ST JOE®

2026

Benefits Guide

January 1 – December 31, 2026

Welcome

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits as a full-time employee working at least 30 hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Under Florida state law, coverage may be extended up to age 30 subject to marital status, place of residence, student status, or other factors. Please contact the Benefits department for more details.

Coverage Begins

- **New Hires:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following 30 days of continuous employment. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1, 2026 – December 31, 2026.

Enrollment

Go to the St. Joe Benefits Resource Center. There you will find detailed information about the plans available to you and instructions for enrolling via Paycom.

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse or child
- Lost coverage under your spouse's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact the Benefits department within 30 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

Mid-Year Changes

Qualifying life events allow you to change your coverage during the year outside of Open Enrollment. Common examples of these include:

Event	When you can change coverage	Benefits affected	Effective date
Marriage	Elect or change coverage within 30 days following your marriage.	Medical, Dental, Vision, FSA, DCAP, Life, Supplemental benefits	Date request is initiated in Paycom
Divorce	Elect or change coverage within 30 days following the date of divorce; notify HR within that time. Spousal coverage ends the date the divorce is final.	Medical, Dental, Vision, FSA, DCAP, Life, Supplemental benefits	The date of the divorce
Birth, adoption, or adoptive placement of a child	Elect, change, or cancel coverage within 60 days of the birth, adoption, or adoptive placement.	Medical, Dental, Vision, FSA, DCAP, Life, Supplemental benefits	Date of birth, adoption, or adoptive placement
Change in employment status of the spouse and/or dependent child	Elect, change, or cancel coverage within 30 days of the date of the employment status change. This change must result in a gain or loss of eligibility for the employee, spouse, or dependents.	Medical, Dental, Vision, FSA, DCAP, Life, Supplemental benefits	The latter of the date the coverage ended or the date the request for the change is initiated in Paycom
Child reaches dependent age limit	Your child's coverage ends on the day following the end of the calendar year of his or her 30th birthday.	Medical, Dental, Vision, Life, Supplemental benefits	Midnight on the day your child loses coverage for reaching the age limit COBRA is available for Medical, Dental, Vision
Reduction in hours (full-time to part-time)	Within 30 days following the change to part-time status.	Medical, Dental, Vision, FSA, DCAP, Life, Supplemental benefits	The latter of the date you initiate the request in Paycom or the date you become part-time
State Group Health Program	Within 60 days following the event.	Medical, Dental, Vision, FSA, DCAP	The latter of the date of the effective date or the date of the letter

MEDICAL COVERAGE

PPO

The Preferred Provider Organization (PPO) plan, provided through Blue Cross Blue Shield of Florida, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

A PPO plan relies on a network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered “in-network." In general, you will pay less for in-network services than you would were you to seek care outside the network.

How You Pay for Services

- You pay a flat dollar amount–or copay–for covered health care treatments and services, such as doctor’s office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage–or coinsurance–of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider, visit www.floridablue.com.

Scan this code to watch a video about comparing medical plan types.

MEDICAL COVERAGE

HMO

The Health Maintenance Organization (HMO) plan, provided through Blue Cross Blue Shield of Florida, has a network of providers and hospitals that discount their services. With this plan, you select a primary care provider (PCP) from the participating network of providers, who will coordinate your health care needs, refer you to specialists (if needed) and approve further medical treatment. Services received outside of the HMO's network are not covered, except in the case of emergency medical care. For HMOs, premiums and out-of-pocket costs are typically low as long as you stay within the HMO plan's network.

How You Pay for Services

- You pay a predetermined flat dollar amount—or copay—for services received from your PCP.
- You must obtain a referral for treatment from outside specialists and certain types of tests and procedures. **Note:** Women generally do not need a referral to see an obstetrician/gynecologist or OB-GYN for routine care.
- If you go outside of the HMO's network, you are responsible for 100% of the cost of the services you receive.

To find an in-network provider, visit www.floridablue.com.

Scan this code to watch a video about comparing medical plan types.

MEDICAL COVERAGE

HDHP + HSA

The High-Deductible Health Plan (HDHP) comes with a health savings account (HSA) that allows you to save pre-tax dollars[1] to pay for any qualified health care expenses as defined by the IRS, including most out-of-pocket medical, prescription drug, dental and vision expenses. For a complete list of qualified health care expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf.

Here's how the plan works:

- **Annual Deductible:** You must meet the entire annual deductible before the plan starts to pay for non-preventive medical and prescription drug expenses. NOTE: *If you enroll one or more family members, you must meet the full FAMILY deductible before the plan starts to pay expenses for any one individual.*
- **Coinsurance:** Once you've met the plan's annual deductible, you are responsible for a percentage of your medical expenses, which is called coinsurance. For example, the plan may pay 80 percent and you may pay 20 percent.
- **Out-of-Pocket Maximum:** Once your deductible and coinsurance add up to the plan's annual out-of-pocket maximum, the plan will pay 100 percent of all eligible covered services for the rest of the calendar year. NOTE: *If you enroll one or more family members, you must meet the full FAMILY out-of-pocket maximum before the plan starts to pay covered services at 100 percent for any one individual.*
- **Health Savings Account (HSA):** You can open an HSA through Health Equity and contribute to your HSA through pre-tax payroll deductions to help offset your annual deductible and pay for qualified health care expenses. In addition, we will contribute $500 annually to your HSA if you enroll in employee-only coverage and $1,000 annually if you enroll yourself and one or more family members. **To be eligible for the HSA, you cannot be covered through Medicare Part A or Part B or TRICARE programs. See the plan documents for full details.**

To open up an HSA, visit Health Equity's website at www.healthequity.com. The group number for HSA is 7974621.

Refer to page 14 for the annual IRS limits on your Health Savings Account (HSA) contributions.

Your HSA is yours for life. The money is yours to spend or save, regardless of whether you change health plans[2], retire or leave the company. There is no "use it or lose it" rule. Your account grows tax free over time as you continue to roll over unused dollars from year to year. You decide how or if you want to spend your HSA funds. You can use them to pay for you and your dependents' doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

To find an in-network provider, visit www.floridablue.com.

1. *Tax free under federal tax law; state taxation rules may apply*
2. *You must be enrolled in a qualified health plan to contribute to an HSA.*

Medical Plan

The St. Joe Company is proud to offer employees three competitive medical options through **Blue Cross Blue Shield of Florida**. Please note that any deductibles, copays, and coinsurance shown in the chart below are amounts for which you are responsible. For complete coverage details, please refer to the Summary Plan Description (SPD). The following is a high-level overview of your benefits.

Key Benefit Details	BlueOptions PPO 3769		BlueOptions HSA 5192/5193		BlueCare HMO 130/131
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]	In-Network
Calendar Year Deductible					
Individual	$500	$1,500	$2,500	$5,000	$1,650
Family	$1,500	$4,500	$5,000 (per family)	$10,000 (per family)	$3,300 (per person and per family)
Embedded or Non-embedded	Embedded		Non-embedded		Non-embedded
Max OOP (includes deductible)			Embedded: $6,850	Embedded: $23,200	
Individual / Family	$3,000 / $6,000	$6,000 / $12,000	$5,800 / $11,600	$11,600 / $23,200	$4,950 / $9,900
HSA Annual Company Contribution	N/A	N/A	$500 / $1,000		$500 / $1,000
Coinsurance	20%	50%	20%	40%	20%
Office Visits Copay					
Preventive/Wellness	No charge	50%	No charge	40%	No charge
PCP Office Visit	$25	50%*	20%*	40%*	20%*
Specialist Office Visit	$60	50%*	20%*	40%*	20%*
Diagnostic Labs and Low Tech X-Rays	$50	50%*	20%*	40%*	20%*
Inpatient Hospital	20%*	50%*	20%*	$500 + 40%*	20%*
Outpatient Surgery	20%*	50%*	20%*	40%*	20%*
Emergency Care					
Emergency Room	$300	$300	20%*	20%*	20%*
Urgent Care	$65	$65*	20%*	20%*	20%*
Prescription Drugs					
Retail Generic	$10	50%	$10*	50%*	$10*
Retail Preferred Brand	$30	50%	$50*	50%*	$50*
Retail Non-Preferred Brand	$50	50%	$80*	50%*	$80*
Specialty	Same as retail price	50%	Same as retail price	50%*	Same as retail price
Mail Order (90 day supply)	2.5 times retail price	50%	2.5 times retail price	50%*	2.5 times retail price

Please note that the above benefit description is a brief summary. Official plan documents will supersede what is shown here.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

COINSURANCE: *The percentage the plan or you pay for a covered service or supply. For example, the plan may pay 80% while you pay 20%.*

COPAYMENT (COPAY): *A copay is a flat-dollar amount you pay for a specific covered service upon each visit to the provider. It is not impacted by the plan deductible, coinsurance, or out-of-pocket maximum.*

DEDUCTIBLE: *The amount you pay each year before the plan begins to pay coinsurance.*

Employee Biweekly/Monthly Rates

Medical	BlueOptions PPO 3769	BlueOptions HSA 5192/5193	BlueCare HMO 130/131
Employee Only	$87.18 / $188.90	$57.96 / $125.57	$47.21 / $102.30
Employee & Spouse	$243.18 / $526.90	$163.38 / $353.98	$148.15 / $320.99
Employee & Child(ren)	$196.85 / $426.51	$131.80 / $285.56	$114.15 / $247.33
Family	$348.17 / $754.38	$228.45 / $494.97	$203.26 / $440.40

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Telemedicine

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

Cost and Time Considerations**

- Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Cost and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.
** Costs and time information represent averages only and are not tied to a specific condition or treatment.

Where to Go for Care

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Cost and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Do Your Homework
What may seem like an urgent care center could actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Cost and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.
** Costs and time information represent averages only and are not tied to a specific condition or treatment.

PREVENTIVE CARE

What is Preventive Care?

Regular preventive care can help you stay well, catch problems early on and may be potentially lifesaving. The ACA requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services. If you use an out-of-network provider, a deductible and out-of-network expenses may apply.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Scan this code to watch a video about preventive care.

Telemedicine

Blue Virtual Care is Blue Cross and Blue Shield of Florida's telehealth platform, which lets you have online visits with medical and behavioral health providers using a computer, smartphone, tablet or any device with internet and a camera. Blue Virtual Care is available 24/7 to give patients more access to doctors. Blue Virtual Care is faster, easier and less expensive than going to an ER or urgent care for minor health needs. Blue Virtual Care can be useful for treating non-emergency, minor conditions like: sinus infections, cold or cough, flu symptoms, bladder infections, fever, rashes, allergies, vomiting, diarrhea, pink eye, etc.

Log in to your member account, on the web, or Florida Blue app, and go to **Find & Get Care.**

Select **Find a Doctor & More**, click on **Find Virtual Care**, then select **BlueVirtualCare**.

Utilize Telemedicine when you have....

Cold & Flu, Rx Refill, Aches & Pain, Skin Rash, Allergies, Sinus Issues, UTIs, and More

Scan this code to watch a video about how telehealth works.

Dental Plan

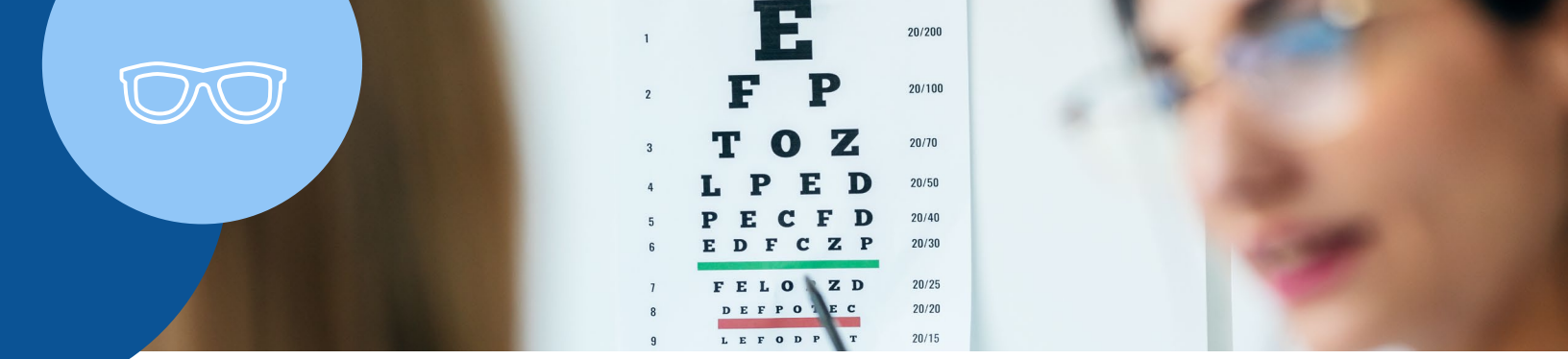
The St. Joe Company offers two dental plans through **Sun Life**. The following is a high-level overview of the coverage available.

	Low Plan	High Plan
Calendar Year Maximum		
Per Individual	$1,500	$2,000
Calendar Year Deductible		
Individual / Family	$50 / $150	$50 / $150
Preventive Services (does not count toward deductible)		
Oral Exams, Cleaning, X-Rays, Sealants	No charge	No charge
Basic Services		
Space Maintainers, Fillings, Oral Surgery, Extractions, Non-surgical and Surgical Periodontics (gum disease), Endodontics (root canal)	20%*	10%*
Major Services		
Crowns, Dentures, Bridges, Implants	50%*	20%*
Orthodontia		
Adult & Child(ren)	$1,500 lifetime maximum; 50%	$2,000 lifetime maximum; 50%

Coinsurance percentages shown in the above chart represent what the member is responsible for paying.
To maximize your benefits, use the Sun Life Dental network. *Non-network providers balance billing may apply.*
Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

Dental Plan Biweekly/Monthly Rates

Dental	Low Plan	High Plan
Employee Only	$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
Family	$29.61 / $64.16	$42.56 / $92.22



Vision Plan

The St. Joe Company offers a vision plan through **EyeMed**. All copays shown in the chart below are amounts for which you are responsible. The following is a high-level overview of the coverage available.

	In-Network	Out-of-Network Reimbursement
Exam (once every plan year)		
Copay	$10	Up to $40
Materials		
Copay	$25	-
Frames (once every 2 plan years)		
Allowance	$130, plus 20% off additional balance	Up to $91
Lenses (once every plan year)		
Single	$25	Up to $30
Bifocal	$25	Up to $50
Trifocal	$25	Up to $70
Lenticular	$25	Up to $70
Contacts (once every plan year; in lieu of glasses)		
Fit and Evaluation (standard / premium)	Up to $40 / 10% off retail price	Not covered
Elective Allowance	$130, plus 15% off additional balance	Up to $91
Medically Necessary Copay	No charge	Up to $300

To maximize your benefits, use providers in the Insight network by visiting www.eyemed.com or call 866-804-0928.

Vision Plan Biweekly/Monthly Rates

Vision	EyeMed Plan
Employee Only	$2.52 / $5.46
Employee & Spouse	$4.79 / $10.37
Employee & Child(ren)	$5.04 / $10.92
Family	$7.41 / $16.05

Spending Accounts

Spending accounts allow you to set aside a portion of your income, before taxes, to pay for qualified healthcare expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

These accounts let you:

☑ Use pre-tax money to pay for qualified medical expenses, including dental & vision
☑ Make pre-tax payroll contributions
☑ Pay for your spouse and dependents too

	Health Savings Account (HSA)	Healthcare Flexible Spending Account (FSA)	Dependent Care Flexible Spending Account (DFSA)
Qualified Expenses	You and your family members' eligible medical, prescription drug, dental, and vision expenses. For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p502.pdf		Eligible child and/or adult day care expenses
Fund Availability	Funds available as you contribute	Full annual amount available on day 1 of plan year	Funds available as you contribute
Fund Expiration	Keep your money forever (even if you change health plans, jobs, or retire)	Use-it-or-lose-it rule applies	Funds expire at the end of the plan year
Investing	Invest your HSA funds tax-free, like a 401(k)	Cannot invest FSA funds or grow your account	Cannot invest DCFSA funds or grow your account
Contribution Changes	Change or update anytime	Only during enrollment or 'qualifying life event'	Only if you experience a qualified life event that changes your childcare costs
Health Plan Type	Requires HSA-qualified high deductible health plan	Works with any health plan type	Health plan enrollment is not required
Contribution Limits	**$8,750** (Family plan) **$4,400** (Individual plan) *Members 55+ can contribute an extra $1,000*	**$3,400**	**$7,500** per family

Life and AD&D

Life insurance provides your named beneficiary(ies) with a benefit in the event of your death. Accidental Death and Dismemberment (AD&D) insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the life and the AD&D benefit would be payable.

Employer-Paid Life and AD&D

The St. Joe Company provides eligible employees with Basic Life/AD&D insurance through **The Hartford Group** at no cost to you.

	Benefit Amount
Employee	1x's annual earnings up to a maximum of $300,000

Voluntary Life and AD&D

If you determine you need more than the basic coverage, you may purchase additional coverage through The Hartford for yourself and your eligible family members.

	Benefit Option	Guaranteed Issue[1]
Employee	Increments of $10,000 up to the lesser of 5x's annual earnings or $600,000	Increments of $10,000 subject to the lesser of 3x's annual earnings or $300,000
Spouse	Increments of $5,000, with a minimum of $5,000 and a maximum of $150,000, not to exceed 50% of employee amount	Increments of $5,000, with a minimum of $5,000 and a maximum of $30,000
Child(ren)	Birth to age 6 months: Up to $250 Age 6 months to 26 years: Up to $10,000	N/A

1. During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

The benefits will be paid to the person(s) listed as the beneficiary in Paycom. Be sure you have the correct beneficiary listed and to update as needed.

Scan this code to watch a video about how disability insurance works.

Disability

In the event you are unable to work because of an illness or injury, the St. Joe Company provides Short-term and Long-term Disability insurance through **The Hartford Group.** Disability coverage provides financial protection for employees who are unable to work due to an illness or injury. This coverage replaces a portion of employee's income while they are not able to work due to a qualifying medical condition, ensuring financial stability during recovery.

Employer-Paid Short-term Disability

Short-Term Disability provides temporary income replacement commonly used for recovery from surgery, childbirth, or serious illnesses.

Benefit Percentage	**60%**
Weekly Benefit Maximum	$1,000
When Benefits Begin	After your doctor certifies your disability, you have completed the 7-day elimination period, and The Hartford Group approves your claim.
Maximum Benefit Duration	Up to 13 weeks from the date of disability.

Contributory[1] Long-term Disability

Long-Term Disability offers income replacement for an extended duration designed for more severe, long-lasting conditions such as chronic illnesses or permanent disabilities.

Benefit Percentage	**60%**
Monthly Benefit Maximum	$10,000
When Benefits Begin	After your doctor certifies your disability, you have completed the 90-day elimination period, and The Hartford Group approves your claim.
Maximum Benefit Duration	Social Security Normal Retirement Age, or a Maximum Benefit Period (inquire with Benefits Dept. for details).

[1]Both employee and employer contribute 50%.

Ensure correct beneficiaries are on file

The Hartford Group: Additional Benefits

Beneficiary Assist – Counseling Services

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

The loss of a loved one can leave 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.

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 with the services provided by **ComPsych**, you can spare them a potentially awkward and contentious situation.

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

Travel Assistance Program and ID Theft Protection

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

Travel Assistance Identification Number: **GLD-09012**

For more information, visit
www.thehartford.com/employeebenefits.

Valuable Extras

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a service offered by **ComPsych** via The Hartford Group to help you and members of your household deal with the daily stressors of work and life. ComPsych's EAP professionals can help with:

- Depression, grief, loss and emotional well being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation

EAP Services Include:

- Assistance for you, your dependents (including children to age 26, and household family members)
- Up to three (3) in-person or virtual sessions with a counselor, per year, per individual
- Unlimited toll-free phone access 24/7. Call 800-964-3577
- Online resources 24/7 at guidanceresources.com
  - Organization Web ID field: **HLF902**
  - Company Name field: **ABILI**

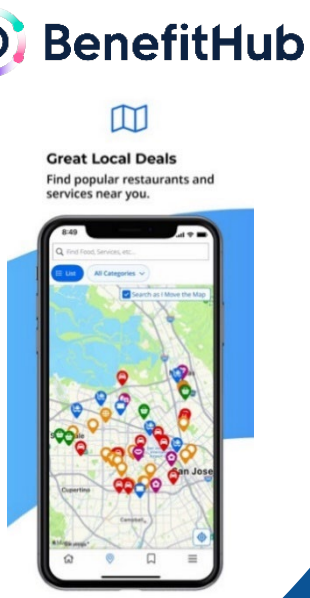
Scan this code to watch a video about how an EAP works.

BenefitHub

This benefit — which is exclusive to you — allows you to access thousands of amazing discounts that you cannot find anywhere else. You will find deals on travel, restaurants, shopping, family care, car rentals, your favorite local establishments and much more! All through an easy-to-use online marketplace.

It's easy to access & start saving!

1. Go to https://mypathperks.benefithub.com/welcome/register
2. Enter referral code: K7WEWL
3. Start saving today!



401(k)

We are proud to offer you a 401(k) plan powered by Vanguard. You are eligible to contribute to the 401(k) plan after the 2nd month of employment. You will receive a link from Vanguard to enroll in the 401(k) plan.

Contributions:

- **100% Company match on the first 3% contributed**
- **50% Company match on the next 2% contributed**

You are fully vested at FIRST CONTRIBUTION.

You can login at my.vanguardplan.com/login/participant or call (866) 794-2145.

Once you have registered, don't forget to confirm your electronic delivery preferences, enter your beneficiary and more.

Take smart steps with personalized insights.

- Project potential monthly retirement income based on your current savings strategy.
- Model different scenarios, such as savings more or changing your expected retirement age, with Retirement Outlook. Include outside assets in addition to your retirement plan to see your full financial picture.
- Adjust your savings rate at any time to stay on track with your goals and timeline to retirement.

Contact Directory

Benefit	Carrier	Group #	Phone #	Website
Medical	BCBS FL	51490	800-352-2583	www.floridablue.com
Health Savings Account	Health Equity	7974621	866-346-5800	www.healthequity.com
Flexible Spending Account	Health Equity	7974621	877-924-3967	www.healthequity.com
Dental	Sun Life	981263	800-442-7742	www.sunlife.com/dentalhealthcenter
Vision	EyeMed	5000685	866-939-3633	www.eyemed.com
Life/AD&D	The Hartford Group	GL-922173	888-563-1124	www.thehartford.com
Disability	The Hartford Group	GLT-922173 (LTD) / GRH-922173 (STD)	888-563-1124	www.thehartford.com
Employee Assistance Program (EAP)	ComPsych via The Hartford Group	-	800-964-3577	www.guidanceresources.com
401(k)	Vanguard	-	866-794-2145	my.vanguardplan.com/login/participant

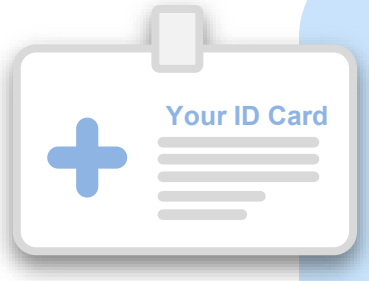
Questions?

For more information on your benefits, please reach out to:

Kristy Wright
850-231-7104
kristy.wright@stjoe.com

Nancy Otano
850-231-7105
Nancy.Otano@stjoe.com

Whitney Yeager
850-231-7113
Whitney.Yeager@stjoe.com



ID Cards

If you are a new enrollee for the BCBS Medical Plan or making changes to your current medical enrollment, you will receive a new ID Card from BCBS. ID cards can also be accessed through the member portal at www.floridablue.com

EyeMed will send two ID cards in the subscriber's name when you join the EyeMed Vision Plan. ID cards can also be accessed through the member portal at www.member.eyemedvisioncare.com/member/en-us.

If you enroll in the Sun Life Dental Plan, you can access your ID card through the member portal at www.sunlife.com/us/en/plan-members-and-families/.

Medicare Part D Creditable Coverage Notice

Important Notice from The St. Joe Company About Your 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 The St. Joe Company (the "Plan Sponsor") 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) The Plan Sponsor has determined that the prescription drug coverage offered by the The St. Joe Company Group Health

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 Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

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 the Plan Sponsor 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 the Plan Sponsor changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.

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

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

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

Date:	10/1/2025
Name of Entity/Sender:	The St. Joe Company
Contact-Position/Office:	Director - Payroll, Benefits & HRIS
Address:	130 Richard Jackson Blvd., Suite 200 Panama City Beach, FL 32407
Phone Number:	850-231-7104

CHIPRA/CHIP Notice

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

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – 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	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
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	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)
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
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, 2025, 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

Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at **850-231-7104** for more information.

Notice of Availability of HIPAA Notice of Privacy Practices

The St. Joe Company
130 Richard Jackson Blvd., Suite 200 Panama City Beach, FL 32407
10/1/2025

To: Participants in the Medical, HSA, FSA, Dental, Vision, Life and Disability

From: Kristy Wright, Director - Payroll, Benefits & HRIS

Re: Availability of Notice of Privacy Practices

The Medical, HSA, FSA, Dental, Vision, Life and Disability (each a “Plan”) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Kristy Wright, Director - Payroll, Benefits & HRIS at 130 Richard Jackson Blvd., Suite 200 Panama City Beach, FL 32407, 850-231-7104, kristy.wright@stjoe.com.

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 9.12% 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 payment of the credit, if you do not enroll 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 9.12% of the employee’s household income.[1, 2]

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.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 November 30, 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 November 30, 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 November 30, 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, Director - Payroll, Benefits & HRIS** at **130 Richard Jackson Blvd., Suite 200 Panama City Beach, FL 32407**, **850-231-7104**, **kristy.wright@stjoe.com**.

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 The St. Joe Company	4. Employer Identification Number (EIN) 45-4640111
5. Employer address, 7. City, 8. State, 9. Zip Code 130 Richard Jackson Blvd., Suite 200 Panama City Beach, FL 32407	6. Employer phone number 850-231-7104
10. Who can we contact about employee health coverage at this job? Kristy Wright, Director - Payroll, Benefits & HRIS	
11. Phone number (if different from above) 850-231-7104	12. Email address kristy.wright@stjoe.com

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

- As your employer, we offer a health plan to:

  ☒ All employees. Eligible employees are:

  All full-time employees working 30 or more hours per week.

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are:

  Spouses, domestic partners, and dependent children up to age 30.

  ☐ We do not offer coverage.

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

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

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than **30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 dependents. However, you must request enrollment no later than **30 days** after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have **60 days** after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request. .

To request special enrollment or obtain more information, contact **The St. Joe Company**, Human Resource Dept. at **850-231-7104**.

General COBRA Notice

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

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.

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;
-
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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: Kristy Wright.

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.

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 period[1] 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.

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

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

Paycom, at PO BOX 735814; DALLAS, TX 75373, 1-800-580-4505, cobra@paycomonline.com.

[1] **https://www.medicare.gov/basics/get-started-with-medicare/sign-up/how-do-i-sign-up-for-medicare.**