2022

Benefit Wise

CHARLOTTE COUNTY Public Schools

Employee Benefit Guide

TABLE OF CONTENTS

Benefit Wise

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.

This guide is an overview and does not provide a complete description of all benefit provisions. 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.

The benefits in this summary are effective:

January 1, 2022 - December 31, 2022

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 Annual Notices for more details.

Who Can You Cover?

WHO IS ELIGIBLE?

You can enroll the following family members in our medical, dental and vision plans.

- Your legal spouse
- Your legal dependent child(ren):
  - Under age 26 are eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
  - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

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

DISABLED DEPENDENTS

Coverage for an unmarried dependent child may be continued beyond age 26. (Proof of disability will be required upon request.)

1.) The dependent is physically or mentally disabled and incapable of self-sustaining employment (prior to age 26) and
2.) Primarily dependent upon the employee for support and
3.) The dependent is otherwise eligible for coverage under the group medical plan, and
4.) The dependent has been continuously insured.

DUAL SPOUSE OPTION

If an employee and spouse work at CCPS and are covering dependent children, they may have the option of having Dual Spouse coverage. This option allows two spouses' board contributions to combine and help decrease the deduction of medical premiums from their pay.

Employees who choose this option must contact the Employee Benefits Assistant for this arrangement.

Please note that any changes must be in conjunction with Qualifying Life Events if it is not requested during the Open Enrollment period.

CASH ONLY OPTION

Employees who opt-out of health insurance and FSA, may elect to receive the cash only option. Employees that opt out will receive $100 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 FSA option, but you may elect to return to one of the health plans in accordance with statute and IRS rules. This benefit will be reduced and prorated based on the number of hours the employee work

Who Can You Cover?

ENROLLMENT PERIODS

Coverage for new hires begins on the first of the month following 43 days of employment.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. **Open Enrollment will take place October 25 – November 5, 2021.**

Employee must notify Human Resources within 30 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Beyond 30 days, requests will be denied and employee will be responsible for claims/expenses incurred by the dependent.

Life events include (but are not limited to):

- Marriage or divorce
- Birth or adoption of a baby or child
- Death of spouse or other dependent
- Spouse's employment begins or ends
- Dependent's eligibility change due to age
- Gain or loss of Medicare coverage
- You or spouse experience a change in works hours (e.g., from full-time to part-time or vice versa)
- A child gains or loses coverage with other parent or legal guardian
- Losing or becoming eligible under a state Medicaid or CHIP (including Florida Kid Care Program)

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, 2022 (documentation required). Employees' premiums for critical illness coverage remain in place the entire plan year. 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.

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 first. The secondary plan may then pay additional benefits. Health insurers follow a common set of guidelines to determine which plan pays first and which plan pays second for family members. Contact your spouse benefits representative to inquire about COB.

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 you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 941-255-0808 and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

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.

	HDHP 3000		HDHP 6650	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible	$3,000 $6,000	$6,000 $12,000	$6,650 $13,300	$13,300 $26,600
Annual Out-of-Pocket Max	$5,000 $10,000	$10,000 $20,000	$6,650 $13,300	$13,300 $26,600
Coinsurance	80% / 20%	50% / 50%	100% / 0%	100% / 0%
Office Visit				
Primary Provider	20%	50%	0%	0%
Specialist	20%	50%	0%	0%
Preventive Services	$0	50%	0%	0%
Chiropractic Care	20%	50%	0%	0%
Lab and X-ray	20%	50%	0%	0%
Inpatient Hospitalization	20%	50%	0%	0%
Outpatient Surgery	20%	50%	0%	0%
Urgent Care	20%	50%	0%	0%
Emergency Room	20%	30%	0%	0%

*all benefits are after deductible

Wellness Credit for School Board Health Plans

Employees who are enrolled in one of the four School Board health care plans have the option of participating in the Wellness Credit program. The District subsidizes the premium costs towards participant's health care benefits ($25 per pay/$600 max annually).

1. Participants schedule an appointment (941-623-4444) for their first Health Risk Assessment (HRA), completed at the Wellness Center accompanied by a lipid panel/fasting glucose blood draw;
2. Participant reviews their HRA results with one of the Wellness Center's Nurse Practitioners;
3. The Nurse Practitioner assigns the participant a number of visits they are required to make over the next 12 months (based on the number of risk factors identified);
4. Communication reminders are sent out to participants who miss an appointment or never complete an HRA;
5. All appointments are expected to be fulfilled at the CCPS Employee Wellness Center

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

UMR
A UnitedHealthcare Company

Pharmacy

	HDHP 3000	HDHP 6650
	In-Network	In-Network
Retail (*Up to 31 day supply)* Generic / Preferred Brand / Non-Preferred Brand	$20 / $35 / $50 copay	0% coinsurance
Mail Order *(Up to 90-day supply)* Generic / Preferred Brand / Non-Preferred Brand	$40 / $70 / $100 copay	0% coinsurance
Retail 90 Day *(Up to 3 month supply, at least 84 days)* Generic / Preferred Brand / Non-Preferred Brand	$60 / $105 / $150 copay	0% coinsurance

Note: all benefits are after deductible

Maintenance Medications

90-day fills are a money-saving feature of your prescription benefit. It makes it easy for you to fill prescriptions for your maintenance medications (those drugs you take regularly for ongoing conditions) at a lower cost. You must fill a 90-day supply of your maintenance medications at a preferred pharmacy (Walgreens) - but you will pay less for each 90-day supply than you would pay for three 30-day supplies at a non-preferred retail pharmacy.

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.

Health Savings Account (HSA)

Charlotte County Public Schools will provide a one-time contribution in the amount of $1,250 to a Health Savings Account for each employee enrolled in the HDHP 6650 Plan as of January 1, 2022 and that provides proof of being fully vaccinated

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.

An HSA is similar to a 401(k) plan in that you own the account and contributions are tax-free. Money placed in the HSA is available for paying qualified health expenses that apply to your deductible or that are not covered through the health plan, including dental, vision and orthodontic expenses. The HSA rewards conscientious use of your health plan because unused HSA money accumulates in your account over time. If you leave the company, you keep your HSA and the money in it; however, you must be enrolled in a qualified high deductible health plan in order to contribute to your account.

ELIGIBILITY:

You are <u>not</u> eligible to set up or contribute to an HSA if:

- You are claimed as a dependent on someone else's tax return
- You are eligible to receive benefits from any plan that is not a qualified high deductible health plan including:
  - Enrollment in your spouse's non-qualified health plan
  - Enrollment in a non-limited purpose flexible spending account by either you or your spouse
  - Enrollment in Medicare, Medicaid, Military or veteran's healthcare program (e.g. TRICARE)

The IRS maximum annual contribution (including both employer and employee dollars) amounts for 2022 is $3,650 individual / $7,300 family. If you are 55 or older, you can contribute an additional $1,000 in catch-up contributions.

If you enroll in the plan mid-year, you are eligible to contribute up to the IRS maximum.

QUALIFED MEDICAL EXPENSES:

Once you've contributed to your account, you can use the funds in your HSA to pay for qualified medical expenses, such as:

- Medical Deductible/Coinsurance
- Doctor office visits
- Dental care, including extractions and braces
- Vision care, including contact lenses, prescription sunglasses and LASIK surgery
- Prescription medications
- Chiropractic services
- Acupuncture
- Hearing aids and batteries

For a full list of qualified medical expenses, visit IRS.gov.

OPTUM

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. Monies should be used in your account by the end of the plan year, December 31, 2022. You must re-enroll in this program every year. UMR administers this program.

REMINDER: THIS BENEFIT IS USE IT OR LOSE IT!

FSA HEALTHCARE ACCOUNT

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $2,750 this year.

If you are enrolled in the UMR plan or any Health Savings Account, you are not eligible to have a Healthcare FSA.

LIMITED PURPOSE FSA ACCOUNT

If participating in a HDHP plan and you have an HSA, you're eligible to enroll in this plan. This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars up to $2,750. Eligible expenses include dental and vision costs.

If you have a Health Savings Account, you are eligible to have a Limited Purpose FSA.

FSA DEPENDENT CARE ACCOUNT

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.

Note: Please consult your tax advisor before electing an FSA account if you are eligible for Medicare.

If you elect FSA only, and opt out of our health insurance, you will receive

Per Pay	Hours/Week
$103	35-40
$77.25	30<35
$51.50	20<30

It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 01/01/22 and 12/31/22 and submitted for reimbursement no later than 03/31/23. Any unused funds in your account at the end of the plan year that are not reimbursed will be forfeited.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- FSA funds can be used for you, your spouse, and / or your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on our healthplan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.
- Upon termination from the plan, you may submit claims for reimbursement within 90 days of the termination date.
- Your FSA may be used to purchase eligible items online. Go to www.fsastore.com for medical related products that may be used with your plan

Know Where to Go

	Your Cost		
Telemedicine For a minor illness, such as a sore throat, cold, or sinus infection	Highest Moderate **Lowest**	Call 24 hours/ 7 days a week/ 365 days a year	**15+ Mins** No appointment needed A virtual visit can take 15 minutes or more.
Primary Care Physician / Marathon Health Clinic For a free annual check-up, ongoing medical conditions, immunizations	Highest **Moderate** Lowest	Hours vary by location, usually open weekdays	**20+ Mins** Appointment needed. A visit can take 20 minutes or more.
Urgent Care For an illness or injury that is non life-threatening but important to manage quickly, such as a stomach virus, cold, flu, fever, sinus infection, minor fracture or sprain	Highest **Moderate** Lowest	Hours vary by location, usually open 7 days	**20+ Mins** No appointment needed. A visit can take 20 minutes to an hour.
Emergency For a serious or life threatening illness or injury, such as a heart attack, stroke, major bleeding, broken bone, severe burn or difficulty breathing	**Highest** Moderate Lowest	Open 24 hours/ 7 days a week	**4+ Hours** No appointment needed. Wait 4 hours or more depending on the urgency

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a voluntary vision plan through United Healthcare.

	United Healthcare Vision Plan (Spectera Network)	
	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 reimbursed up to $105	Reimbursed up to $105
Frequency	Once every 12 months from last date of service	In-network limitations apply

UnitedHealthcare

Dental

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: Solstice S700B

Regular visits to your dentists can protect more than your smile; they can help protect your 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.

Charlotte County Public Schools gives you a choice of dental plans through United Healthcare.

	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.

UnitedHealthcare

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death 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.

LIFE AND AD&D

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, or hearing, or if you die in an accident. The cost of coverage is paid in full by CCPS. Coverage is provided by Lincoln Financial Group.

Class 1: Administrators, Board Members and Superintendents

Basic Life Amount	$50,000
Basic AD&D Amount	$50,000

Class 2: Full time employees excluding Class 1

Basic Life Amount	$20,000
Basic AD&D Amount	$20,000
Buy-up option	Increments of $10,000, $20,000 or $30,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary unless they sign a waiver.

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.

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln Financial Group.

Employee Voluntary Life Amount	Increments of $10,000 up to Lesser of 5 x annual covered earnings or $200,000
Spouse Voluntary Life Amount	Increments of $5,000 up to $100,000 or 50% of the covered employee amount, whichever is lesser.
Child(ren) Voluntary Life Amount	Increments of $5,000 up to $25,000.

Note: The amount of Dependent Life Insurance may not exceed 50% of the amount of Employee Life Insurance in force on the covered employee.

Evidence of Insurability: 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

Lincoln Financial Group®

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

LONG-TERM DISABILITY INSURANCE

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 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.

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

Coverage is provided by Lincoln Financial Group.

Monthly Benefit Amount	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	$8,334
Benefits Begin After:	
Accident	90 days of disability
Sickness	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.

Voluntary Programs

ACCIDENT INSURANCE

Accident insurance helps you cover medical deductibles, copays and coinsurance. This coverage is budget friendly and an excellent complement to your health insurance. Coverage is provided by Lincoln.

Examples of covered injuries include:

- Broken Bones
- Eye Injuries
- Burns
- Lacerations
- Ruptured Discs
- Torn Ligaments
- Concussions
- Coma due to a covered injury

Some covered expenses include:

- Physical Therapy
- Speech Therapy
- Occupational Therapy
- Doctor Office Visit
- Chiropractic Visit
- Hospitalization
- Emergency Room Treatment

CRITICAL ILLNESS

Critical Illness insurance pays a lump sum benefit upon diagnosis of a covered critical illness, such as major organ failure, blindness, cancer, heart attack, and stroke. Coverage is provided by Lincoln.

HOSPITAL INDEMNITY MEDICAL

When an accident or illness results in an inpatient hospital stay, the costs can add up. If you or a covered family member has a covered inpatient hospital stay, this plan will pay. Coverage is provided by Lincoln.

Coverage becomes effective on the first day of the month in which payroll deductions begin.

Lincoln Financial Group®

Focus on Your Wellbeing

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.

All health information is confidential and protected by the Health Insurance Portability and Accountability Act (HIPAA). For more information about this benefit and Marathon Health, visit www.marathon-health.com

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!

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

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

Cost of Coverage – Per Pay Period

For Employees hired on, or after 1/1/2011

UMR Medical	HDHP 3000	HDHP 6650	Board Contribution 100% ≥ 7 hrs	75% 6<7 hrs	50% 4<6 hrs
Employee Only	$391.50	$292.98	$292.98	$219.74	$146.49
Employee + Spouse	$1,135.50	$841.00	$374.90	$281.18	$187.45
Employee + Child(ren)	$704.50	$522.00	$376.86	$282.65	$188.43
Employee + Family	$1,311.50	$971.50	$402.46	$301.85	$201.23
All plans subject to Tobacco a surcharge ($50/month)					

For Employees hired on, or after 07/01/2019

UMR Medical	HDHP 3000	HDHP 6650	Board Contribution 100% ≥ 7 hrs	75% 6<7 hrs	50% 4<6 hrs
Employee Only	$391.50	$292.98	$292.98	$219.74	$146.49
Employee + Spouse	$1,135.50	$841.00	$292.98	$219.74	$146.49
Employee + Child(ren)	$704.50	$522.00	$292.98	$219.74	$146.49
Employee + Family	$1,311.50	$971.50	$292.98	$219.74	$146.49
All plans subject to Tobacco a surcharge ($50/month)					

Charlotte County Public Schools will provide a one-time contribution in the amount of $1,250 to an HSA for each employee enrolled in the HDHP 6650 Plan as of January 1, 2022 that shows proof of full vaccination

Cost of Coverage

UHC Dental Rates	PPO High Plan Per Pay	PPO Low Plan Per Pay	DMO Plan Per Pay
Employee Only	$20.55	$15.00	$7.35
Employee + Spouse	$40.60	$29.65	$12.85
Employee + Child(ren)	$47.45	$34.65	$15.90
Employee + Family	$67.30	$49.10	$20.20

UHC Vision Rates	Per pay
Employee Only	$2.55
Employee + Spouse	$5.25
Employee + Child(ren)	$4.85
Employee + Family	$11.90

Lincoln - Basic Life & AD&D Rates			
Benefit Amount	Per Pay Period Rate	Benefit Amount	Per Pay Period Rate
$20,000	$1.53	$40,000	$3.06
$30,000	$2.30	$50,000	$3.83

Lincoln - Employee Voluntary Supplemental Life Rates			
Age	Monthly Rate	Age	Monthly Rate
<25	$0.057	50-54	$0.275
25-29	$0.060	55-59	$0.463
30-34	$0.080	60-64	$0.670
35-39	$0.090	65-69	$1.270
40-44	$0.101	70-74	$2.060
45-49	$0.154	75+	$3.168

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

Cost of Coverage

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

HOW MUCH WILL I PAY FOR VOLUNTARY LIFE INSURANCE?

	Calculation Example	Example	You
Step 1	Using the table above, enter the rate that corresponds with your age	$0.080	$
Step 2	Enter the desired coverage amount in dollars	$100,000	$
Step 3	Enter the desired coverage amount in increments of $1,000. To calculate, divide the coverage amount by $1,000.	100	
Step 4	Calculate the monthly cost. Multiply Step 1 by Step 3	$8.00	$
Step 5	Monthly rate x 12 / 24 = Per Paycheck rate	$4.00	$

Cost of Coverage

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

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

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website
MEDICAL	UMR	1-800-826-9781	www.umr.com
PHARMACY	Optum Rx	Member Services: 855-524-0381 Specialty: 877-656-9604 OE Hotline: 844-783-1402	www.optumrx.com
EMPLOYEE CLINIC	Marathon		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
FSA ACCOUNTS	UMR	866-868-0145	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

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.

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.

Medicare Part D Notice

Important Notice from Charlotte County Public Schools About
Your Prescription Drug Coverage and Medicare

3000 Plan and 6650 Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Charlotte Count Public Schools 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 UMR 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 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 Charlotte County Public Schools 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 can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 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 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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:	01/01/2022
Name of Entity/Sender:	Charlotte County Public Schools
Contact-Position/Office:	Human Resources
Address:	1445 Education Way, Port Charlotte, FL 33948
Phone Number:	(941) 255-0808

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.

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. If you would like more information on WHCRA benefits, call your plan administrator at (941) 255-0808

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 at (941) 255-0808

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Charlotte County Public Schools describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources

Michelle's Law

The UMR plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

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

Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify HR in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Notice of Availability of Alternative Standard for Wellness Plan

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

Notice Regarding Wellness Program

The CCPS 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 may 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 may also be asked to complete a biometric screening, which would include a blood test for glucose, HDL, LDL, triglycerides and total cholesterol. 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 towards your medical premiums for completing an HRA, reviewing results with a Nurse Practitioner and attending required number of visits as assigned by the Nurse Practitioner. Although you are not required to complete an HRA or participate in any biometric screenings, only employees who do so will receive the $25 per pay towards your medical premiums.

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 Charlotte County Public Schools may use aggregate information it collects to design a program based on identified health risks in the workplace, the CCPS 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.

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 Employee Benefits at 941-255-0808, select 7.

Nondiscrimination and Equal Employment Opportunity

The School Board does not discriminate (including anti-Semitism – as defined in Bylaw 0100-) on the basis of race, ethnicity, color, national origin, sex (including sexual orientation, transgender 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 opportunities. (School Board Policy 1122, 3122, 4122)

The District 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). The Equity Officers for the District are Adrienne McElroy (Director of Human Resources), available at (941) 255-0808 Ext 2072, and Patrick Keegan (Assistant Superintendent for Human Resources and Employee Relations), available at (941) 255-0808 Ext 2058. (School Board Policy 2260)

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Charlotte County Public Schools 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 Charlotte County Public Schools 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 31 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 31 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 31 day timeframe, coverage will be effective with 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 a Charlotte County Public Schools 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 right, you may add the dependent to your current coverage or change to another health plan.

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, 2021. Contact your State for more information on eligibility –

ALABAMA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 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.colorado.gov/pacific/hcpf/health-insurance- buy-program HIBI Customer Service: 1-855-692-6442

FLORIDA Medicaid

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

GEORGIA Medicaid

Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

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

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

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.maine.gov/dhhs/ofi/applications-forms
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/info-details/masshealth- premium-assistance-pa
Phone: 1-800-862-4840

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

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

NEW HAMPSHIRE Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm 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/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html CHIP 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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ 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 http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/ HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND Medicaid

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 and CHIP

Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS Medicaid

Website: http://gethipptexas.com/ 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: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA Medicaid and CHIP
: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA Medicaid
Website: http://mywvhipp.com/ 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, 2021, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2023)

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 9.78% of your modified adjusted household income.

Notes

CHARLOTTE COUNTY Public Schools

Rev. 10/16/2020