Southwest Florida
Water Management District

Terra Ceia Preserve State Park

2024 EMPLOYEE BENEFIT GUIDE

January 1, 2024 through December 31, 2024

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.

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Southwest Florida Water Management District

INTRODUCTION

The Southwest Florida Water Management District ("The District") provides a comprehensive compensation package including group insurance benefits. The Employee Benefit Guide provides a general summary of these benefit options as a convenient reference. Please refer to the carrier's Summary of Benefits and Coverage document and/or Certificates of Coverage on the Benefits page on Currents for detailed descriptions of all available employee benefit programs and stipulations therein. If you require further explanation or need assistance regarding claims processing, please refer to the customer service telephone numbers under each benefit description heading or contact the Human Resources Office for further information.

ELIGIBILITY GUIDELINES

Employee Eligibility

Southwest Florida Water Management District benefit plan year is from January 1st through December 31st. Employees are eligible to participate in the District's group insurance plans and may elect coverage which will be effective the first of the month following their date of hire. For example, if employee is hired on June 11, then the effective date of coverage will be July 1.

- **Regular Employee:** Employee filling a regular board-authorized position that is normally scheduled to work 40 hours per week.
- **District Couple:** Married couple, both employed by the Southwest Florida Water Management District.
- **Primary Payer:** In a District Couple, employee from whose pay employee contribution is deducted.
- **Secondary Payer:** In a District Couple, employee for whom the District makes contributions, but makes no contributions.
- **Administrative Pay:** Employee eligible to receive Administrative Pay benefits (Assistant Bureau Chief, Bureau Chief, Office Chief, Assistant Division Director, Deputy General Counsel).
- **Administrative Pay EXE (Admin Pay EXE):** Employee eligible to receive Administrative Pay Executive benefits (Division Director, Assistant Executive Director, Executive Director, Inspector General, General Counsel).

Termination

If employee separates employment from the District, medical, dental and vision insurance benefits will continue through the end of month in which separation occurred. COBRA continuation of coverage may be available as applicable by law. The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance program that allows eligible employees and their dependents to continue benefits of their coverage when an employee separates employment.

ELIGIBILITY GUIDELINES (continued)

Dependent Eligibility

A dependent is defined as the participant's legal spouse and dependent child(ren) of the participant or spouse. The term "child" includes any of the following:

- A natural child
- A legally adopted child
- A stepchild
- A newborn (up to age 18 months) of a covered dependent (Florida)
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse

Please note: Dependent eligibility documentation is required.

Dependent Age Requirements

Medical

- A dependent child may be covered through the end of the calendar year in which the child turns age 26.
- An overage dependent may continue to be covered on the medical plan to the end of the calendar year in which the child reaches age 30, if the dependent meets the following requirements:
  - Unmarried with no dependents; and
  - A Florida resident, or full-time or part-time student; and
  - Otherwise uninsured; and
  - Not entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the child is disabled.

Dental & Vision

- A dependent child may be covered through the end of calendar year in which the child turns age 26.

Voluntary Life

- A dependent child may be covered through the end of calendar year in which the child turns age 26.

Disabled Dependents

Coverage for an unmarried dependent child may be continued beyond age 26 if:

- The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26); and
- Primarily dependent upon the employee for support; and
- The dependent has been continuously insured; and
- Coverage with the District began prior to age 26.

Proof of disability may be required; please contact the Human Resources Office if further clarification is needed.

ELIGIBILITY GUIDELINES (continued)

Taxable Dependents

Employees covering adult child(ren) under employee's medical insurance plan may continue to have the related coverage premiums payroll deducted on a pre-tax basis through the end of the calendar year in which dependent reaches age 26. Beginning January 1 of the calendar year in which the dependent reaches age 27 through the end of the calendar year in which dependent reaches age 30, imputed income for the value of the applicable adult child's premium for the coverage period must be reported on the employee's W-2. Imputed income is the dollar value of insurance coverage attributable to covering an adult child. There is no imputed income if an adult child is eligible to be claimed as a dependent for federal income tax purposes on employee's tax return. Check with the Human Resources Office for further details if employee is covering an adult child who will turn age 27 any time in the upcoming calendar year or for more information.

DISTRICT COUPLE PROGRAM

When both spouses are active District employees and have dependent(s), they are eligible for family medical and dental insurance coverage at a reduced cost. The District will make two (2) single contributions toward a family premium. Employee must complete the following steps in order to qualify for this Program:

- During Open Enrollment, employee who will pay the cost of the coverage by having the deduction made from employee's paycheck will select the option containing "District Couple Primary" from the available plan options. The other spouse will select the option indicating "District Couple Secondary."
- New enrollees in the program must provide a copy of their marriage certificate to the Human Resources Office.

Both spouses must notify the Human Resources Office, in writing, within 30 days of becoming ineligible for the Program. Employees become ineligible for the District Couple Program should any of the following occur:

- One or both employees terminate employment;
- The couple is divorced; or
- One or both employees retire.

Failure to contact the Human Resources Office in writing within 30 days may result in loss of coverage. Program participants who fail to notify the Human Resources Office of their ineligibility for the program will be liable for any premiums that were paid by the District during the time that they were not eligible.

MID-YEAR CHANGES

Premiums for medical, dental, vision insurance, contributions to FSA accounts, and/or certain supplemental policies are deducted through a Cafeteria Plan established under Section 125 of the Internal Revenue Code (IRC) and are pre-taxed to the extent permitted. Under Section 125, changes to your pre-tax benefits can be made ONLY during the Open Enrollment period unless you or your qualified dependents experience a qualifying event and the request to make a change is made within 30 days of the qualifying event. **An "eligible" qualifying event is determined by the Internal Revenue Service (IRS) Code, Section 125.**

Under certain circumstances, employees may be allowed to make changes to benefit elections during the plan year, if the event affects employee, spouse or dependent's eligibility for coverage. Any requested changes must be consistent with and due to the qualifying event.

Qualified Life Events include, but are not limited to:

- Change in marital status (marriage, divorce or death of a spouse)
- Change in employment status for employee, spouse or dependent (termination or starting employment)
- Change in employee's work hours causing eligibility or ineligibility
- Entitlement to Medicare
- Change in number of dependents (birth, adoption or death)
- Change in dependent eligibility due to plan requirements (loss of student status, age limit reached)
- Change in residence (employee or dependent moves out of plan service area)
- Losing or gaining eligibility for coverage under a State Medicaid or CHIP (including Florida Kid Care) program (60-day notification period)

IMPORTANT

*If employee experiences a qualifying event, the employee must submit the qualifying event in UKG **within 30 days** of the qualifying event to make the appropriate changes to coverage. Beyond 30 days, requests will be denied, and the employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of the employee or dependent who continues to be enrolled but no longer meets eligibility requirements. If approved, changes are effective on the first of the month following the qualifying event. Newborns are effective on the date of birth. Cancellations will be processed at the end of the month including divorce. In the event of death, coverage will terminate the date of death. Employees will be required to furnish valid documentation supporting a change in status of qualifying event within 30 days of the qualifying event.*

HOW TO ENROLL

The District provides employees with an online benefits enrollment platform through UKG. Employees can select or change insurance benefits online during the annual open enrollment period, new hire period or qualifying events. Accessible 24 hours a day throughout the year, employees may log in and review information regarding benefit plans, and view and print an outline of benefit elections. Employees have access to important forms, carrier links, can report qualifying life events, and review and make changes to life insurance beneficiary designations.

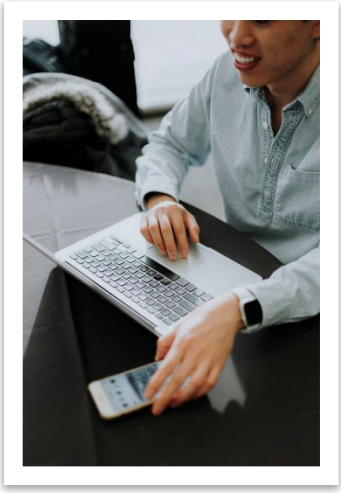
To Access the Online Enrollment through UKG:

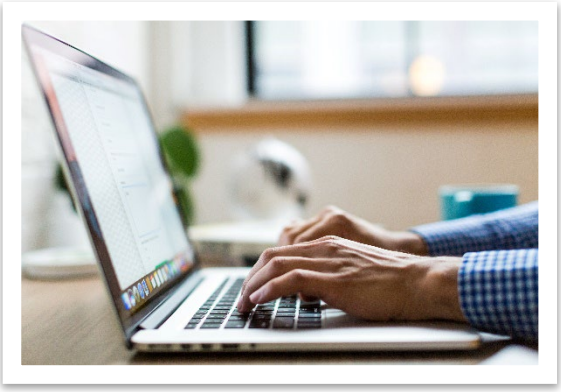
Step 1: Log on to https://ew44.ultipro.com

Step 2: Sign in using employee's work email address and unique password previously created by employee.

Note: If employee has forgotten password, click on the link “Forgot Your Password” and follow the instructions.

Step 3: Once logged on, navigate to Menu > Myself and select Open Enrollment, Benefits or Life Events to enroll or make changes.





MEDICAL INSURANCE

Aetna | (866) 253-0556 | www.aetna.com

The District provides medical insurance through Aetna to benefit-eligible employees. The premium costs for coverage are listed in the premium tables below and a summary of the plan's benefits are provided on the following pages. For more detailed information about the medical plans, please refer to Aetna's summary plan document or contact Aetna or the Human Resources Office.

Aetna Choice POS II High Deductible Health Plan (HDHP)

	Total Monthly Premium	District Share Monthly	Employee Share Monthly	Employee Semi-Monthly Deduction
Employee Only	$909.12	$909.12	$0.00	$0.00
Employee + 1 Dependent	$1,781.82	$1,766.82	$15.00	$7.50
Employee + Family	$1,963.66	$1,938.66	$25.00	$12.50
Administrative Pay: Employee Only*	$909.12	$909.12	$0.00	$0.00
Administrative Pay: Employee + 1 Dependent*	$1,781.82	$1,781.82	$0.00	$0.00
Administrative Pay: Employee + Family*	$1,963.66	$1,963.66	$0.00	$0.00

Aetna Choice POS II Copay Plan

	Total Monthly Premium	District Share Monthly	Employee Share Monthly	Employee Semi-Monthly Deduction
Employee Only	$1,096.16	$1,063.28	$32.88	$16.44
Employee + 1 Dependent	$2,148.44	$1,955.08	$193.36	$96.68
Employee + Family	$2,367.68	$2,154.58	$213.10	$106.55
District Couple: Employee + Family *(Primary Payer)*	$1,183.84	$1,006.26	$177.58	$88.79
District Couple: Employee + Family *(Secondary Payer)*	$1,183.84	$1,183.84	$0.00	$0.00
Administrative Pay: Employee Only*	$1,096.16	$1,085.18	$10.98	$5.49
Administrative Pay: Employee + 1 Dependent*	$2,148.44	$2,116.20	$32.24	$16.12
Administrative Pay: Employee + Family*	$2,367.68	$2,320.32	$47.36	$23.68

*A portion of these benefits provided to this class are subject to Federal Income, Social Security and Medicare taxes.

Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select **Choice POS** network.

AETNA HIGH DEDUCTIBLE MEDICAL PLAN (HDHP) CHOICE POS II PLAN

Group #: 237086	Aetna High Deductible Health Plan (HDHP)	
	Choice Plus Network	Out-of-Network*
Calendar Year Deductible (CYD)		
Single	$1,600	$3,000
Family	$3,200	$6,000
Coinsurance		
Member Responsibility	10%	40%
Calendar Year Out of Pocket Maximum (Includes Deductible, Copays, Coinsurance & Rx)		
Single	$3,000	$6,000
Family	$6,000	$12,000
Physician Services		
Physician Office Visit	10% After CYD	40% After CYD
Specialist Office Visit	10% After CYD	40% After CYD
Virtual Care	10% After CYD	Not covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Blood Work)**	CYD Only	40% After CYD
X-rays	10% After CYD	40% After CYD
Advanced Imaging (MRI, PET, CT)	10% After CYD	40% After CYD
Outpatient Surgery in Surgical Center	10% After CYD	40% After CYD
Physician Services at Surgical Center	10% After CYD	10% After In-Network CYD
Urgent Care (Per Visit)	10% After CYD	10% After In-Network CYD
Hearing Aids		
Hearing Aid Benefit	10% After CYD ($2,500 max every 3 years)	40% After CYD ($2,500 max every 3 years)
Hospital Services		
Emergency Room (Per Visit)	10% After CYD	10% After In-Network CYD
Inpatient (Per Admission)	10% After CYD	40% After CYD
Outpatient (Per Visit)	10% After CYD	40% After CYD
Physician Services at Hospital (Per Visit)	10% After CYD	10% After In-Network CYD
Mental Health / Alcohol & Substance Abuse		
Inpatient Hospitalization (Per Admission)	10% After CYD	40% After CYD
Outpatient Services (Per Visit)	10% After CYD	40% After CYD
Prescription Drugs		
Generic	$10 After CYD	50% After CYD
Preferred Brand Name	$30 After CYD	50% After CYD
Non-Preferred Brand Name	$50 After CYD	50% After CYD
CVS Caremark® Mail Order (90-Day Supply)	2x Retail Copay After CYD	Not Covered

For limitations, exclusions and a full listing of the covered benefits, please refer to the certificate of coverage or benefit summary

*For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the carrier's summary plan document.

**LabCorp or Quest Diagnostics is the preferred lab for blood work through Aetna. When using a lab other than LabCorp or Quest, please be sure to confirm they are contracted with Aetna's Choice network prior to receiving services.

AETNA MEDICAL COPAY PLAN

Group #: 237086	Copay Plan	
	Choice Plus Network	Out-of-Network*
Calendar Year Deductible (CYD)		
Single	$500	$500
Family	$1,500	$1,500
Coinsurance		
Member Responsibility	20%	40%
Calendar Year Out of Pocket Maximum (Includes Deductible, Copays & Coinsurance. Excludes Rx)		
Single	$3,000	$3,000
Family	$6,000	$6,000
Physician Services		
Physician Office Visit (Including Preventive)	$15 Copay	40% After CYD
Specialist Office Visit	$30 Copay	40% After CYD
Virtual Care	$15 Copay	Not covered
Non-Hospital Services; Freestanding Facility		
Clinical Lab (Blood Work)**	No Charge	40% After CYD
X-rays (Outpatient)	10% Coinsurance (CYD does not apply)	40% After CYD
Advanced Imaging (MRI, PET, CT)	$100 Copay	40% After CYD
Outpatient Surgery in Surgical Center	$100 Copay	40% After CYD
Physician Services at Surgical Center	20% After CYD	20% After In-Network CYD
Urgent Care (Per Visit)	$30 Copay	$30 Copay
Hearing Aids		
Hearing Aid Benefit	100% Covered After CYD ($2,500 max every 3 years)	40% After CYD ($2,500 max every 3 years)
Hospital Services		
Emergency Room (Waived if Admitted)	$100 Copay	$100 Copay
Inpatient (Per Admission)	$500 Copay	40% Coinsurance Only
Outpatient (Per Visit)	$150 Copay	$350 Copay
Physician Services at Hospital (Per Visit)	20% After CYD	20% After In-Network CYD
Mental Health / Alcohol & Substance Abuse		
Inpatient Hospitalization (Per Admission)	No Charge	20% Coinsurance Only
Outpatient Services (Per Visit)	No Charge	40% After CYD
Prescription Drugs		
Generic	$10 Copay	50% Coinsurance Only
Preferred Brand Name	$25 Copay	50% Coinsurance Only
Non-Preferred Brand Name	$40 Copay	50% Coinsurance Only
CVS Caremark® Mail Order (90-Day Supply)	2x Retail Copay After CYD	Not Covered

For limitations, exclusions and a full listing of the covered benefits, please refer to the certificate of coverage or benefit summary

*For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the carrier's summary plan document.

**LabCorp or Quest Diagnostics is the preferred lab for blood work through Aetna. When using a lab other than LabCorp or Quest, please be sure to confirm they are contracted with Aetna's Open Access Plus network prior to receiving services.

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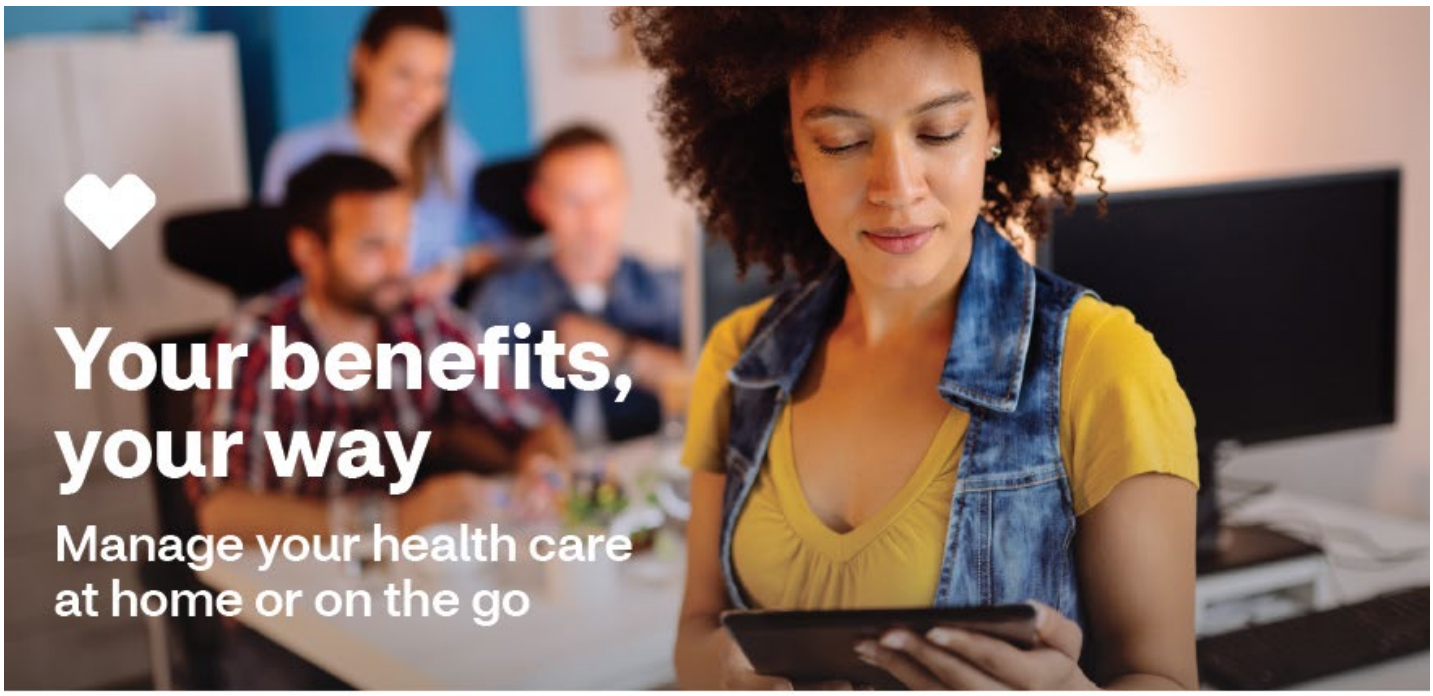

Stay on top of your benefits

- Review your benefits and what's covered.
- Track your spending.
- View and pay claims on your member website.
- See your ID card online.
- Get cost info before you get care.*

Connect to care

- Find in-network providers, including virtual care.
- Locate walk-in clinics and urgent care centers near you.
- See reviews of providers.

Get started today

Visit **MyAetnaWebsite.com** to register for your member website.

Get the **Aetna Health℠ app** by texting **"AETNA"** to **90156** to receive a download link. Message and data rates may apply.**

— OR —

Scan the QR code to download the **Aetna Health℠ app**.

*Estimated costs are not available in all markets or for all services. We provide an estimate for the amount you would owe for a particular service based on your plan at that very point in time. It is not a guarantee. Actual costs may differ from an estimate for various reasons including claims processing times for other services, providers joining or leaving our network or changes to your plan. Health maintenance organization (HMO) members can only get estimated costs for doctor and outpatient facility services.

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Aetna.com

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HOW TO FIND A PROVIDER

Use your custom provider search tool—in English or Spanish—to find doctors, hospitals and other health care providers that participate in the Aetna network. You'll also find useful information, such as:

- Whether your plans is accepted
- Office locations and directions
- Provider's gender, where they went to school, hospital affiliations and languages spoken
- Whether providers are accepting new patients

Multiple ways to search

You can search using a doctor or facility's name, or by:

- City, state, ZIP code
- Specialty
- Common procedure types, such as flu/vaccine shot or back care

You can even search for doctors who treat specific conditions.

Here's how it works:

1. Visit "Find a doctor" on Aetna.com, and under "Guests," choose "Plan from an employer."
2. Enter your home location (ZIP, city, county, or state) to access provider specific to plan benefits
3. Set range of miles around home location (up to 100-mile radius).
4. You can enter the name of the plan and search or scroll and pick the plan. If you do not know your potential plan offering, select "Skip Plan Selection."
5. Search by provider name or provider type. You'll also have the option to search by category: Medical Doctors & Specialist, Hospitals & Facilities, health, Dental Care, Labs & Testing, Alternative Medicine, Durable Medical Equipment, Common Procedures & Conditions, Institutes of Quality/Institutes of Excellence
6. Explore providers in list view or map view
7. If you can't find your provider, please call the Aetna Member Services number

Visit Aetna.com

Go to Aetna.com/individuals-families/find-a-doctor.html

MEDICAL INSURANCE PERKS

Available Plan Resources

Aetna offers all enrolled employees and dependents additional services and discounts through value added programs. For more details regarding other available plan resources, please contact Aetna's customer service at (888) 632-3862 or visit **www.aetna.com**.

Virtual Care

Aetna provides access to virtual care services as part of the medical plan. CVS Health Virtual Care offers convenient phone and video consultations to members where they can receive immediate medical assistance for many conditions.

The benefit is provided to all enrolled members. Registration is required and should be completed ahead of time. This program allows members 24 hours a day, seven (7) days a week on-demand access to a comprehensive suite of convenient virtual care options— available by phone or video whenever it works for you. Board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience and provide personalized care for hundreds of medical and behavioral health needs. Many urgent care ailments can be treated with virtual care, such as:

- Sore Throat
- Fever
- Rash
- Depression
- Headache
- Cold & Flu
- Acne
- Grief/Loss
- Stomachache
- Allergies
- UTIs
- Panic Disorders

Virtual care doctors do not replace employee's primary care physician but may be a convenient alternative for urgent care, ER visits, and wellness screenings. For further information, please contact Aetna or the Human Resources Office.

CVS Caremark Mail Service Pharmacy

Employees can elect to be a part of Aetna Home Delivery Pharmacy with CVS Caremark Mail Service where they will deliver the employee's medications at a location of the employee's choice. Standard shipping is free. These programs are great to utilize when taking maintenance medications. Maintenance medications are taken regularly over time to treat an ongoing health condition.

For more information about the CVS Caremark Mail Service, please contact customer service at (888) 792-3862 or visit **www.aetna.com.**

CVS MinuteClinic Care

Employees can access more than 1,150 CVS MinuteClinic locations to receive quick and convenient care either in person or virtually. Care is available 7 days a week, including evenings and employees can be treated for a variety of conditions, illness and injuries, such as: asthma and allergies, sore throat, diabetes, minor cuts and wounds and many other issues.

HEALTH SAVINGS ACCOUNT (HSA)

Payflex HSA | (844) 729-3539 | www.payflex.com

HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs).

The District's High Deductible Health Plan (HDHP) meets the Internal Revenue Service (IRS) requirements and qualifies enrollees to open a Health Savings Account (HSA). HSA is an interest-bearing account where funds can be used to help pay for employee's deductible, coinsurance and any medical expenses not covered by the plan. Employees can opt to fund their HSA via pre-taxed evenly dispersed payroll deductions or in a lump sum payroll deduction. Employee contributions to the HSA can also be made on an after-tax basis and taken as an above-the-line deduction on employee's tax return (making such contributions tax-free).

2024 IRS Contribution Limitations:

- **Individual Coverage**: $4,150
- **Family Coverage:** $8,300
- **Individuals age 55+:** Additional $1,000 catch-up contribution per year

District Funding for 2024:

- **Employee only coverage**: $1,000
- **Employee + Dependent coverage:** $1,500

Please Note: Amounts will be prorated for new employees hired within 2024 calendar year

What You Need to Know About Your HSA

- Employees own the HSA funds from day one.
- No "use it or lose it" rules like the FSA; funds are in the account when needed, now, or in the future. HSA Participants cannot fund into a traditional Health Care FSA; however, employee may fund into a Limited Purpose FSA for dental and vision expenses only.
- Only funds that have been payroll deducted and funded into the HSA may be used on eligible expenses.
- HSA funds may earn interest.
- HSA funds can be used tax-free on qualified expenses.
- HSA funds are portable from one employer to another.
- The District pays the monthly administration fee for the HSA while actively employed. However, other fees may apply as determined by the bank.
- To be eligible to open an HSA, the employee must be covered by a high deductible medical plan. Employee may not be covered under another medical plan, including the employee's spouse's coverage through another health plan.
- Account holders can track account balance and activity online at www.payflex.com.
- Account holders can withdraw funds with the HSA debit card.
- If the employee is enrolled in Medicare, TRICARE or TRICARE for Life, employee is not eligible to contribute funds into an HSA. In addition, the IRS prohibits the District from contributing HSA funds into employee's account.
- Active Employees not on Medicare but have a spouse enrolled in Medicare: Any active employee who is covering a spouse that is enrolled in Medicare will receive the full family HSA funding. These funds can be utilized for the active employee and spouse expenses.
- Active Employees on Medicare and have a spouse not enrolled in Medicare: Any active employee who is enrolled in Medicare and covering a spouse will not receive any HSA funding. Any remaining balance in the HSA can be utilized until there are no funds remaining.
- Accumulated funds can help plan for retirement.

Please Note: Eligibility status to qualify for an HSA is specifically driven by the District employee and not the dependents.

DENTAL INSURANCE

Aetna | (866) 253-0556 | www.aetna.com

The District offers dental insurance through Aetna to benefit-eligible employees. The premium costs for coverage are listed in the premium table and a brief summary of benefits is provided. For more detailed information about the dental plan, please refer to Aetna's summary plan document or contact Aetna's customer service.

Aetna Dental PPO Basic Plan

	Total Monthly Premium	District Share Monthly	Employee Share Monthly	Employee Semi-Monthly Deduction
Employee Only	$42.18	$39.16	$3.02	$1.51
Employee + 1 Dependent	$68.72	$52.42	$16.30	$8.15
Employee + Family	$90.38	$64.18	$26.20	$13.10
District Couple: Employee + Family *(Primary Payer)*	$50.38	$39.08	$11.30	$5.65
District Couple: Employee + Family *(Secondary Payer)*	$40.00	$40.00	$0.00	$0.00
Administrative Pay EXE: Employee Only*	$42.18	$42.18	$0.00	$0.00
Administrative Pay EXE: Employee + 1 Dependent*	$68.72	$68.72	$0.00	$0.00
Administrative Pay EXE: Employee + Family*	$90.38	$90.38	$0.00	$0.00

Aetna Dental PPO Premium Plan

	Total Monthly Premium	District Share Monthly	Employee Share Monthly	Employee Semi-Monthly Deduction
Employee Only	$50.16	$39.62	$10.54	$5.27
Employee + 1 Dependent	$81.64	$53.06	$28.58	$14.29
Employee + Family	$107.38	$64.44	$42.94	$21.47
District Couple: Employee + Family *(Primary Payer)*	$68.02	$40.46	$27.56	$13.78
District Couple: Employee + Family *(Secondary Payer)*	$39.36	$39.36	$0.00	$0.00
Administrative Pay EXE: Employee Only*	$50.16	$50.16	$0.00	$0.00
Administrative Pay EXE: Employee + 1 Dependent*	$81.64	$81.64	$0.00	$0.00
Administrative Pay EXE: Employee + Family*	$107.38	$107.38	$0.00	$0.00

*A portion of these benefits provided to this class are subject to Federal Income, Social Security and Medicare taxes.

Locate a Provider

To search for a participating provider, contact Aetna's customer service or visit www.aetna.com. When completing the necessary search criteria, select **Dental PPO/PDN with PPO II and Extend** network.

DENTAL INSURANCE

In-Network Benefits

Both Dental PPO plans provide benefits for services received from in-network and out-of-network providers. Both plans are open access plans which allow for services to be received from any dental provider without having to select a Primary Dental Provider (PDP) or obtain a referral to a specialist. The network of participating dental providers the plans utilize is Dental PPO/PDN with PPO II and Extend network. These participating dental providers have contractually agreed to accept Aetna's contracted fee or "allowed amount." This fee is the maximum amount an Aetna dental provider can charge a member for a service. The member is responsible for a Calendar Year Deductible (CYD) and then coinsurance based on the plan's charge limitations.

Out-of-Network Benefits

Out-of-network benefits are used when members receive services by a non-participating Aetna provider. Aetna reimburses out-of-network services based on what it determines is the Maximum Reimbursable Charge (MRC). The MRC is defined as the most common charge for a particular dental procedure performed in a specific geographic area. If services are received from an out-of-network dentist, the member will pay the out-of-network benefit plus the difference between the amount that Aetna reimburses (MRC) for such services and the amount charged by the dentist. This is known as balance billing. Balance billing is in addition to any applicable plan deductible or coinsurance responsibility.

Important Notes

- This summary has been provided as a convenient reference. For a full listing of covered services please refer to the plan's summary of benefits or contact Aetna's customer service .
- Waiting periods, frequency and/or age limitations for certain services may apply.
- For any dental work expected to cost $200 or more, it is suggested that you request a predetermination from your dental provider. This will assist with determining approximate out-of-pocket costs should employee have the dental work performed.

Aetna Dental Wellness Plus

The **Premium Dental PPO** plan includes a dental wellness benefit. This benefit increases the calendar year benefit maximum each year for members who receive preventive services within the calendar year. The benefit will increase to $2,500 for the second calendar year, to $2,900 for the third calendar year, and then to $3,300 for the fourth year. There is a maximum of 3 reward increases per member. The member is required to have at least one (1) preventive service within the current year to receive this increase for the next calendar year. If an employee fails to have at least one (1) preventive service in the calendar year, the calendar year maximum will stay the same. This is also true for your covered dependents.

AETNA DENTAL COMPARISON

Group #: 237087	BASIC PLAN		PREMIUM PLAN	
	Network: PPO/PDN with PPO II and Extend	Out-of-Network*	Network: PPO/PDN with PPO II and Extend	Out-of-Network*
Calendar Year Deductible (CYD)				
Per Member	$50	$50	$50	$50
Per Family	$150	$150	$150	$150
Waived For Diagnostic & Preventive Care	Yes	Yes	Yes	Yes
Calendar Year Benefit Maximum (CYBM)				
Per Member	**$1,250**		**Year 1: $2,100 Year 2: $2,500 Year 3: $2,900 Year 4: $3,300**	
Class 1: Diagnostic & Preventive				
Oral Evaluations	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)	Plan Pays: 100% Deductible Waived	Plan Pays: 100% Deductible Waived (Subject to Balance Billing)
Routine Cleanings				
X-rays (Routine & Non-Routine)				
Fluoride Application (Child Under Age 19)				
Class 2: Basic Restorative				
Fillings (Amalgam or Composite)**	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD (Subject to Balance Billing)	Plan Pays: 80% After CYD	Plan Pays: 80% After CYD (Subject to Balance Billing)
Root Canal Therapy				
Periodontal Scaling & Root Planing				
Simple Extractions				
Complex Extractions				
Class 3: Major Restorative				
Anesthesia (General & IV Sedation)	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD (Subject to Balance Billing)	Plan Pays: 50% After CYD	Plan Pays: 50% After CYD (Subject to Balance Billing)
Bridges				
Dentures				
Crowns				
Class 4: Orthodontia				
Lifetime Maximum	**$1,000**		**$2,000**	
Orthodontia Treatment Adults & Dependent Children	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)	Plan Pays: 50%	Plan Pays: 50% (Subject to Balance Billing)

*For information regarding out-of-network balance billing that may be charged by an out-of-network provider, please refer to the carrier's summary plan document.

** Plan only covers composite fillings on anterior teeth.

For limitations, exclusions and a full listing of the covered benefits, please refer to the certificate of coverage or benefit summary.

VISION INSURANCE

National Vision Administrators | (800) 672-7723 | www.e-nva.com

The District offers vision insurance through National Vision Administrators (NVA) to benefit-eligible employees. The costs per month for coverage are listed in the premium table and a brief summary of benefits is provided on the next page. For more information about the vision plan, please refer to NVA's summary plan document or contact customer service.

NVA BASIC PLAN

	Total Monthly Premium	Employee Semi-Monthly Deduction
Employee Only	$5.62	$2.81
Employee + Spouse	$10.14	$5.07
Employee + Child(ren)	$10.72	$5.36
Employee + Family	$16.92	$8.46

NVA PREMIUM PLAN

	Total Monthly Premium	Employee Semi-Monthly Deduction
Employee Only	$8.92	$4.46
Employee + Spouse	$16.06	$8.03
Employee + Child(ren)	$16.98	$8.49
Employee + Family	$26.80	$13.40

Locate a Provider

To search for a participating provider, contact NVA's customer service or visit www.e-nva.com. When completing the necessary search criteria, select NVA network.

Important Notes

Enrolled members are eligible to participate in the EYEESSENTIAL® Discount Plan for additional purchases during the plan year, after funded benefits have been exhausted.

EPIC Hearing Discount

Members participating in the vision program have access to EPIC Hearing Healthcare's Service Plan which provides hearing aid discounts and access to a large hearing care provider network. Members can save up to 60% off retail on brand name hearing aids. Wellness Reward coupons are also available for additional savings. For more information, please contact EPIC Hearing Healthcare's customer service.

EPIC Hearing Healthcare
Customer Service: (866) 956-5400 | www.epichearing.com

NVA VISION COMPARISON

	BASIC PLAN		PREMIUM PLAN	
	Network: NVA	**Out-of-Network**	**Network: NVA**	**Out-of-Network**
Services				
Eye Exam	$10 Copay	Up to $40	$10 Copay	$40 Copay
Materials	$20 Copay	Reimbursement Based on Service	$20 Copay	Reimbursement Based on Service
Contact Lens Exam (Fit & Follow-Up)	Covered In Full	*Daily Wear: $20 / Extended Wear: $30 / Specialty: $50	Covered In Full	*Daily Wear: $20 / Extended Wear: $30 / Specialty: $50
Frequency of Services				
Examination	Once Every Calendar Year		Once Every Calendar Year	
Lenses	Once Every Calendar Year		Once Every Calendar Year	
Frames	**Once Every 2 Calendar Years**		**Once Every Calendar Year**	
Contact Lenses	Once Every Calendar Year		Once Every Calendar Year	
Lenses				
Single	$20 Copay	Up To $40	$20 Copay	Up To $40
Bifocal	$20 Copay	Up To $60	$20 Copay	Up To $60
Trifocal	$20 Copay	Up To $80	$20 Copay	Up To $80
Frames				
Retail	**Up To $150; 20% Discount On Balance**	Up To $50	**Up To $225; 20% Discount On Balance**	Up To $50
Contact Lenses				
Non-Elective (Medically Necessary)	Covered In Full	Up To $225	Covered In Full	Up To $225
Conventional	**Up To $130; 15% Discount On Balance**	Up To $105	**Up To $225; 15% Discount On Balance**	Up To $105
Disposable	**Up To $130; 10% Discount On Balance**	Up To $105	**Up To $225; 10% Discount On Balance**	Up To $105

*Covered only if member chooses contact lenses.
For limitations, exclusions and a full listing of the covered benefits, please refer to the certificate of coverage or benefit summary.

In-Network Benefits

Both vision plans offer coverage for routine eye exams, eyeglasses (lenses and frames) or contact lenses. To schedule an appointment, covered employees and dependents can select any provider who participates in the NVA network. At the time of service, routine vision examinations and basic optical needs will be covered as shown on the plan's schedule of benefits. Cosmetic services and upgrades will be additional if chosen at the time of the appointment.

Out-of-Network Benefits

Covered employees and dependents may also choose to receive services from vision providers who do not participate in the NVA network. When going out of network, the provider will require payment at the time of appointment. NVA will reimburse members based on the plan's out-of-network reimbursement schedule upon receipt of proof of services rendered.

Please Note: Member options, such as LASIK, UV coating, progressive lenses, etc. are not covered in full, but may be available at a discount.

FLEXIBLE SPENDING ACCOUNT (FSA)

Payflex | (844) 729-3539 | www.payflex.com | Group #: 237088

The District offers Flexible Spending Accounts (FSA) administered through Payflex. If an employee or family member(s) have predictable health care, dental, vision or work-related day care expenses, then participating in an FSA may be beneficial. FSAs allow employees to use pre-tax funds from their paychecks for reimbursement of health care, dental, vision and day care expenses. The elected amount is automatically deducted from the employee's paycheck and deposited into the FSA. After the plan year and grace period ends and all claims have been filed, all unused funds will be forfeited and cannot be returned or carried forward to the next plan year. This rule is known as "use it or lose it".

Maximum Election Limits	
Health Care FSA:	$3,200
Limited Purpose FSA:	$3,200
Dependent Care FSA:	Married Filing Separately: $2,500 Single or Married Filing Jointly: $5,000

A **Health Care FSA** is used to reimburse out-of-pocket health care expenses incurred by the employee, their spouse and/or children. Eligible expenses include deductibles, coinsurance, copays, etc. The employee's Health Care FSA election is pre-loaded to a debit card. The employee has immediate access to the funds and will pay them back throughout the year via payroll deduction. **Important Note: If you will be funding an HSA, you cannot participate in the Health Care FSA.**

Qualified expenses eligible for reimbursement through the Health Care FSA include, but not limited to, the following:

- Medical Copays, Coinsurances, & Deductibles
- Dental Fees/Orthodontic Fees*
- Diagnostic Tests/Health Screenings
- Over-the-Counter Medications
- Eyeglasses & Contact Lenses*
- Hearing Aids & Exams
- Prescription Drugs
- Sunscreen
- Walking Aids
- Home Medical Equipment
- First Aid Kits
- Orthopedic & Surgical Supports

These items may qualify as eligible expenses under the Limited Purpose FSA.

A **Limited-Purpose FSA** is similar to a health care FSA—the difference being that there are fewer eligible expenses. A Limited-Purpose FSA is typically offered to employees enrolled in a High Deductible Health Plan (HDHP) with an HSA. IRS regulations prohibit employees from contributing to both an HSA and Health Care FSA. However, employees are eligible for an HSA if they use a Limited-Purpose FSA for their dental and vision needs.

A **Dependent Care FSA** is used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child or adult daycare. Eligible dependents are children under age 13, or a dependent who is physically or mentally not able to care for himself and spends at least 8 hours a day in the participant's household. Eligible expenses include nanny, nursery school, before care/after care, late pick-up fees, day camp, or day care. The Dependent Care FSA annual elected amount is not pre-loaded to a debit card. Employees can only access what has been payroll deducted and is in the Dependent Care FSA.

Log on to http://www.irs.gov/publications/p502 for additional details regarding qualified and non-qualified expenses.

FLEXIBLE SPENDING ACCOUNT (FSA)

Payflex | (844) 729-3539 | www.payflex.com | Group #: 237088

FSA Guidelines

- The Health Care FSA has an extended claim period that ends on March 15, 2024 to incur expenses and file claims against last year's Health Care FSA balance. Employees have until April 30, 2024 (including those 2.5 months) to submit what they may have incurred.
- The Health Care FSA has a claim filing deadline for terminated employees. Once an employee is terminated from the plan, they have up to 90 days to submit claims which they incurred during their active timeframe.
- After the extended claim period ends, all unused funds will be forfeited.
- Employees can enroll in an FSA only during the Open Enrollment period, a Qualifying Event, or New Hire Eligibility period.
- Money cannot be transferred between FSAs.
- Employee and dependent(s) cannot be reimbursed for services they have not received.
- Reimbursed expenses cannot be deducted for income tax purposes.
- Employee and dependent(s) cannot receive insurance benefits or any other compensation for expenses which are reimbursed through an FSA.

Filing a Claim

A completed claim form along with a copy of the receipt as proof of the expense can be submitted by mail or fax. The IRS requires FSA participants to maintain complete documentation, including copies of receipts for reimbursed expenses, for a minimum of one (1) year.

FSA participants will automatically receive a debit card for payment of eligible expenses. With the card, most qualified services and products can be paid at the point of sale versus paying out-of-pocket and requesting reimbursement. The debit card is accepted at a number of medical providers and facilities, and most pharmacy retail outlets. Payflex may request supporting documentation for expenses paid with a debit card. Failure to provide supporting documentation when requested, may result in suspension of the card and account until funds are substantiated or refunded back to Payflex. This card will not expire at the end of the benefit year. Please keep the issued card for use next year. Additional or replacement cards may be requested, however, a small fee may apply.

Claim Reimbursement

Download reimbursement forms at
www.payflex.com
Claims Fax: (402) 231-4310 or (855) 703-5305
Address: Payflex Systems USA, Inc.
PO Box 981158
El Paso, TX 79998-1158

Example Of How It Works		With a HealthCare FSA	Without a Healthcare FSA
Employee earning $30,000 elects to place $1,000 into a Health Care FSA. The payroll deduction is $41.67 based on a 24 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $227.	Salary	$30,000	$30,000
	FSA Contribution	-$1,000	-$0
	Taxable	$29,000	$30,000
	Estimated Tax 15% + 7.65% FICA = 22.65%	-$6,568	-$6,795
	After Tax Expenses	-$0	-$1,000
	Spendable Income	$22,432	$22,205
	Tax Savings	$227	

PAYFLEX®

PayFlex Mobile® app

Plan, save and pay on the go

With our free PayFlex Mobile app, you can easily access your account information in the palm of your hand.

Simply "tap" to:

- Check your account balance and view account activity
- View your account alerts
- Access the Eligible Expense Scanner to verify if an item is an eligible health care expense
- Review a list of common eligible expense items
- Pay your providers directly from your account
- Take pictures of receipts and pay yourself back for eligible expenses

What's new with the PayFlex Mobile app?

- PayFlex's Eligible Expense Scanner makes it easy for you to scan an item barcode to determine if it's an eligible health care expense.
- Enhanced security and complimentary fraud protection.

How do I get the PayFlex Mobile app? And is there a fee to use it?

- You can download the app from your mobile device's app store.
- The app is supported by the following devices:
    - **iOS version** 10 or above on iPhone® 5S, iPad Air®, iPad Mini® 2 or newer models
    - **Android version** 4.4 (Kitkat) or above on phones or tablets
- There's no fee to download the app. Anyone with a PayFlex account can use it for free.

Can I submit a claim using the app?

Yes, you can submit a claim through the app if you want to reimburse yourself for an expense.

- After you log in, select **Manage Funds** to get started.
- When sending documents with your claim, simply take a picture and upload it through the app.

Can I use the app to transfer funds to and from my HSA?*

Yes, you can transfer funds through the app.

- After you log in, select **Manage Funds** to get started.
- You can deposit funds into your HSA or request funds from your HSA.

How do I access the Eligible Expense Scanner?

After you log in to the app, you can find it on the home page or tap HELP to access the Eligible Expense Scanner.

*Please check your plan details if offered.

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How do I get started with the app?

It's easy. Just use the same username and password you use for the PayFlex member website. If you haven't set up your online account with PayFlex, go to **payflex.com** to get started.

What if I have trouble signing in?

Tap on **Trouble logging in?** on the log in page.

Is the app secure?

Yes. Here are a few of the ways we make your security our priority:

- Log in with Secure Touch ID or Face ID.
- Get protected access to your account information.
- Use the same secure username and password you use on our site.

Download the PayFlex app today for free.

Questions?

Log in to your PayFlex member website and click **Contact Us** under **Help & Support**. Here you can also **Live Chat** with us.

Note: Standard text messaging rates and other rates from your wireless carrier may apply when using the PayFlex Mobile® app. PayFlex Systems USA, Inc. This material is for informational purposes only and is not an offer of coverage. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. It does not contain legal or tax advice. You should contact your legal counsel if you have any questions or if you need additional information. In case of a conflict between your plan documents and the information in this material, the plan documents will govern. Eligible expenses may vary from employer to employer. Please refer to your employer's Summary Plan Description ("SPD") for more information about your covered benefits. Information is believed to be accurate as of the production date; however, it is subject to change. PayFlex cannot and shall not provide any payment or service in violation of any United States (U.S.) economic or trade sanctions. For more information about PayFlex, go to **PayFlex.com**. PayFlex Mobile® is a registered trademark of PayFlex Systems USA, Inc. Apple, the Apple logo, iPad and iPhone are trademarks of Apple Inc., registered in the U.S. and other countries. Android is a trademark of Google LLC.

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PAYFLEX®

EMPLOYEE ASSISTANCE PLAN (EAP)

Aetna Resources for Living | (888) 238-6232 | www.resourcesforliving.com

The District provides, at no cost to employees, a comprehensive Employee Assistance Program (EAP). The EAP is available to employees, household members and dependents up to age 26 through Resources for Living. Resources for Living offers access to licensed mental health professionals through a confidential program except were prohibited by law. The EAP program is available to help employees gain a better understanding of problems that affect an employee, locate the best professional help for the problem, and decide upon a plan of action. When you call Resources for Living, you can access support in the moment with a licensed counselor and/or receive a referral to a licensed EAP provider for six counseling sessions (face to face/telephone/tele-video). All EAP counselors are professionally trained, certified and licensed in their fields. Master-level counselors are available 24 hours a day, seven (7) days a week.

Services include support for:

- Anxiety
- Depression
- Stress
- Couples/Relationship/Parenting
- Crisis Support
- Substance Abuse
- Grief and Loss
- Work Conflict
- Domestic Violence
- Legal and Financial Concerns
- Childcare and Eldercare
- ID Theft
- Healthy Living Tips

What Can You Use the EAP For?

The District recognizes that employees' personal responsibilities may, at times, spill over into the workplace. To help ensure employees are able to address these concerns with minimal disruption, the program provides employees and household members assistance for a variety of concerns – including child care, elder care, daily-living issues, and other issues employee may encounter. Coverage includes six (6) face-to-face visits with a specialist, per person, per issue, as well as telephonic consultation, online material/tools and webinars.

Are Services Confidential?

Yes. Receipt of EAP services is completely confidential. If, however, participation in the EAP is the direct result of a Management Referral (a referral initiated by a supervisor or manager), EAP will ask permission to communicate certain aspects of employee's care (attendance at sessions, adherence to treatment plans, etc.) to referring supervisor/manager. The referring supervisor will not, however, receive specific information regarding referred employee's case. The supervisor will only receive reports on whether referred employee is complying with the prescribed treatment plan.

Here's how to get started

Give Resources for Living a call at (888) 238-6232 to connect with the right resource or professional.

Visit Aetna Resources for Living's website to learn more about all services available at www.resourcesforliving.com

Username: SWFWMD

Password: EAP

BASIC LIFE AND AD&D INSURANCE

The Hartford | (888) 563-1124 | www.thehartford.com | Group #: 921975

Basic Life Coverage Amount

The District provides a Basic Term Life insurance benefit to all eligible employees through The Hartford. Regular full-time board-approved employees will receive a Basic Term Life insurance benefit in the amount of 1.5 times employee's salary, and Administrative Pay and Executive employees will receive a Basic Term Life insurance benefit in the amount of two (2) times their annual salary both up to a maximum of $500,000, rounded to the next higher $1,000.

Basic AD&D Coverage Amount

Also, at no cost to the employee, the District provides Accidental Death & Dismemberment (AD&D) insurance to all eligible employees through The Hartford, which pays in addition to the Basic Term Life benefit when death occurs as a result of an accident. The AD&D benefit amount will equal the Basic Term Life benefit amount. Employees may also be eligible for a full or partial benefit payable for an accidental loss or use of certain body parts.

Age Reductions

Basic Life and AD&D insurance coverage amounts reduce to 65 percent at the age of 65, to 50 percent at the age of 70, and to 25 percent at the age of 75, adjusted at policy renewal following the change in age.

Life Insurance Imputed Income

The IRS requires that the imputed cost of employer paid Employee Life insurance benefit in excess of $50,000 must be included in income and is subject to Federal, Social Security and Medicare taxes.

Important Reminders

- Always remember to keep beneficiary information updated. Employee may update beneficiary information at anytime by logging onto UltiPro: https://ew44.ultipro.com.
- Please refer to the Certificate of Coverage for additional information regarding the plan benefits.

For limitations, exclusions and a full listing of the covered benefits, please refer to the certificate of coverage or benefit summary.

VOLUNTARY LIFE AND AD&D INSURANCE

(post-tax)

Eligible employees may elect to purchase Voluntary Life, and Accidental, Death, and Dismemberment (AD&D) insurance on a voluntary basis through The Hartford. This coverage may be purchased in addition to the Basic Term Life and AD&D coverages.

Voluntary Life Highlights

Enrollment Tier	Monthly Rate	Minimum	Incremental Unit	Guarantee Issue Amount	Maximum
Employee	$4.00 per $10,000	$10,000	$10,000	$270,000	$500,000 (not to exceed 5x employee annual income)
Spouse (terminates age 70)	$2.00 per $5,000	$5,000	$5,000	$50,000	$250,000 (not to exceed 50% of employee amount)
Child (covered up to age 26)	$0.15 for $5K $0.30 for $10K	6 months to age 26: $5,000 Birth to 6 months: $500	$5,000	All dependent child(ren) benefits are Guaranteed Issue.	$5,000 or $10,000 (not to exceed 50% of employee amount)

What Is Guarantee Issue?

This is the maximum amount of coverage you can elect during your initial enrollment as a new hire or during a carrier approved open enrollment opportunity without answering health questions. Otherwise, all elections require the completion of Evidence of Insurability (EOI) and are subject to underwriting approval.

Employees currently enrolled in Voluntary Life may increase by one benefit unit of $10,000 annually, up to the guaranteed issue amount without being subject to EOI.

A spouse currently enrolled in the Voluntary Spouse Life benefit may be increase by one benefit unit of $5,000 annually, up to the Guaranteed Issue amount of $50,000 without being subject to EOI.

Voluntary AD&D Highlights

Enrollment Tier	Monthly Rate	Incremental Unit	Maximum
Employee	$0.30 per $10,000	$10,000	$500,000
Spouse (terminates age 70)	$0.15 per $5,000	$5,000	$250,000 (not to exceed 50% of employee amount)
Child (covered up to age 26)	$0.15 for $5K $0.30 for $10K	$5,000	$5,000 or $10,000 (not to exceed 50% of employee amount)

Admin Pay EXE employees are provided a $250,000 AD&D employee only, $125,000 AD&D spouse and/or $10,000 AD&D child benefit at no cost.* In addition, Admin Pay EXE employees may purchase voluntary AD&D up to an additional $250,000 for employee only, and $125,000 for spouse based on the rates listed. **A portion of these benefits provided to this class are subject to Federal Income, Social Security and Medicare taxes.*

Age Reductions

Voluntary Life and AD&D insurance coverage amounts reduce to 65 percent at the age of 65, to 50 percent at the age of 70, and to 25 percent at the age of 75, adjusted at policy renewal following the change in age.

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary and Booklet.

OUR LIFE INSURANCE HELPS PROTECT EVEN MORE THAN YOUR LIFE

Life insurance from The Hartford can help protect the financial future of your loved ones. And, your coverage includes valuable services that can help you and your family.

FUNERAL CONCIERGE[1]

Helps provide peace of mind when it's needed most.

The Hartford's Funeral Concierge offers a suite of online tools to help guide you through key decisions. It allows for pre-planning, documentation of wishes, and even offers cost comparisons of funeral-related expenses. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in significant savings. And Express Pay guarantees beneficiaries can receive payment in as little as 48 hours.

Find out more by calling: **866-854-5429**
Visit: **www.everestfuneral.com/hartford**
Use code: **HFEVLC**

BENEFICIARY ASSIST® COUNSELING AND HEALTHCHAMPION℠[2]

Getting through a loss is hard. Getting support shouldn't be.

The Hartford offers Beneficiary Assist counseling services, where compassionate professionals can help you or your beneficiaries cope with emotional, financial and legal issues that can arise after a loss. Includes unlimited 24/7 phone access for legal advice, financial planning and emotional counseling, and up to five face-to-face sessions or equivalent professional time for one or a combination of services for up to a year from the date a claim is filed.[3]

HealthChampion offers Health Care Navigation support if you've become disabled from an accident or are diagnosed with a terminal illness. You'll receive guidance on care options, helpful resources and help with timely and fair resolution of issues.

Learn more: **800-411-7239**

What do I do first?

In the event of a life-threatening emergency, call local emergency authorities first for immediate assistance.

Then, contact Travel Assistance via phone:
U.S. and Canada:
800-243-6108 (toll-free)

Outside U.S.: **202-828-5885**

Or email:
assist@imglobal.com

(Cut here, or snap a photo with a mobile device to capture information above.)

ESTATEGUIDANCE® WILL SERVICES[2]

Create a simple will from the convenience of your home.

Whether your assets are few or many, it's important to have a will. Through The Hartford you have access to EstateGuidance® Will services. It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys. Just follow the instructions to create a will that's customized and legally binding.[4]

Visit: **www.estateguidance.com**
Use code: **WILLHLF**

TRAVEL ASSISTANCE WITH IDENTITY THEFT SUPPORT SERVICES[5]

Travel Assistance is available when traveling more than 100 miles from home and for 90 days or less. Services include but are not limited to:

- Medical assistance, including worldwide medical referrals, medical monitoring, prescription transfer, replacement of medical devices and corrective lenses.
- Emergency transports, medical repatriations and evacuations and repatriations of mortal remains.
- Pre-trip information, lost luggage/document assistance and legal referrals.

Identity Theft Support Services provide 24/7/365 assistance including education on how to prevent theft and guidance on what to do if a theft occurs.

Caseworkers help review credit information, and if a theft has occurred, will notify major credit bureaus, assist with completing an identity theft affidavit, help with replacing credit/debit cards and more.

Visit **TheHartford.com/employeebenefits**

THE HARTFORD

Business Insurance
Employee Benefits
Auto
Home

Some services may not be available in all states. For more information, visit www.TheHartford.com/employee-benefits/value-added-services.

[1] Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates. The Hartford is not responsible and assumes no liability for the services provided by Everest Funeral Package, LLC, as described in these materials and reserves the right to discontinue any of these services at any time.

[2] EstateGuidance®, Beneficiary Assist® and HealthChampion℠ are offered through The Hartford by ComPsych® Corporation. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time.

[3] California residents are limited to three prepaid behavioral health counseling sessions in any six-month period. Except for acute emergencies and other special circumstances, additional sessions for California employees are available on a fee-for-service basis.

[4] The EstateGuidance® website is secured with a GoDaddy.com Web Server Certificate. Transactions on the site are protected wth up to 256-bit Secure Sockets Layer encryption. A simple will does not cover printing or certain other features. These features are available at an additional cost to you.

[5] Travel Assistance and Identity Theft Support services are offered through a vendor which is not affiliated with The Hartford. These services are not insurance. The Hartford is not responsible and assumes no liability for the goods and services described in this material and reserves the right to discontinue any of these services at any time. Services may vary and may not be available in all states.

The Hartford's Privacy Policy is available at: www.TheHartford.com/online-privacy-policy.

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DISABILITY INSURANCE

The Hartford | (888) 301-5615 | www.thehartford.com | Group #: 921975

Voluntary Short-Term Disability

The District offers Voluntary Short-Term Disability (STD) insurance to all eligible full-time employees through The Hartford. The STD benefit pays you a percentage of weekly earnings if you become disabled due to an illness or non-work related accident. Premium is calculated based on your age and salary.

Pre-existing Condition

If you have a medical condition that begins before your coverage takes effect, and you receive treatment for this condition within the 3 months leading up to your coverage start date, you may not be eligible for benefits for that condition until you have been covered by the plan for 12 months.

Guaranteed Issue

This plan will be Guaranteed Issue during your new hire election period and first annual open enrollment period only. Guaranteed Issue means you will be guaranteed coverage regardless of health status. Enrollment outside of those two (2) opportunities will require an evidence of insurability to be approved by The Hartford.

Long-Term Disability

The District provides Long Term Disability (LTD) insurance to all eligible full-time employees through The Hartford. The LTD benefit pays you a percentage of monthly earnings if you become disabled due to an illness or non-work-related injury.

Pre-existing Condition

If you become disabled within the first 12 months of your effective date of coverage, The Hartford will do pre-existing investigation to determine if your disability is due to a pre-existing condition (sickness or injury) that occurred in the 3 months prior to your effective date. If a pre-existing condition did exist, your claim could be denied for benefits.

	Voluntary Short-Term Disability	Long-Term Disability
Elimination Period	14 days accident 14 days illness	90 days
Percentage of Pre-Disability Income Replaced	60% of weekly earnings	60% of pre-disability monthly earnings
Duration of Benefits Payable	13 weeks	To Social Security Normal Retirement Age or the date the 48th monthly benefit is payable
Maximum Benefit	$2,000 weekly	$10,000 monthly

Please Note: *Like any insurance, this short-term and long-term disability insurance policy does have some exclusions. Your benefits may be reduced if you are eligible to receive benefits from other sources. For a complete list of benefit exclusions and reductions, please refer to the certificate of coverage.*

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summary and Booklet.

PREFERRED LEGAL & IDENTITY PLAN

Preferred Legal | (888) 577-3476 | www.preferredlegal.com

District employees have the opportunity to enroll in a voluntary pre-paid legal program through Preferred Legal Plan. By enrolling in this plan, a participant will have direct access to attorneys who will provide legal assistance 24 hours a day / seven (7) days a week for a variety of situations such as those examples provided below. Additional services may also be provided at discounted rates.

The cost to the employee to participate in this legal plan is $9.96 per month. This cost is the same for all employees regardless of the number of eligible dependents enrolled in the plan. All premiums will be payroll deducted on a post-tax basis for the employee's convenience.

Member benefits include unlimited legal advice, review of legal documents, letters and phone calls on your behalf and credit repair. Legal forms are available through the Form Library and pre-existing issues are covered. Membership is unlimited and available immediately upon effective date of coverage.

Services would include:

- Divorce
- Domestic Violence
- Identity Theft Issues
- Bankruptcy
- Immigration
- Loan Modifications
- Civil Litigation
- Child Custody and Support
- Personal Injury
- Criminal Defense
- Contract Review
- Foreclosure Defense
- Probate
- Wills (Member and Spouse)
- Credit Report Issues
- Traffic Tickets
- Real Estate

Preferred Identity | (888) 577-3476 | www.experianidworks.com/plus

Eligible employees have the opportunity to enroll in a voluntary identity theft protection/credit monitoring service through IdentityWorks (a part of Experian). **IdentityWorks is available for an additional $7.00 per month for employee only or $14.00 per month for employee plus family when added to the Preferred Legal Plan (or $9.00 stand alone for employee only, $18.00 stand alone for employee plus family).**

By enrolling in this plan as an add-on benefit to the Preferred Legal Plan or as a stand alone benefit, a participant will have the following benefits:

- Early warning Surveillance Alert™ notifications via email or mobile text.
- Credit report monitoring checks for new credit cards, loans, inquiries, delinquent accounts and more on a member's credit report, including a personal Experian credit report.
- Dark Web internet monitoring.
- Registration and protection of important personal data and information.
- $1,000,000 Identity Theft Insurance with a $0 deductible may cover illegal electronic fund transfers, lost wages, legal fees and private investigator costs.
- Additional resources so consumers can learn more about identity protection.

SUPPLEMENTAL INSURANCE

Aetna | (800) 607-3366 | www.myaetnasupplemental.com

Aetna offers a variety of voluntary group supplemental insurance plans that may be purchased separately on a voluntary basis and premiums paid by payroll deduction post-tax for most offerings. Aetna pays money directly to you, regardless of what other insurance plans you may have. Details regarding available Aetna plans and services are also available online at www.myaetnasupplemental.com. Available plans include:

Group Accident Insurance Plan (Post Tax)

By enrolling in the Group Accident Insurance Plan, you will have the following benefits:

- On & off the job injuries
- Wellness Benefits
- Guaranteed Issue
- All injuries post-effective date are covered

	Total Monthly Premium	Employee Semi-Monthly Deduction
Employee Only	$6.40	$3.20
Employee + Spouse	$12.80	$6.40
Employee + Child(ren)	$13.44	$6.72
Employee + Family	$19.86	$9.93

Group Hospital Indemnity Insurance Plan (Post Tax)

By enrolling in the Group Hospital Indemnity Insurance Plan, you will have the following benefits:

- In & outpatient benefits
- Wellness Benefit
- Guaranteed Issue

	Total Monthly Premium	Employee Semi-Monthly Deduction
Employee Only	$18.38	$9.19
Employee + Spouse	$41.96	$20.98
Employee+ Child(ren)	$35.54	$17.77
Employee + Family	$57.46	$28.73

Group Critical Illness Insurance Plan (Post Tax)

By enrolling in the Group Critical Illness Insurance Plan, you will have the following benefits:

- Lump sum benefit
- Wellness Benefit
- Guaranteed issue ($10,000 / $20,000)

Employee Only	***Please Note:*** *Premiums are calculated by your age, and selected tier level and benefit amount. Please see UKG for additional details*
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	

Administrative Pay EXE employees only are provided single coverage of Group Hospital and Group Critical Illness paid for by the District. A portion of these benefits provided to this class are subject to Federal income, Social Security, and Medicare taxes.

For a full listing of the covered benefits, please contact your HR Department for copies of the Benefit Summaries.

FLORIDA RETIREMENT SYSTEM (FRS)

(866) 446-9377 | www.myfrs.com

Both the District and employees contribute to the employee's selected retirement plan. All members are required in accordance with Florida State Statute to contribute 3% of employee's earnings (pre-tax) toward their total retirement contributions. The District also makes a contribution to employee's account each pay period. For those in DROP, no contribution is required.

Florida Retirement System (FRS) Pension Plan is a defined benefit plan in which you are guaranteed a benefit at retirement if you meet certain criteria. The amount of your future benefit is determined by a formula based on your earnings, length of service and membership class.

FRS Investment Plan is a defined contribution plan in which employer and employee contributions are defined by law, but your ultimate benefit depends in part on the performance of your investment funds. The FRS Investment Plan is funded by the District and the employee contributions that are based on your salary and FRS membership class.

Additionally, effective July 1, 2011, all members of the FRS Pension Plan achieve vested status upon completing eight (8) years of creditable service (including military leaves of absence); FRS Investment Plan members achieve vested status upon completing one (1) year of creditable service.
To learn more about the benefits of the FRS and each plan option, contact FRS at www.myfrs.com or through the MyFRS Financial Guidance Line at (866) 44-MyFRS (69377).

DEFERRED COMPENSATION (457b)

Nationwide Retirement Solutions | (877) 677-3678 | www.nrsforu.com

Deferred Compensation is a benefit option in addition to the FRS. Deferred Compensation is an optional benefit provided by the District to assist employees with an additional retirement savings plan. No federal income tax is paid on the salary deferred, or any of the investment earnings until it is drawn out at retirement. There are tax implications for an early withdrawal. To enroll or make contribution changes, contact Nationwide Retirement Solutions directly.

YOUR HEALTH MATTERS

Your Health Matters, the District's wellness program, is designed to encourage all employees to engage in healthy lifestyle behaviors. You are offered a variety of ways to help achieve health and wellness goals.
Our medical plan is self-insured, and one way to keep premiums low is to be healthy in your mind, body and spirit. The program includes:

• Fitness Challenges	• Wellness Newsletters & Seminars	• Gym Membership Discounts
• Wellness & Benefits Fair	• Meditation & Yoga	• Omada Weight Loss Program
• Blood Drives	• Group Fitness Classes	• Incentive Reward Program

Visit the Your Health Matters page on Currents for more information.

Participation in wellness program activities is voluntary. You should review the Wellness Program Notice on the Your Health Matters webpage on Currents before choosing to participate.

ADDITIONAL BENEFITS

Please refer to the District's Benefits page on Currents or appropriate Personnel Guideline for additional details on the benefits below, as well as other important benefits that may be offered to employees.

Holiday Time Off

The District pays regular salary for up to eight (8) hours for all regular full-time employees eligible for holiday pay. The district pays for nine (9) holidays each year. A list of the scheduled holidays is listed below. The District also pays regular pay for one (1) Floating Holiday of the employee's choice after completion of six (6) months of continuous service. This day must be used during the payroll fiscal year in which it was earned.

Holiday Schedule	
New Year's Day	Veteran's Day
Martin Luther King Jr. Day	Thanksgiving Day
Memorial Day	Day after Thanksgiving
Independence Day	Christmas Day
Labor Day	

Annual Leave

Employees will receive full regular salary for approved use of accrued annual leave hours. Employees accrue four (4) hours of annual leave each pay period during years 0 through 5, five (5) hours during years 5 through 10 and six (6) hours after ten years of employment. Administrative pay employees are credited with 176 hours at the beginning of the fiscal year or a pro-rated amount if hired or promoted into an Administrative pay schedule position during the year.

Annual Leave Sell Back

Employees may elect to be paid for a portion of accrued annual leave balance at the current rate of pay up to 24 hours in a payroll fiscal year, in .25 hour increments. A minimum balance of 120 hours or more of annual leave must be maintained at the end of the pay period in which the sell back occurs, after the sell back hours and other annual leave hours used in that pay period are deducted. Annual leave sell back counts towards FRS retirement calculations.

Adoption Assistance

The District is a qualified employer for the State Adoption Program. As a District employee, you may be eligible for adoption assistance to include a monetary benefit in the amount of $5,000 or $10,000 per child. Visit the Benefits page on Currents for more details.

Sick Leave Incentive Program

Eligible employees may be compensated for up to 24 hours of employee's unused sick leave accrued during the fiscal year.

Sick Leave

Employees will receive full regular salary for approved use of accrued sick leave hours. Employees accrue four (4) hours of sick leave each pay period. Administrative pay employees are credited with 104 hours at the beginning of the payroll fiscal year or a pro-rated amount if hired or promoted into the Administrative pay schedule during the year.

Sick Leave Pool

Employees may join the sick leave pool by donating eight (8) hours of accrued sick leave to the pool during two (2) open enrollment periods each year after completing one (1) year of employment if employee has a sick leave balance of 80 hours or more. Participants in the pool may draw up to 404 hours per rolling year for an illness or non work related injury or 808 hours per lifetime, after all other leave is exhausted.

Other Paid Time Off

Other paid time off includes time for bereavement, donating blood, jury duty, and certification exams. See Attendance and Leave Guideline for more details.

Education Reimbursement Program

The District offers reimbursement to eligible employees for certain expenses related to post-secondary education that is deemed related to the District in the accomplishment of its mission. All regular employees in Board-authorized positions are eligible to apply for education benefits. Employees may be reimbursed up to $5,250 per fiscal year for tuition, books and required fees for academic credit courses taken at regionally accredited institutions. Approval of education reimbursement requests is contingent upon criteria being met, procedures followed, and availability of funds.

Nursing Mothers Private Time and Space

The District provides nursing mothers with a private space and reasonable time during the work day to express milk for up to one (1) year after the birth of the child. Each private room has a door lock and indicator when the room is in use. A table, chair, power strip and mini-fridge are available as well.

PSLF Program

The District is a qualified employer for the Public Service Loan Forgiveness (PSLF) Program. As a District employee, you may be eligible for the Federal PSLF program. The PSLF Program forgives the remaining balance on your Direct Loans after you have made 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer.

IMPORTANT NOTICES

Please remember that the Southwest Florida Water Management District maintains an employment at will relationship. Simply, that means that you can leave at any time for any reason and the District can terminate your employment and ask you to leave at any time for any reason. Nothing in this documentation should be construed as a contract of employment. Also, there are no other promises, pay or benefits offered. Employment with the District is not guaranteed for any specified length of time. Nothing in any Personnel Guideline, employee benefit plan description or any other document in whatever form or media issued by the District or any of its personnel constitutes a contract for employment or for any other benefit, or guarantees District employment for any specified period. No representative of the District has the authority to make any agreement to the contrary.

Notification of Grandfathered Status

The Southwest Florida Water Management District has determined the Aetna POS II Copay medical plan offered to the District (excluding the High Deductible Health Plan (HDHP) option), is considered to be a "grandfathered medical plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered medical plan can preserve certain basic medical coverage that was already in effect when that law was enacted. Being a grandfathered medical plan means that employee's plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered medical plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Employee's may contact the U.S. Department of Health and Human Services at www.healthcare.gov for questions regarding which protections apply and which protections do not apply to a grandfathered medical plan and what might cause a plan to change from a grandfathered medical plan status.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. **For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at (800) 244-6224**.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier. For additional information, contact your plan administrator at (800) 244-6224.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother of her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Summary of Benefits & Coverage (SBC)

A Summary of Benefits & Coverage (SBC) for each medical plan option is provided as a supplement to this booklet being distributed to new hires and existing employees during open enrollment. These summaries are an important item in understanding the benefit options. A free paper copy of the SBC document may be requested from Human Resources at:

Address:	**2379 Broad St., Brooksville, FL 34604**
Phone:	**(352) 269-3940**
Email:	**HR.Central@watermatters.org**
Online:	**Benefits page on *Currents***

The SBC is only a summary of the plan's coverage. A copy of the plan document, policy, or certificate of coverage should be consulted to determine the governing contractual provisions of the coverage. A copy of the group certificate of coverage can be reviewed and obtained by contacting the Human Resources Office or logging onto the District's Intranet site, Currents.

If employees have any questions about the plan offerings or coverage options, please contact the Human Resources Office at (352) 269-3940 or email HR.Central@watermatters.org.

IMPORTANT NOTICES

Notice of Special Enrollment Rights

This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact the plan administrator (see cover page for contact information).

Patient Protections

Southwest Florida Water Management District generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at (866) 253-0556.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member, or an embryo lawfully held by a member receive assistive reproductive services.

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long-Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http://www.dol.gov/vets
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

IMPORTANT NOTICES

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Premium Assistance Under Medicaid and the Children's Health Insurance Program

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (continued)

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2

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

U.S. Department of Labor
Employee Benefits Security Administration
Web: www.dol.gov/agencies/ebsa Phone:(866) 444-EBSA (3272)
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Web: www.cms.hhs.gov
Phone: (877) 267-2323, Menu Option 4, Ext. 61565

Women's Health and Cancer Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan. If you would like more information on WHCRA benefits, contact HR at (352) 269-3940.

IMPORTANT NOTICES

Important Notice from Southwest Florida Water Management District about Your Prescription Drug Coverage and Medicare (Aetna High Deductible Health Plan)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Southwest Florida Water Management District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Southwest Florida Water Management District has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Southwest Florida Water Management District coverage will be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. Aetna administers the group health coverage available to Southwest Florida Water Management District employees, retirees and dependents. The included prescription drug benefit provides:

	Network Only	Mail Order (In-Network Only)	Non-Network
Calendar Year Deductible	Single: $1,500 / Family $3,000		Single: $3,000 / Family: $6,000
Tier 1	$10 after Calendar Year Deductible	$20 after Calendar Year Deductible	50% after Calendar Year Deductible
Tier 2	$30 after Calendar Year Deductible	$60 after Calendar Year Deductible	50% after Calendar Year Deductible
Tier 3	$50 after Calendar Year Deductible	$100 after Calendar Year Deductible	50% after Calendar Year Deductible

If you do decide to join a Medicare drug plan and drop your current Southwest Florida Water Management District coverage, be aware that you and your dependents will not be able to get this coverage back. **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?** You should also know that if you drop or lose your current coverage with Southwest Florida Water Management District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage… Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Southwest Florida Water Management District changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/15/2023 Name of Entity/Sender: Southwest Florida Water Management District

Contact--Position/Office: Stefanie Taverna / Risk and HR Manager

Address: 2379 Broad Street, Brooksville, FL 34604-6899

Phone Number: (352) 269-5628

IMPORTANT NOTICES

Important Notice from Southwest Florida Water Management District about Your Prescription Drug Coverage and Medicare (Aetna Copay Plan)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Southwest Florida Water Management District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Southwest Florida Water Management District has determined that the prescription drug coverage offered by Aetna is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Southwest Florida Water Management District coverage will be affected. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will not be eligible to receive all of your current health and prescription drug benefits. Aetna administers the group health coverage available to Southwest Florida Water Management District employees, retirees and dependents. The included prescription drug benefit provides:

	Network Only	Mail Order (In-Network Only)	Non-Network
Tier 1	$10	$20	50% Coinsurance
Tier 2	$25	$50	50% Coinsurance
Tier 3	$40	$80	50% Coinsurance

If you do decide to join a Medicare drug plan and drop your current Southwest Florida Water Management District coverage, be aware that you and your dependents will not be able to get this coverage back. **When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?** You should also know that if you drop or lose your current coverage with Southwest Florida Water Management District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage… Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Southwest Florida Water Management District changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 10/13/2023 Name of Entity/Sender: Southwest Florida Water Management District

Contact--Position/Office: Stefanie Taverna / Risk and HR Manager

Address: 2379 Broad Street, Brooksville, FL 34604-6899

Phone Number: (352) 269-5628

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options & Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. [1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Office at HR.Central@watermatters.org. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer Name **Southwest Florida Water Management District**	**4. Employer Identification Number (EIN)** **59-0965067**	
5. Employer Address **2379 Broad Street, Brooksville, FL**	**6. Employer Phone Number** **(352) 269-5628**	
7. City **Brooksville**	**8. State** **Florida**	**9. ZIP Code** **34604-6899**
10. Who can we contact about employee health coverage at this job? **Stefanie Taverna**		
11. Phone Number **(352) 269-5628**	**12. Email Address** **Stefanie.Taverna@swfwmd.state.fl.us**	

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs

IMPORTANT NOTICES

New Health Insurance Marketplace Coverage Options & Your Health Coverage

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

☐ All employees.
☒ Some employees. Eligible employees are working 30 or more hours per week.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are: a spouse of the employee, a natural child, a stepchild, a legally adopted child, a child for whom legal guardian ship has been awarded to the employee or spouse, the newborn child of an enrolled dependent until the newborn reaches 18 months of age.

☐ We do not offer coverage.

☒If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums. The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☒**Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☒**Yes** (Go to question 15)☐**No** (Stop and return this form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

How much would the employee have to pay in premiums for this plan per month? $0.00

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

A. How much will the employee have to pay in premiums per month for that plan? $_____
Date of Change: _____

KEY CONTACTS

Teresa Jepma Human Resources Office Chief (352) 269-3929 Teresa.Jepma@swfwmd.state.fl.us	Human Resources Office (352) 505-4053 Email: HR.Central@watermatters.org
Stefanie Taverna Risk & HR Manager (352) 269-5628 Stefanie.Taverna@swfwmd.state.fl.us	

Plan	Carrier	Phone	Website
Online Benefits Enrollment	UKG		https://ew44.ultipro.com
Medical Insurance	Aetna Group #: 237086	(866) 253-0556	www.aetna.com
Prescription Drug Coverage & Mail-Order Program	CVS Caremark Mail Service Pharmacy Group #: 237086	(800) 238-6279	www.aetna.com
Health Savings Account	Payflex	(844) 729-3539	www.payflex.com
Flexible Spending Account	Payflex Group #: 237088	(844) 729-3539	www.payflex.com
Dental Insurance	Aetna Group #: 237087	(866) 253-0556	www.aetna.com
Vision Insurance	National Vision Administrators (NVA) Group #: 8762	(800) 672-7723	www.e-nva.com
Employee Assistance Program	Aetna Resources for Living Username: SWFWMD Password: EAP	(888) 238-6232	www.resourcesforliving.com
Basic & Voluntary Life Insurance	The Hartford Group #: 921975	(888) 563-1124	www.thehartford.com
Basic & Voluntary AD&D Insurance	The Hartford Group #: 921975 Standalone AD&D Group #: S09335	(888) 563-1124	www.thehartford.com
Voluntary Short-Term Disability	The Hartford Group #: 921975	(888) 301-5615	www.thehartford.com
Long Term Disability	The Hartford Group #: 921975	(888) 301-5615	www.thehartford.com
Supplemental Insurance	Aetna Group #: 802409	(800) 607-3366	www.myaetnasupplemental.com
Preferred Legal & Identity	Preferred Legal Plan	(888) 577-3476	www.preferredlegal.com
	IdentityWorks	(888) 577-3476	www.experianidworks.com/plus
Retirement	Florida Retirement Systems (FRS)	(866) 446-9377	www.myfrs.com
	Nationwide Retirement Solutions Plan #0045421001	(877) 677-3678	www.nrsforu.com

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