CHARLOTTE COUNTY Public Schools

Benefit Wise

2024

Employee Benefits Guide

Welcome

At Charlotte County Public Schools we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

The benefits outlined in this guide are only a summary and are not intended to be controlling.

For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs) on CCPS benefits website. The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

Open enrollment is October 16th – October 27th.

Don't miss this opportunity to review your coverage and make elections for yourself and your family.

The benefits in this summary are effective: January 1, 2024 - December 31, 2024

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Medicare Part D Notice
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the legal notices in the back of this guide for more details.

Eligibility And Enrollment

Eligibility

- **Employee:** Current employees must enroll during the open enrollment period. New employees or newly eligible employees must enroll prior to the fifteenth (15th) day of the month prior to the date of benefits eligibility. Coverage for new hires begins on the first of the month following 43 days of employment.
- **Dependents:** You may also enroll eligible spouses and dependent child(ren).

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Cash Only Option

Employees who opt-out of health insurance and the EBHRA, may elect to receive the cash only option. Employees that opt out will receive $75 per month, which is a taxable event and does not contribute to your FRS retirement earnings. If you select this cash only option, you are not eligible to return to the EBHRA option, but you may elect to return to one of the health plans in accordance with statute and IRS rules. Any employee hired prior to January 1, 2011 shall be eligible for both the EBHRA and the Cash Out option.

Enrollment

Prior to enrollment, make sure that your personal information, such as your home address ,date of birth and marital status, are updated so you receive important communications.

To enroll online: https://benefits.plansource.com

Qualifying Life Events

If you experience a qualifying life event change during the year, you may change your coverage within 30 days of that event. Qualified life events include (but are not limited to):

- Becoming legally married, divorced, or separated
- A child reaching age 26 and losing eligibility
- Having (or adopting) a child
- Death of your covered spouse or child
- Your dependents gaining or losing eligibility for benefits through his or her own employer

Coordination of Benefits

An employee who has coverage for themselves and under their spouse may fall under the Coordination of Benefits reimbursement. Coordination of benefits determines which group health plan pays first and which plan pays benefits second. The secondary plan may then pay additional benefits. Contact your spouse's benefits representative to inquire about COB.

You will not be able to change your benefit elections after the enrollment period unless you experience a qualifying life event.

Important Information

Wellness Program for School Board Health Plans

Employees who are enrolled in the School Board health care plan have the option of participating in the Wellness program.

Part 1: Make an appointment for initial clinic visit and complete the health risk assessment

- This will earn two points towards the overall total as well as $600 premium credit
- This step **must** be completed in order to be eligible for part 2
- During this visit an annual tobacco test will be administered. Being tobacco free will earn three points

Part 2: Biometric results from testing can qualify for lower individual medical plan deductible from $6,650 to $5,000

- Biometric results that fall within the prescribed range will earn the employee one point each (up to five total)
- Employees who chose to work to get their numbers in range will be able to have these metrics tested again prior to the end of the eligibility window.
- Employee premium contributions for the earned lower deductible of $5,000 will be the same as for the $6650 plan

Incentive Program Point Goal: 10 points		
Incentive Program Activity	**Activity Verification**	**Credit**
Biometric Screening Health Outcomes		
Initial clinic visit **and** completion of HRA	Verified by Health Center Data/Screening Form Submission	2
Blood Pressure ≤ 130 mm / 85 hg		1
Fasting Glucose ≤ 100 mg / dl or A1c of 5.7 or below		1
HDL (Good Cholesterol) Men ≥ 40 mg / dl; Women ≥ 50 mg / dl		1
Triglycerides ≤ 150 mg / dl		1
Waist Circumference Men ≤ 40" ; Women ≤ 35"		1
Non-tobacco user (annual testing at initial clinic visit)		3

How the program works:

Points achieved 9/1/2023 – 8/31/2024	Eligible plan
7 - 10	$5000 deductible plan
0 - 6	$6650 deductible plan

Employees should monitor their points progress in the Marathon eHealth Portal

Tobacco Surcharge

During open enrollment, employees will be asked if they or their covered spouses have used tobacco in the past twelve months. If employees answer "YES", there is a $50 per month tobacco surcharge added to the health insurance premium and higher rates on the critical illness premiums, if elected. Employees whom complete a qualified tobacco cessation program during the plan year will have their health insurance premiums adjusted retroactively to that of a non-tobacco user, effective January 1, 2024 (documentation required). If employees have questions pertaining to cessation program opportunities or this surcharge, please contact Employee Benefits at 941-255-0808, select 7. Marathon Health provides health coaching to assist you in reaching your cessation goals. You may also reach out to Tobacco Free Florida at 877-822-6669 to Create a free personalized quit plan.

Note: Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees who enroll in a CCPS medical plan. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at 941-255-0808 option 7 and we will work with you to develop another way to qualify for the reward.

Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

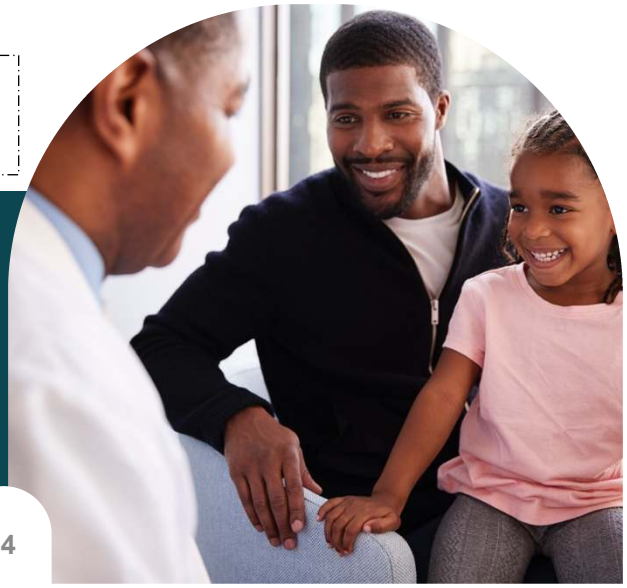
	6650 Plan	
	In-Network	**Out-of-Network**
Annual Deductible	$6,650 $13,300	$13,300 $26,600
Annual Out-of-Pocket Max	$6,650 $13,300	$13,300 $26,600
Coinsurance	100% / 0%	100% / 0%
Office Visit		
Primary Provider	0%	0%
Specialist	0%	0%
Preventive Services	0% deductible waived	0%
Chiropractic Care	0%	0%
Lab and X-ray	0%	0%
Inpatient Hospitalization	0%	0%
Outpatient Surgery	0%	0%
Urgent Care	0%	0%
Emergency Room	0%	0%

Note: All benefits are after deductible

Note: *Official plan documents are the definitive source of information and take precedence over the benefits described above and available on CCPS website*

If 7-10 points are earned in wellness program the below deductible will apply.

	In-Network	Out-of-Network
Annual Deductible	$5,000 $10,000	$13,300 $26,600
Annual Out-of-Pocket Max	$5,000 $10,000	$13,300 $26,600



Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	6650 Plan
	In-Network
Retail (*Up to 31 day supply)* Generic / Preferred Brand / Non-Preferred Brand	0% coinsurance
Mail Order *(Up to 90-day supply)* Generic / Preferred Brand / Non-Preferred Brand	0% coinsurance
Retail 90 Day *(Up to 3 month supply, at least 84 days)* Generic / Preferred Brand / Non-Preferred Brand	0% coinsurance

Note: All benefits are after medical deductible has been met

There are Two Ways to Save on Your Maintenance Prescriptions

1. For savings and convenience, take advantage of home delivery from Optum Rx. Get a 90-day supply of your medications delivered direct to you, safely and securely, with free standard shipping. Log in at optumrx.com or call 855-524-0381 to learn how to get started with home delivery. Optum Rx can contact your doctor to have a new 90-day prescription sent right to you.

2. You can transfer your maintenance prescriptions to a nearby preferred (Walgreens) pharmacy. The pharmacist will contact your doctor to get a new 90-day prescription or will transfer your current 90-day prescriptions from the non-preferred pharmacy. Your copayment for your 90-day supply will be the same whether you fill your prescriptions through Optum Rx home delivery or at a Walgreens network pharmacy.

Affordable Insulin Program

Members will have more predictable out-of-pocket costs for their insulin and pay no more than $25 per 30-day insulin Rx.

Eligible Insulins: Humalog, Humalin, Lantus and Toujeo

When a member fills a prescription for a preferred product, they will automatically pay the reduced out-of-pocket amount at the point-of-sale for both home delivery and in-network retail pharmacies. No need to enroll.

Ask your physician if there is a generic, they can prescribe instead of a name brand drug. Generic medications are FDA approved and have the same active ingredients, strength and testing standards at a lower cost.

Note: *Official plan documents are the definitive source of information and take precedence over the benefits described above and available on CCPS website*

Know Where to Go

When you're not feeling well or when caring for a loved one, you don't want to waste time trying to find what place of care is best. Use this guide to save yourself from the stress.

Telehealth

When you have a minor medical concern and need to see a doctor quickly from anywhere. With telehealth, you can speak to a healthcare professional in just a few clicks with your phone, tablet or computer. Use this for non-emergent concerns such as cold or flu symptoms, allergies or sinus infections.

Primary Care

When you need your annual check-up, treatment of a chronic condition, or see someone who already knows your history and has access to your records. Primary care physicians typically require appointments and are not available nights and weekends. Your annual check-up is free.

Urgent Care

Visit urgent care when you have a pressing medical concern, but not an emergency. Urgent care is the best fit for sprains, strains, minor broken bones, minor infections, small cuts that need a few stitches, minor burns and x-rays. Urgent care facilities are commonly open on nights and weekends.

Emergency Room

Emergency rooms are designed to treat serious, life-threatening incidents, like a head injury, heart attack, severe burn, choking, breathing problems, deep wound, injury to neck or spine, to name a few examples. If you visit the emergency room when you are not having an emergency, you'll have a long wait and you'll pay the most out-of-pocket.

Health Savings Account

When you enroll in a HDHP with HSA Plan you will be set up with a Health Savings Account (HSA) through OptumBank. An HSA is an account that allows you to pay for qualified health expenses without paying taxes on the money. Here's how the account works:

Make contributions. You can set aside pre-tax money through payroll deductions up to IRS limits ($4,150 for employee-only and $8,300 for all other coverage, plus $1,000 annual catch up contribution for those over age 55). Charlotte County Public Schools will provide a one-time contribution in the amount of $1,000 to a Health Savings Account for each employee enrolled in the HDHP 6650 Plan as of January 1, 2024

Use your funds. You can use your funds to pay for eligible medical, dental and vision costs now or in the future. View a full list of eligible expense at www.irs.gov. You can pay for eligible expenses out-of-pocket and reimburse yourself from your HSA savings at a later date or, you can pay with a HSA debit card.

Save your funds. You can also use your account as a savings account. The account is yours, even if you leave the company, and your funds will roll over each year accruing interest tax-free.

Are you eligible?

You are eligible to contribute to an HSA if:

- You are enrolled in the HDHP medical plan
- You are not covered by your spouse's health plan or flexible spending account (FSA)
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in Medicare, TRICARE or TRICARE for life
- You have not received Veterans Administration Benefits

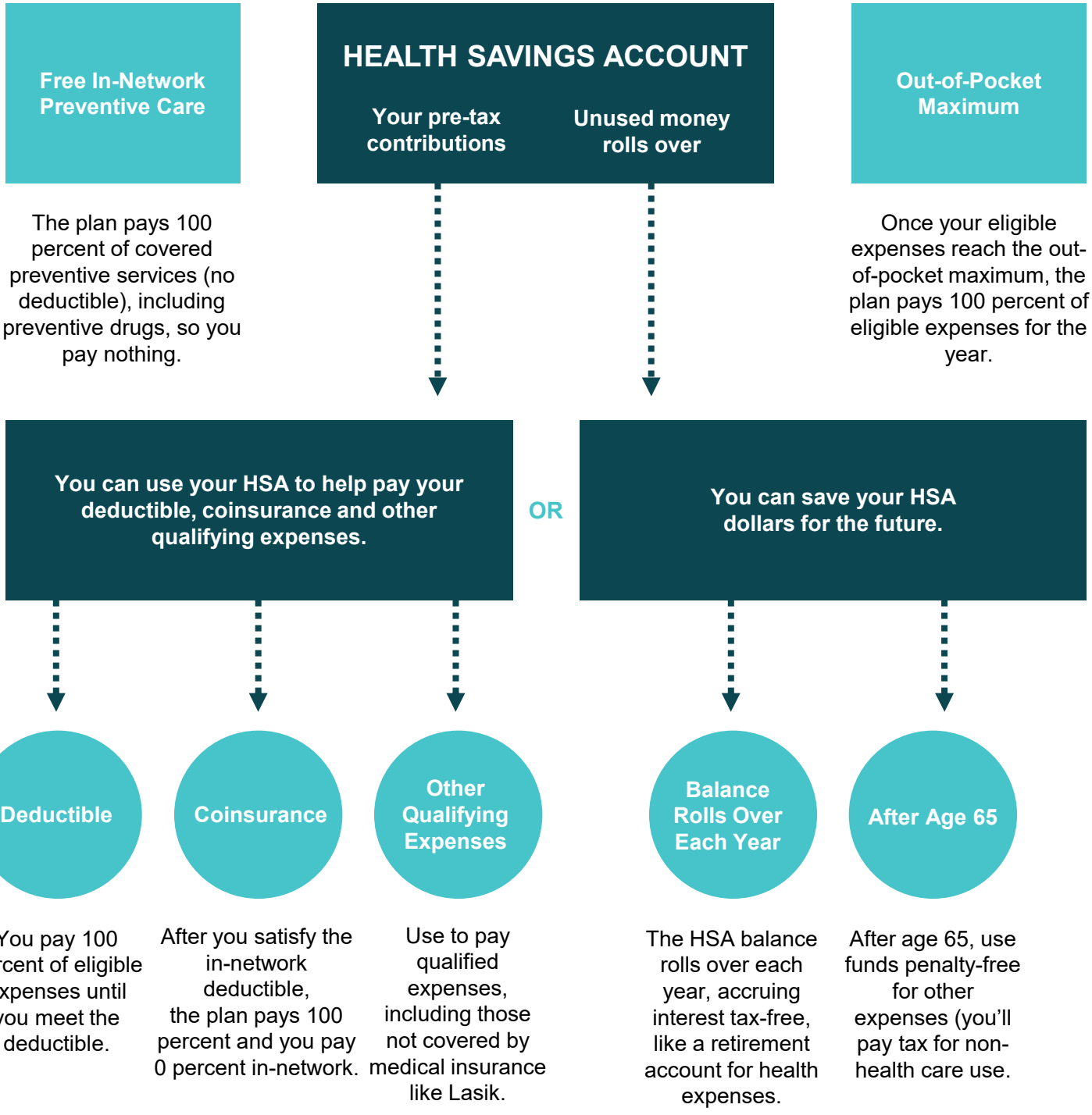
Wondering how much to save?

What you save in your HSA is up to you and your budget. Here are a few strategies:

- **To see the biggest tax advantage,** max out your contributions up to the 2023 federal IRS limits.
- **To be prepared for a rainy day,** set aside enough each month to fund the annual deductible or out-of-pocket maximum. That way, you have funds available should you be faced with big medical bills.
- **To simplify your savings,** set aside $10 per paycheck per enrolled family member. For a family of four, that will give you about $1,000 set aside each year to help you cover the cost of an unexpected doctor's visit or a monthly generic medication.

Under a high deductible plan, prescription drugs are covered the same as any other medical care, such as a doctor's visit or lab test. You pay the full cost of the prescription at the pharmacy until you meet your deductible. Savings in your HSA can help you be prepared for these initial expenses.

Health Savings Account



Excepted Benefit Health Reimbursement Account (EBHRA)

A Excepted Benefit Health Reimbursement Account (EBHRA) is provided to you if you decline the medical plan. Excepted Benefit HRAs can reimburse eligible Internal Revenue Service Code Section 213(d) expenses such as medical, dental, vision, Rx and over-the-counter medication and supplies. This plan will also allow for COBRA premiums. Premiums for traditional group or individual health care coverage, or Medicare, are not a covered expense.
Final determination of coverage is made at the time a claim is received and processed. If a conflict exists between the information provided to you and the terms of the plan, the terms of the plan will control.

Company contributions. The company will make tax-free contributions of $1,800 to your EBHRA for employees hired prior to June 30th and $900 for employees hired July 1st or after. You are not eligible to make your own personal contributions.

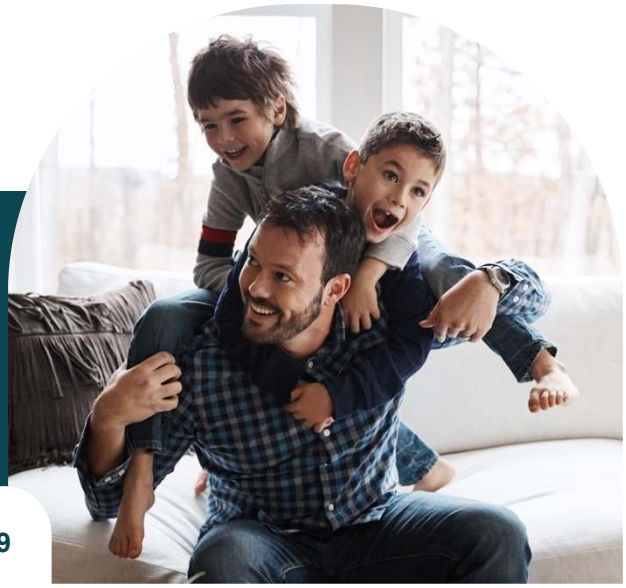
Use your funds. The money in your account will be automatically added to a debit card to be used for qualified expenses as stated above. Premium claims must be submitted to UMR with a claim form and you must include the premium statement due or check stub showing the premium amount. This account can be used for covered dependents as well. For a list of qualified expenses, register on UMR.com OR visit www.irs.gov.

Don't lose your funds. The money in your EBHRA grows year-over-year. The EBHRA is not portable. If you leave the company or change plans, you will no longer have access to accumulated funds.

Members will receive two debit cards with the employee's name on them. (Any family member can use the cards) If you already have a card for the Dependent FSA, you will utilize the same card.

If covered under another Health insurance Plan, you will need to submit an Explanation of Benefits (EOB) statement as well as an itemized bill. If documents are not received in a timely manner, your EBHRA account will be suspended until the claim is settled.

If you decline Medical, you will be provided the EBHRA. Should an employee separate from service, the account will be inactivated on the day the employee separates service.
Any employee hired prior to January 1, 2011 and currently participating in the Opt-out FSA prior to January 31, 2011, shall be eligible for both the EBHRA and the Cash Out option.



Dependent Care Flexible Spending Account

Dependent care flexible spending accounts (DCFSAs) enable you to set aside some of your pay, on a pre-tax basis, into an account to pay for eligible dependent care expenses. By setting aside money pre-tax, which you would normally be spending post-tax, you save between 25 percent and 40 percent on your everyday expenses.

The dependent care FSA covers child care expense while you are at work for children under age 13 or other dependents who are incapable of self-care.

Make contributions. You set aside pre-tax money through payroll deductions up to IRS limits. For a dependent care FSA, you must contribute no more than $5,000. Please note, if you are married and file a separate income tax return, the maximum you can contribute is $2,500. Dependent care FSA funds are available after they've been deducted from your paycheck.

Use your funds. This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care.

Don't lose your funds. The money you set aside must be used during the plan year – it will not roll over into your account. Any money left in the account will be forfeited. You have until March to turn in receipts for reimbursement.

Important Considerations

- Your elections cannot be changed during the plan year, unless you experience a qualifying life event.
- You need to keep your receipts as proof that your expenses were eligible for IRS purposes.

REMINDER: THIS BENEFIT IS USE IT OR LOSE IT!

Elder care services may be covered under specific criteria. Please contact the Employee Benefits Assistant for further information

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your overall health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

	PPO High Plan	PPO Low Plan		DMO Plan
	In-Network/Out of Network	In-Network	Out-Of-Network	In-Network
Calendar Year Deductible	$50 per individual $150 per family	$50 per individual $150 per family	$50 per individual $150 per family	$0 per individual $0 per family
Annual Plan Maximum	$2,000	$1,000	$1,000	N/A
Diagnostic and Preventive	Plan pays 100%	Plan pays 80%	Plan pays 60%	Most procedures pay at 100%
Basic Services				
Fillings	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	$0 amalgam $30-$155 resin composite
Root Canals	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	$75 - $440 copay
Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible	$50 - $375 copay
Major Services	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 40% after deductible	$0 - $990 copay then plan pays 100%
Orthodontic Services	Adults & Children	Not Covered		Adults & Children
Orthodontia	Plan pays 50%	Not Covered		$2,250 child copay $2,350 adult copay
Lifetime Maximum	$1,500	Not Covered		N/A
Dependent Children	Covered to age 26	Not Covered		Covered to age 26

For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

The DHMO plan is open access so there is no need to designate a general dentist at time of enrollment.

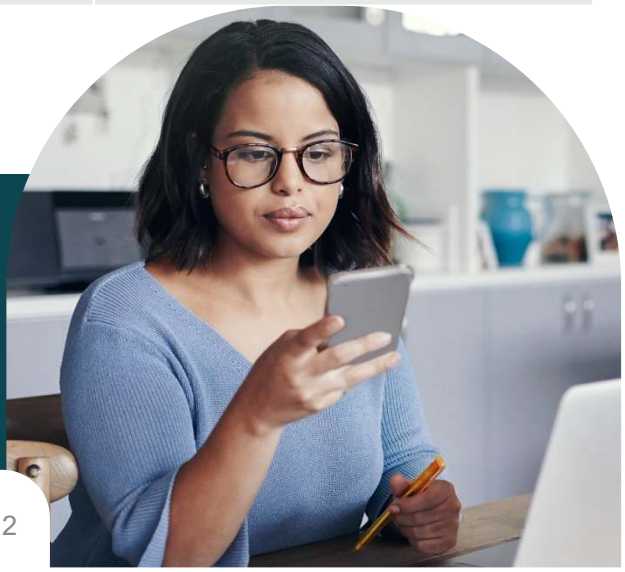
To find a provider visit www.myuhcdental.com
PPO Network:
National Options PPO20
DHMO Network:
National Exclusive Network

Vision

Whether it's a routine eye exam, glasses or contact lenses, the vision plan has you covered.

UnitedHealthcare Vision Network	Vision Plan	
	In-Network	**Out-of-Network**
Examination		
Benefit	$10 copay	Reimbursed up to $40 allowance
Frequency	Once every 12 months from last date of service	In-network limitations apply
Materials	$15 copay then plan pays 100%	Copay Applies
Eyeglass Lenses		
Single Vision Lens	$15 copay	Reimbursed up to $40
Bifocal Lens	$15 copay	Reimbursed up to $60
Trifocal Lens	$15 copay	Reimbursed up to $80
Frequency	Once every 12 months from last date of service	In-network limitations apply
Frames		
Benefit	$15 copay reimbursed up to $115	Reimbursed up to $45
Frequency	Once every 24 months from last date of service	In-network limitations apply
Contacts (In lieu of frames)		
Benefit	$15 copay for formulary; reimbursed up to $105 for non formulary	Reimbursed up to $105
Frequency	Once every 12 months from last date of service	In-network limitations apply

Routine eye exams are important. Your eyes provide a unique look into your health and can reveal other health concerns such as stress, high cholesterol, diabetes, liver problems, and more.



Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death and dismemberment (AD&D) insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

Company-Paid Life and AD&D Insurance*

Basic life insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, hearing, or if you die in an accident. Coverage is provided by Lincoln Financial Group and is paid in full by the company. Coverage amount is $50,000 for basic life and $50,000 for AD&D.

Voluntary Life and AD&D Coverage*

You may choose to buy additional coverage for yourself or your family by enrolling in voluntary life and AD&D insurance.

- Employee: Increments of $10,000 up to $200,000
- Spouse: Increments of $5,000 up to $100,000 or 50% of the covered employee amount, whichever is lesser.
- Child(ren): Increments of $5,000 up to $25,000.

Evidence of Insurability

Evidence of Insurability (EOI) is a process in which you provide information on the condition of your health or your dependent's health to get certain types of insurance coverage. During your initial eligibility period, if you select a coverage amount above the guarantee issue, you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage. After your initial eligibility period, any increase during a future enrollment period requires EOI.

Guarantee Issue •Employee - $100,000 •Spouse - $50,000

Taxes

A life insurance benefit of $50,000 or more is a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2

*Age reduction schedule applies to enrollees age 65 and older

Remember to add beneficiaries to your policy! It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Disability Insurance

Disability plans, offered through Lincoln Financial Group, are intended to replace a portion of your income if an illness or injury leaves you unable to work. Disability benefits are subject to applicable taxes and are offset by any other income or disability benefits you receive (or are eligible to receive), such as Social Security and workers' compensation.

Long-Term Disability

Long-Term Disability (LTD) coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long period of time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

- Monthly Benefit: Plan pays 66.67% of covered monthly earnings
- Maximum Monthly Benefit: $8,334
- Benefits begin: After 90 days of disability
- Maximum Payment Period: Social Security National Retirement Age (changes based on disability date) *

*The age at which the disability begins may affect the duration of the benefits.

Additional Benefits

Accident Insurance

Accident coverage is designed to help meet the out-of-pocket expenses and extra bills that can follow an accidental injury. Indemnity lump sum benefits through Lincoln Financial Group are paid directly to you based on the amount of coverage listed in the schedule of benefits.

Critical Illness

Critical Illness insurance, available through Lincoln Financial Group, is designed to help you offset the financial effects of a catastrophic illness with a lump sum benefit if you or a covered dependent are diagnosed with a covered critical illness.

Hospital Indemnity

Hospital Indemnity coverage, available through Lincoln Financial Group, pays a benefit when you are admitted to the hospital for a covered stay. This coverage can compliment your health insurance to help you pay for the costs associated with a hospital stay. It can also provide funds which can be used to help pay the out-of-pocket expenses your medical plan may not cover, such as coinsurance, copays and deductibles.

You or your spouse should contact your HR department if you need to file a Life or Long Term Disability claim.

Wellbeing Programs

Marathon Health

CCPS has partnered with Marathon Health, a national leader in workplace health, in an effort to provide more information and care opportunities so that we can help our employees live heathier, more productive lives. They do that in many different ways:

- You will receive personalized and confidential health coaching designed to address your individual healthcare needs.
- Access to the Marathon eHealth Portal, your online resource for managing and achieving your personal health goals. This online resource offers a wide array of health tools and resources! These tools include: secure messaging with your Marathon Health provider, access to your personal health record and online appointment scheduling of virtual and in person appointments! Access to the Marathon eHealth Portal is available at my.marathon-health.com with the username and password you will receive at your home mailing address.

Employee Assistance Program

When you have questions, concerns or emotional issues surrounding your personal or work life, you can count on ComPsych Guidance Resources program (EAP) to offer help. Access to consultant by telephone, resources and tools online, and up to five face-to-face visits with a consultant to help with a short term problem. Our EAP can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free!

Help is available 24/7, 365 days a year!
Telephone: 1(888) 628-4824
Online: www.guidanceresources.com
User Name: LFGsupport
Password: LFGsupport1

Health Advocate

Navigating the healthcare system can be a challenge. Health Advocate offers a unique level of personalized support you won't find anywhere else.
As an independent third party, our experts will answer your questions and take on virtually any healthcare issue -- so you and your family get the right care at the right time. Health Advocate services are all at no cost to you!

866.695.8622 | answers@healthadvocate.com | www.HealthAdvocate.com/members.com

Our Personal Health Advocates can help you get to the right care at the right time and resolve a wide range of issues. They can:

- Support medical issues, from common to complex
- Answer questions about diagnoses and treatments
- Research the latest treatment options
- Coordinate services related to all aspects of your care
- Find the right in-network doctors and make appointments
- Coordinate second opinions and transfer medical records
- Research and locate eldercare services
- Resolve insurance claims and medical billing issues

EAP and Health Advocate services are provided at no cost to the employee

Focus on Wellbeing: Tim's Story

My name is Tim and I work for Charlotte County Public Schools. I had an issue with drinking, I love to say "had." It started innocently enough. Remember those toothpick holders shaped like a beer stein? Well, I would use that when my dad would come home so I could share a beer with dad. I got a taste for beer, and no, I do not blame my dad for what I eventually became. As I got older it became a habit and I thought "I can control this!" However, eventually, you run into loaded dice, which is what happened to me. I "damn" near lost my job with district, which I thoroughly enjoy and the people I work with.

Some people and family reached out to me to help, but they were the people I wanted to distance myself from the most. At times, I had police officers knocking at my door, as well as a good friend that I work with, trying to help me and get me help. He told me about the wellness center and giving that a try. That got through to me because it showed me that someone truly cared about me.

So, I agreed to go to the CCPS Employee Wellness Center that is ran by Marathon Health for the district insured employees just like me. The Marathon folks working there jumped at the opportunity to help me. I had never utilized the health center and they did not even know me, and I literally just walked in asking for help. Elizabeth Timpe NP agreed to see me right away because I had quit drinking on my own two days prior and the withdraw symptoms were unbearable and she could see I was in a crisis. They all just made time for me, stopped what they were doing and helped me. I felt I didn't deserve the help but was humbled by the fact that these strangers cared enough to help me. I told her I stopped drinking because if I didn't, I was going to lose my job and a lot of other things and that "I need help." She originally wanted to put me in a rehab facility, but I told her I couldn't do that, I needed to be in my home. I reassured her all alcohol was out of my house. She took a step of faith and trusted me. We came up with what she calls "a care plan." She started me on some medication that would help with the withdraw symptoms. She encouraged a large amount of Gatorade and water and that I had to promise to return to the health center for the next four days. I agreed and felt some weight off my shoulders that I was not alone, and I was what you call "all in!" I followed her directions to the T and after 24 hours my elevated BP and other symptoms were improving, and I didn't feel like I was "coming out of my skin." She saw me for the next 3 days and was constantly encouraging me and proud of my progress. She helped me so much and I was constantly thanking her, however she said that I should be proud of myself because I was doing all the hard work.

My last drink was July 9, 2023, and I continue to be alcohol free, and I am still on my wagon ride. After just four visits at the health center, I was able to understand what had been bothering me for 10 years or so. I feel much better about so many things in my life. I was cleared and able to return to work that next Monday after I first went to the clinic. Having an employee health center saved my life and I am forever grateful. I usually do not like talking about myself, but I wanted to share my story and let others know that if they haven't been to the health center, please give it a try, I promise you will not be disappointed.

CCPS Employee Wellness Center
Charlotte Technical Center Campus
18150 Murdock Circle, Building G
Port Charlotte, Florida 33948
Phone: (941) 623-4444

Cost of Coverage – Per Pay

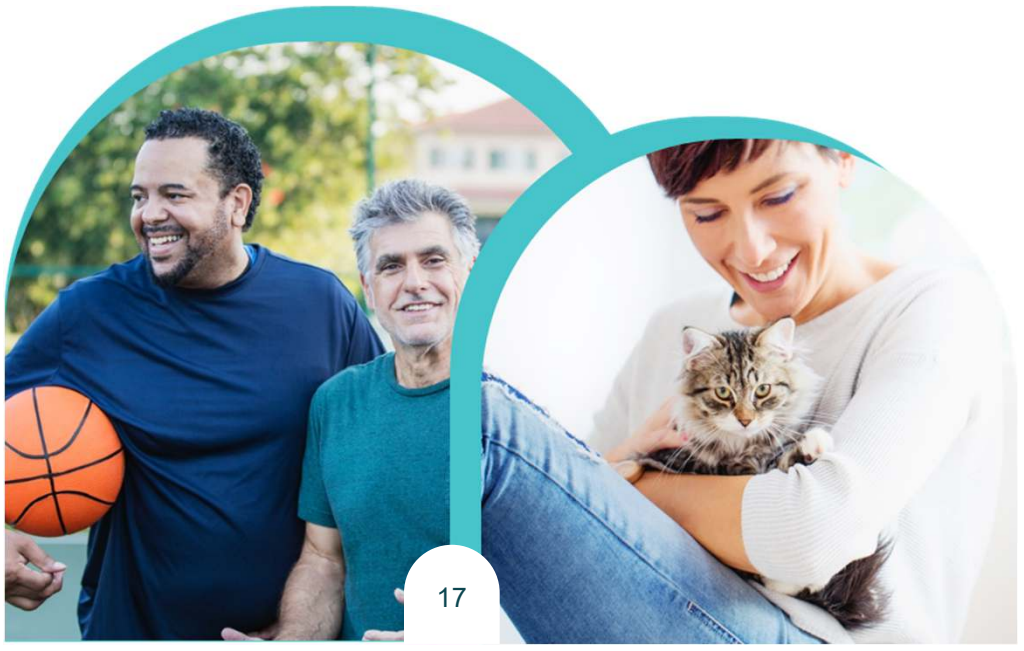
UMR Medical	HDHP 6650 Premium	Hired prior to 6/30/2019		Hired after 7/1/2019	
		Board Contribution	Employee Cost	Board Contribution	Employee Cost
Employee Only	$300.00	$300.00	$0.00	$300.00	$0.00
Employee + Spouse	$675.00	$374.90	$300.10	$300.00	$375.00
Employee + Child(ren)	$450.00	$376.86	$73.14	$300.00	$150.00
Employee + Family	$825.00	$402.46	$422.54	$300.00	$525.00
All plans subject to Tobacco Asurcharge ($50/month)					

DENTAL PPO High			
Employee	Employee + Spouse	Employee + Child(ren)	Family
$20.55	$40.60	$47.45	$67.30

DENTAL PPO Low			
Employee	Employee + Spouse	Employee + Child(ren)	Family
$15.00	$29.65	$34.65	$49.10

DENTAL DHMO			
Employee	Employee + Spouse	Employee + Child(ren)	Family
$7.35	$12.85	$15.90	$20.20

VISION			
Employee	Employee + Spouse	Employee + Child(ren)	Family
$2.55	$5.25	$4.85	$11.90



Cost of Coverage - Monthly

Lincoln - Employee Voluntary Supplemental Life Rates			
Age	Monthly Rate	Age	Monthly Rate
<25	$0.063	50-54	$0.303
25-29	$0.070	55-59	$0.510
30-34	$0.090	60-64	$0.740
35-39	$0.100	65-69	$1.400
40-44	$0.111	70-74	$2.270
45-49	$0.170	75+	$3.490

Costs are per $1,000

Lincoln - Spouse Voluntary Supplemental Life Rates			
Age	Monthly Rate	Age	Monthly Rate
<30	$0.070	50-54	$0.360
30-34	$0.090	55-59	$0.580
35-39	$0.110	60-64	$1.060
40-44	$0.130	65-69	$1.820
45-49	$0.190	70-74	$2.980

Costs are per $1,000

Lincoln - Voluntary AD&D Rate		
	Cost Per	Monthly Rate
Employee Only	$1,000	$0.013
Spouse	$1,000	$0.016
Child	$1,000	$0.016

Lincoln - Voluntary Child Life Rate		
	Cost Per	Monthly Rate
Child	$1,000	$0.070

Lincoln Accident - Monthly Rates		
	Low Plan	High Plan
Employee Only	$ 7.85	$ 10.05
Employee + Spouse	$ 13.50	$ 17.13
Employee + Child(ren)	$ 15.26	$ 19.24
Employee + Family	$ 20.70	$ 26.10

Lincoln Hospital Indemnity - Monthly Rates		
	Low Plan	High Plan
Employee Only	$13.31	$26.63
Employee + Spouse	$31.42	$62.83
Employee + Child(ren)	$29.68	$59.37
Employee + Family	$45.15	$90.30

Cost of Coverage - Monthly

Lincoln Critical Illness - Monthly Rates

Employee Rates

Employee Age Range	$10,000		$20,000		$30,000	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco	Non Tobacco	Tobacco
0 - 24	$5.39	$6.42	$10.78	$12.84	$16.17	$19.26
25 - 29	$7.37	$9.60	$14.74	$19.20	$22.11	$28.80
30 - 34	$9.69	$13.60	$19.38	$27.20	$29.07	$40.80
35 - 39	$13.00	$19.73	$26.00	$39.46	$39.00	$59.19
40 - 44	$17.68	$29.10	$35.36	$58.20	$53.04	$87.30
45 - 49	$23.19	$40.99	$46.38	$81.98	$69.57	$122.97
50 - 54	$29.17	$54.64	$58.34	$109.28	$87.51	$163.92
55 - 59	$34.63	$66.93	$69.26	$133.86	$103.89	$200.79
60 - 64	$39.06	$75.42	$78.12	$150.84	$117.18	$226.26
65 - 69	$44.68	$85.65	$89.36	$171.30	$134.04	$256.95
70 - 99	$66.21	$114.67	$132.42	$229.34	$198.63	$344.01

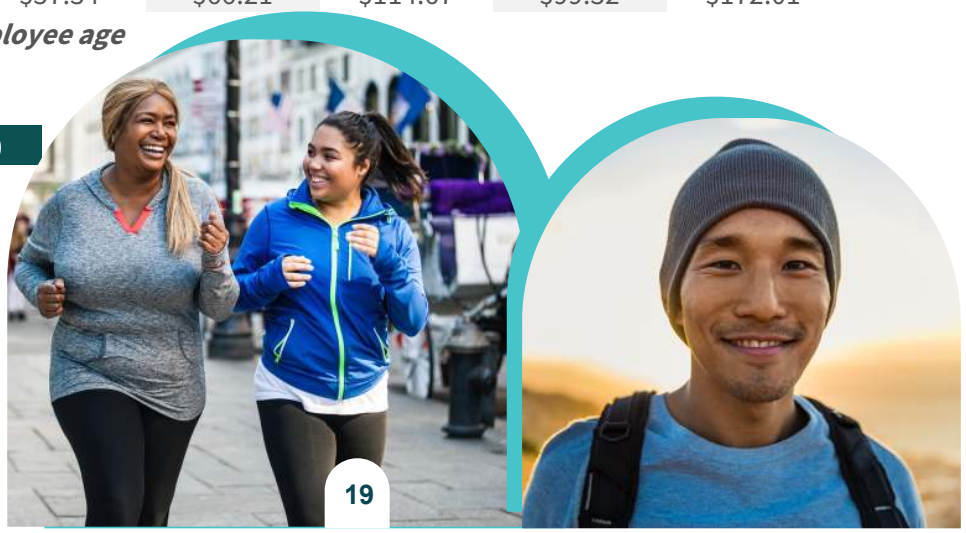
Spouse Rates*

Employee Age Range	$10,000		$20,000		$30,000	
	Non Tobacco	Tobacco	Non Tobacco	Tobacco	Non Tobacco	Tobacco
0 - 24	$2.70	$3.21	$5.39	$6.42	$8.09	$9.63
25 - 29	$3.69	$4.80	$7.37	$9.60	$11.06	$14.40
30 - 34	$4.85	$6.80	$9.69	$13.60	$14.54	$20.40
35 - 39	$6.50	$9.87	$13.00	$19.73	$19.50	$29.60
40 - 44	$8.84	$14.55	$17.68	$29.10	$26.52	$43.65
45 - 49	$11.60	$20.50	$23.19	$40.99	$34.79	$61.49
50 - 54	$14.59	$27.32	$29.17	$54.64	$43.76	$81.96
55 - 59	$17.32	$33.47	$34.63	$66.93	$51.95	$100.40
60 - 64	$19.53	$37.71	$39.06	$75.42	$58.59	$113.13
65 - 69	$22.34	$42.83	$44.68	$85.65	$67.02	$128.48
70 - 99	$33.11	$57.34	$66.21	$114.67	$99.32	$172.01

Note: Spouse rates are based on employee age

Dependent Children

Dependent Age Range	$5,000	$10,000
0-26	$3.39	$6.77



Important Contacts

BENEFIT	PROVIDER	PHONE NUMBER	WEBSITE
MEDICAL	UMR	800-826-9781	www.umr.com
PHARMACY	Optum Rx	Member Services: 855-524-0381 Specialty: 877-656-9604	www.optumrx.com
EMPLOYEE CLINIC	Marathon	941-623-4444	my.marathon-health.com
DENTAL	United Health Care	877-816-3596	www.myuhcdental.com
VISION	United Health Care	800-638-3120	www.myuhcvision.com
HSA ACCOUNTS	Optum Bank	866 234-8913	www.optumbank.com
DEPENDENT CARE FSA ACCOUNTS	UMR	866-868-0145	www.umr.com
EBHRA	UMR	866-868-7406	www.umr.com
LIFE & DISABILITY	Lincoln Financial Group	888-787-2129 800-713-7384	www.mylincolnportal.com
EAP	ComPsych Guidance Resources	888-628-4824	www.guidanceresources.com
TELADOC	UMR	800-835-2362	www.teladoc.com
PERSONAL HEALTH ADVOCATE	Health Advocate	866-695-8622	www.healthadvocate.com/members
VOLUNTARY BENEFITS	Lincoln Financial Group	800-423-2765	www.mylincolnportal.com
MEDICARE ASSISTANCE	Alliant Medicare Solutions	855-325-4044	www.alliantmedicaresolutions.com
FLORIDA STATE RETIREE BENEFITS CONSORTIUM	FSRBC	1-833-686-0983	www.myfsrbc.bswift.com

Insurance and Termination/Resignation of Employment

COBRA Benefits

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a Federal Law that provides employees the opportunity to continue existing group insurance coverage upon separation of service from CCPS.

Employee and covered dependents may choose to elect COBRA rights as a CCPS employee if one (1) of the following qualifying events occur.

1. Termination of employment from the District, unless it was due to gross misconduct
2. A reduction of work hours which would result in no longer meeting the eligibility requirements for coverage
3. In the event of death
4. In the event of divorce or legal separation
5. Becoming eligible for Medicare, or
6. A child no longer meets eligibility requirements to be covered as a dependent

Certain coverages may be continued for up to 18 months in the event of a termination or up to 36 months for other qualifying events. Employee and Dependents have up to 60 days to elect COBRA. The election date will be one of the latter: 60 days from the qualifying event, or 60 days the County notified employee of the COBRA rights.

If an employee is terminated or voluntarily resigns from CCPS, their medical, dental and vision insurance will be terminated from the group plan on the last day of the month. The insurance companies will be notified of the termination date and will send COBRA information to the employee's current home address. This information will inform you of the option of continuing the coverage on a direct pay basis. Please notify HR if there is a change of address upon termination.

If the employee terminates with a Flexible Spending Account, the last day of employment will be the termination date of the account. The employee will have 90 days to submit any claims for the period prior to the termination date for reimbursement.

If the employee terminates with a Cash Out option, no COBRA is offered, nor any additional gross pay relating to this option.

Long Term Disability is terminated regardless of the medical/cash out option chosen.

Life Insurance is cancelled the last day of the month of employment. You have 30 days from the termination date to contact the Employee Benefits Assistant for information to continue life insurance on a direct pay basis.

Insurance and Termination/Resignation of Employment Continued

RETIREMENT AND INSURANCE

The criteria for continuing coverage after retirement is the employee's age at the retirement date.

If the employee is under 65, they may have the option to pay for their medical insurance until age 65. A certified letter will be sent to the employee informing them of their options. If continuing, premium payments will be sent to the CCPS main office. For those electing this option, you will receive notification in the mail that your CCPS insurance will be terminating a month prior to turning 65.

If the employee retires at age 65, all insurances are automatically terminated.

If the employee has covered their spouse or dependents who are under 65 on their policies, the spouse or dependents may continue coverage under a COBRA policy directly to the insurance vendors. A premium statement will be sent upon notification to the insurance vendors. Spouses and dependents can not continue coverage with the CCPS plan if the retiree is terminated.

Long Term Disability and Life Insurance are automatically cancelled. Retirees do have the option to continue Life Insurance on a direct pay basis. The request for information must be made within 30 days of the termination date. For those electing to continue coverage until age 65, you will receive notification in the mail that your CCPS insurance will be terminating.

All retirees who continue to carry insurance through CCPS will also participate in the Open Enrollment period.

Retirees at age 65 and older may elect the Florida State Retiree Benefits Consortium (FSRBC)., which provides Medicare-eligible employees and their dependents with access to Medicare medical, dental, and vision benefits. For more information, please call FSRBC at 1-833-686-0983 or visit their website at: www.myfsrbc.bswift.com

Legal Notices

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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. For further details on WHCRA benefits, please refer to the Plan's Summary Plan Description.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother 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.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in your employer's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in your employer's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in your employer's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

HIPAA: Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. This notice is available to you by contacting Human Resources.

Legal Notices

Nondiscrimination and Equal Employment Opportunity

The School Board of Charlotte County does not discriminate (including anti-Semitism [as defined in Bylaw 0100]) on the basis of race, ethnicity, color, national origin, sex (including sexual orientation, gender status, or gender identity), recognized disability, pregnancy, marital status, age (except as authorized by law), religion, military status, ancestry, or genetic information which are classes protected by State and/or Federal law (collectively, "protected classes") in its programs and activities, including employment. The School Board also ensures equal access for Boy Scouts of America and other identified patriotic youth groups, as required by 34 C.F.R. §108 (Boy Scouts Act). (School Board Policy 1122, 3122, 4122, 2260)

The District Title IX Coordinators and Equity Compliance Officers for the District are Danielle Hudzina (Director of Human Resources), available at (941) 255-0808, Adrienne McElroy (Assistant Superintendent for Human Resources and Employee Relations), available at (941) 255-0808, and Michael Desjardins (Assistant Superintendent for School Support), available at (941) 255-0808 The District Section 504 Compliance Officer and ADA Coordinator is Rebecca Marazon (Coordinator of Psychological Services), available at (941) 255-0808 (School Board Policy 2260)

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 of your modified adjusted household income.

What You Need to Know About the "No Surprises" Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Legal Notices

Important Notice 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 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. Charlotte County Public Schools has determined that the prescription drug coverage offered by the Optum Rx pharmacy 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 15 to December 7.

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 Charlotte County Public Schools coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Optum Rx is creditable (e.g. as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Charlotte County Public Schools prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Charlotte County Public Schools 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 one percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent 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.

Legal Notices

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 Charlotte County Public Schools 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).

CMS Form 10182-CC Updated April 1, 2011
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Legal Notices

Notice Regarding Wellness Program

Our wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which would include a blood test for glucose, triglycerides, blood pressure, waist circumference, and HDL. You are not required to complete an HRA or to participate in any blood tests or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $25 per pay period towards your medical premiums and qualify for a lower deductible if at least 7 out of 10 metrics are met. To earn these incentives an employee would need to complete a visit at the Marathon Health clinic and complete an HRA questionnaire located in the Marathon portal under the incentives tab. Although you are not required to complete an HRA or participate in any biometric screenings, only employees who do so will receive the incentive of $25 per pay period towards your medical premium or qualify for the lower deductible.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Marathon Health Clinic at 941-623-4444.

The information from your HRA and/or the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual that may receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program.

Legal Notices

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources at 941-255-0808, select 7

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, 2023. Contact your State for more information on eligibility.

Legal Notices

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://www.colorado.gov/pacific/hcpf/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
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 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

Legal Notices

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://kidshealth.ky.gov/Pages/index.aspx | 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)
MAINE – Medicaid
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: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

Legal Notices

NEW HAMPSHIRE – Medicaid
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. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

Legal Notices

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
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, 2023, 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

Notes

CHARLOTTE COUNTY Public Schools