2020 - 2021 BEST places to work ST. LUCIE COUNTY

2022 Benefits Guidebook

A message from Human Resources

GREAT FUTURES START HERE.

BOYS & GIRLS CLUBS OF ST. LUCIE COUNTY

Human Resources Department

Boys & Girls Clubs of St. Lucie County is committed to the health and wellness of its employees. We do our best to guide our employees to make the best decisions for their health. As part of this dedicated effort to provide you with the most up-to-date resources, we present this Benefits Guide. We designed the Benefits Guide to help you understand all available benefit options so you can make the best possible decisions for you and your family.

As you may be aware, health care costs have been increasing substantially over the years.

Specifically for 2022, there was an increase in the health insurance premium costs as well as dental and vision (see pages 13 & 44). Fortunately, we are proud to announce that the current employee health, dental, and vision insurance premium costs will remain the same for 2022!

Open enrollment will begin the week of 12/06/2021 and close on 12/13/2021. **All employees who wish to be covered under the Boys & Girls Clubs of St. Lucie County's insurance benefits must make an affirmative election to do so. Failure to complete an election/ enrollment during this open enrollment period will result in no insurance coverage.**

You are encouraged to carefully review the enrollment options to ensure your insurance selections meets your needs and your budget. Please do not hesitate to contact Human Resources for any questions regarding the plan options available to you or to request additional information.

We hope you find this guide to be a helpful tool as you make your benefits decisions.

Sincerely,
Human Resources Department

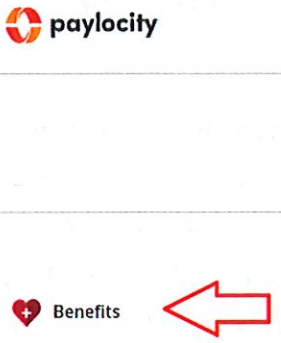
BOYS & GIRLS CLUBS
OF ST. LUCIE COUNTY

WELCOME ONBOARD!

Enroll your insurance benefits through paylocity

Step 1: Log into your Paylocity Account

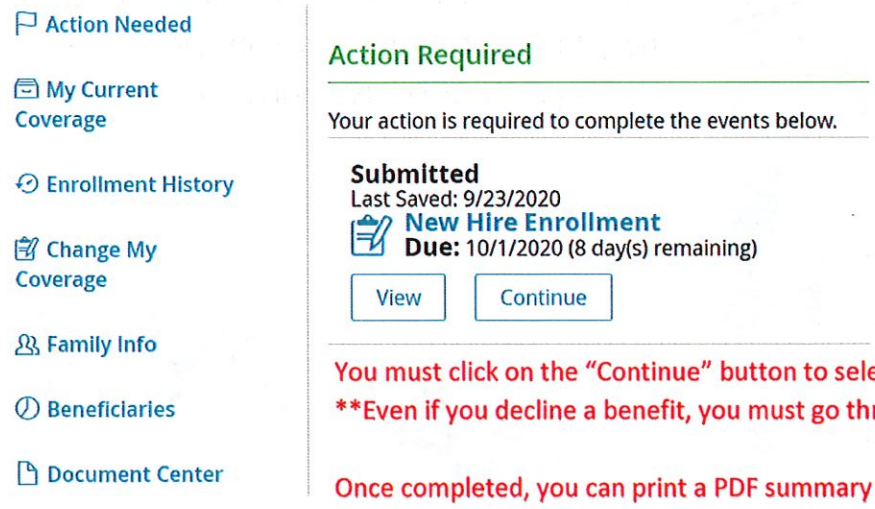
Navigate to the left Panel under Paylocity, click "Benefits" as shown below:



Step 2: Click on "Benefits" as shown below:

Step 3: Benefit options will display as such:

Example:



You must click on the "Continue" button to select you benefits.
**Even if you decline a benefit, you must go through and select that option.

Once completed, you can print a PDF summary of your benefit elections.

HR will review and approve elections that will be submitted for payroll deductions.

If you have additional questions, email: Nabria randolph@bgcofslc.org or Maurine mseptimus@bgcofslc.org

BOYS & GIRLS CLUBS
OF ST. LUCIE COUNTY

EMPLOYEE BENEFITS

HEALTH CARE (Full-Time Employees)

BGCSLC offers (3) medical plans provided through Florida Blue and pays 79% of the employee's insurance premium. Employees are responsible for additional dependents added to the insurance.

DENTAL & VISION CARE (Full-Time Employees)

BGCSLC offers (2) dental & (2) vision options provided through Guardian and pays 100% of the employee's insurance premium ($0 per paycheck for coverage). Employee's are only responsible for additional dependents added to the insurance.

401K RETIREMENT BENEFITS

(All qualified employees)

Retirement benefits are administered through Principal. Employees who are 21 years of age and completes at least 90 days of service with BGCSLC are eligible to contribute up to 100% towards their retirement with the ability to roll over previous plans into the (1) account under Principal. BGCSLC contributes dollar for dollar up to 5% of the employee's earnings. Example: Jane Doe contributes 5% of her earnings ($200), so BGCSLC will match $200.

LIFE INSURANCE (Full-Time Employees)

All full-time employees are eligible to participate in a $10,000 group life and accidental death and dismemberment insurance program administered through Guardian. BGCSLC pays 100% of the employee's premium ($0 per paycheck for coverge.)

ADDITIONAL INSURANCE THROUGH GUARDIAN (All employees)

BGCSLC offers employee to enroll in additional benefits at their cost:

- Voluntary/Supplemental Life Insurance
- Accident Insurance
- Cancer Insurance
- Hospital Indemnity Insurance (seperate from medical insurance)
- Critical Illness Insurance

SHORT& LONG TERM DISABILITY

(Full-Time Employees)

BGCSLC offers both short-term and long-term disability insurance provided through Guardian to full-employees and pays 100% of the employee's insurance premium ($0 per paycheck for coverage). Short-term pays the employee 66.6% of earnings for 26 weeks of disability. Long-term pays the employee 66.6% of earnings after 26 weeks of disability.

BEREAVEMENT LEAVE (All Employees)

BGCSLC pays employees for up to 3 days for the death of an immediate family member: include spouses, parents, brothers, sisters, children, grandparents, grandchildren, brothers-in-law, sisters-in-law and parents-in-law.

JURY DUTY LEAVE (All Employees)

BGCSLC will pay employees, who are summoned for jury duty, the difference between jury duty pay and regular salary (not including travel allowance) provided the day falls on a regularly scheduled workday, and does not exceed two weeks.

FAMILY MEDICAL LEAVE/MILITARY LEAVE (All qualified employees)

FMLA allows an eligible employee to take up to twelve (12) weeks of job-and-benefit-protected-leave from work within a twelve-month period to attend to specific family and medical needs. To qualify an employee must have worked for the same employer for at least 12 months (not necessarily continuously) and clocked at least 1,250 hours of service (slightly more than 24 hours per week) during the 12 months leading up to FMLA.

Uniformed Services Employment and Reemployment Rights Act guarantees the rights of military service members to take a leave of absence from their civilian jobs for active military service and to return to their jobs with accrued seniority and other employment protections. An unpaid leave of absence for a period not to exceed 5 years to perform any form of military service, whether voluntarily or involuntarily, called or activated, such as being placed on active duty, for annual training, and for training weekends.

HOLIDAYS (Full-Time Employees)

BGCSLC provides full-time with 10 paid holidays to include a Floating Holiday; see attached for more details.

PAID TIME OFF (Full-Time Employees)

BGCSLC provides new full-time employees up to 2 weeks for the 1st year which may be used for any purpose including illness or vacation. Employees accrues each pay period and can carry up to 40 hours maximum for following year. See attached for more details.

EMPLOYEE ASSISTANCE PROGRAM

(All Employees)

BGCSLC pays 100% for all employees to use the "EAP" program administered through Guardian, which offers up to 3 face to face counseling visits per employee/ household member per year. This program offers a variety of benefits to include: Counseling, Coaching, College Planning, Legal Consultation, etc.

PUBLIC SERVICE LOAN FORGIVENESS (federal direct loan)

Boys & Girls Clubs of St. Lucie County qualifies as a “not for profit organization” to those employees who may qualify for the student loan forgiveness program. For more information go to StudentAid.gov/publicservice

SERVICE AWARDS

Employees receive certificates and awards for continued service, with BGCSLC, annually.

Holiday Schedule

10 Paid Holidays
(Full-Time Employees Only)

*Memorial Day
*Independence Day
*Labor Day
*Thanksgiving Day
*Day after Thanksgiving - "Black Friday"
*Christmas Eve
*Christmas Day
*New Year's Eve
*New Year's Day
*Floating Holiday

If one of the above holidays falls on a Saturday, it will be observed the preceding Friday. If one falls on a Sunday, it will be observed the following Monday. All full time employees, regardless of introductory period, are eligible for paid holidays immediately upon hire.

Paid Time Off ~ PTO

Paid Time Off (FULL-TIME EMPLOYEES ONLY)

Paid Time Off (PTO) program combines all vacation, personal, and sick days into one bank, and is available for full-time employees only.

PTO will accrue per period as shown below, and will be available to use immediately. All full-time new hires will begin accruing PTO from the first day of work.

Years	Accrual Rate	Accrual Frequency	PTO Amount (hrs. wks. days)
0 – 1 year	accrues 3.076923 hours	per pay period	(80 hours/2 weeks/10 days)
2 – 4 years	accrues 4.6153846 hours	per pay period	(120 hours/3 weeks/15 days)
5 – 9 years	accrues 6.1538461 hours	per pay period	(160 hours/4 weeks/20 days)
10 – 14 years	accrues 7.6923076 hours	per pay period	(200 hours/5 weeks/25 days)
15 and over	accrues 9.2307692 hours	per pay period	(240 hours/6 weeks/30 days)

The management staff strongly encourages all employees to use their accumulated PTO hours for rest and relaxation or personal use.
Each January (unless indicated otherwise), full-time employees will only roll over 40 hours of PTO or less and then continue to accrue his/her normal hours on top of the new balance.

BOYS & GIRLS CLUBS
OF ST. LUCIE COUNTY

25 years
Whatever it Takes

We're bringing it back! Stay tuned...

"Shining Star" Recognition Program

Each quarter a part-time, full-time, and administrative employee is recognized, by peers, for representing one or more of our organizational values;
Respect, Commitment, Work Ethic, Teamwork, Innovation, Passion, Caring, and FUN!
Each quarterly winner is entered in the Shining Star of The Years' pool.
The Part-Time yearly winner receives a plaque, photo & $1000.
The Full-Time yearly winner receives a plaque, photo & $500.
Administrative yearly winner receives a plaque, photo & $250.

BOYS & GIRLS CLUBS
OF ST. LUCIE COUNTY

EMPLOYEE REFERRAL BONUS

Current employees will receive a $30 Referral Bonus for every applicant he/she refers.

The applicant referred must be hired and have worked the first 90 days of employment with BGCSLC before the referral bonus will be disbursed to the employee who referred the applicant.

Employee Child/ren Membership Discount

CLUB TUİTİON FEES ARE WAİVED FOR EMPLOYEE'S CHİLD/REN. EMPLOYEES ARE ONLY REQUİRED TO PAY CLUB MEMBERSHİP FEES AND FİELD TRİP FEES.

FOR ADDİTİONAL INFORMATİON OR OTHER UNİQUE SİTUATİONS, PLEASE CONTACT THE FİNANCE DEPARTMENT, 772-460-9918

Principal®

Principal is the #1 provider of Defined Benefit retirement plans
#1 Record keeper of Employee Stock Ownership Plans
#1 Provider of Non-qualified Deferred Compensation plans

Eligibility Requirements:

- Employed with Boys & Girls Clubs of St. Lucie County "BGCSLC"
- At least 21 years of age
- Must complete at least 90 days of service with BGCSLC

An employee may choose to contribute up to 100% of his/her total pay.
An employee may stop making salary contributions at any time andchange the amount daily. Changes will be implemented as soon as administratively feasible.
Retirement accounts from previous employers may be rolled over into this plan all or a portion. BGCSLC contributes dollar for dollar up to 5% of the employee's earnings.
Example: Jane Doe contributes 5% of her earnings ($200), so BGCSLC will match $200.

Start Saving For Retirement!

Visit principal.com/welcome

For more detailed information, please contact Susanne Patterson (CFO), Plan Administrator at 772-460-9918, ext. 104 (M-F 9am-5pm)

BOYS & GIRLS CLUBS
OF ST. LUCIE COUNTY

25 years
Whatever it Takes

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Boys & Girls Clubs of St. Lucie County's Medical Insurance Premium Rates for 2022

* FULL-TIME Employees ONLY*

NO CHANGE IN PRICING!!!

BGCSLC- 2021 TRUE Monthly Rates	BlueOptions 5800	BlueCare 51	BlueCare 124/125	
Employee Only	$614.83	$605.75	$595.90	
Employee + Spouse	$1,463.29	$1,441.70	$1,220.09	
Employee + Child(ren)	$1,155.87	$1,138.82	$963.77	
Family	$1,952.07	$1,923.28	$1,627.65	
BGCSLC - 2022 TRUE Monthly Rates	**BlueOptions 5800**	**BlueCare 51**	**BlueCare 124/125**	
Employee Only	$605.21	$627.57	$617.36	
Employee + Spouse	$1,440.41	$1,493.61	$1,264.04	
Employee + Child(ren)	$1,137.81	$1,179.83	$998.49	
Family	$1,921.55	$1,992.53	$1,686.26	
BGCSLC - Employee pricing per paycheck/per month	**BlueOptions 5800**	**BlueCare 51**	**BlueCare 124/125**	
Employee Only	$59.80 PP/$129.56 PM	$58.76 PP/$127.31 PM	$57.80 PP/$125.23 PM	
Employee + Spouse	$389.88 PP/$844.74 PM	$383.12 PP/$830.09 PM	$300.01 PP/$650.02 PM	
Employee + Child(ren)	$270.28 PP/$585.60 PM	$265.60 PP/$575.46 PM	$200.56 PP/$434.54 PM	
Family	$580.03 PP/$1,256.73 PM	$569.98 PP/$1,234.95 PM	$458.15 PP/$992.65 PM	

BOYS & GIRLS CLUBS
OF ST. LUCIE COUNTY

BOYS AND GIRLS CLUB OF ST. LUCIE COUNTY
Florida Blue Plans
1/1/2022 - 12/31/2022

	Plan 1	Plan 2	Plan 3
In-Network Benefits	Florida Blue	Florida Blue	Florida Blue
Plan Name	**BlueOptions Lower Premium 5800**	**BlueCare HSA Compatible 124/125**	**BlueCare 51**
Plan Type	**PPO**	**HMO**	**HMO**
Network Name	**BlueOptions**	**BlueCare HSA**	**BlueCare**
Metallic Teir	**N/A**	**N/A**	**N/A**
Individual Deductible (In/Out)	$1,500 / $4,500 per person	$1,500 per person / not covered	$1,500 per person / not covered
Family Deductible (In/Out)	$1,500 / $4,500 per person	$3,000 per person / not covered	$1,500 per person / not covered
Coinsurance - Carrier (In)	50%	90%	50%
Individual Out-Of-Pocket Max (In/Out)	$10,000 / $20,000 per person	$3,000 per person / not covered	$10,000 per person / not covered
Family Out-Of-Pocket Max (In/Out)	$10,000 / $20,000 per person	$6,000 per person / not covered	$10,000 per person / not covered
Primary Care Physician CoPay (In)	$35	Deductible + 10%	$35
Specialist CoPay (In)	$50	Deductible + 10%	$50
Telehealth (In)	$0	Deductible + 10%	$0
Lab and X-ray (In)	L-$0 / X-Deductible + 50%	Deductible + 10%	L-$0 / X-$50
Advanced Imaging (In)	$250	Deductible + 10%	$200
Rx Deductible (Ind/Fam)	N/A	N/A	$300* (Excludes Generic)
Rx Drug Card (In)	Generic Only - $10	Access to Discounts	$10 / $30* / $50*
Specialty Medications (In)	N/A	N/A	N/A
Mail Order (In)	Generic Only - $25	Access to Discounts	$25 / $75* / $125*
Urgent Care (In)	50% coinsurance	Deductible + 10%	$70
Emergency Room (In/Out)	Deductible + 50%	Deductible + 10%	$300
Inpatient Hospital Stay (In)	Deductible + 50%	Deductible + 10%	Deductible + 50%
Outpatient Surgery (In)	$300	Deductible + 10%	Deductible + 50%
Out-of-Network Benefits	**See SBC**	**See SBC**	**See SBC**

Premiums & Payroll Deductions (26)	**Monthly Premiums**	**Payroll Deductions**	**Monthly Premiums**	**Payroll Deductions**	**Monthly Premiums**	**Payroll Deductions**
Employee	$605.21	$59.80	$617.36	$57.80	$627.57	$58.76
Employee + Spouse	$1,440.41	$389.88	$1,264.04	$300.01	$1,493.61	$383.12
Employee + Child	$1,137.81	$270.28	$998.49	$200.56	$1,179.83	$265.60
Employee + Family	$1,921.55	$580.03	$1,686.26	$458.15	$1,992.53	$569.98

This summary is not intended to be a complete explanation of benefits of the proposed insurance policies. Actual premiums and benefits will be determined by the final enrollment and are subject to underwriting approval.

Florida Blue HMO

BlueCare 124

HSA Compatible with Rx Discount

Coverage Period: 01/01/2022 - 12/31/2022

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/groupor call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$3,000** Per Person. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible + 10% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Access to Discounts	Not Covered	——none——
	Preferred brand drugs	Access to Discounts	Not Covered	——none——
	Non-preferred brand drugs	Access to Discounts	Not Covered	——none——
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	——none——
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	——none——
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	——none——
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: Deductible/ Urgent Care Visits: Deductible + 10% Coinsurance	Not Covered	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Not Covered	Inpatient Rehab Services limited to 21 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	——none——

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 10% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs	Children's eye exam	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,670**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,200
The total Joe would pay is	**$5,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,610**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Florida Blue HMO

BlueCare 125

HSA Compatible with Rx Discount

Coverage Period: 01/01/2022 - 12/31/2022

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/groupor call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,000** Per Person/**$3,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,000** Per Person/**$6,000** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible + 10% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Access to Discounts	Not Covered	——none——
	Preferred brand drugs	Access to Discounts	Not Covered	——none——
	Non-preferred brand drugs	Access to Discounts	Not Covered	——none——
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	——none——
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	——none——
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	——none——
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: Deductible/ Urgent Care Visits: Deductible + 10% Coinsurance	Not Covered	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Not Covered	Inpatient Rehab Services limited to 21 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	——none——

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 10% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs	Children's eye exam	Not Covered	Not Covered	Not Covered

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,070**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,200
The total Joe would pay is	**$5,300**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Florida Blue HMO

BlueCare 51

with Rx $300 Rx Deductible $10/$30/$50

Coverage Period: 01/01/2022 - 12/31/2022

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual and/or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/groupor call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$300** Pharmacy Deductible; . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$10,000** Per Person/**$10,000** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge/ Primary Care Visits: $35 Copay per Visit/ Virtual Visits: No Charge	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $50 Copay per Visit/ Virtual Visits: $50 Copay per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $50 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Physician Office: $300 Copay per Visit/ Independent Diagnostic Testing Center: $200 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$300 Pharmacy Deductible + $30 Copay per Prescription at retail, $300 Pharmacy Deductible + $75 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$300 Pharmacy Deductible + $50 Copay per Prescription at retail, $300 Pharmacy Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 50% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 50% Coinsurance	Not Covered	——none——
If you need immediate medical attention	Emergency room care	$300 Copay per Visit	$300 Copay per Visit	——none——
	Emergency medical transportation	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: No Charge - Visits 1-2 $70 Copay for remaining Visits/ Urgent	Not Covered	——none——

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Care Visits: $70 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 50% Coinsurance	Not Covered	Inpatient Rehab Services limited to 21 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 50% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office: $50 Copay per Visit/ Specialist Virtual Visits: No Charge/ Hospital: No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Physician Services: $50 Copay per Visit / Hospital: No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$50 Copay on initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 50% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 50% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	$50 Copay per Visit	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 50% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Durable medical equipment	Motorized Wheelchairs: $500 Copay per Visit/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 50% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	50%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$5,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,570**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	50%
Other No Charge	$0

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$300
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,530**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	50%
Other Copayment	$300

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,190**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Florida Blue

BlueOptions 5800

Mental Health Parity with Rx $10 Generic Only

Coverage Period: 01/01/2022 - 12/31/2022

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Individual and/or Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/groupor call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person. Out-of-Network: **$4,500** Per Person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$10,000** Per Person/**$10,000** Family. Out-Of-Network: **$20,000** Per Person/**$20,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SBCID: 2368701

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge/ Primary Care Visits: $35 Copay per Visit/ Virtual Visits: No Charge	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $50 Copay per Visit/ Virtual Visits: $50 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$250 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Not Covered	Not Covered	Not Covered
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital Option 1: $300 Copay per Visit	Deductible + 50% Coinsurance	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 50% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 50% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Emergency medical transportation	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge - Visits 1-2 + 50% for remaining Visits/ Urgent Care Visits: 50% Coinsurance	Value Choice Provider: Not Covered/ Urgent Care Visits: Deductible + 50% Coinsurance	————none————
If you have a hospital	Facility fee (e.g., hospital room)	Deductible + 50%	Deductible + 50%	Inpatient Rehab Services limited to 21 days.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
stay		Coinsurance	Coinsurance	
	Physician/surgeon fees	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge/ Specialist Virtual Visits: No Charge	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge	Physician Services: No Charge/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$50 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 50% Coinsurance	In-Network Deductible + 50% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 10 visits.
	Rehabilitation services	$50 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 25 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 50% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs	Children's eye exam	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Preferred brand drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 25 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **No**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	50%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$5,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,570**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	50%
Other Coinsurance	50%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,200
The total Joe would pay is	**$4,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

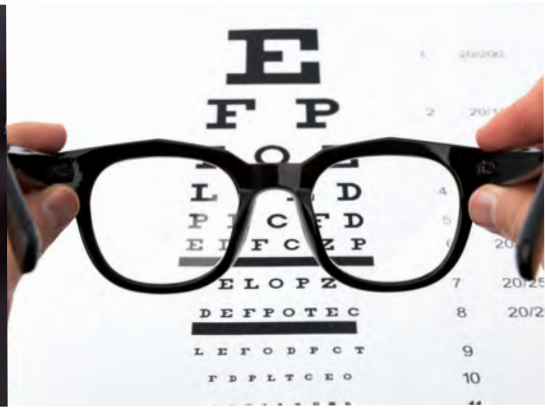
The plan's overall deductible	$1,500
Specialist Copayment	$50
Hospital (facility) Coinsurance	50%
Other Coinsurance	50%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Guardian



BOYS & GIRLS CLUBS
OF ST. LUCIE COUNTY

25 years
Whatever it Takes

BOYS & GIRLS CLUBS
Workers Association

BGCWA Life, LTD, STD, Dental, and Vision 2022 Rate Sheet

DENTAL PLUS PLAN				
	EMPLOYEE	**EE+SPOUSE**	**EE+ CHILDREN**	**FAMILY**
EE COSTS	$0	$15.09 PP/$32.70 PM	$19.04 PP/$41.25 PM	$27.83 PP/$60.30 PM
TRUE COSTS	$40.29 PM	$78.47 PM	$88.47 PM	$110.70 PM
DENTAL BASE PLAN				
	EMPLOYEE	**EE+SPOUSE**	**EE+CHILDREN**	**FAMILY**
EE COSTS	$0	$7.55 PP/$16.36 PM	$9.52 PP/$20.63 PM	$13.91PP/ $30.14 PM
TRUE COSTS	$20.13 PM	$39.21 PM	$44.21 PM	$55.31 PM

VISION PLUS PLAN				
	EMPLOYEE	**EE+SPOUSE**	**EE+ CHILDREN**	**FAMILY**
EE COSTS	$0	$3.47 PP/$7.51 PM	$5.36 PP/$11.61 PM	$9.14 PP/$19.80 PM
TRUE COSTS	$8.40 PM	$15.54 PM	$19.43 PM	$27.21 PM
VISION BASE PLAN				
	EMPLOYEE	**EE+SPOUSE**	**EE+CHILDREN**	**FAMILY**
EE COSTS	$0	$1.97 PP/$4.27 PM	$2.69 PP/$5.83 PM	$4.67 PP/ $10.12PM
TRUE COSTS	$4.51 PM	$8.56 PM	$10.04 PM	$14.12 PM

BASIC LIFE & AD&D		SUPPLEMENTAL LIFE INSURANCE PLAN			
Employee Age	Employee Rates per $1,000 with AD&D	Employee Age	Employee Rate Per $1,000 with AD&D	Spouse Rate per $1,000 with AD&D *use Employee Age	Child Rate for $10,000 of coverage
<30	$0.17 per Thousand	<30	$0.063	$0.093	$1.60 Per Child(ren)
30-39		30-39	$0.090	$0.120	
40-44		40-44	$0.144	$0.174	
45-49		45-49	$0.216	$0.246	
50-54		50-54	$0.324	$0.354	
55-59		55-59	$0.495	$0.525	
60-64		60-64	$0.792	$0.822	
65-69		65-69	$1.197	$1.227	
70+		70+	$2.718	$2.748	

SHORT TERM DISABILITY	LONG TERM DISABILITY
Coverage for first 26 weeks of disability	Coverage starts after 26 weeks of disability
$19.00 per Month	$.39 per $100 of gross monthly salary

BOYS & GIRLS CLUB WORKERS ASSOCIATION

2022 GUARDIAN ANCILLARY BENEFITS

Dental

PLAN NAME	LOW OPTION		HIGH OPTION	
	IN	OUT	IN	OUT
INDIVIDUAL DEDUCTIBLE	$50	$50	$0	$0
DEDUCTIBLE PERIOD	Calendar Year		Calendar Year	
FAMILY LIMIT	2x Individual	2x Individual	2x Individual	2x Individual
WAIVED FOR	Preventive	Preventive	Preventive	Preventive
PREVENTIVE	100%	100%	100%	100%
BASIC	70%	70%	70%	70%
MAJOR	50%	50%	70%	70%
ANNUAL MAXIMUM	$800		$1,350	
CLAIM PAYMENT BASIS	Fee Schedule	90th UCR	Fee Schedule	90th UCR
CHILD AGE LIMIT	To age 26		To age 26	
ORTHODONTIA	None		70% Adult & Child Orthodontia	
ORTHODONTIA LIFETIME MAXIMUM	N/A		$1,500	
MAXIMUM ROLLOVER	Included		Included	

Life/AD&D

PLAN NAME	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
BENEFIT AMOUNT	$10,000	$20,000	1x salary	2x salary	3x salary
GUARANTEED ISSUE	$10,000	$20,000	$100,000	$400,000	$400,000
AGE REDUCTION					
AGES 65-69	65%				
AGES 70+	50%				

Voluntary Life/AD&D

PRIMARY BENEFITS	PLAN
EMPLOYEE	
BENEFIT AMOUNT	$10,000 - $500,000
INCREMENTS	$10,000
AD&D	100% of Life benefit
DEPENDENT	
SPOUSE BENEFIT AMOUNT	$5,000 - $100,000 (subject to 100% of EE amount)
SPOUSE INCREMENTS	$5,000
CHILD(REN) BENEFIT AMOUNT	$10,000 ((subject to 100% of EE amount)
CHILD(REN) INCREMENTS	$10,000
INFANT (birth to 14 days)	$500
AD&D	100% of Life benefit
GUARANTEE ISSUE	
EMPLOYEE	$100,000
SPOUSE	$30,000
CHILD(REN)	$10,000

Vision

PLAN NAME	LOW OPTION		HIGH OPTION	
	IN	OUT	IN	OUT
EYE EXAMS				
FREQUENCY	12 months		12 months	
MATERIALS	$10 copay	$59 reimb.	$10 copay	$59 reimb.
LENSES				
FREQUENCY	12 months		12 months	
SINGLE VISION	$25 copay	$30 reimb.	$25 copay	$30 reimb.
BIFOCAL	$25 copay	$50 reimb.	$25 copay	$50 reimb.
TRIFOCAL	$25 copay	$65 reimb.	$25 copay	$65 reimb.
LENTICULAR	$25 copay	$100 reimb.	$25 copay	$100 reimb.
CONTACT LENSES	*(in lieu of complete set of glasses)*			
FREQUENCY	12 months		12 months	
ELECTIVE ALLOWANCE	Up to $150; copay waived	Up to $120; copay waived	Up to $150; copay waived	Up to $120; copay waived
FITTING & EVALUATION	Standard: $50 Custom: $75	Included in allowance	Standard: $50 Custom: $75	Included in allowance
FRAMES				
FREQUENCY	12 months		12 months	
ALLOWANCE	Up to $150 max; +20%	Up to $70	Up to $150 max; +20%	Up to $70
CHILD AGE LIMIT	To age 26		To age 26	

Long Term Disability

PRIMARY BENEFITS	PLAN
BENEFIT PERCENTAGE	66.67%
MAXIMUM MONTHLY BENEFIT	$15,000
MINIMUM MONTHLY BENEFIT	$100
ELIMINATION PERIOD	180 days
DURATION OF BENEFITS	SSNRA

Short Term Disability

PRIMARY BENEFITS	PLAN
BENEFIT PERCENTAGE	66.67%
MAXIMUM WEEKLY BENEFIT	$2,000
BENEFITS BEGIN	
ACCIDENT/INJURY	8th day
SICKNESS	8th day
MAXIMUM BENEFIT DURATION	26 weeks

Guardian

Dental Insurance

Guardian

Boys & Girls Club Workers Association
Plan Number: 553830

Smile. There's an affordable way to care for your teeth.

Helping you stay healthy

Taking care of your teeth can be expensive. That's why dental insurance is so important — it not only pays for preventive care that can keep you and your family healthy, but it also helps pay for more extensive, costly and often unexpected expenses — such as fillings, crowns and root canals. Plus, you save money and have the assurance that you are getting the care you want when you use one of our in-network dentists.

Why choose Guardian® for your dental coverage

- We have been providing outstanding dental plans to Americans for more than 50 years. When you enroll in a Guardian Dental plan, you have access to one of the nation's largest dental networks, so you know there's always high quality dental care close by.
- From preventive checkups and cleanings, to comprehensive oral care treatments, we have you covered.

How Guardian Dental can help save you money*

Here is an example of how much a root canal can cost when you have dental insurance and use an in-network dentist vs. not having insurance.

Cost with no dental insurance	$2,400
Cost with Guardian Dental and using in-network dentist	$1,600
Your estimated savings with Guardian Dental Insurance:	$800

Did you know...?

92.4 million work or school hours are lost each year to emergency dental care in the U.S.[1]

80% of the U.S. population has had at least one cavity by age 34 and 50% show signs of periodontal (gum) disease.[2]

It's easy to use your plan

To find an in-network dentist go to guardianlife.com or download Guardian's *'Find a Provider and ID Card'* app to your mobile device.

Get the benefits of having Guardian Dental

- No ID cards needed
- Quick and easy claim payments
- Convenient payroll deduction
- Most plans cover 100% of preventive care costs

Learn more about Dental Insurance at guardianlife.com

The Guardian Life Insurance Company of America
New York, NY

guardianlife.com

*Illustrative example only. See your plan for specific details regarding covered services.
1 "Hours Lost to Planned and Unplanned Dental Visits Among US Adults," 2018, Center for Disease Control and Prevention. 2 "Oral Health Basics," May 2, 2018, Centers for Disease Control and Prevention. DentalGuard Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides DENTAL insurance only. GUARDIAN ® is a registered trademark of The Guardian Life Insurance Company of America®.
 Policy Form # GP-1-DG2000, et al; GP-DEN-16.

2020-105170 (07/22)

PRIMARY BENEFITS	LOW OPTION		HIGH OPTION	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
INDIVIDUAL DEDUCTIBLE	$50	$50	$0	$0
DEDUCTIBLE PERIOD	CALENDAR YEAR		CALENDAR YEAR	
FAMILY LIMIT	2 INDIVIDUAL DEDUCTIBLES		NOT APPLICABLE	
WAIVED FOR COINSURANCE	PREVENTIVE SERVICES		PREVENTIVE SERVICES	
ANNUAL MAXIMUM	$800		$1,350	
CHILD AGE LIMI T	TO AGE 26		TO AGE 26	
MAXIMUM ROLLOVER	INCLUDED		INCLUDED	
COLLEGE TUITON BENEFIT	INCLUDED		INCLUDED	
PREVENTIVE				
EXAMS	100%	100%	100%	100%
CLEANINGS	100%	100%	100%	100%
SEALANTS (PER TOOTH)	100%	100%	100%	100%
X-RAYS	100%	100%	100%	100%
BASIC				
FILLINGS	70%	70%	70%	70%
ORAL SURGERY	70%	70%	70%	70%
PERIODONTICS	70%	70%	70%	70%
ENDODONTICS	70%	70%	70%	70%
MAJOR				
IMPLANTS	50%	50%	70%	70%
CROWNS	50%	50%	70%	70%
BRIDGES	50%	50%	70%	70%
DENTURES	50%	50%	70%	70%
REPAIRS	50%	50%	70%	70%
ORTHODONTIA				
BENEFITS	None		70% ADULT & CHILD(REN)	
LIFETIME MAXIMUM	None		$1,500	

*The content and plan information contained in this document is provided to you by your Plan Sponsor, and Boys & Girls Club Workers Association and is for illustration purposes only. If you have questions about the actual terms of coverage including any applicable limits and exclusions, please contact your plan administrator for a copy of Certificate of Coverage issued by Guardian, or the Summary Plan Description. The Policy of Group Insurance and the Certificate of Coverage provide the terms of your coverage, and control in the event of any conflict with any other documents.

** Frequencies and limits apply.

Important information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO Plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect or injury. Deductibles apply. Waiting periods may also apply for some services. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provide for), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no change is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic and prosthodontic services. The services, exclusions, and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final documents are the final arbiter of coverage.

Welcome to the College Tuition Benefits Rewards program! Your Plan Sponsor has worked with Guardian to make College Tuition Benefit services available to eligible participants enrolling in the following coverage/option(s):

Coverage	Option
Dental	Option 1: LOW OPTION Option 2: HIGH OPTION

Register Today!

You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at over 380 private colleges and universities across the nation. In 2016, over $60 million in College Tuition Benefit Rewards were submitted by high school seniors. **Here is how it works:**

- Annual enrollment in this plan earns you 2,000 Tuition Rewards (1 Reward = $1 in tuition reduction at a network of Private Colleges and Universities) for each line of Guardian coverage (up to four lines).
- Guardian Dental participants receive a bonus after year four.
- These rewards are yours for your lifetime and can be given to children, grandchildren, nieces, nephews and godchildren.

The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian.

Print and cut out ID Card

College Tuition Benefits Rewards- ID Card

Register@
www.Guardian.CollegeTuitionBenefit.com

User ID: Is Your Guardian Group Plan Number that can be found on your benefit booklet
Password: Guardian

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The College Tuition Benefit
435 Devon Park Drive
Building 400, Suite 410
Wayne, PA 19087
Phone:(215) 839-0119
Fax: (215) 392-3255

Vision Insurance

Guardian

Boys & Girls Club Workers Association
Plan Number: 553830

Keep an Eye on Your Vision Health

Helps save you money and improves your health

Whether you have perfect vision, or require some type of corrective lenses, preventive eye care can be an important part of your overall health. Guardian® Vision Insurance can help you offset the expensive costs of exams, frames, contact lenses, corrective surgery and more.

Regular Eye Exams Can Detect Medical Problems

Research shows that regular vision exams can help identify vision issues before they become serious.[1] Having a vision plan can also benefit your family, and in particular your children, since problems with vision can affect their progress in school. Other conditions that can be detected with regular vision exams include:[2]

- Diabetes
- High Blood Pressure
- Increased Stroke Risk
- Autoimmune Diseases
- Excessive Thyroid Hormones

Vision Insurance with Guardian

With Guardian Vision coverage, you have access to quality vision care from an extensive network of eye care providers with thousands of service locations across the nation. For just a few dollars a month, you and your family can take advantage of affordable coverage that can save you time and money.

It's Easy to Use Your Plan

To quickly find vision providers or retail locations go to guardiananytime.com or download Guardian's 'Find a Provider and ID Card' app to your mobile device.

Get the Benefits of Guardian Vision

- No ID cards needed
- Nationwide network including convenient retail locations
- Quick and easy claim payments
- Convenient payroll deductions

See the Values of Healthy Vision

- Two-thirds of all adults report wearing some type of eyewear.[2]
- 90% of adults who use a computer at least 3 hours a day suffer vision problems associated with computer eye strain.[3]
- 1 in 4 school-age children have vision problems that, if left untreated, can affect learning ability, personality and adjustment in school.[4]

Learn more about Vision Insurance at guardiananytime.com

The Guardian Life Insurance Company of America
New York, NY

guardiananytime.com

2019-85052 (09-21)

1 VSP, Eye Health and Wellness, Serious Diseases Detected Through an Eye Exam, vsp.com/eyewear-wellness/eye-health/eye-exams-detect-health-problems, 2019; 2 Why Are Eye Exams Important?Allaboutvision.com/eye exam/importance.htm, 2016. 2 "Vision Care: Focusing on the Workplace Benefit", The Vision Council, 2018; thevisioncouncil.org/sites/default/files/members/Vision%20Coverage%20Report%20 FINAL.pdf; 3 "Vision Care: Focusing on the Workplace Benefit", The Vision Council, 2018, thevisioncouncil.org/sites/default/files/members/Vision%20Coverage%20Report%20FINAL.pdf; 4 "School-aged vision: 6 to 18 years of age," American Optometric Association, aoa.org, 2019. Guardian's Vision Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides vision care limited benefits health insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America®. GP-1-GVSN-17; GP-1-VSN-96-VISGP-1-Davis-05-VIS.

GUARDIAN VISION

COPAYS	LOW OPTION		HIGH OPTION	
EXAMS	$10 copay		$10 copay	
MATERIALS	$25 copay		$25 copay	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
EYE EXAMS (Every 12 months)				
EXAMS	$10 copay	$59 reimbursement	$10 copay	$59 reimbursement
LENSES (Every 12 months)				
LENS-SINGLE VISION	$25 copay	$30 reimbursement	$25 copay	$30 reimbursement
LENS-BIFOCAL	$25 copay	$50 reimbursement	$25 copay	$50 reimbursement
LENS-TRIFOCAL	$25 copay	$65 reimbursement	$25 copay	$65 reimbursement
LENS-LENTICULAR	$25 copay	$100 reimbursement	$25 copay	$100 reimbursement
CONTACT LENSES (Every 12 months) [1,2]				
ELECTIVE ALLOWANCE	Guardian will pay $150 maximum (copay waived)	Guardian will pay $120 maximum (copay waived)	Guardian will pay $150 maximum (copay waived)	Guardian will pay $120 maximum (copay waived)
FITTING & EVALUATION[3]	Standard: $50 Custom: $75 (member pays)	Included in contact lens allowance	Standard: $50 Custom: $75 (member pays)	Included in contact lens allowance
FRAMES (Every 12 months)				
ALLOWANCE	Guardian will pay $150 retail maximum and 20% off balance	Guardian will pay $70 maximum	Guardian will pay $150 retail maximum and 20% off balance	Guardian will pay $70 maximum
OPTIONS INCLUDE	Scratch Resistant Coating	N/A	Scratch Resistant Coating; Polycarbonate Lenses for Adults; Progressive Lens; Glasses & Contacts	N/A

1. Low option: benefit includes coverage for glasses or contact lenses, not both
2. High option: members can purchase one set of contact lenses and one pair of glasses in a benefit period
3. The contact lens allowance is applied to the cost of the contacts and the fitting and evaluation when the member utilizes an OON provider.

+ Complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period.

*The services, exclusions, and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and employer-sponsored plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium deducted from your paycheck, the latter prevails.

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS:
Coverage is limited to those charges that are necessary to prevent, diagnose and treat a vision condition; If the member purchases contact lenses they must wait one calendar year/two calendar years to purchase frames; Members cannot bank unused allowance amounts for future use, they must use their allowance during the same office visit; The plan does not pay for: Orthoptics or vision training and any associated supplemental testing, Medical or surgical treatment of the eye, Eye examination or corrective eyewear required by an employer as a condition of employment, Lenses and frames furnished under this plan, which are lost or broken (except when services are otherwise available); The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses, U-V protected lenses, and optional cosmetic processes Medically necessary contact lenses are covered only if needed: (1) after cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with eyeglasses; (3) for certain conditions of Anisometropia; or (4) for Keratoconus. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage.]

Life Insurance

Guardian

BOYS & GIRLS CLUB WORKERS ASSOCIATION
Plan Number: 554610

A Guarantee You Can Count On

Helping to secure your financial future

We all want to live a long and happy life. However, life can be unpredictable and few things in life are guaranteed. Having an appropriate amount of life insurance for yourself and those who depend on you provides a guarantee they can count on.

Life insurance is not just about final expenses. Depending on your unique circumstances, it could take years to financially recover from the loss of an income earner. When the unexpected happens, life insurance is there to help those left behind get back on their feet and cover expenses such as:

- Mortgage/rent
- Legal or medical fees
- Childcare assistance
- Education/college tuition
- Outstanding debts

Why enroll for Life Insurance at work

Taking advantage of your benefits at work is a smart and affordable way to get the financial protection you want for you and your family. As your life changes, so should your life insurance coverage. You should review your options each year and consider increasing your coverage if you get married, have a child or purchase a home.

How it works

Your company's plan may come with features and benefits that you can use during your lifetime. Take a few minutes to review your plan details and determine how much life insurance you need, and what plan features can help you live better today.

How much do you need?

While your situation is unique, a good 'rule of thumb' is to have coverage equal to seven to ten times your annual salary.

7 to 10 years × Annual Salary = Policy Amount

It's never been easier to get the protection you want

- Simple enrollment and affordable group rates
- Available for spouse and dependent children
- Convenient payroll deductions

Did you know...?

70% of all households said they would have trouble covering everyday living expenses after several months if the primary wage earner died.[1]

Is the benefit to my beneficiary taxed?

Life insurance proceeds paid to your beneficiary are not typically subject to income tax but check with your tax advisor before making any changes to your policy.

Can I take my coverage with me if I retire or leave the company?

Yes, many plans offer options to continue your coverage through direct payment to Guardian®.

Learn more about Life Insurance at guardiananytime.com

The Guardian Life Insurance Company of America
New York, NY

guardiananytime.com

[1] Facts About Life 2016, LIMRA: https://www.limra.com/uploadedFiles/limra.com/LIMRA_Root/Posts/PR/_Media/PDFs/Facts-of-Life-2016.pdf. Guardian Group Life Insurance is underwritten by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America®. Group Term Life Policy Form No. GP-1-Life-15.

2018-64029 (08/20)

Basic Term Life	Employee Coverage
EMPLOYEE BENEFIT	OPTION CHOSEN BY LOCATION: $10,000; $20,000; 1X SALARY TO $100,000 MAXIMUM; 2X SALARY TO $400,000 MAXIMUM; OR 3X SALARY TO $400,000 MAXIMUM
ACCIDENTAL DEATH AND DISMEMBERMENT	INCLUDED
COMMON CARRIER	INCLUDED
CONVERSION	INCLUDED
ACCELERATED LIFE BENEFIT	50% OF THE DEATH BENEFIT; MINIMUM OF $10,000: MAXIMUM OF $250,000
WAIVER OF PREMIUM	IF DISABLED, INSURANCE WILL CONTINUE UNTIL AGE 65 OR UNTIL NO LONGER DISABLED
BENEFIT REDUCTIONS	35% AT AGE 65; 50% AT AGE 70

VOLUNTARY TERM LIFE			
EMPLOYEE BENEFIT	$10,000 TO $500,000 IN $10,000 INCREMENTS		
EMPLOYEE AD&D BENEFIT	100% of LIFE BENEFIT		
SPOUSE BENEFIT	$5,000 TO $100,000 IN $5,000 INCREMENTS, SUBJECT TO 100% OF THE EMPLOYEE'S AMOUNT		
SPOUSE AD&D BENEFIT	100% OF LIFE BENEFIT		
CHILD(REN) BENEFIT	$10,000, SUBJECT TO 100% OF THE EMPLOYEE'S BENEFIT | $500 (INFANT BENEFIT)		
CHILD(REN) AD&D BENEFIT	100% OF LIFE BENEFIT		
BENEFIT REDUCTIONS	35% AT AGE 65; 50% AT AGE 70		
WAIVER OF PREMIUM	IF DISABLED, INSURANCE WILL CONTINUE UNTIL AGE 65 OR UNTIL NO LONGER DISABLED		
PORTABILITY	INCLUDED		
COVERSION	INCLUDED		
ACCELERATED LIFE BENEFIT	50% OF THE DEATH BENEFIT; MINIMUM OF $10,000: MAXIMUM OF $250,000		
CHILD(REN) AGE LIMIT	14 DAYS TO AGE 26 | 14 DAYS (INFANT)		
GUARANTEE ISSUE Guaranteed issue is the amount of coverage you can enroll for without answering medical questions	**EMPLOYEE:** $100,000	**SPOUSE:** $30,000	**CHILD(REN):** $10,000

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Disability Insurance

Boys & Girls Club Workers Association
Plan Number: 554610

Guardian

Protect your paycheck if you are unable to work

Your income is one of your most valuable assets

No one plans on becoming disabled, but a serious illness or injury can strike anyone at any time, and at any age, taking away your ability to earn a paycheck. In fact, more than one in four of today's 20-year olds can expect to be out of work for at least a year because of a disabling condition before they retire.* Disabilities can result not just from accidents, but illnesses such as a heart attack, cancer and stroke. How long can you live on your savings if you became disabled?

The value of Disability Insurance for you and your family

Disability Insurance can be an integral part of your workplace benefits plan — it provides a steady stream of income to ease the financial stress of a disability, illness or injury while you are out of work and not receiving a paycheck.

For just a few dollars a month, you can help to provide financial security for yourself and those who depend on you. And enrolling for Disability Insurance at the workplace is simple and cost effective — with convenient payroll deductions.

Income protection when you need it most

Did you realize that if you became disabled and couldn't work, Disability Insurance provides you with an income until you are able to return to work. Depending on your plan, it can cover things like:

- Starting a family and having a new baby
- Having back pain, digestive disorders, depression or other mental disorders
- Major accidents or life-changing diagnoses, such as diabetes or cancer

If you become disabled, you can count on us

Guardian's Disability Insurance not only provides you with income protection while you are unable to work, but we also have a team of experienced professionals that will provide you with guidance and support while you're disabled. We are committed to getting you back on your feet and giving you the attention, vocational rehabilitation and outplacement services you need to give you the best chance of resuming employment.

Disability Insurance with Guardian is easy

- Affordable group rates
- Extensive resources and support to help you get back to work and live a productive life
- Timely and efficient claims review and payment

This plan is a smart choice for:

- Anyone who relies on their paycheck to meet basic expenses
- Those seeking to help protect their savings in the event of a disabling illness or injury
- Protecting your family or someone who depends on you financially

Learn more about Disability Insurance at guardianlife.com

The Guardian Life Insurance Company of America
New York, NY

guardianlife.com

*SSA, Disability and Death Probability Tables for Insured Workers Born in 1997 https://www.ssa.gov/oact/NOTES/ran6/an2017-6.pdf, Table A. Guardian's Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage. GUARDIAN® is a registered trademark of The Guardian Life Insurance Company of America®. STD Policy Form #GP-1-STD-15, GP-1-STD07-1.0, et al; LTD Policy Form #GP-1-LTD-15, GP-1-LTD07-1.0, et al.

2020-105167 (07/22)

GUARDIAN SHORT TERM DISABILITY BENEFITS	EMPLOYEE COVERAGE
WEEKLY BENEFIT	66.67% TO $2,000
MAXIMUM PAYMENT PERIOD	26 WEEKS
ACCIDENT BENEFITS BEGIN	8TH DAY
ILLNESS BENEFITS BEGIN	8TH DAY
DEFINITION OF DISABILITY	OWN JOB
RETURN TO WORK	ZERO DAY RESIDUAL
MINIMUM WEEKLY BENEFIT	$25 FLAT
COVERAGE TYPE	OFF JOB

GUARDIAN LONG TERM DISABILITY BENEFITS	EMPLOYEE COVERAGE
MONTHLY BENEFIT	66.67% TO $15,000
MAXIMUM PAYMENT PERIOD	SOCIAL SECURITY RETIREMENT AGE
ACCIDENT/ILLNESS BENEFITS BEGIN	180 DAYS
DEFINITION OF DISABILITY	OWN JOB
RETURN TO WORK	ZERO DAY RESIDUAL
MINIMUM BENEFIT	$100
MENTAL HEALTH AND SUBSTANCE ABUSE	24 MONTH LIFETIME PAYMENT LIMIT (COMBINED)
PRE-EXISTING CONDITION	3 MONTHS PRIOR; 12-MONTHS EXCLUSION
STATE INTEGRATION	STATE MANDATED DISABILITY – CA, NY, NJ, HI, RI

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Short Term Disability Summary of Plan Limitations and Exclusions:
We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane, and for the voluntary inhalation or ingestion of poison, gas, solvent, chemical, or other substance not intended for internal consumption. • We do not pay benefits due solely to the risk of relapse, during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability. • During the exclusion/limitation period, this disability plan does not pay charges relating to a pre-existing condition. A pre-existing condition includes any condition for which an employee, in a specified period of time prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition exclusion /limitation period. Please refer to the plan details for specific time periods. Contract # GP-1-STD-15-1.0 et al. (Disability 2016) •In order to be eligible for coverage; employees must be legally working (a) in the United States or (b) outside the United States, for a US based employer in a country or region approved by Guardian. • This policy provides disability income insurance only. It does not provide "basic hospital," "basic medical," or "major medical" insurance as defined by the New York State Insurance Department. • Evidence of Insurability is required for all late enrollees. Guardian Group Short Term Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Coverage will not be effective until approved by a Guardian underwriter. This proposal is subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage.]

Long Term Disability Summary of Plan Limitations and Exclusions:
We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane, and for the voluntary inhalation or ingestion of poison, gas, solvent, chemical, or other substance not intended for internal consumption. • We do not pay benefits due solely to the risk of relapse, during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability. • During the exclusion/limitation period, this disability plan does not pay charges relating to a pre-existing condition. A pre-existing condition includes any condition for which an employee, in a specified period of time prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition exclusion /limitation period. Please refer to the plan details for specific time periods. Contract # GP-1-LTD-15-1.0 et al. (Disability 2016) • In order to be eligible for coverage; employees must be legally working: (a) in the United States or (b) outside the United States, for a US based employer in a country or region approved by Guardian. • This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "major medical" insurance as defined by the New York State Insurance Department. • Evidence of Insurability is required on all late enrollees. Guardian Group Long Term Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Coverage will not be effective until approved by a Guardian underwriter. This proposal is subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description; plan documents are the final arbiter of coverage.]

Group & Worksite Benefits

Guardian

Employee Assistance Program Overview

Our comprehensive WorkLifeMatters Employee Assistance Program[1], available through Integrated Behavioral Health, provides you and your family members with confidential, personal and web-based support on a wide variety of important and relevant topics — such as stress management, dependent/elder care, nutrition, fitness, and legal and financial issues.

Employee assistance program (EAP) consultative services

- **Telephonic Counseling** — Unlimited, 24/7 consultations with master's and doctoral-level counselors
- **Face-to-face Counseling** — Up to 3 visits per employee/household member per year
- **Bereavement** — Support available through telephonic or face-to-face sessions; online resources available on EAP website
- **Tobacco Cessation Coaching** — Unlimited telephonic support and resources to assist with tobacco cessation; refers members directly to the American Lung Association's Quit program
- **EAP Website Resources** — Comprehensive website that includes articles, videos, FAQs, etc.; additionally, individuals can chat online with an EAP Consultant or email an EAP Counselor through the website
- **College Planning Resources** — Expert assistance in finding the right college that fits your child academically, socially and financially, provided by College Planning USA

Work/life assistance & resources

- **WorkLife Services** — Unlimited 24/7 access to WorkLife Specialists (subject matter experts) in the areas of: family and care giving, health and wellness, emotional well-being, daily living, and balancing work/life responsibilities
- **Child and Elder Care Referral** — Unlimited telephonic consultation with a WorkLife Specialist (part of WorkLife Services)
- **Employee Discounts** — Access to discounts on a large number of products and services, from gym memberships to dental, vision and pharmacy items, entertainment, restaurants, computers, cars, and much more
- **Webinars, Podcasts, Articles and FAQs** — Various topics available on the EAP website

Legal/financial assistance & resources

- **Legal Consultation** — Unlimited telephonic support and free initial 30 minute face-to-face consultation with an attorney, includes a 25% discount on attorney services thereafter; online legal forms; extensive online law library
- **Financial Consultation** — Unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching; extensive online financial library and calculators
- **ID Theft** — Free consultation with a trained Fraud Resolution Specialist that will assist with ID theft resolution and education; ID theft educational materials available online
- **Will Prep** — Online self-service documents available on EAP website; 30 minute consultation (part of Legal Consultation offering) can be used for estate planning/will preparation
- **Legal Document Preparation** — Online self-service documents available on the EAP website
- **Tax Consultation** — Tax questions only can be answered as part of the Financial Consultation offering
- **Online Self-Service Documents** — Examples include, but are not limited to: Living Trust, Will, Power of Attorney, Deeds

lbhworklife.com

User Name: Matters
Password: wlm70101
Phone: 1 800 386 7055
Available 24 hours a day, 7 days a week[2]

The Guardian Life Insurance Company of America

guardiananytime.com

New York, NY

2018-58488 (04-20)

[1] WorkLifeMatters Program services are provided by Integrated Behavioral Health, Inc., and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and IBH reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, IBH, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.

[2] Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

Voluntary Insurances

Available to both Full-time and Part-Time Employees

For more information on enrollment and/or benefit changes, please contact:

Anne Gambino

800-293-8963

Renewal Rates At-a-Glance

This plan is currently offered for Insurance Class 1

VOLUNTARY LIFE PLAN RATES		
EMPLOYEES	**CURRENT**	**RENEWAL**
Employee Age	**Monthly Rate**	**Monthly Rate**
15-29	$0.097/$1000	$0.097/$1000
30-34	$0.104	$0.104
35-39	$0.148	$0.148
40-44	$0.221	$0.221
45-49	$0.356	$0.356
50-54	$0.603	$0.603
55-59	$0.996	$0.996
60-64	$1.729	$1.729
65-69	$3.980	$3.980
70-99	$7.198	$7.198

This plan is currently offered for Insurance Class 1

VOLUNTARY LIFE PLAN RATES		
SPOUSE	**CURRENT**	**RENEWAL**
Employee Age	**Monthly Rate**	**Monthly Rate**
15-29	$0.097/$1000	$0.097/$1000
30-34	$0.104	$0.104
35-39	$0.148	$0.148
40-44	$0.221	$0.221
45-49	$0.356	$0.356
50-54	$0.603	$0.603
55-59	$0.996	$0.996
60-64	$1.729	$1.729
65-69	$3.980	$3.980
70-99	$7.198	$7.198

This plan is currently offered for Insurance Class 1

VOLUNTARY LIFE PLAN RATES		
CHILD(REN)	**CURRENT**	**RENEWAL**
	Monthly Rate	**Monthly Rate**
CHILD(REN)	$0.167/$1000	$0.167/$1000

Renewal Rates At-a-Glance

This plan is currently offered for Insurance Class 1

VOLUNTARY AD&D PLAN RATES					
		CURRENT		RENEWAL	
Tier	Volume	Monthly Rate	Annual Premium	Monthly Rate	Annual Premium
EE	$1,210,000	$0.025/$1000	$363	$0.025/$1000	$363
SPOUSE	$250,000	$0.025	$75	$0.025	$75
CHILD(REN)	$25,000	$0.025	$8	$0.025	$8

This plan is currently offered for Insurance Class 1

VOLUNTARY ACCIDENT PLAN RATES - PREMIER					
		CURRENT		RENEWAL	
Tier	Enrolled Employees	Monthly Rate	Annual Premium	Monthly Rate	Annual Premium
EMPLOYEE	17	$21.26	$4,337	$21.26	$4,337
SPOUSE	4	$12.28	$589	$12.28	$589
CHILD(REN)	6	$13.38	$963	$13.38	$963
TOTAL	**27**		**$5,889**		**$5,889**

Renewal Rates At-a-Glance

This plan is currently offered for Insurance Class 1

VOLUNTARY CANCER PLAN RATES - PREMIER					
		CURRENT		RENEWAL	
Tier	Enrolled Employees	Monthly Rate	Annual Premium	Monthly Rate	Annual Premium
EMPLOYEE	8	$28.19	$2,706	$28.19	$2,706
SPOUSE	0	$25.93	$0	$25.93	$0
CHILD(REN)	0	$6.54	$0	$6.54	$0
TOTAL	**8**		**$2,706**		**$2,706**

Renewal Rates At-a-Glance

This plan is currently offered for Insurance Class 1

VOLUNTARY CRITICAL ILLNESS PLAN RATES		
	CURRENT	**RENEWAL**
EMPLOYEES **Issue Age**	**Monthly Rate**	**Monthly Rate**
15-29	$0.640/$1000	$0.640/$1000
30-39	$0.930	$0.930
40-49	$1.780	$1.780
50-59	$3.230	$3.230
60-69	$4.950	$4.950
70-99	$9.740	$9.740
SPOUSE **Issue Age**	**Monthly Rate**	**Monthly Rate**
15-29	$0.640/$1000	$0.640/$1000
30-39	$0.930	$0.930
40-49	$1.780	$1.780
50-69	$4.950	$4.950
70-99	$9.740	$9.740
CHILD(REN)	$2.750/$1000	$2.750/$1000

Renewal Rates At-a-Glance

This plan is currently offered for Insurance Class 1

VOLUNTARY RIDER PLAN RATES		
	CURRENT	**RENEWAL**
EMPLOYEES **Issue Age**	**Monthly Rate**	**Monthly Rate**
15-29	$0.000/EE	$0.000/EE
30-39	$0.000	$0.000
40-49	$0.000	$0.000
50-59	$0.000	$0.000
60-69	$0.000	$0.000
70-99	$0.000	$0.000
SPOUSE **Issue Age**	**Monthly Rate**	**Monthly Rate**
15-29	$0.000/SP	$0.000/SP
30-39	$0.000	$0.000
40-49	$0.000	$0.000
50-59	$0.000	$0.000
60-69	$0.000	$0.000
70-99	$0.000	$0.000
CHILD(REN)	$0.000/CH	$0.000/CH

Renewal Rates At-a-Glance

This plan is currently offered for Insurance Class 1

VOLUNTARY HOSPITAL INDEMNITY PLAN RATES		
	CURRENT	**RENEWAL**
EE	**Monthly**	**Monthly**
Age	**Rate**	**Rate**
15-99	$43.230	$43.230
EE & SP	**Monthly**	**Monthly**
Age	**Rate**	**Rate**
15-99	$78.410	$78.410
EE & CH	**Monthly**	**Monthly**
Age	**Rate**	**Rate**
15-99	$70.790	$70.790
FAMILY	**Monthly**	**Monthly**
Age	**Rate**	**Rate**
15-99	$105.960	$105.960

Your plan may have a maximum enrollment age and/or a termination age, Please refer to your policy for full details.

Current Plan Benefits Summaries

VOLUNTARY AD&D

This plan is currently offered for Insurance Class 1

AD&D BENEFITS SUMMARY			
	EMPLOYEE	**SPOUSE**	**CHILD(REN)**
Benefit Type	Increment	Increment	Increment
Multiple	N/A	N/A	N/A
Maximum Benefit	$400,000	$250,000	$10,000
Earnings Definition	N/A		

Current Plan Benefits Summaries

VOLUNTARY ACCIDENT

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY

Schedule	Premier
Coverage Type	On & Off Job
Spouse Coverage Included	Yes
Child Coverage Included	Yes
Dependent Age Limits	26/26

This coverage includes benefits for treatments or procedures due to an accident. These include hospitalization, emergency room treatment, Xrays and much more. Please see your certificate booklet for specific benefits.

Wellness Benefit Included	Yes
Amount	$75

Disability Benefit Type	N/A
Accident Disability Type	N/A

	Employee	Spouse
Amount	N/A	N/A
Accident Elimination Period	N/A	N/A
Sickness Elimination Period	N/A	N/A
Duration	N/A	N/A

Hospital Confinement due to Sickness Included No

	Employee	Spouse	Child
Amount	N/A	N/A	N/A
Elimination Period	N/A	N/A	N/A
Maximum Number of Days	N/A	N/A	N/A

Current Plan Benefits Summaries

Optional Riders:			
Rainy Day Fund	500.00	500.00	500.00
Auto Increase %	N/A		
Injury-Free Benefit	N/A		

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.

Current Plan Benefits Summaries

VOLUNTARY CANCER

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY	
Schedule	PREMIER
Spouse Coverage Included	Yes
Child Coverage Included	Yes
Dependent Age Limits	26/26
This coverage includes benefits for treatments or procedures due to cancer. These include chemotherapy, radiation, surgery, experimental treatment, and much more. Please see your certificate booklet for specific benefits.	
Initial Diagnosis Benefit Included	Yes
Amount	
Employee	$7,500
Spouse	$7,500
Child(ren)	$7,500
Cancer Screening Benefit Included	Yes
Amount	$100

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.

Current Plan Benefits Summaries

VOLUNTARY CRITICAL ILLNESS

This plan is currently offered for Insurance Class 1

PLAN BENEFITS SUMMARY

	EMPLOYEE	SPOUSE	CHILD(REN)
Benefit Amount	$20,000	50% of employee benefit	25% of employee benefit
Covered Conditions	**1st Occurrence**	**2nd Occurrence**	
Arteriosclerosis	30%	0%	
Benign Brain Tumor	75%	0%	
Carcinoma In Situ	30%	0%	
Heart Failure	100%	50%	
Heart Attack	100%	50%	
Invasive Cancer	100%	50%	
Kidney Failure	100%	50%	
Organ Failure	100%	50%	
Skin Cancer	$250	N/A	
Sudden Cardiac Arrest	0%	N/A	
Stroke	100%	50%	

Coverage includes benefits for Acute Respiratory Distress Syndrome, Addison's Disease, ALS, Alzheimer's Disease, Coma, Huntington's Disease, Multiple Sclerosis, Loss of Speech, Sight or Hearing, Parkinson's Disease, Permanent Paralysis, Severe Burns.
See plan contract for benefit percentage and state variations.

Covered Childhood Illnesses:
Cerebral Palsy, Cleft lip/palate, Club Foot, Cystic Fibrosis, Down's Syndrome, Muscular Dystrophy, Spina Bifida, Type 1 Diabetes.
See plan contract for benefit percentage and state variations.

Current Plan Benefits Summaries

RIDER BENEFITS			
	EMPLOYEE	**SPOUSE**	**CHILD(REN)**
Hospital Admission Rider	N/A	N/A	N/A
Elimination Period	N/A	N/A	N/A
Wellness Rider	N/A	N/A	N/A
Alzheimer's For Parents	$0	$0	N/A
Recovery Supplement Benefit	Included	Included	Included
Cancer Death Benefit	$0	$0	$0
Cancer Vaccine	$0	$0	$0

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.

Current Plan Benefits Summaries

VOLUNTARY HOSPITAL INDEMNITY

This plan is currently offered for Insurance Class 1

Hospital/ICU Admission	$1,000/ $1,000 per day to a max of 1 day(s) per year per insured
Hospital/ICU Confinement	$100/ $100 per day to a max of 31 day(s) per year
Inpatient Surgical Procedure	$1,500 per day of surgery to a max of 1 day(s) per year
Outpatient Surgical Category1/Category2	$1,500/ $3,000 per day of surgery to a max of 1 day(s) per year
Health Screenings	$50 per day of screening to a max of 1 days(s) per insured per year

Plan information is for illustrative purposes only. Please consult plan contract for specific benefit levels.