2025

EMPLOYEE BENEFITS GUIDE

ST JOE®

2025 Benefits Guide

This guide provides a summary of your benefit options and costs. It will help you make informed benefit decisions for you and your family.

We hope you find this guide useful as you consider your options. The benefit programs listed are just some of the many ways the St Joe Company helps its employees take care of themselves and their dependents. Thank you for being part of the St Joe Company family, and for making a difference in the communities we serve.

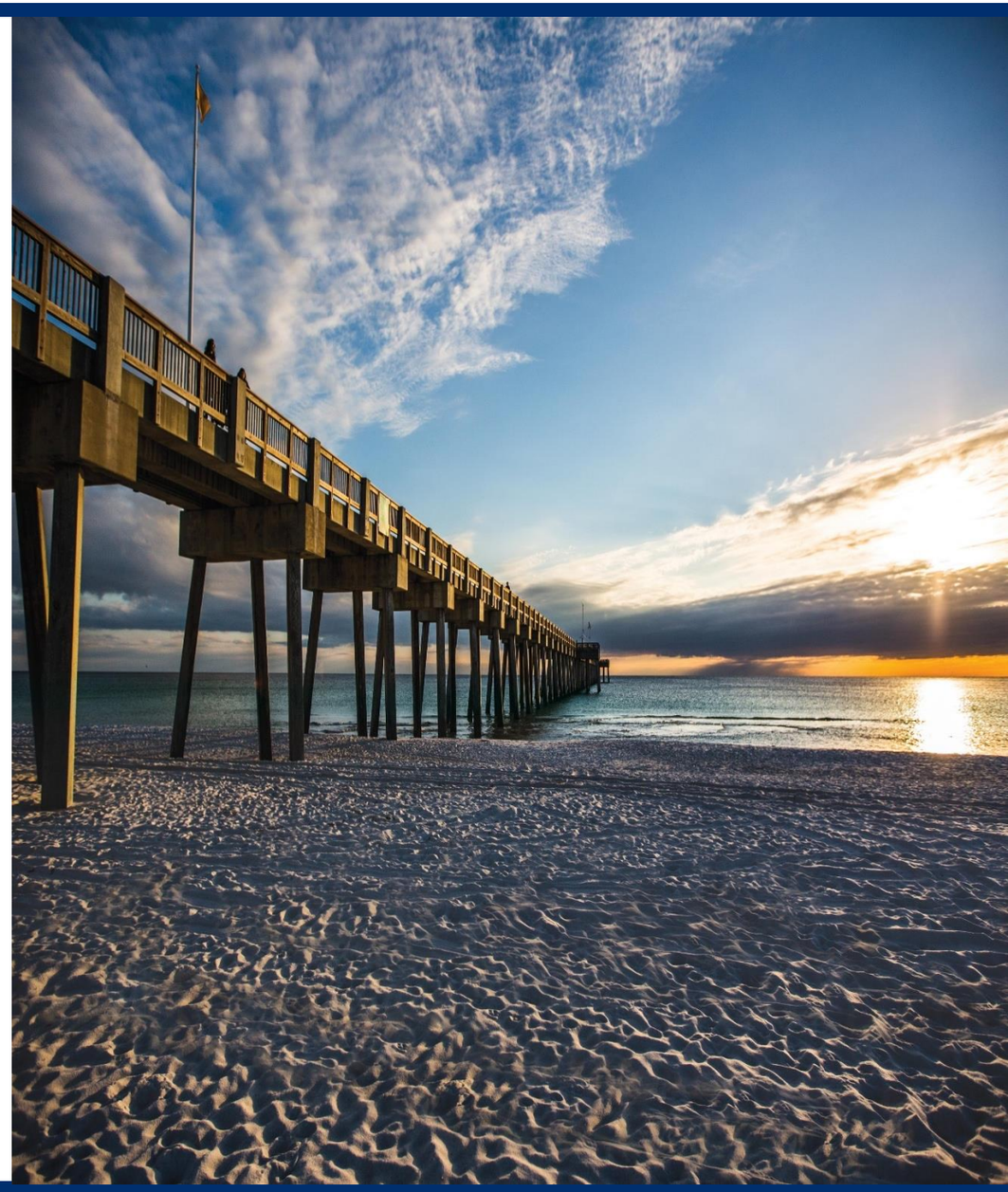
This is your opportunity to choose the benefits and coverage that will help you feel and perform at your best in everything you do.

Notice!

If you do not take action, you will not be enrolled in benefit programs for 2025, *except for Basic Life and Short-Term Disability.* If you miss your new hire window, the next opportunity to enroll will be at the next Annual Enrollment for benefits in 2025.

Even if you do not want to enroll, you should complete the Enrollment process and select waive coverage for each benefit and complete your beneficiary selections for the company provided basic life Insurance policy. It is important to inform the company of your life insurance beneficiary(ies).

*Please note: The BlueCare HMO plan option is only available to Florida employees



What's Inside

YOUR HEALTH

Medical benefits from the St Joe Company help you stay healthy and get the care you and your family need. Your plans also offer many resources and tools to help you maintain a healthy lifestyle.

Who is Eligible?

You are eligible for coverage if you are a regular full-time employee working 30 hours or more per week. Coverage begins on the first of the month following 30 days of continuous employment. Coverage elected during Annual Enrollment is effective January 1st of the following year.

Eligible dependents are:

- A legal spouse: including spouses of same sex.
- Child* (eligibility for Medical plan only): Under federal law, child up to the age of 26 without regard to financial dependency, marital status, place of residence, student status, employment, or availability of other cover. Under Florida state law, coverage may be extended from age 26-30 subject to financial dependency, marital status, place of residence, student status, or other factors (please contact Benefits department for more details).
- Minor child by court order (eligibility for Medical plan only): Child must be under age 19 and you (not your spouses) must be required to cover the child pursuant to a Qualified Medical Child Support Order ("QMCSO") or a divorce decree specifically requiring that you (not your spouse) cover the child.
- Minor child living with you (eligibility for Dental and Vision plan only): Child must be under age 19, live more than 50% of the time with you, and primarily dependent upon** you or your spouse for support and maintenance.
- Disabled child: Child must be mentally or physically disabled and primarily dependent upon** you or your spouse for support and maintenance.

** Definition of "child" include a natural child, stepchild, adopted child or legal ward. An "eligible dependent" cannot be covered if on active military duty for any country or not living in the United States.*

*** "Primarily dependent upon" means you must declare the child as a deduction on your income taxes and you or your spouse must provide over 50% of the child's support. As a general rule, children of divorced or separated parents are treated as being "primarily dependent upon" the parent who has legal custody for a greater portion of the calendar year, regardless of who provides more monetary support. Certain exceptions may apply. Contact Benefits department with any questions.*

Before you enroll: Learn about Benefits at the St Joe Benefits Resource Center

1. Detailed benefit plan Information can now be found on the St Joe Benefits Resource Center, powered by FLIMP Communications. The site includes helpful videos to explain important features of your benefit plans, view plan documents/brochures, and view links to the carrier web sites.

2. Review the details found in this guide and determine which plans will work best for you and your eligible dependents.

3. Gather the necessary data prior to enrollment.

Where to Enroll

Log in to Paycom to complete enrollment. A link to the Benefits section of Paycom is at the top of the St Joe Benefits Resource Center.

This is a web-based system that can be accessed from any computer with internet access. While at work or home, employees can access it at https://paycom.com/.

Cost of Your Benefits

The St Joe Company pays the full cost of some of your benefits: you share the cost for some others. Also, you pay the full cost for any voluntary benefits elected.

Benefit	Who Pays	Tax Treatment
• **Medical/Pharmacy Coverage**	Company/You	Pre-tax
• **Dental Coverage**	Company/You	Pre-tax
• **Vision Coverage**	You	Pre-tax
• **Flexible Spending Accounts**	You	Pre-tax
• **Health Savings Account**	You	Pre-Tax
• **Basic Life Insurance**	Company	After-tax
• **Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance**	You	After-tax
• **Short-Term Disability**	Company	Pre-tax
• **Long-Term Disability**	Company/You	After-Tax

Medical/Rx Option 1 – Blue Care HMO with H.S.A. 130/131

BlueCare HMO 130/131	
Summary of Services	In-Network
Calendar Year Deductible (CYD)	$1,650 Individual / $3,300 Family
Out-of-Pocket Limit	$4,800 Individual/ $9,200 Family
Member Coinsurance	20%
Office Visits PCP/Specialist	Covered at 80% after CYD
Routine Preventive Care	**Covered at 100%**
Labs and X-rays	Covered at 80% after CYD
Complex Imaging (MRI, PT scans)	Covered at 80% after CYD
Emergency Room	Covered at 80% after CYD
Urgent Care Facility	Covered at 80% after CYD
Outpatient Facility	Covered at 80% after CYD
Inpatient Facility	Covered at 80% after CYD
Prescription Drug Benefits Retail 30-day supply • Tier 1 • Tier 2 • Tier 3 Mail Order – 90-day supply	Deductible must be satisfied before prescriptions are covered by copays below. $10 copay $50 copay $80 copay 2.5 times retail price

Note: Please make sure to examine network providers at www.floridablue.com. This plan is only available to Florida employees.

Note: This is only a summary of your coverage; actual benefits described in the Certificate of Coverage will prevail.
In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

BlueCare HMO 130/131	Employee Biweekly Contributions	Employee Monthly Contributions
Employee	$47.21	$102.30
Employee + Spouse	$148.15	$320.99
Employee + Child(ren)	$114.15	$247.33
Employee + Family	$203.26	$440.40

Medical/Rx Option 2 – Blue Options PPO with H.S.A. 5192/5193

BlueOptions HSA 5192/5193		
Summary of Services	In-Network	Out-Of-Network
Calendar Year Deductible (CYD)	$2,500 Individual / $5,000 Family	$5,000 Individual / $10,000 Family
Out-of-Pocket Limit	$5,800 Individual / $11,600 Family	$11,600 Individual/ $23,200 Family
Member Coinsurance	20%	40%
Office Visits PCP/Specialist	Covered at 80% after CYD	Covered at 60% after CYD
Routine Preventive Care	**Covered at 100%**	Covered at 60% after CYD
Labs and X-rays	Covered at 80% after CYD	Covered at 60% after CYD
Complex Imaging (MRI, PT scans)	Covered at 80% after CYD	Covered at 60% after CYD
Emergency Room	Covered at 80% after CYD	Covered at 80% after CYD
Urgent Care Facility	Covered at 80% after CYD	Covered at 80% after CYD
Outpatient Facility	Covered at 80% after CYD	Covered at 80% after CYD
Inpatient Facility	Covered at 80% after CYD	Covered at 80% after CYD
Prescription Drug Benefits Retail 30-day supply • Tier 1 • Tier 2 • Tier 3 Mail Order – 90-day supply	Deductible must be satisfied before prescriptions are covered by copays below. $10 copay $50 copay $80 copay 2.5 times retail price	Deductible must be satisfied before prescriptions are covered by copays below. Covered at 50% after CYD Covered at 50% after CYD Covered at 50% after CYD Covered at 50% after CYD

Note: Please make sure to examine network providers at www.floridablue.com.

Note: This is only a summary of your coverage; actual benefits described in the Certificate of Coverage will prevail.
In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

BlueOptions HSA 5192/5193	Employee Biweekly Contributions	Employee Monthly Contributions
Employee	$57.96	$125.57
Employee + Spouse	$163.38	$353.98
Employee + Child(ren)	$131.80	$285.56
Employee + Family	$228.45	$494.97

Medical/Rx Option 3– Blue Options PPO 3769

BlueOptions PPO 3769		
Summary of Services	In-Network	Out-Of-Network
Calendar Year Deductible (CYD)	$500 Individual / $1,500 Family	$1,500 Individual / $4,500 Family
Out-of-Pocket Limit	$3,000 Individual/ $6,000 Family	$6,000 Individual/ $12,000 Family
Member Coinsurance	20%	50%
Office Visits PCP/Specialist	$25 / $60 copay	Covered at 50% after CYD
Routine Preventive Care	**Covered at 100%**	Covered at 50% after CYD
Labs and X-rays	$50 copay	Covered at 50% after CYD
Complex Imaging (MRI, PT scans)	Covered at 80% after CYD	Covered at 50% after CYD
Emergency Room	$300 copay per visit	$300 copay per visit
Urgent Care Facility	$65 copay per visit	CYD + $65 copay per visit
Outpatient Facility	Covered at 80% after CYD	Covered at 50% after CYD
Inpatient Facility	Covered at 80% after CYD	Covered at 50% after CYD
Prescription Drug Benefits Retail 30 day supply • Tier 1 • Tier 2 • Tier 3 Mail Order – 90-day supply	 $10 copay $30 copay $50 copay 2.5 times retail price	 Covered at 50% Covered at 50% Covered at 50% Covered at 50%

Note: Please make sure to examine network providers at www.floridablue.com.

Note: This is only a summary of your coverage; actual benefits described in the Certificate of Coverage will prevail.

In-network services are based on negotiated charges; out-of-network services are based on reasonable and customary (R&C) charges.

BlueOptions PPO 3769	Employee Biweekly Contributions	Employee Monthly Contributions
Employee	$87.18	$188.90
Employee + Spouse	$243.18	$526.90
Employee + Child(ren)	$196.85	$426.51
Employee + Family	$348.17	$754.38

Telemedicine Benefits

Speak with a doctor – anytime, anywhere

Getting sick after hours or on weekends used to mean a lengthy, costly trip to the emergency room or urgent care center. But with your telemedicine benefit, provided by Florida Blue and powered by Teladoc®, you will have access to doctors 24/7/365 days a year without leaving the comfort of your home. Virtual visits allow you to consult a doctor for non-emergencies by phone, mobile app, or online video. Speak to a doctor or schedule an appointment at a time that is convenient for you.

Some conditions doctors can treat:

- Allergies
- Asthma
- Cold/flu
- Ear problems (Age 12 and over) Fever (Age 3 and over)
- Nausea
- Pink eye
- Rash
- Sinus infections

Talk Therapy

Speak with a licensed counselor, therapist, or psychiatrist for support with virtual visits, available by appointment. You can choose who you want to work with for issues such as anxiety, depression, trauma, and loss or relationship problems.

You Have Options – Teladoc ®

866.789.8155 or visit https://www.teladoc.com/

TelaDoc – medical and behavioral/mental health virtual care.

- Use your phone, the app, or the website
- Request a time and a Teladoc doctor will contact you
- The doctor will diagnose symptoms and send a prescription if necessary

Health Plan Helpful Savings Tips – How Best to Navigate Your Plan

Get the Most from your Pharmacy benefit services

- Choose a pharmacy that's in the Florida Blue network.
- Be aware that filling your prescriptions at a non-network pharmacy will increase your costs, and your prescriptions may not be covered.
- To find a pharmacy, you can log into www.floridablue.com.
- When you visit a pharmacy, simply show your health plan ID card to the pharmacist, and they will inform you of your costs for the prescription.

Remember—Go Generic and Get a Dose of Savings!

When it comes to prescription medications, you and your doctor usually have a choice between a brand name drug and its generic equivalent. Generic drugs offer the same strength and active ingredients as the brand name but often cost much less. In most cases, when you take your prescription for a brand name medication to the pharmacy, your prescription will be filled with the generic equivalent. However, if you ask for the brand name medication instead of the generic, even though your doctor is ok with you taking the generic, you will pay a higher amount, which will be your generic copay plus the difference in cost between the brand name medication and the generic.

Urgent Care vs Emergency Room

Don't pay for more if you don't have to. The ER is meant for true emergencies such as life threatening illnesses and injuries. The ER costs an average of three times more than a visit to the Urgent Care Center. In a non-life threatening situation, you can most likely be treated at an Urgent Care Center.

Emergency Room	Urgent Care
Chest Pain	Coughs and Sore Throat
Broken Bones	Minor Injuries & Burns
Allergic Reactions	Ear/Sinus Infections
Continuous Bleeding	Flu and Cold
Head Injury	Sprains and Strains
Severe Shortness of Breath	Fever
Deep Wounds	Vaccinations

Health Savings Account (HSA)

HSA eligibility

In order to establish and contribute to an HSA:

- You must be enrolled in a high deductible health plan. In 2025, there are two (2) St Joe Plans which are considered high deductible plans - HMO 130/131 and the PPO 5192/5193. The other PPO plan is NOT HSA eligible.
- You cannot be covered by any other medical plan that is not a qualified high deductible plan. This includes a spouse's medical coverage unless it's an HSA-qualified plan.
- Cannot be enrolled in a traditional health care FSA in 2025.
- Cannot be enrolled in Medicare, including Parts A or B, Medicare, or TRICARE.
- Cannot be claimed as a dependent on another person's tax return.
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months.

How does an HSA work?

Build tax-free savings for health care. You can make before-tax deductions from your paycheck into your HSA, allowing you to save money by using tax-free dollars to pay for eligible medical, prescription, dental, and vision expenses. The total amount that can be contributed to your HSA each year is limited by the IRS. The following limits for 2025 include any company contributions you receive:

- Up to $4,300 for employee-only coverage.
- Up to $8,550 if you cover dependents.
- Add $1,000 to these limits if you're age 55 or older.
- The company will contribute $500 annually for individuals, and $1,000 annually for families.

Keep your money. Unlike an FSA, the money in your HSA is always yours to keep and can be rolled over from year to year. You can take your unused balance with you when you retire or leave the St Joe Company.

Use it like a bank account. You will receive a debit card to use to pay for eligible medical, prescription, dental, and vision expenses for yourself and your family by swiping your HSA debit card or reimburse yourself for payments you've made (up to the available balance in your account).

Keep in mind that you may only access money that is actually in your HSA when making a purchase or withdrawal. There's no need to turn in receipts (but keep them for your records).

Earn interest and invest for the future. Once your interest-bearing HSA reaches a minimum balance, you can invest in a variety of no-load mutual funds similar to 401(k) investments. You can learn more at www.healthequity.com.

Never pay taxes. Contributions are made on a before-tax basis, and your withdrawals will never be subject to federal income taxes when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too.*

* *Money in an HSA grows tax-free and can be withdrawn tax-free if it is used to pay for qualified health care expenses (for a list of eligible expenses, see IRS Publication 502, available at www.irs.gov). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax if you withdraw the money for ineligible expenses before age 65. After age 65, withdrawals for ineligible expenses are only subject to ordinary income tax. Please review your state regulations as you may have to pay state taxes depending on your residency.*

Flexible Spending Accounts

The St Joe Company offers two Flexible Spending Accounts administered through Health Equity. Flexible Spending Accounts (FSAs) are designed to allow you to use pre-tax dollars to pay for out of pocket medical and or Dependent Day Care expenses. You will receive a debit card, and each pay period, funds are deducted from your pay on a pretax basis and are deposited to your Health Care and/or Dependent Care FSA account. You then use your funds to pay for eligible health care or dependent day care expenses.

Account Type	Health Care FSA	Dependent Care FSA
Purpose	Pay for eligible expenses for yourself and eligible family members	Pay for eligible dependent day care expenses so you and, if you are married, your spouse can work. *Maximum dependent age is 13.
Plan Year Pre-Tax Election	Minimum amount: $100 Maximum amount: Federal limit - $3,200**	Minimum amount: $100. Maximum amount: $5,000 ($2,500 if married and filling separate tax returns)
Eligible Expenses	• Medical, dental, and vision out-of-pocket expenses • Prescription or certain over the counter drugs • Healthcare products, such as bandages and diagnostic tests and monitors • Glasses and contact lenses not already paid for by the vision plan as well as LASIK Surgery	• Child and elder care provided in your home • Child and elder care provided in an approved daycare center • Before and after school programs • Day camp, but not overnight camp

**This is an example only, and may not reflect your actual experience. It assumes a 25% federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary and are not included in this example. However, you will also save on any state and local taxes as well.*
***The IRS has not yet released 2025's FSA contribution limit. The limit that is being shown is 2024's limit.*

Your FSA elections will be in effect from January 1 through December 31. Claims for reimbursement must be submitted within 90 days of the end of the Plan year. Please plan your contributions carefully. An enrolled employee may carry over between $50 and $610 from any unused health FSA balance to the following year. Under this guidance, the health FSA money carried over to the next year may be used only for claims incurred within the new plan year.

Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

- If you are currently enrolled in the FSA and choose not to re-enroll in the plan, balances under $610 at the end of the year will **not** carry forward to the next plan year. Please note, monies left unused in your FSA are forfeited upon termination.

Save on your taxes with an FSA

The below is an example of the potential advantages of an FSA:	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$11,701	$12,355
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses	$36,299	$35,645
Tax savings with the Medical and Dependent Care FSA	**$654**	N/A

Florida Blue Resources

Health Information Line
Dial 1.800.352.2583 or log in to www.floridablue.com for more information

Whether it is guidance on medical treatment, or assistance with a health question, you can call the health information line and get live support 24 hours a day, 7 days a week. You'll be connected directly to a specialist who is ready to help answer your health questions.

Florida Blue
Your local Blue Cross Blue Shield

Dental Coverage

Regular dental exams can help detect problems in the early stages when treatment is simpler. Keeping teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease. Strong teeth and gums are an important part of good health, which is why the St Joe Company offers you and your eligible dependents comprehensive dental coverage through Delta Dental.

Delta Dental Dental Plans	Dental Low PPO PPO / Premier Network		Dental High PPO PPO / Premier Network	
Summary of Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual deductible	$50 per individual / $150 family	$50 per individual / $150 family	$50 per individual / $150 family	$50 per individual / $150 family
Annual Benefit Maximum	$1,500 per person		$2,000 per person	
Preventive • Exams, cleanings, sealants, X rays	Covered 100%, not subject to the deductible	Covered 100%, not subject to the deductible	Covered 100%, not subject to the deductible	Covered 100%, not subject to the deductible
Basic • Fillings, extractions, root canals, oral surgery	20% after deductible	20% after deductible	10% after deductible	10% after deductible
Major • Crowns, Bridges, Dentures	50% after deductible	50% after deductible	20% after deductible	20% after deductible
Orthodontia	50%, not subject to deductible; $1,500 Lifetime Coverage for Children (up to age 26)		50%, not subject to deductible; $2,000 Lifetime Coverage for Children (up to age 26)	
Employee Contribution	Low PPO Per Pay Period (Biweekly / Monthly)		High PPO Per Pay Period (Biweekly / Monthly)	
Employee	$7.83 / $16.96		$12.52 / $27.12	
Employee + Spouse	$17.03 / $36.90		$26.41 / $57.22	
Employee + Child(ren)	$22.02 / $47.71		$28.46 / $61.66	
Employee + Family	$29.61 / $64.16		$42.56 / $92.22	

Preventive services cost much less than fillings, root canals, and extractions. Therefore, routine exams and dental cleanings may help prevent the incidence of these higher–cost treatments and other health-related issues. It's best to establish a relationship with a dentist you trust.

Note: This is only a summary of your coverage; actual benefits described in the Certificate of Coverage will prevail. Please make sure to examine network providers at www.deltadentalins.com. You are able to utilize providers within both the PPO as well as the Premier network, however you will realize greater cost savings in the Premier network.

Vision Coverage

EyeMed Vision PPO Plan		
Summary of Services	In-Network	Out-of-Network
Eye Exams (once every 12 months)	$10 copay	Up to a $40 reimbursement
Lenses (once every 12 months) • Single Vision • Bifocal • Trifocal	 $25 copay then 100% $25 copay then 100% $25 copay then 100%	 Up to a $30 reimbursement Up to a $50 reimbursement Up to a $70 reimbursement
Frames (once every 24 months)	0$ copay; 20% off balance over $130	Up to a $91 reimbursement
Contact Lenses Elective (once every 12	$130 allowance	Up to a $105 reimbursement
Contact Lenses Medically Necessary	Covered at 100%	Up to a $300 reimbursement
Employee Contributions	EyeMed Vision PPO Plan (Biweekly / Monthly)	
Employee Only	$2.52 / $5.46	
Employee + Spouse	$4.79 / $10.37	
Employee + Chid(ren)	$5.04 / $10.92	
Employee + Family	$7.41 / $16.05	

Your eyes are an indicator of your overall health. Eye exams can reveal early warning signs of eye disease, as well as other serious health problems such as high blood pressure, high cholesterol, and diabetes. Regardless of your age, it is recommended that you have your eye exam once a year. Visit EyeMed's website or call (866)-939-3633 to find a Vision network provider.

Basic Life, Voluntary Life & AD&D Insurance

Coverage provided by The Hartford Group

Protecting Yourself and Your Loved Ones with Life Insurance

The St Joe Company understands how important financial stability is to you and your family: we provide Basic Life insurance at no cost to you. The benefit for full-time employees is equal to one times your annual earnings (up to a maximum of $300,000).

Optional Term Life for You, Your Spouse and Children

In addition to Basic Life coverage, you may purchase additional Optional Life and AD&D insurance for yourself. You may elect coverage for yourself or your spouse at this time, up to the Guaranteed Issue Amount, with no medical underwriting. Future requests to add coverage will be subject to the Evidence of Insurability process.

The maximum benefit is the lesser of 5x base annual earnings or $600,000. If you are a newly eligible employee, you have access to a Guaranteed Issue amount of the lesser of 3 times earnings or $300,000. If you elect Optional Life Insurance, you may also buy coverage for your spouse and children:

- **Spouse:** Maximum of $150,000 not to exceed 50% of employee benefit.
- **Child(ren)**: Flat benefit of $250 from birth to 6 months, $10,000 for children 6 months but less then 26 years of age.

Check your beneficiary information:
You must designate your beneficiary for your Basic Employee Life and AD&D and Supplemental Insurance in the Enrollment system. Your beneficiary is the person who receives the insurance benefit if you die. You may designate more than one beneficiary to share the benefit amount.

Short and Long Term Disability Coverage

Provided by The Hartford Group

STD Coverage	Benefit	When Benefits Begin	How Long Benefits Last
Regular full-time employees.	**Employer-provided:** 60% of weekly earnings, up to $1,000 per week.	After your doctor certifies your disability, you have completed the 7-day elimination period, and The Hartford Group approves your claim.	Up to 13 weeks from the date of disability.

During benefit enrollment, employees may enroll in LTD coverage. If you waive coverage now and wish to enroll at a later date, you will be required to complete medical evidence of insurability for carrier approval.

LTD Coverage	Benefit	When Benefits Begin	How Long Benefits Last
Regular full-time employees. Age banded rates will display during the enrollment process.	**Both Employee and Employer contribute (50%).** Benefit is 60% of monthly pay, up to $10,000 per month.	After your doctor certifies your disability, you have completed the 90-day elimination period, and The Hartford Group approves your claim.	Benefits for a disabled employee are payable to the employee's Social Security Normal Retirement Age, or a Maximum Benefit Period (inquire with Benefits Dept. for details).

Employee Assistance Program

Provided by The Hartford Group

It’s good to know you’re not alone.

Reaching out to an EAP consultant is a good first step. They’re trained to understand your concerns so they can connect you with the consultant or service best able to help you:

- Address depression, anxiety or substance use issues
- Improve relationships at home or work
- Manage stress
- Work through emotional issues or grief
- Assistance with legal and financial concerns

The service includes up to three face-to-face emotional or work-life counseling sessions per occurrence per year. This means you and your family members won’t have to share visits. Each individual can get counseling help for his/her own unique needs. Legal and financial counseling are also available by telephone during business hours.

One call puts you in touch with a clinician, counselor, mediator, lawyer or financial adviser who could help change your life for the better.

Call the member phone number and ask to speak to an EAP consultant at 1-800-964-3577.

The Hartford Group: Value Added Benefits

Beneficiary Assist – Counseling Services

Getting through a loss is hard. Getting support to cope is easy.

The loss of a loved one can you feeling overwhelmed. In addition to grief, you may have financial and legal worries. Questions you can't easily answer alone. And maybe some unresolved issues. If you're covered under The Hartford's Group Life or Accident insurance policy, you have access to **Beneficiary Assist®** counseling services provided by **ComPsych**.

Funeral Planning and Concierge Services

Added peace of mind when it's needed most.

The death of a loved one is one of life's most stressful situations. Quick, often costly decisions must be made while emotions are at their peak. Yet, how many people know how to plan a funeral? That's why your employer offers a funeral planning and concierge service through **The Hartford's Group Life** insurance program— provided by **Everest**, the first to offer this service nationwide.

Travel Assistance Program & ID Theft Protection Services

If you are covered by your employer's group policy from **The Hartford** and you need pre-trip information, emergency medical assistance or personal assistance services while traveling, contact **Generali Global Assistance**. Have a serious medical emergency? Please obtain emergency medical services first (contact the local "911"), and then contact **Generali Global Assistance** to alert them to your situation.

Call: 800-243-6108 | Fax: 202-331-1528
Collect from other locations: 202-828-5885

WHAT TO HAVE READY:

- Your employer's name
- Phone number where you can be reached
- Nature of the problem
- Travel Assistance Identification Number: GLD-09012
- Your Policy No. # _____

(Policy Number can be obtained through your Human Resources department.)

Estate Guidance Will Services

"What about my privacy?" All information is kept secure and confidential with the latest encryption technology." So, what happens if I don't create a will?" The state, not you, would decide how your property is distributed. In most states, all of your community and joint property would pass to your spouse if you have one. Separate property is passed according to a complex order of distribution, regardless of your loved ones' wishes. By drafting a will, you can spare them a potentially awkward and contentious situation.

Visit www.estateguidance.com/wills today. Use this code: WILLHLF.

Need more facts?
Just visit our Web site at
thehartford.com/employeebenefits.

NEXT STEPS

1. Review Benefit Plan information at the St Joe Benefits Resource Center. Watch videos. Ask questions.

2. Gather information about your dependents (like SSNs)

3. When Annual Enrollment starts on October 28th, go to Paycom, complete and SUBMIT your enrollment.

4. Payroll deductions for the Flexible Spending Accounts, the Health Savings Account, and elected benefits begin on the January 10th, 2025 pay date.

5. Check your paystub for accuracy and contact the Benefits Manager immediately.

Benefit Enrollment FAQs

Q. What if I miss the Enrollment period and need to enroll or make changes to my benefits?
A. Federal law limits your ability to change most of your elections outside of New Hire Enrollment unless you experience a 'qualifying event' and, if you do, the change must be made within 30 days of the event. Supporting documentation will need to be submitted to the Benefits department along with any election change. If you've missed the Enrollment deadline and have a concern, contact the Benefits department.

Q. What is considered in-network and out-of-network?
A. The insurance providers' contracts with a wide range of doctors, as well as specialists, hospitals, labs, radiology facilities, and pharmacies. These are the providers in your "networks". Each of these providers has agreed to accept your plan's contracted rate as payment in full for services. Out-of-network providers have no contracted rate. Your plan may require higher co-pays, deductibles, and co-insurance for out of network care up to the out-of-pocket maximum. Some plans may not cover out-of-network care at all, leaving you to pay the full cost of the care.

Q. I have a child that attends college out of state, what plan benefits me?
A. Do some research and check to see if providers and hospitals near your child's school are in the network you select. The carriers provide a very large provider network, which means there is a good chance you should be able to find an in-network doctor and/or hospital in the geographic area of your child's school. Remember that your child can seek care anywhere even at out-of-network providers and hospitals. If out-of-network, those costs would just be subject to additional expenses up to the out-of-pocket maximum (assuming that the medical plan offers out-of-network benefits).

Q. How long can my child be covered under my medical coverage?
A. The Affordable Care Act allows parents to add their adult children (to age 26) to their health plans.

Required Legal Notices

Important Notice to Employees from St Joe Company
About Creditable Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. Joe has determined that the prescription drug coverage offered by the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current St. Joe coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current St. Joe coverage, be aware that you and your dependents will not be able to get this coverage back until our next Annual Open Enrollment.

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

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

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

For more information about this notice or your prescription drug coverage, contact:

Kristy Wright

Talent and Leadership Director
St Joe Company
100 Richard Jackson Blvd., Suite 100, Panama City Beach, FL 32407
Office: (850) 231-7104
Email: Kristy.wright@stjoe.com

Required Legal Notices

Notice of Special Enrollment Rights for Medical Plan Coverage

As you know, if you have declined enrollment in Orlando Health's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

St Joe Company will also allow a special enrollment opportunity if you or your eligible dependents either:

Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or

Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the St Joe Company group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

All stages of reconstruction of the breast on which the mastectomy was performed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance;

Prostheses; and

Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at kristy.wright@stjoe.com or call (850) 231-7104.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at kristy.wright@stjoe.com or call (850) 231-7104.

Required Legal Notices

St Joe Company HIPAA Privacy Notice

St Joe Company HIPAA privacy notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by St Joe Company health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: *Medical, Dental, and Vision*. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not St Joe Company as an employer — that's the way the HIPAA rules work. Different policies may apply to other St Joe Company programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with St Joe Company

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to St Joe Company for plan administration purposes. St Joe Company may need your health information to administer benefits under the Plan. St Joe Company agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources, Benefits, Compliance, Payroll, and/or Finance are the only St Joe Company employees who will have access to your health information for plan administration functions.
Here's how additional information may be shared between the Plan and St Joe Company, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to St Joe Company, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to St Joe Company information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that St Joe Company cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by St Joe Company from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts).
You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work- related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

St Joe Company HIPAA Privacy Notice

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

St Joe Company HIPAA Privacy Notice

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.
If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

St Joe Company HIPAA Privacy Notice

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2025. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice either mailed to your home or emailed.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact Human Resources.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Human Resources.

Model COBRA continuation coverage general notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

St Joe Company Model COBRA continuation coverage general notice

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

St Joe Company HIPAA Privacy Notice

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Related Group, Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Related Group, Human Resources.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov.**

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

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

St Joe Company HIPAA Privacy Notice

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you. If you have questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Related Group, Human Resources. You may also contact Human Resources.

Summary of Material Modifications [or Summary of Material Reductions]

This enrollment guide constitutes a [Summary of Material Modifications (SMM)] OR [Summary of Material Reductions (SMR)] to the [insert full name and year of SPD] summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Required Legal Notices

CHIP/MEDICAID NOTICE

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program
(HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

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

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

Required Legal Notices

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 or 1-866-614-6005	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

Required Legal Notices

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427`	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 1-833-522-5582 TDD: 1-888-221-1590
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Wellness Program Notices

HIPAA Notice of Reasonable Alternative Standards (for Health-Contingent Wellness Programs)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at kristy.wright@stjoe.com or call (850) 231-7104 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

St Joe Company's HIPAA Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by St Joe Company's health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Dental, and Vision. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not St Joe Company as an employer — that's the way the HIPAA rules work. Different policies may apply to other St Joe Company programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information
The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

St Joe Company's HIPAA Privacy Notice, Continued

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with St Joe Company

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to St Joe Company for plan administration purposes. St Joe Company may need your health information to administer benefits under the Plan. St Joe Company agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources, Benefits, Compliance, Payroll and/or Finance staff are the only St Joe Company employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and St Joe Company, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to St Joe Company, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to St Joe Company information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that St Joe Company cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by St Joe Company from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.02% for 2025 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payenroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% of the employee's household income. **Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

New Health Insurance Marketplace Coverage Options and Your Health Coverage, Continued

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact kristy.wright@stjoe.com or call (850) 231-7104.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: St Joe Company	4. Employer Identification Number (EIN): 59-0432511	
5. Employer address: 100 Richard Jackson Blvd., Suite 100	6. Employer phone number: (850) 231-7104	
7. City Panama City Beach	8. State: FL	9. Zip code: 32407
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address:	

Required Legal Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage, Continued

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

As your employer, we offer a health plan to:
All employees working at least 30 hours per week
With respect to dependents:
Eligible dependents are spouses, domestic partners, child(ren) by birth, marriage, adoption, etc
This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Michelle's Law Notice – Extended dependent medical coverage during student medical leaves

St Joe Company's plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school – or change in school enrollment status (for example, switching from full-time to part-time status) – starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, as soon as the need for the leave is recognized to St Joe Company. In addition, contact Florida Blue to see if any state laws requiring extended coverage may apply to his or her benefits.

Your 2025 Benefits Program Resources At A Glance

Provider	Coverage	Member Services	Website
St Joe Company	Benefits Advocacy and Enrollment Assistance	Contact Benefits Dept. (850) 231-7104	Kristy Wright kristy.wright@stjoe.com
BCBS	Medical Plans	1-800-352-2583	www.floridablue.com
BCBS	Prescription Drugs	1-800-352-2583	www.floridablue.com
Teledoc	Telemedicine	1-866-789-8155	www.teledoc.com/go
Health Equity	Health Savings Account / Flexible Spending Account	HSA: 866-346-5800 FSA: 877-924-3967	www.healthequity.com
Delta Dental	Dental PPO	1-888-335-8227	www.deltadental.com
EyeMed	Vision	1-866-939-3633	www.eyemed.com
The Hartford	Life/AD&D, Short-term & Long-term Disability	(888)-563-1124	www.thehartford.com
The Hartford	Employee Assistance Program (EAP)	1-(800)-964-3577.	www.thehartford.com

While every effort has been made to ensure accuracy of this benefits guide, the plan documents and contracts will prevail in case of discrepancy between this guide and the plan documents and contracts. In addition, the St Joe Company reserves the right to modify or terminate any benefit plans at any time.