 2024. This plan provides broad access to in-network care, including Health First PCPs and Specialists for a copay. This plan also offers a benefit that saves you money: when using a Tier 1 provider, you'll pay a lower copay. Tier 1 providers have been identified as providing quality, cost-effective care and may be found on Cigna.com.

Additionally, in-network preventive care, virtual care with Cigna's contracted partners, and visits to the BPS Well-Care Centers are covered at no charge! Details can be found on page 9.

The Silver Plan

The Silver plan is staying the same for 2024. There are two different pricing schedules within the Silver plan to choose from. Schedule 1 offers lower cost to you for using Parrish and Steward Hospital Systems and their Affiliates, plus Cigna Ancillary and Network providers (excluding Health First), and Independent Physicians in Brevard County. The higher Schedule 2 pricing applies to Health First and other Cigna network providers excluding Schedule 1 providers, plus out-of-network providers.

Additionally, in-network preventive care, virtual care with Cigna's contracted partners, and visits to BPS Well-Care Centers are covered at no charge. More details can be found on page 10.

MEDICAL: GOLD PLAN

Cigna

mycigna.com

Member Services: 1.800.244.6224
Pre-Enrollment: 1.888.806.5042

Your medical benefits are administered by Cigna and provide coverage for both in-network and out-of-network providers. You'll always receive richer benefits and save money when visiting in-network providers.

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
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		
Pharmacy Out-of-pocket maximum (Individual/Family)*	$2,200/$4,400	N/A
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	$60	N/A
Brand preferred	$150	N/A
Brand non-preferred	$450	N/A

This is a summary of coverage; please refer to your summary plan description for the full scope of coverage. In-network services are based on negotiated charges; Out-of-network services are based on a percentage of Medicare charges. AD=After Deductible.

*Includes Deductible and Copayments.

**TIER 1 = For lower copay, provider must have the Tier 1 symbol Tier 1 Provider - next to their name in Cigna's provider directory.

***To be compliant with the Prescription Drug Reform Act (Florida SB 1550), Mail Order copays cannot be advantaged over retail. Mail Order copays have been increased to match the Retail (90-day) copays.

MEDICAL: SILVER PLAN

Cigna

mycigna.com
Member Services: 1.800.244.6224
Pre-Enrollment: 1.888.806.5042

Medical	Silver Plan	
	Parrish & Steward Hospital Systems & their Affiliates, plus Cigna Ancillary and Network providers (excluding Health First), and Independent Physicians in Brevard County	Health First 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
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		
Pharmacy Out-of-pocket maximum (Individual/Family)*	$2,200/$4,400	N/A
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	$60	N/A
Brand preferred	$150	N/A
Brand non-preferred	$450	N/A

This is a summary of coverage; please refer to your summary plan description for the full scope of coverage. In-network services are based on negotiated charges; Out-of-network services are based on a percentage of Medicare charges. AD=After Deductible

*Includes Deductible and Copayments.

**To be compliant with the Prescription Drug Reform Act (Florida SB 1550), Mail Order copays cannot be advantaged over retail. Mail Order copays have been increased to match the Retail (90-day) copays.

HOW TO BE A SMART HEALTH CARE CONSUMER

Pharmacy

- Find an in-network pharmacy or use the drug cost estimator tool by visiting **mycigna.com** or call **1.800.285.4812**.
- Discount sites like GoodRx and WellRx can help you instantly save (please note: prescriptions acquired under these plans do not go through your insurance).
- Ask if a generic/mail order is available.
- Generic contraceptives and diaphragms are covered and available at no cost.
- See if your drug has a Patient Assistance Program.

Enroll in SaveonSP and save

Certain specialty medications are eligible for the SaveonSP program. If you're filling an eligible medication, a representative from SaveonSP will call you to talk about enrolling in the program.

If you choose to participate, you'll pay $0 for your medication. If you choose not to participate in SaveonSP, you'll pay a higher copay 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
- Oncology

24/7 Nurse Line

1.800.564.9286

- Choose appropriate medical care.
- Find a doctor or hospital.
- Understand treatment options.
- Achieve a healthier lifestyle.
- Answer medical questions.

Cost Estimator

Different doctors and hospitals may charge different amounts for the same service. **mycigna.com** can help you compare costs based on your own benefits.

Cigna Mobile App

The Cigna myCigna app lets you easily access your healthcare information and gives you tools to help estimate costs, manage claims and find providers — anytime and anywhere. It's built to be your go-to healthcare resource when you're on the go.

Available on the App Store

GET IT ON Google Play

CIGNA VIRTUAL CARE (TELEHEALTH)

The Care You Need – When, Where and How You Need It

CIGNA PROVIDES VIRTUAL CARE SERVICES AS PART OF YOUR MEDICAL PLAN, INCLUDING BEHAVIORAL/MENTAL HEALTH CARE, PRIMARY CARE, URGENT CARE, AND DERMATOLOGY, ALL ACCESSED FROM MDLIVE VIA MYCIGNA.COM

- **Choose when:** Day or night, weekdays, weekends and holidays.
- **Choose where:** Home, work or on the go.
- **Choose how:** Phone or video chat.
- **Choose who:** MDLIVE doctors.

If you pre-register on MDLIVE, you can speak with a doctor for help with:

- Sore throat, headache, fever
- Stomach ache, cold and flu
- Allergies, rash
- Urinary Tract Infection
- Depression
- Parenting issues & more

The Cost and Savings are Clear

Televisits with MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center and cost less than going to the emergency room -- **there is NO cost for a phone or online urgent care visit**. Remember, your virtual care services are only available for minor, non-life threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

Virtual Wellness Screenings*

Choose with Confidence

Register today so you'll be ready to use a virtual care service when and where you need it.

myCigna.com
or
888.726.3171

Availability may vary by location and plan type and is subject to change.

Enrollment in a BPS medical plan includes convenient and HIPAA-compliant virtual wellness screenings though MDLIVE. Simply make an appointment online and visit a lab for your blood work and biometrics. The rest is completed online via video or phone.

Follow these steps to complete your screening:

- Complete the MDLIVE online health assessment.
- Choose an in-network Lab **(Lab work must be completed 3 days prior to virtual doctor visit.)** and schedule an appointment.
- Choose an MDLIVE provider and schedule the virtual visit.
- Go to lab appointment. You will receive a notification when the results are available in the MDLIVE customer portal.
- Attend the virtual visit from anywhere via phone or video. You will receive a summary of the screening results for your records.

*__NOTE__: These screenings apply towards a reduced BPS medical plan deductible.

Get the most from the benefits offered through your employer.

For Brevard Public Schools plan participants and their covered family members.

Life can be busy and complicated

As part of BPS's health plan, you get access to a variety of programs and services to help make your life easier – and healthier.

Cigna One Guide

The Cigna One Guide® service can help you make smarter, informed choices and get health-related recommendations based on what matters most to you. It's our highest level of support that combines the ease of a powerful app with the personal touch of live service. One Guide personal support tools and reminders can help you stay healthy and save money.

During the pre-enrollment period, you can call the One Guide team at **800.244.6224** for help with all your questions about available health plans and coverage. After enrollment, One Guide continues to offer ongoing support to help you:

Understand your plan

- Know your coverage and how it works
- Get answers to all your healthcare or plan questions

Get care

- Find an in-network doctor, lab, or urgent care center
- Connect to health coaches, pharmacists, and more
- Stay on track with appointments and preventive care
- Take advantage of dedicated one-on-one support for complex health situations

Save and earn

- Maximize your benefits and earn incentives (if provided by your employer)
- Get cost estimates and service comparisons to avoid surprises
- Check account balances and claim activity to manage expenses

Once you have enrolled, start using the Cigna One Guide support service by downloading the enhanced myCigna App, click to chat, or by phone.

MyCigna

Nothing is more important than your good health.

That's why there's the myCigna website – your online home for assessment tools, plan management, medical updates, and much more. On myCigna.com you can:

- Find in-network doctors, dentists, and medical services
- View ID card information
- Review your coverage
- See how much your medication will cost you at the different pharmacies in your network
- Manage and track claims
- Order refills or talk with a pharmacist at Cigna Home Delivery Pharmacy℠
- Compare prescription drug prices
- Compare cost and quality information for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Sign up to receive alerts when new plan documents are available
- Track your account balances and deductible

Download the myCigna App and access your account with just a fingerprint on any compatible device.

24/7 Customer Assistance

Anytime you need us, feel free to call the toll-free number printed on the back of your Cigna ID card.

- You can reach us 24 hours a day, 7 days a week.
- You can get answers to your health, claims and benefit questions.
- Ask for a Spanish-speaking service representative or someone who can translate one of 200 languages.
- You can order an ID card, update insurance information, and check claim status.

24/7 customer assistance is available for medical and dental plan customers only.

Health Information Line

Call the Health Information Line available 24 hours a day, 7 days a week. Speak with a clinician trained as a nurse who is ready to provide medical guidance and help answer health questions like how to treat a twisted ankle or child's fever. This toll-free number is printed on the back of your Cigna ID card.

- Get information to help you decide where and when you should get treatment for your immediate care needs.
- Call if you need general health information or have a specific health concern.
- You can also listen to hundreds of podcasts to help you stay informed about your health.

Select a topic and listen via live-stream on your computer at myCigna.com.

You can use telehealth for 24/7 care

Cigna Telehealth Connection lets you get the care you need – including most prescriptions (when appropriate) – for a wide range of minor conditions. You can connect with a board-certified provider via video chat or phone, when, where, and how it works best for you.

- **Choose when:** 24/7/365. Day or night, weekdays, weekends, and holidays.
- **Choose where:** Home, work, or on the go.
- **Choose how:** Phone or video chat.

Cigna Lifestyle Management Programs

If weight, tobacco, or stress is affecting your health or your ability to live an active life, it may be time to make some changes. A health coach can provide you with personalized support to help you:

- Learn to manage your weight using a non-diet approach that helps you build confidence, change habits, eat healthier and become more active.
- Develop a personal quit plan to become and remain tobacco-free.
- Understand the sources of your stress, and learn to use coping techniques to better manage stress both on and off the job.

You can use an online or telephone coaching program – or both – for the support you need.

Weight Management

If issues about your weight are affecting your health or your ability to live an active life, it may be time to make some changes. A health advocate can provide you with personalized support to help you learn to manage your weight using a non-diet approach that helps you build confidence, change habits, eat healthier, and become more active.

Use an online or telephone coaching program – or both – for the support you need.

Tobacco Cessation

If your use of tobacco is affecting your health or your ability to live an active life, it may be time to make some changes. A health advocate can provide you with personalized support to help you develop a personal quit plan to become and remain tobacco-free.

Use an online or telephone coaching program – or both – for the support you need.

Stress Management

If daily stress is affecting your health or your ability to live an active life, it may be time to make some changes. A health advocate can provide you with personalized support to help you understand the sources of your stress, and learn to use coping techniques to better manage stress both on and off the job.

Use an online or telephone coaching program – or both – for the support you need.

Health Assessment

Taking a health assessment is a quick and easy way to learn more about your health today, and to figure out how you can improve your health in the future. After all, when you're healthy, you have the strength and confidence to be your true self. After completing the health assessment, you'll get a wellness score and recommendations to help you get started on a path to better health. Share your report with your doctor at your next visit.

Because the information learned through a health assessment can be such a valuable tool, your employer may give you an opportunity to complete it before you enroll in your medical plan.

You may receive an incentive for completing the health assessment, which may reduce the amount you will have to pay for your benefits (if offered by your employer).

Cigna Healthy Rewards®

Get discounts on the health products and programs you use every day for:

- Weight management and nutrition
- Fitness clubs and equipment
- Mind/body programs and equipment
- Vision and hearing care
- Alternative medicine
- Health and wellness products

Just use your Cigna ID card when you pay and let the savings begin.

Annual Physical

Knowing certain test results will help you and your doctor better understand your health and where you might need to make improvements. Be sure to get the right screenings/bloodwork during an annual physical, and remember your numbers for:

- Blood pressure ideally should be lower than 120/80
- Body Mass Index (BMI) will vary by gender and age, but generally a normal BMI falls between 18.5 and 24.9
- Desirable lipid profile values include: Total cholesterol < 200; LDL – cholesterol < 100
- HDL – cholesterol > = 40 for men and > = 50 for women; triglycerides < 150

These numbers will also be helpful when you take the health assessment – another great tool to help you manage your health. These numbers are general guidelines only and you should speak with your doctor about appropriate treatment, testing and care recommendations.

Flu vaccinations

Help protect yourself against the flu. One of the best ways to avoid catching the flu is to get vaccinated. Germs spread fast, especially around the workplace, so help protect yourself and others by getting a flu shot.

Onsite health

When you're juggling work and life, finding the time to focus on your health can be hard. Cigna Onsite Health makes it easier. We bring health care resources right to your workplace to help you take the right steps toward a healthier life. Your onsite health program offers health coaching.

Health coaching

You can schedule an appointment with an onsite health coach for one-on-one, face-to-face support to help you reach your health goals.

Preventive care

Getting and staying healthy is important. That's why most health plans include coverage for eligible preventive care services at no additional cost to you, when you receive them from a doctor who participates in your plan's network.

This means no money taken from your account and no out-of-pocket costs to you. Covered preventive care services can include, but are not limited to:

- Blood pressure screenings
- Cholesterol screenings
- Diabetes screenings
- Testing for colon/rectal cancer
- Clinical breast exams
- Pap tests
- Mammograms

Cigna Veteran Support Line

This free hotline is available 24/7/365 to all veterans, their families and caregivers. No need to be a Cigna customer. Call Cigna's hotline at 855.244.6211 to get connected with:

- Pain management resources
- Substance use counseling
- Financial support
- Aging services
- Food, clothing, housing
- Legal assistance
- Parenting and child care
- Weekly Mindfulness for Vets phone sessions & more

Questions

Want to learn more about these programs and services – as well as the many other benefits in your health plan?

Call 800.Cigna24 (800.244.6224)

Visit myCigna.com once your coverage begins.

TAKE PART IN THE CIGNA HEALTHY PREGNANCIES, HEALTHY BABIES PROGRAM AND EARN A REWARD

You're pregnant

You're going to be choosing a name. Looking for a healthcare provider for your baby. And seeing big changes – to your body and your life.

Where do you start?

Sign up for the Cigna Healthy Pregnancies, Healthy Babies® program, designed to help you and your baby stay healthy during your pregnancy, and in the days and weeks after your baby's birth.

Find support early and often.

- Tell us about you and your pregnancy, so we can meet your needs.
- Ask us anything – our maternity specialists have nursing experience and are here to support you during your whole pregnancy.
- Connect with us through the Cigna Healthy Pregnancy® app. This valuable resource offers you an easy way to track and learn about your pregnancy. It also provides support for baby's first two years.

Use the app to:

- Click to call a Cigna maternity specialist or case manager.
- Keep a list of things to talk about with your provider, and set reminders.
- Watch educational videos about your baby's weekly development.
- Get personalized notifications on developmental milestones and to-dos for baby's first two years.
- View our expanded content library with helpful information on topics such as behavioral health, loneliness, gun safety, coping with loss, and pediatrics for baby's first two years.
- Add toddlers (age 0–2) to your profile and receive new specific content just for them.

Get rewarded for a good decision

When you enroll in Cigna Healthy Pregnancies, Healthy Babies and complete the program, including your postpartum check-in, you'll be eligible to receive a:

$150 GIFT CARD - if you enroll in the first trimester.

Or

$75 GIFT CARD - if you enroll in the second trimester.

Enroll today.
Call 800.615.2906

MARATHON HEALTH EMPLOYEE WELL-CARE CENTERS

Log in and explore all the resources available to you at: https://member.ourhealth.org/sign_in

Appointment Details

Eligible members can schedule appointments at any of the three Well-Care Centers.

Call any of the three Well-Care Centers or **log on to the Marathon eHealth Portal** to make an appointment. Same-day appointments may be available.

Appointments typically last 20-30 minutes.

Please bring your insurance card and photo ID to your appointment.

There is no charge for the healthcare services provided at the Well-Care Centers, however, some lab tests may require additional payment. Contact the Well-Care Center for questions about fees.

The Well-Care Centers carry commonly-prescribed medications, which can be dispensed during your appointment for no charge after diagnosis from a Well-Care Center provider. Additionally, 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.

Locations

Central

ESF Overflow Parking Lot
2694 Judge Fran Jamieson Way
Melbourne, FL 32940
321.252.1169
Mon/Tues: 6:30 a.m. - 5:00 p.m.
Wed/Thu: 6:30 a.m. - 7:00 p.m.
Fri: 7:00 a.m. - 7:00 p.m.
Saturday: 8:00 a.m. - 1:30 p.m.

South

Central Middle School
2550 Wingate Blvd.
West Melbourne, FL 32904
321.369.9514
Mon/Wed: 9:00 a.m. - 6:00 p.m.
Tue/Thu: 6:30 a.m.- 5:30 p.m.
Fri: 10:00 a.m. - 2:00 p.m.

North

Jackson Middle School
1505 Knox McRae Drive
Titusville, FL 32780
321.222.9070
Mon/Thurs: 7:00 a.m. - 6:00 p.m.
Tue/Wed/Fri: 7:00 a.m. - 7:00 p.m.
Saturday: 8:00 a.m. - 1:30 p.m.

MARATHON HEALTH EMPLOYEE WELL-CARE CENTERS

The Well-Care Centers

BPS offers all employees and their families (age 6+, enrolled in the BPS health plan) access to receive medical care at one of three on-site health 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 drugs dispensed on site by the center's medical provider.

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.

The Marathon eHealth Portal

In addition to the on-site centers, personalized healthcare is accessible via the Marathon eHealth Portal and helps you get the most out of your new healthcare benefit. The eHealth Portal is one of the most important stops on your journey to better health. Use it to schedule appointments, view your health record, communicate with clinicians, and learn more about health conditions.

As a member of the BPS health plan, you, your spouse, and your kids ages 6 and up can take advantage of a wide range of personalized, confidential healthcare services at no cost including:

Common Illness

- Allergies
- Digestive problems
- Eye irritations and Infections
- Headaches
- Respiratory issues
- Skin conditions
- Urinary symptoms

Minor Injury

- Back pain
- Burns
- Extremity pain
- Joint pain
- Sprains & strains

Health Assessment

- Blood pressure
- Cholesterol
- Glucose
- Height
- Physicals
- Weight

Health Coaching

- Nutrition
- Physical activity
- Smoking cessation
- Stress management
- Weight loss

Chronic Conditions

- Asthma
- Depression
- Diabetes
- Heart conditions
- High blood pressure
- Low back pain

For a list of medications available onsite at all BPS well-centers please visit: https://www.brevardschools.org/cms/lib/FL02201431/Centricity//Domain/1149/Well-Care%20Centers%20Onsite%20Medication%20List_August%202022.pdf

Primary Care Services

Common health concerns, including illnesses and minor injuries. Also includes health screenings, lab tests, and dispensing of common medications, including prescriptions for conditions treated at the centers. (Available to eligible employees and retirees).

Understand Health

Through biometric tests and health assessment questionnaires, healthcare providers can draw attention to health risks and answer questions about concerns.

Wellness Plans

Wellness plans are like road maps to help people manage chronic conditions. They also address concerns about stress, diet, exercise, smoking, and other factors that impact health.

WELLNESS

Save $1,000 on an Individual deductible or $2,000 on a Family Deductible!

For employees who do not fall into one of the three categories noted below, here's how *you* can save money on your medical plan deductible: complete **BOTH** an Annual Physical (1st) and Cigna Health Assessment (2nd) in order and by the designated deadline of August 31st, 2024.

Annual Physicals can be completed at any of the three BPS Employee Well-Care Centers and are free. You can log-in to schedule an Annual Physical appointment at **https://member.ourhealth.org/sign_in** or call one of the locations listed above. You may also have an Annual Physical performed by your own primary care doctor. Annual Physicals with in-network doctors are free. If you are newly enrolling for medical coverage, you must wait until your benefits are effective to schedule an Annual Physical.

If you are currently enrolled for medical coverage, a Cigna Health Assessment at **mycigna.com**, can be completed at any time. If you are newly enrolling for medical coverage, you must wait until your benefits are effective to complete a 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.

As noted above, the three categories are: 1) new employees, 2) current employees who enroll for medical coverage due to a Qualifying Event, and 3) employees newly electing medical coverage during Open Enrollment. If you're in one of these, then your opportunity to complete two wellness activities – a routine Annual Physical and a Health Assessment at **mycigna.com** – in order to earn a reduced medical plan deductible for the current and following year, is as follows:

1. **New employees** will have 30 days from their benefits effective date.
2. **Current employees who experience a Qualifying Event** must notify the benefits department of the event within 30 days of its occurrence and receive approval to make benefit change.
    - If the approved benefit change will include the election of medical coverage where medical coverage doesn't already exist, then the newly-covered employee and/or spouse will have 30 days from the effective date of their medical coverage to complete the two wellness activities.
3. **During Open Enrollment:** Employees (and spouses if applicable) who currently do not have medical coverage and elect it during Open Enrollment will have the opportunity to complete the two wellness activities between January 1 and January 31 following Open Enrollment. This would earn a reduced deductible for the new year and the following year.



2024 BPS MOTIVATEME® INCENTIVE PROGRAM

Program Effective Date: 9/1/2023 - 8/31/2024
(90 day run-out) for Employees and covered Spouses

Current Incentives to Earn: Employee & covered Spouse must complete a Health Assessment & Annual Physical for 2025 medical plan reward (subject to change)

Gift Card Incentive Rewards: Employee Maximum: $75 & Spouse Maximum: $50

Goal	Value (Employee/ Spouse)	Timeframe	Eligible Participants	Additional Information
Health Assessment (must complete to earn other rewards)		9/1/2023 - 8/31/2024	Employee & Spouse	For 2025 Medical Plan Reward: **Complete the myCigna.com online personalized Health Assessment. Automatically updated via myCigna.**
Annual Physical (must complete to earn other rewards)		9/1/2023 - 8/31/2024	Employee & Spouse	For 2025 Medical Plan Reward: **Complete Annual Physical preventive exam with your PCP, Marathon Well-Care Centers, or MDLive Virtual Wellness Screening. Verified by claims.**
Tobacco Cessation Coaching Completion	Remove Tobacco Surcharge	9/1/2023 - 8/31/2024	Employee & Spouse	Get help for tobacco cessation with Cigna telephonic coach or onsite Health Coach, Joni.
Biometric Outcome Goals	$25/$10	9/1/2023 - 8/31/2024	Employee & Spouse	Achieve a Healthy cholesterol ratio; a healthy fasting or non-fasting blood sugar level, healthy blood pressure (1x each).
Preventive Care Screenings	$25/$10	9/1/2023 - 8/31/2024	Employee & Spouse	Complete age appropriate preventive screenings: Mammogram, Cervical, Colon, Prostate, Well Woman exam. Claims verified by screening codes.

Goal	Value (Employee/ Spouse)	Timeframe	Eligible Participants	Additional Information
Telephonic Health Coaching	$10/$10	9/1/2023-8/31/2024	Employee & Spouse	Get help improving lifestyle habits for weight and/or stress with Cigna telephonic coach or onsite Cigna Health Coach, Joni.
Dental Cleaning; Vision Exam*	$10/$10	9/1/2023-8/31/2024	Employee & Spouse	Members 2 self-report goals: Dental Cleaning (1x max); Vision exam (1x max).
Fill Your Prescriptions Through Home Delivery	$10	9/1/2023-8/31/2024	Employee & Spouse	Make life easier and switch to home delivery for your maintenance medications through Express Scripts Pharmacy®, our home delivery pharmacy. Get a 90-day supply delivered right to your home–at no extra cost.
BPS Customized Health & Wellness*	$5	9/1/2023-8/31/2024	Employee & Spouse	Members self-report goal: Participate in a health or benefit education seminar (max of 3).
BPS Sponsored 5k*	$5/$5	9/1/2023-8/31/2024	Employee & Spouse	Members self-report goal: Participate in BPS Sponsored 5k (max of 3).
Brevard Cigna Fitness Challenge	$25	9/1/2023-8/31/2024	Employee & Spouse	Complete the challenge by logging at least 30 minutes of exercise, at least 3 times per week, for any 3 weeks of the challenge.
Cigna Healthy Pregnancies, Healthy Babies® program	$150/$75 (1st trimester/ 2nd trimester)	9/1/2023-8/31/2024	Employee & Spouse	Speak with a maternity nurse starting in your 1st or 2nd trimester, and after your baby is born. Goal separate of Gift Card maximum cap.

*Self-reported goals subject to audit verification, and any discrepancies will be addressed with Human Resources.

*Incentives are funded by the employer and may be subject to taxes. Gift card merchant terms and conditions apply. Cigna is not responsible for lost or stolen gift cards. When required, Cigna will work with the customer (or their doctor) to allow for an incentive reward by different means if the customer is unable to meet a standard for a reward. Customers may also be entitled to a reasonable accommodation for participation, or an alternative standard for a reward, if they have a disability.

FLEXIBLE SPENDING ACCOUNT (FSA)

TASC

What is a Flexible Spending Account?

An FSA is an account that can reimburse you for qualified healthcare or dependent care expenses. You can fund qualified expenses with pre-tax dollars deducted from your paychecks.

FSA funds have a limited Rollover:
It is important to be conservative in making elections because **any unused funds left in your FSA at the close of the Plan Year are generally not refundable to you**. The only exception to this rule is for the Healthcare FSA where funds, up to $640, will carry over to the next plan year Healthcare FSA. Therefore, you are urged to monitor your account balances via the FlexSystem website or Interactive Voice Response System, to avoid having funds remaining in your account at year-end.

For both the Healthcare Flexible Spending Account and the Dependent Care Spending Account, you must submit claims **no later than 90 days** after the end of the Plan Year. The goal is to choose an amount that will cover medical or dependent care expenses, but that is not so high that the money will be forfeited at the end of the year.

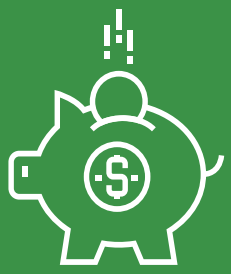
You can choose to participate in one or both accounts, and it's not necessary to "sign up" specific family members for these accounts.

You do not need to be enrolled in a BPS medical, dental, or vision plan to enroll in an FSA.

Healthcare FSA

A healthcare FSA reimburses employees for eligible medical expenses, up to the amount contributed for the plan year. Eligible healthcare expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. Visit **irs.gov** for a full list of eligible expenses.

For 2024, you may contribute up to $3,200 of your own funds annually. Funds will be available as of the election effective date.



Dependent Care FSA

You may use pre-tax dollars from your Dependent Care FSA to pay expenses for the care of a dependent child, spouse or elderly parent inside your home (from a qualified provider), and expenses outside your home, such as baby-sitters, nursery schools, or day care centers.

You may contribute up to $5,000 annually (or $2,500 if you are married and file a separate tax return). You can only be reimbursed up to the amount that you have contributed.

FLEXSYSTEM

As eligible expenses are incurred, you have two options to access your available FlexSystem FSA funds:

1. **TASC Benefits Card**

Upon enrollment into the Plan, you will receive a TASC Card in the mail, which can be used to pay for eligible expenses at the point of purchase. Simply swipe your TASC Card where credit cards are accepted.

With smart card technology, the TASC Card automatically pays for and substantiates most eligible expenses without requiring any paperwork.

2. **Request a Reimbursement**

Simply submit a request for reimbursement to FlexSystem using one of the following methods:

- Submit via **MyTASC MobileApp** (free download)
- Submit online at tasconline.com
- Download paper Request for Reimbursement form online

Your reimbursement is direct deposited into your MyCash account or a designated bank account. MyCash funds are accessible via your TASC Card to be used for any type of purchase or ATMcash withdrawal.

Pre-Tax Savings Example		
	Without FSA	With FSA
Gross Monthly Pay	$3,500	$3,500
FSA Pre-Tax Contributions	$0	-$150
Taxable Monthly Pay	$3,500	$3,350
Taxes (federal, state, FICA):	-$968	-$926
Take-home Pay	$2,532	$2,424
Out-of-pocket Expenses	$150	$0
Net Take-home Pay	$2,382	$2,424

Savings with FSA = $42/month!
For illustration only. Actual dollar amounts may vary.

SUPPLEMENTAL HEALTH BENEFITS

The Standard

Our medical plans provide great coverage for you and your family's healthcare needs. Still, everyone's needs are slightly 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. These benefits are offered to you through The Standard. Please visit standard.com/individual for additional details.

Accident Insurance

Accident plans pay cash benefits directly to you to help pick up some of the costs remaining after your health insurance plan kicks in following a covered accident.

Critical Illness Insurance

Critical illness insurance helps protect your income and personal assets when out-of-pocket expenses increase as a result of a specified illness. This plan covers conditions like: heart attack, stroke, end stage renal failure, invasive cancer, and more.

Hospital Indemnity Insurance

An unexpected or even planned stay in the hospital can be expensive as you meet your deductible and out-of-pocket obligations under the medical plan. The Hospital Indemnity plan is designed to provide financial protection by paying you a direct benefit to meet out-of-pocket expenses and extra bills that can occur. Lump sum benefits are paid directly to you based on the type of facility and number of days of confinement.

Health Maintenance Screening Benefit

If you are enrolled in Accident Insurance and/or Critical Illness Insurance, you can receive a Health Maintenance Screening Benefit if you or your dependent have a health maintenance screening performed during the calendar year. The benefit is $50 per line of coverage, so if you are enrolled in Accident Insurance and Critical Illness Insurance, you can receive $100 per calendar year after completing a health maintenance screening.

SUPPLEMENTAL HEALTH BENEFITS

	Monthly Premiums	
	Accident	**Hospital Indemnity**
Employee:	$12.14	$23.55
Employee + Spouse	$19.13	$49.12
Employee + Children	$22.76	$46.37
Family	$35.72	$77.10

FOR ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY INSURANCE: These benefits are under limited benefit insurance policies. These policies are a supplement to health insurance and are not a substitute for major medical coverage. They are not intended to satisfy the individual mandate of the Affordable Care Act (ACA) or provide the minimum essential coverage required by the ACA. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with your taxes.

Critical Illness Monthly Premiums

(More rate options will appear in the enrollment portal)

Employee Non-Tobacco

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$2.50	$3.10	$3.70	$4.90	$6.90	$9.90	$14.20	$19.40	$27.20	$37.40	$52.00
$20,000	$5.00	$6.20	$7.40	$9.80	$13.80	$19.80	$28.40	$38.80	$54.40	$74.80	$104.00
$30,000	$7.50	9.30	$11.10	$14.70	$20.70	$29.70	$42.60	$58.20	$81.60	$112.20	$156.00

Employee Tobacco

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$10,000	$2.70	$3.30	$4.30	$6.10	$9.80	$15.60	$24.90	$37.10	$56.40	$82.20	$110.40
$20,000	$5.40	$6.60	$8.60	$12.20	$19.60	$31.20	$49.80	$74.20	$112.80	$164.40	$220.80
$30,000	$8.10	$9.90	$12.90	$18.30	$29.40	$46.80	$74.70	$111.30	$169.20	$246.60	$331.20

Spouse Non-Tobacco

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$5,000	$1.25	$1.55	$1.85	$2.45	$3.45	$4.95	$7.10	$9.70	$13.60	$18.70	$26.00
$10,000	$2.50	$3.10	$3.70	$4.90	$6.90	$9.90	$14.20	$19.40	$27.20	$37.40	$52.00
$15,000	$3.75	$4.65	$5.55	$7.35	$10.35	$14.85	$21.30	$29.10	$40.80	$56.10	$78.00

Spouse Tobacco

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
$5,000	$1.35	$1.65	$2.15	$3.05	$4.90	$7.80	$12.45	$18.55	$28.20	$41.10	$55.20
$10,000	$2.70	$3.30	$4.30	$6.10	$9.80	$15.60	$24.90	$37.10	$56.40	$82.20	$110.40
$15,000	$4.05	$4.95	$6.45	$9.15	$14.70	$23.40	$37.35	$55.65	$84.60	$123.30	$165.60

DENTAL — HMO

Humana.

humana.com

Member Services: 800.233.4013

Humana

To locate an in-network provider, please visit humana.com. When enrolling for this plan, you'll need to put the office ID number of your selected office in the designated field of the enrollment screen.

	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

Humana

How to Find a Primary Dentist – go to Humana.com

1. Choose “Shop for Plan” and click “Find a Dentist” from the drop down menu.
2. Click “Find a Dentist”.
3. Enter your in 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 Dentists who is accepting new patients!

If I am enrolled in the DHMO, what if I don’t choose a Primary Care Dentist (PCD)?

You will receive a letter from Humana informing you that a PCD needs to be assigned. Your member ID card will indicate “unassigned” until you select a Primary Care Dentist. The member services phone number will be on the ID card. 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 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.

DENTAL — PPO

Humana.

Humana

humana.com

Member Services: 800.233.4013

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less. **If you choose an out-of-network provider, you may be billed the difference between what Humana pays, and what your out-of-network provider charges for the services.** To locate an in-network provider, please visit humana.com.

	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	Maximum Allowable Fee	N/A	UCR 90th

Plan includes out-of-network benefits, see plan summary for additional details.
*If you choose an out-of-network provider, you may be billed the difference between what Humana pays, and what your out-of-network provider charges for the services.

Program Features:

- 4 cleanings per year
- 4 periodontal cleanings covered 100% 4 times per year
- 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

humana.com

Member Services: 877.398.2980

Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around the Humana providers, who have higher benefits at a lower cost to you. When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. To locate an in-network provider, visit humana.com.

	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

GROUP TERM LIFE AND AD&D

standard.com/individual

Member Services: 800.325.5757

The Standard

BPS provides Basic Life insurance at no cost to you! If you would like additional coverage, Voluntary Life and AD&D insurance is available to you, your spouse and your dependent children.
You must enroll in coverage for yourself in order to cover your spouse or children. If you don't enroll in Voluntary Life when it's first available to you, or elect an amount over the Guaranteed Issue, you will be required to complete an Evidence of Insurability (EOI) form.

Insurance coverage	Coverage Options	Additional Information
Basic Life	1x annual earnings to a maximum of $1,000,000. Guarantee Issue: $1,000,000	Coverage automatically provided to eligible employees at no cost to them. Coverage guaranteed – no proof of good health is required.
Additional Life	**Minimum Benefit:** Choice of 1-4x annual earnings, in increments of 1x. **Maximum Benefit:** $1,000,000. Guarantee Issue: $1,000,000	All coverage guaranteed for employees if elected within 10 days of initial eligibility, or within 30 days of a qualified family status change. An employee may increase his/her supplemental life coverage by one times annual earnings, provided the resulting amount doesn't exceed the plan max.
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	All coverage guaranteed for dependents of employees if elected within 10 days of initial eligibility period or within 30 days of a qualified family status change. Dependent coverage cannot exceed 100% of the employee's total amount of life coverage (Basic and Additional Life combined). Children are eligible from live birth until the end of the month in which they attain age 26 (See policy details for over age 26 coverage options). If both parents are employees, children may be covered by only one parent. If your spouse or child is eligible for coverage as an employee, they cannot be covered as a dependent.
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%	All coverage is guaranteed – no proof of good health is required. Family plan percentages reflect percentage of employee's AD&D coverage amount. **Family plan maximums:** Spouse: $250,000 Child: $50,000 Children are eligible from live birth until the end of the month in which they attain age 26

Coverage	Rate	
Additional Life	$0.220/$1,000/month	
Dependent Life	Spouse: $5,000/Child: $2,500 Spouse: $5,000/Child $5,000 Spouse: $10,000/Child $2,500 Spouse: $10,000/Child $5,000 Spouse: $25,000/Child $2,500 Spouse: $25,000/Child $5,000	$3.01/month $3.26/month $5.83/month $6.08/month $12.76/month $13.01/month
AD&D	$0.023/$1,000/month $0.032/$1,000/month	

How Much Life Insurance Do I Need?

Find help at The Standard's Benefit Scout site:

standard.com/individual

DISABILITY INSURANCE

The Standard

***SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.**

You have the opportunity to purchase Short-Term and/or Long-Term Disability insurance through The Standard. These plans give you income protection in the event you are ill or injured in a non-work related accident, and can't come to work. If you don't enroll in Disability coverage when it's first available, you will be required to complete an Evidence of Insurability (EOI) form.

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

Guaranteed Issue Offer: This coverage is offered to you without providing proof of good health only if you elect it during your initial eligibility period.

Important: New Employees may elect STD coverage without filling out a medical questionnaire. Current Employees electing for the first time will require a medical questionnaire to be completed. Coverage will be approved, or denied, by The Standard.

Eligibility: Regular full-time employees who work more than 25 hours.

Coverage Option: Replaces 60% of your eligible income during an approved disability leave following a waiting period.

Example STD Premium Calculation

Employee cost is $0.523 per $100 of annual salary.

Employee earning $35,000 per year with a pay frequency of 24 pays per year.

Calculation $35,000/100 x .523 divided by 24 (pay frequency) = $7.63 (per pay cost)

Calculation results are estimates only. Final deduction amount is determined by computer rounding.

Long-Term Disability Rate Chart (per $100 of annual salary)

LTD Premium					
AGE	LTD ONLY	Taken with STD	AGE	LTD ONLY	Taken with STD
<25	0.069	0.062	45-49	0.248	0.242
25-29	0.083	0.069	50-54	0.386	0.359
30-34	0.097	0.097	55-59	0.442	0.414
35-39	0.124	0.117	60-64	0.545	0.511
40-44	0.166	0.152	65+=	0.552	0.511

ADDITIONAL BENEFITS

Benefit	Description	Contact Information	Who pays?

Employee Assistance Program	We are pleased to offer an Employee Assistance Program to assist you and your family through difficult times.
	• 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.
	• You can also reach out to an experienced, certified counselor for help with balancing work and life issues. Just call and one of your 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.
	• Referrals available.
		Charles Nechtem Associates
		1.800.531.0200
		English/Spanish
		charlesnechtem.com
			Employer Paid.
			Free to all BPS employees.

Surgery Plus SurgeryPlus™	The SurgeryPlus™ Benefit is a supplemental benefit offered by BPS for planned, non-emergency surgeries that provides a personalized concierge experience through a dedicated Care Advocate, as well as 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.	Employer Paid. Free to Employees and 18+ dependents enrolled in a BPS medical plan.

ADDITIONAL BENEFITS

Benefit	Description	Contact information	Who pays?
Hinge Health Hinge Health	Hinge Health helps you conquer back and joint pain, recover from injuries, prepare for surgery, or stay healthy and pain free. Best of all, Hinge Health's programs are provided at no cost to you and your eligible dependents enrolled in a Cigna medical plan through Brevard Public Schools. 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 **hingehealth.com/mybrevard** If you have any questions, please feel free to email **hello@hingehealth.com** or call **855.902.2777**	Employer Paid. Free to employees and eligible dependents enrolled in a BPS medical plan.

FORMS

Below are all the forms related to the health and wellness programs offered. Click on the form you require and either save or print it. If you have any questions, please contact your benefits representative.

Affidavit – Medical Plan

Medical Plan Affidavit

Instructions to Change Your Beneficiary

Changing Beneficiary

Proof of Handicapped Disability

Verification of
Disabled Dependent Eligibility
(To be Completed by Employee)

Verification of
Disabled Dependent Eligibility
(To be Completed by Physician)

GLOSSARY OF TERMS

COPAYMENT: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

DEDUCTIBLE: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,000 deductible. After that, you share the cost with your plan by paying coinsurance.

FORMULARY: A list of prescription drugs covered by the plan. Also called a drug list.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): This is a type of medical plan that requires the member to reach a deductible prior to having services covered by coinsurance. All expenses paid by the member count toward the deductible and out-of-pocket maximum.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

FREQUENTLY ASKED QUESTIONS & ANSWERS

When will I receive my insurance ID cards?

It can take up to two weeks from your fifteenth (15th) day of employment for vendors to set your coverages up in their systems and send identification cards. Your medical, dental, and FSA cards will be sent separately from each vendor.

Who is included in the Calendar-Year-Deductible and Out-of-Pocket (OOP) Maximum when you refer to an "Individual" or "Two or more"?

To fulfill the requirements of the CYD and/or OOP Maximum, an individual BPS Health Plan member must incur the total amount for the "Individual." However, when you cover "Two or more" members through the BPS Health Plan, any combination of incurred amounts by any member will count toward the total amount.

If I'm a BPS employee, can I be covered for medical by my spouse or parent who also works for the school board and is benefit eligible?

If you become eligible for BPS benefits and are currently covered by your spouse for medical insurance, it is required that you select medical coverage for yourself and be removed as a dependent from your spouse's medical coverage. However, if you are a benefit-eligible BPS employee, until you reach age 26 you may be covered by your parent who is also a benefit-eligible BPS employee. These coverage provisions only apply to the medical plan; the BPS dental and vision plans allow you to be a covered dependent under your spouse's dental and vision coverage.

What is a spousal surcharge and a Medical Plan Affidavit?

The spousal surcharge of $250 per month is added for a spouse who has access to a medical plan through his or her employer yet is enrolled in the BPS Health Plan as the primary coverage. This surcharge will not apply if your spouse doesn't work, works for an employer who does not offer medical insurance, or if your spouse elects medical coverage through his or her employer but is also enrolled in medical coverage as a dependent under your plan. In the latter instance, your spouse's plan will be used as primary coverage, and the BPS Health Plan will be used as secondary coverage.

When you link your spouse to medical coverage during open enrollment, you will be guided to the online Medical Plan Affidavit to complete. If you are adding your spouse midyear with a qualifying event, then you **MUST** complete a paper Affidavit, sign it, and return the original document to the Office of Employee Benefits. Failure to complete the Affidavit within prescribed time frames results in the **automatic** application of the surcharge.

Why do I have to complete an Over-Age Dependent Affidavit?

The State of Florida mandates that group plans allow parents to keep children between 26 and 30 years of age on their health plan as long as the child is not married, has no children, has no other medical coverage, lives in Florida or, if not a Florida resident, is a full- or part-time student.

When you link an over-age child to medical, dental or vision coverage during open enrollment, you will be guided to the online dependent affidavit to complete. If you are adding your child midyear with a qualifying event, then you MUST complete a paper affidavit, sign it, and return the original document to the Office of Employee Benefits.

FREQUENTLY ASKED QUESTIONS & ANSWERS

What is a Tobacco-use surcharge and a Medical Plan Affidavit?

BPS maintains a Tobacco-use surcharge program. Use of any tobacco product by employees and spouses enrolled in a BPS medical plan will result in the $50/month surcharge being added to the medical premium.

You are required to complete the online Medical Plan Affidavit during Open Enrollment. If both you and your covered spouse use tobacco, only one surcharge will apply. However, both of you must complete the coaching in order to have the surcharge refunded. Please see page 6 for full details.

How do I determine if a medical service will be covered by the BPS Health Plan?

It is **YOUR responsibility** to confirm if a service will be covered by the health plan. A provider's office may or may not know the specifics of the BPS Health Plan. Whenever possible, you should contact Cigna's customer service at 800.244.6224 **BEFORE** you receive medical services if there is any question about coverage.

How are laboratory services covered?

Covered **in-network** laboratory expenses at a physician's office, independent lab, outpatient facility, and urgent care facility are paid at 100% by the plan. If lab work is performed at your physician's office, you will only be charged the office visit copay for that visit. In an emergency room setting, the plan pays **in-network** laboratory expenses at 80% after you have met your deductible.

How can I find a lab or health care provider in the BPS health plan network?

You can check for a laboratory or healthcare provider by signing on to our plan administrator's website http://www.cigna.com. You can also call Cigna's customer service number at 1.800.244.6224.

1. On the top left-hand corner, click on "Find Care & Costs"
2. **Click** on the link related to your search, e.g., "Doctor by Type" or "Health Facilities."
3. If not pre-selected, enter your desired search location. From there, you can search for providers.
4. The Gold Plan utilizes the **Open Access Plus (OAP)** network; the Silver Plan a client-specific network

You can also call Cigna's customer service number at 1.800.244.6224.

RETIREMENT

Ask yourself two questions:

1. Will I be able to live on half my salary at retirement?
2. Is my retirement investment planing getting me closer to where I want to be tomorrow?

If you don't know how to make your money grow, read and consider investing as described below:

- Voluntary Retirement Savings Plans
- 403(b) or 457(b) Tax Deferred Plans

What is a 403(b) or 457(b) Tax Deferred Investment?

Brevard Public Schools provides the opportunity for eligible employees* to make tax-sheltered investments through payroll deductions in accordance with Internal Revenue Code 403(b) and 457(b). You will not have to pay federal income tax on the money you invest until the money is withdrawn. This is a smart way to save money for retirement.

These plans allow employees to:

- Strengthen employee's financial future
- Save for retirement with tax advantages
- Contribute through payroll deductions
- Take it with them upon separation from BPS

*Special Note: Private contractors, appointed/elected trustees, school board members and student workers are not permitted to elect a voluntary retirement savings plan

QuickENROLL

Brevard Public Schools now offers an easy and quick 403(b) or 457(b) enrollment option called **QuickENROLL.** This new option helps employees enroll rapidly in a 403(b) or 457(b) retirement savings account without having to do a lot of personal research or initially meet with an Investment Provider Representative. You do not have to make an investment decision immediately and your contribution for this plan is deposited into a Guaranteed Income Fund (GIF), which has a guarantee of principal and interest crediting. Get started with **QuickENROLL**; the earlier you start saving for retirement, the better!

Simply complete the short enrollment process steps below or use the QR code with your smartphone, and you will be on your way to saving for your future retirement as soon as your next available payday.

Employees Currently Enrolled in a 403(b) or 457(b) Plan

Enhancements have been made to the 403(b) and 457(b) Salary Reduction Agreement (SRA) process. 403(b) and 457(b) Salary Reduction Agreements will be submitted online through ART, the Plan Administrators (TSA Consulting Group).

Website: https://www.tsacg.com/individual/art-help/

The online process eliminates the need for paper SRAs and allows around-the-clock access for employees. For further information regarding QuickENROLL and online SRAs, please visit or contact:

BREVARD PUBLIC SCHOOLS OFFICE OF RETIREMENT
321.633.1000 EXT. 260 | BREVARDSCHOOLS.ORG

Enrollment is as easy as 1, 2, 3

1. Log on to the website at **myquickenroll.com.**
2. Enter your basic information.
3. Choose your initial amount (you can make changes at any time).

QuickENROLL QR Code

As an employee, you have the choice of a **traditional defined Benefit Retirement Pension Plan** or a **defined Contribution Retirement Investment Plan**, both administered by the Florida Retirement System (FRS). They are both excellent plans to which both you and BPS contribute toward. Within 2 months of your date of hire, you will receive an **FRS Benefit Comparison Statement** in the mail with details about your choices.(*)

All new and current FRS members have a one-time “Second Election” opportunity to change from the Pension Plan to the Investment Plan or vice versa. Once your Second Election is made, you may not change plans again. Making a Second Election can have financial implications, so it’s recommended that members first contact the **MyFRS Financial Guidance Line** at **866.446.9377** before making this very important decision.

The Two Plans

The traditional **FRS Pension Plan** is a defined benefit plan designed for employees who want a guaranteed monthly retirement benefit. Your guaranteed benefit is based on a formula using your earnings, membership class, length of service, and average of your eight highest years of salary. Upon retirement, your benefit will be paid to you in monthly installments for the rest of your life.

The **FRS Investment Plan** is a defined contribution plan and is similar to a 401 (k) plan. It is designed for employees who want greater control over their retirement plan and flexibility in how their benefit is paid at retirement. Your retirement benefit will depend on how much had been contributed to your account, the performance of your investments, and the impact of account fees and expenses. When ready to withdraw your funds, you can choose from a variety of payment options.

From your date of hire, you have **8 months to decide** which Plan works best for you. While waiting for your enrollment information to arrive, you can access information on the BPS Retirement Web Page-New Employee Section: https://www.brevardschools.org/Domain/2189 Once there, you will find links to valuable information that will help you understand and compare the plans.

(*) If you previously worked for another FRS Employer and have already made your initial retirement plan choice, you may not receive an FRS Benefit Comparison Statement.

New Employees will receive from FRS

- A Personal Identification Number (PIN) to access your personal information on the MyFRS website (During your career and into retirement you will continue to use this same number, so write it down and keep in a safe place.)
- A comparison of the two FRS retirement plan options
- An FRS EZ Retirement Plan Enrollment Form
- Enrollment instructions (Once complete, mail or FAX to the address on the form.)

Educational Services

Free educational services are provided to all FRS members through the MyFRS Financial Guidance line. Once you receive your **PIN number**, the planners and counselors can help you understand the:

- Difference between the two FRS plans;
- Importance of retirement planning and anticipating future income needs; and
- Basics of investing and how to be an effective long-term investor.

Independent, experienced financial education firms provide the services for this program: Financial Engines® and Ernst and Young (EY). Neither is connected with retirement plans and they do not sell investment or insurance products, so there's no potential conflict of interest. Their goal is to help you make the best choice for you and your family's needs.

CONTACTS

Medical Plan(s)

Cigna

Member services: 800.244.6224
Pre-Enrollment: 888.806.5042
mycigna.com

Prescription Services

Cigna

Member services: 800.285.4812
mycigna.com

Wellness

Marathon Health

Central: 321.252.1169
South: 321.369.9514
North: 321.222.9070
https://member.ourhealth.org/sign_in

Onsite Cigna Health Coach:

Joni: 321.338.5955
Email: Josephina.Deblecourt-Whelen@evernorth.com

Onsite Cigna Customer Service Representative:

Laricia Eason
321.633.1000 x 11219

Dental

Humana

Member services: 800.233.4013
humana.com

Vision

Humana

Member services: 877.398.2980
humana.com

Employee Assistance Program

CN Associates

Member Services: 800.531.0200
charlesnechtem.com

Flexible Spending Account (FSA)

TASC

Member services: 800.422.4661
tasconline.com

Group Term Life & AD&D Insurance

The Standard

Customer Service: 800.325.5757
Supplemental Claims: 866.851.8505
standard.com/individual

Disability Insurance

The Standard

Member services: 800.325.5757
standard.com/individual

Accident, Critical Illness, and Hospital Indemnity

The Standard

Member services: 800.325.5757
standard.com/individual

Surgery Plus

Member services: 833.709.2441
brevardschools.surgeryplus.com

Hinge Health

Member Services: 855.902.2777
hingehealth.com/mybrevard

BPS Office of Employee Benefits

Benefit Specialist
Phone: 321.633.1000 ext. 11216
Email:
PSBenefitsWellnessandChoice@Brevardschools.org

Annual Notices can be found HERE

Benefits Education & Call Center

321.800.4490
M – F 9 a.m. – 9 p.m. EST
https://pesenroll.com/bps/

Email: BPS@pesenroll.com for any benefit questions

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

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