LAKE WALES CHARTER SCHOOLS

Employee Benefits Guide

July 1, 2020 – June 30, 2021

What's Inside

This brochure provides only a brief summary of the benefits available under the Lake Wales Charter Schools benefit plans. In the event of a discrepancy between this summary and the plan document, the plan document will prevail. Lake Wales Charter Schools retains the right to modify or eliminate these or any other benefits at any time and for any reason.

Contact Information

Below is important contact information should you have further questions:

HUMAN RESOURCES: Dr. Julio Acevedo
863-679-6560
julio.acevedo@lwcharterschools.com

ADG ONLINE ENROLLMENT SYSTEM:
Human Resources
863-679-6560
julio.acevedo@lwcharterschools.com

MEDICAL: United Healthcare
800-782-3158 www.myuhc.com

Care24 SERVICES: United Healthcare
888-887-4114 www.myuhc.com

DENTAL: United Healthcare
800-445-9090 www.myuhc.com

VISION: United Healthcare
800-638-3120 www.myuhc.com

LIFE/AD&D: United Healthcare
800-421-0344 www.myuhc.com

DISABILITY: United Healthcare
888-299-2070 www.myuhc.com

PRE-TAX SPENDING ACCOUNTS
(FSA and Dependent Care):
Asure Software (formerly Mangrove)
888-862-6272
https://www.mywealthcareonline.com/emangrove/Resources/FSAResources.aspx

VOLUNTARY PRODUCTS
(Cancer, Accident, etc)
TransAmerica (ExplainMyBenefits)
321-296-8060 x2

MEMBER ASSISTANCE PROGRAM (MAP):
United Healthcare
877-660-3806 www.liveandworkwell.com

BENEFIT RESOURCE CENTER (BRC) at USI Insurance Services
855-874-0835 www.BRCSouth@usi.com

For questions regarding your benefits or enrollment questions, please contact Lake Wales Charter Schools Human Resources at 863-679-6560

USI: FREE MOBILE BENEFITS APP

The USIeb mobile app gives you on-the-go access to Lake Wales Charter Schools benefit and insurance policy details, HR contact information and more!

The mobile benefits app provides a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. The app also offers the ability to take photos of ID cards to store on the phone, as well as a way to easily locate carrier and HR contact information—all in one place—24/7 and on the go. The USIeb app is free and available for iPhone and Android platforms. App benefits include:

- **Staying Organized**
  The app gives you access to benefit plan information and ID cards - - all in one place!

- **Keeping Up-to-Date**
  The app automatically connects you with the most updated plan information.
- **Lightening Wallets**
  The app allows you to take and access images of your ID cards. Images are stored on the phone itself; no personal health information is transmitted or saved.
- **Getting In Touch**
  The app provides you with a single location to find contact information for the Human Resources team and the Benefit Resource Center, as well as insurance carriers.

In your APP STORE, download the app for "USIeb", then enter this code after the intro pages: 341678

Benefit Information

Introduction

Lake Wales Charter Schools offers an excellent selection of benefits and this Guide is designed to familiarize you with the benefits that are available and the value they represent as benefits are a significant part of your total compensation package.

As a healthcare consumer, we encourage you to take an active role to review the benefit options and understand how the changes you make will impact you and your family's evolving needs.

You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

Benefit Plans Offered

Good news! Plans remain with the current Carriers:

- Medical, dental and vision plans with United have a few NEW enhancements (these will be noted **in BOLD**)
- Life and disability remain with United Healthcare
- Voluntary products remain with TransAmerica
- Pre-Tax Flexible Spending Accounts (FSA/DCA) remain with AsureSoftware (formerly Mangrove)

Enrollment in Benefit Plans

Employees will complete enrollment in the online payroll system. See instructions on the following page ("how to enroll").

Eligibility

All Regular full-time employees are eligible to join the Benefits Plan on the first of the month following 30 days of employment. "Regular Full-Time Employees" must be regularly scheduled and working at least 30 hours per week.

You may also enroll your dependents in the Benefits Plan when you enroll.

Eligible dependents include:

- Your legal spouse
- Your natural children, step-children living with you, legally adopted or foster children, and any other children for whom you have legal guardianship. Children may be covered:
  - To age 26 for medical, dental and vision (can be covered until end of calendar year they turn age 26)
  - For voluntary life, dependent children are covered until age 19 or age 25 if a FT student (until end of month at age 19 or 25)
  - For medical benefits, a dependent who is older than 26 years of age, but less than 30 years of age may be eligible for benefits (can be covered until end of birthday month of age 30). To be eligible, a Dependent must:
    - Be Unmarried and not have dependents of his or her own; AND
    - Be a resident of any of the 50 states or a Student at an accredited institution of higher learning; AND
    - Not have coverage of their own, or covered under any other plan; AND
    - Not entitled to benefits under Medicare

When Can You Enroll?

You can sign up for Benefits at any of the following times:

- After completing initial eligibility period;
- During the annual open enrollment period;
- Within 30 days of a qualified family-status change.

If you do not enroll at one of the above times, you must wait for the next annual open enrollment period.

Key Benefit Terms

COBRA – A Federal law that allows workers and dependents who lose their medical, dental, or vision coverage to continue any of these coverages for a specified length of time by electing and paying for continuation benefits.

Coinsurance – The percentage of the medical or dental charge that you pay after the deductible has been met.

Copayment – A flat fee that you pay for medical services, regardless of the actual amount charged by your doctor or another provider. This generally applies to physicians' office visits and prescription drugs.

Deductible – The amount you pay toward medical and dental expenses each calendar year before the plan begins paying benefits.

Out of Pocket Maximum – The maximum amount you will pay in coinsurance during the calendar year

Balance Billing – Applies with "out of network" providers. The provider can bill you the difference between the provider's charge and the allowed amount. A preferred provider(ie in network provider) may not balance bill you for covered services.

Benefit Information

How to Enroll?

We will be using the ADG online system for our online enrollment. There will be no paper forms to complete. To begin your enrollment, follow these easy steps. Enter the following address into your internet browser:

From Home: https://lwchartershoolsjobs.com/adg/adg/index.php
School:http://192.168.1.8/adg/adg/index.php

1. Next, enter you personnel ID number (SEMS ID) as your log on ID in "account" box and the first letter of your Last Name (capital) plus last 4 digits of your SSN in the "password" box, then press "login"
2. Click on the underlined section that says "Employee Benefits Enrollment". You will see your employee & contact information.
3. On the right of your personal info, there will be a box of available benefit plans that are offered. YOU MUST SELECT OR DECLINE EACH OF THE PRODUCTS LISTED. If you are selecting dependents for medical, dental and/or vision: YOU MUST CLICK ON THE DEPENDENT TAB AND ENTER ALL OF THE REQUESTED INFO FOR EACH DEPENDENT THAT YOU ARE ADDING (max 10 dependents).
4. The system will prompt you to complete a beneficiary form if adding life insurance for you, spouse and/or child(ren). It will also prompt you to complete an "Evidence of Insurability" (EOI) form if you electing amounts over the guarantee issue or electing at a later date after you were initially eligible for benefits (the EOI would apply to voluntary life and short term disability).
5. Once you complete or decline benefits, you'll be prompted to "sign" and print the form. FOR SIGNATURE: ENTER IN YOUR ELECTRONIC PIN NUMBER, IT SERVES AS A SIGNATURE.
6. AFTER YOU SIGN THE FORM WITH YOUR PIN NUMBER, READ THE INFORMATION AND CLICK ON THE BUTON THAT SAYS "I AGREE."
7. Once you have signed the form electronically, you can NOT go back in to make changes. Should you select a coverage in error omitted any information, please contact Human Resources at 863-679-6560 to make changes, or omissions or email: julio.acevedo@lwcharterschools.com
8. To add dependents: In the "tasks and sections", click on "dependents, beneficiates & contacts. Click on "edit" , then ORANGE STAR and complete info needed or changes.

Making Changes

Due to IRS Section 125 regulations, you can only change your benefit choices during the annual benefits enrollment period. However, you may be able to change your benefit choices at anytime if you have a change in status including:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

Why do I pay for benefits with before-tax money?

There is a definite advantage to paying for some benefits with before-tax money:

Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

If you do not notify Human Resources within 30 days of a family status change, you will have to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

When Does Coverage End

Coverage will stop on the last day of the month in which employment with the LWCS ends.

If You/Spouse Are Medicare Eligible

If you (and/or your Spouse) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug. Please see the "Medicare D" notice at the end of this guide and keep for your records.

Getting more from your Health Care Dollars & Savings Tips

United Healthcare Resources

United Health Member Website – www.myuhc.com
United Health Member App – Health4Me (see Apple and Google App Store)

It's where you go to:

- Search the network for a physician or hospital
- Print or order replacement ID cards
- Review your coverage
- Use the Cost Estimator for an estimate of out of pocket costs for various procedures
- Check the payment status and history of your claims
- Keep track of health care costs
- Order your prescriptions through UHC home delivery pharmacy
- Take a health assessment and get confidential results about your
- overall health, plus health improvement suggestions. Choose from a variety of online programs designed to help you achieve your health & wellness goals
- Keep track of all your personal health conditions, medications, procedures and lab results

Wellness: Rally Program
Rally is designed to help you make changes to our daily routine, set smart goals and track your progress. You'll get personalized recommendations to help you move more, eat better, improve your health and have fun doing it. PLUS, you win cool stuff by participating. Enroll/register at www.myuhc.com

Wellness: Real Appeal
This program gives members tools and support to lose weight, feel good and prevent weight related conditions. This is a digital program that provides support for a year of support for lasting weight loss. On average, participants lose 10 pounds after attending just 4 online classes! You receive a Success Kit to include a success guide, workout DVD, recipes, nutrition guide and much more. Register at www.realappeal.com

Care24-Hour EAP and Health Information Line℠ Whether you need guidance on medical treatment or assistance with a health question you can call the Care24 Information Line. Seven days a week, 24 hours a day you can get live support. Dial 1-888-877-4114 and you will be connected to a nurse who is ready to help answer your question.

Member Assistance Program (MAP)
To help you thru difficult times, the MAP Program offers members assistance 24/7 with counseling services, help with financial and legal issues, family support and help with relationships, coping & depression. Call 1-877-660-3806 or login at liveandworkwell.com, then create your own User Name and password or use the access code "LTDEAP" under Guest Access.

Savings Tips

Prescription Drug Benefits at a Reduced Cost – Did you know you can obtain prescription drugs at local retailers at a reduced cost and sometimes even free? **Publix** and Winn Dixie offer a variety of generic Oral Antibiotic medications to you absolutely free. Bring in your prescription for an approved medication and receive it FREE, up to a 14-day supply. Publix recently approved a medication for diabetes. **CVS, Walgreens & Walmart** also offer over 400 generic prescriptions for $4 and a 90 day supply for approx. $10 . Remember DO NOT show your UHC ID card to receive these benefits, or you will be charged your UHC drug copay.

Convenience Care Clinics
In addition to the network of physicians, hospitals, emergency rooms, and urgent care clinics, you also have the option of going to the convenient care clinics located within some grocery and drug stores, for minor illness such as ear aches, colds, flu and so on. By selecting one of these providers, you pay only the regular office visit copay; a significant savings over the emergency room and urgent care copayments.

Please visit the various websites for locations, hours of operations and scope of services.

- CVS Minute Clinic: www.cvs.com
- Walgreen's Take Care Clinic: www.walgreens.com
- Walmart's The Clinic at Walmart: www.Walmart.com

Virtual Visits (a $10 copay through United Healthcare)

A virtual visit lets you see and talk to a certified medical professional for your mobile devise or computer without an appointment. Most visits take about 10-15 minutes and doctors can write a prescription, that if needed, you can pick up at your local pharmacy. **Doctors can diagnose and treat a wide range of non-emergency medical conditions to include: bladder/urinary infection, bronchitis, cold/flu, diarrhea, fever, migraine/headaches, rash, sinus problems, sore throat, stomach ache and pink eye.**

Virtual visits are NOT good for: anything requiring an exam or test, complex or chronic conditions, or injuries requiring bandaging or sprains/broker bones.

How do you access this benefit? Register for virtual visits on www.myuhc.com or the Health4Me app. Click on Virtual Visit, chose your provider, then complete the registration process.

Medical Insurance

Lake Wales Charter Schools offers an "open access" medical plan from United Healthcare. To find participating providers go to www.myuhc.com and click on "Find a Doctor/Facility," choose the appropriate provider type and click "Continue." For network, choose "Choice." Complete the remaining selection information and click "Search." The plan Is Medicare D creditable.

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	United "Choice" Plan BWOH
IN-NETWORK:	
Plan Year / Contract Year Basis	**Calendar Year (Jan-Dec)**
Deductible (Individual / Family)	$2000 / $4000
Max Out-of-Pocket (Ind./Family)	$5000/ $10,000
Out-of Pocket Max Includes	Annual Deductible, Coinsurance, Copay & Rx
Lifetime Major Medical Maximum	Unlimited
Coinsurance (Plan Pays after Deductible is Met)	**New: 80% (You pay 20%)**
PREVENTATIVE SERVICES:	
Wellness Immunizations Mammography/Colonoscopy	Covered at 100% (must be coded as preventative services)
OFFICE AND FACILITY SERVICES:	
Virtual Visits	$10 Copay
Primary Care Office Visits	$25 copay
Specialist Visits (No referral required)	$50 copay
Inpatient Hospital	**You pay 20% after Deductible**
Outpatient Surgery	**You pay 20% after Deductible**
Physician Fees	**You pay 20% after Deductible**
Emergency Room	$300 copay
Urgent Care	**New: $50 Copay**
Convenience Care (Minute Clinic, Take Care Clinic)	$25 copay
DIAGNOSTIC SERVICES:	
Lab (LabCorp) Services	Covered 100%
X-Ray Services	Covered 100%
Complex/Major Diagnostics (MRI, PET, CAT, etc)	**You pay 20% after Deductible**
PRESCRIPTIONS:	**MANDATORY GENERIC (Unless "DAW"(dispense as written) is noted on prescription)**
Retail: Tiers 1-3 (30 day supply)	$10 / $35 / $70
Specialty Pharmacy (GH, Self Injectable, etc)	Applicable Cost Share
Mail Order (90 day supply)	2.5x Copay (excludes Specialty)
OUT-OF-NETWORK:	**No benefit except Emergency Services**

Medical	Semi-Monthly Payroll Deductions
Employee Only	$0.00
Employee + Spouse	$325.97
Employee + Child	$199.29
Family	$507.06

Wellness & Preventative Care:

Your plan covers preventative care for services such as physicals, wellness exams, annual screenings and child immunizations at "no cost" to you! Using your wellness benefit is one way to identify and address health issues before they get out of control. Remember, your preventative care services must be coded as "preventative" in order for the cost to be $0.

Be a wise consumer, check the preventative care list to see what is covered, at what age and how often at:
www.uhcpreventativecare.com

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Frequently Asked Questions About Your Medical Plan

Q. What should I do if I have a problem getting a claim paid?

A. Start by contacting the carrier's member services number to determine the nature of the problem. If the issue is the way the doctor or service provider has billed the claim, then contact your doctor or a Benefits Resource Center (BRC) Advocate at USI. If the insurance company has an eligibility issue, contact Human Resources for assistance.

Q. What is the difference between Tier 1, Tier 2 and Tier 3 prescription drugs?

A. Drugs that are covered on the plan are listed on the formulary list. Note that the list may change periodically as new drugs are added, changed from one tier to another, or excluded if offered over the counter. Many of the drugs you see on television are the most expensive (and in Tier 3) because they are protected by a patent issued to the original innovator or marketer. A generic equivalent drug (usually Tier 1 drugs) can become available when the patent protection runs out, and is deemed equal in therapeutic power to the brand name originals.

Q. When should I go to the Urgent Care vs. Emergency Room?

A. The ER is meant for true emergencies such as life threatening illnesses and injuries. In a non-life threatening injury/illness, you can most likely be treated at an Urgent Care facility that can treat you for the following: coughs/sore throats, minor injuries and burns, ear/sinus infections, flu/colds, sprains/strains, fever and vaccinations.

Dental Insurance

Lake Wales Charter Schools offers dental through United Healthcare with in and out of network benefits. For a list of "in network" providers, login to www.myuhc.com and choose the PPO network noted below TIP: In the event you need to have dental work estimated to cost $300 or more, we recommend you have your dentist submit the charges to the carrier for pre-authorization. They will then review the intended treatment plan and let your dentist know how much of the bill they will cover. We recommend this to avoid any billing issues.

*If out-of-network dentists are used, you may be subject to "balance billing" and will be responsible to pay the difference between UHC's allowed amount and what the dentist may charge.

	Base Plan Dental PPO 20 Network		High Plan Dental PPO 30 Network	
	In-Network	**Out-of-Network (MAC)**	**In-Network**	**Out-of- Network (85th UCR)**
Deductible (Jan-Dec)				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum Benefit Per Individual	$1000	$1000	**New: $1500**	**$1500**
Perks: Preventative Max or Rollover	Preventative Max: All preventative services do not accumulate toward annual benefit (a $300-$400 value).		Rollover: Must have a service in the year but not more than $500 of claims. By doing this, you add $250-$350 to your annual benefit NEXT year (ex=$1750 or $1850)	
Diagnostic & Preventative	Deductible Waived		Deductible Waived	
Exams Cleanings Fluoride X-Rays	Covered at 100%	Covered at 100%*	Covered at 100%	Covered at 100%*
Regular Restorative Services	Deductible Applies		Deductible Applies	
Amalgam Fillings Extractions - Single Tooth Endodontics (Root Canal) Periodontics (Scaling & Planing)	You pay 20% after deductible	**NEW: You pay 20% after deductible***	You pay 20% after deductible	You pay 20% after deductible*
Major Services	Deductible Applies		Deductible Applies	
Crowns Bridges Dentures	You pay 50% after deductible	**NEW: You pay 50% after deductible***	You pay 50% after deductible	You pay 50% after deductible*
Orthodontics	NO BENEFIT		**Children & (New) Adults**	
Appliances and Related Services Lifetime Maximum			Lifetime Max: 50% **New: $1500**	Lifetime Max: 50% **New: $1500**

Dental	**BASE Plan: Semi-Monthly Payroll Deductions**	**HIGH Plan: Semi-Monthly Payroll Deductions**
Employee Only	$0	$7.02
Employee + Spouse	$16.16	$32.06
Employee + Child	$16.50	$32.59
Family	$28.00	$50.41

Vision Insurance

Lake Wales Charter Schools offers vision through United Healthcare that includes coverage for both an annual vision exam as well as vision hardware benefits. You should always use an in network provider when possible to receive the highest level of benefits. For further details about this plan, please refer to your certificate of coverage.

For a list of "in network" providers, login to www.myuhc.com and choose the Spectera network.

	United Vision Plan Spectera Network	
	In-Network	**Out-of-Network**
Exams	$10 copay	Reimbursed up to $40 after copay
Lenses		
Single	$25 copay	Reimbursed up to $40 after copay
Bifocal	$25 copay	Reimbursed up to $60 after copay
Trifocal	$25 copay	Reimbursed up to $80 after copay
Progressive	Standard: $70 copay; Other $110-$250 copay	
Frames	$25 copay (no copay if included with lenses) **New: $150 allowance** after copay with 30% of amount over allowance	Reimbursed up to $45 after copay
Contact Lens Exam & Fitting	Deducted from lens allowance	
Contact Lenses	Elective: From selection: up to 4 boxes; Other contacts: **New: $150 allowance** Medically necessary: covered in full	Elective: Reimbursed up to $105 after copay; Medically necessary: reimbursed up to $201
Frequency		
Exam	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frames	**New: Once every 12 months**	

Vision	**Semi-Monthly Payroll Deductions**
Employee Only	$3.90
Employee + Spouse	$7.06
Employee + Child	$7.32
Family	$11.29

Life and AD&D Insurance

Basic Life Insurance

Lake Wales Charter Schools provides all active employees working 30 or more hours per week Basic Life and AD&D Insurance in the amount of $20,000. Lake Wales Charter Schools pays the full cost of this benefit.

Voluntary Life Insurance

Lake Wales Charter Schools offers all active employees working 30 or more hours per week the option to purchase life insurance coverage through a group plan. The chart below provides an overview of the plan available through United Healthcare.

Voluntary Life Insurance	United Healthcare
Employee Life	Increments of $10,000 up to 3x your annual salary to a max of $100,000
Guarantee Issue	3x your salary, max $100,000
Spouse Life	Increments of $5,000 up to $50,000 (not to exceed 50% of employee amount) :GI - $20,000
Dependent Life	Increments of $5,000 up to $25,000 (not to exceed 25% of employee amount): GI - $10,000
Benefit Reduction Schedule	At age 65, reduced to 65% At age 70, reduced to 50%
Convertible Portable	Included

When You Reach Age 65

By the time you reach age 65, chances are that your children will be grown and your mortgage paid. At age 65, providing you are still employed, your coverage will decrease to 65% of the benefit amount. It will decrease to 50% at age 70.

Guaranteed Issue

The only time you can enroll in guaranteed issue voluntary life insurance, is at the date you first become eligible to enroll. If you do not enroll then, and later decide that you would like to enroll, you will be required to complete an Evidence of Insurability Form (EOI) and go through the medical underwriting process. The insurance carrier reserves the right to decline coverage based on medical information obtained on the EOI. Premiums will not be collected until notification of approval for the benefit is received.

VOLUNTARY LIFE RATES (Updated)

Below is the cost for the voluntary life; rate/premium are age banded based on the employee's age as of 7/1 each year for both employee and spouse. NOTE: IT IS THE EMPLOYEE RESPONSIBILITY TO SUBMIT EVIDENCE OF INSURABILITY (EOI) FORM IF OVER THE GUARANTEE ISSUE OR IF YOU DECLINED COVERAGE WHEN FIRST ELIGIBLE. Coverage and payroll deductions will not take effect until EOI is approved by the carrier.

EMPLOYEE SEMI-MONTHLY PAYROLL DEDUCTION (DEDUCTION MAY VARY DUE TO ROUNDING)

Coverage Amounts	<24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64*
$10,000	$0.22	$0.25	$0.28	$0.33	$0.39	$0.72	$1.05	$2.11	$2.99
$20,000	$0.44	$0.50	$0.55	$0.66	$0.78	$1.44	$2.10	$4.21	$5.98
$30,000	$0.66	$0.75	$0.83	$0.99	$1.17	$2.16	$3.15	$6.32	$8.97
$40,000	$0.88	$1.00	$1.10	$1.32	$1.56	$2.88	$4.20	$8.42	$11.96
$50,000	$1.10	$1.25	$1.38	$1.65	$1.95	$3.60	$5.25	$10.53	$14.95
$60,000	$1.32	$1.50	$1.65	$1.98	$2.34	$4.32	$6.30	$12.63	$17.94
$70,000	$1.54	$1.75	$1.93	$2.31	$2.73	$5.04	$7.35	$14.74	$20.93
$80,000	$1.76	$2.00	$2.20	$2.64	$3.12	$5.76	$8.40	$16.84	$23.92
$90,000	$1.98	$2.25	$2.48	$2.97	$3.51	$6.48	$9.45	$18.95	$26.91
$100,000	$2.20	$2.50	$2.75	$3.30	$3.90	$7.20	$10.50	$21.05	$29.90

SPOUSE SEMI-MONTHLY PAYROLL DEDUCTION (DEDUCTION MAY VARY DUE TO ROUNDING)

Coverage Amounts	<24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64*
$5,000	$0.11	$0.13	$0.14	$0.17	$0.20	$0.36	$0.53	$1.05	$1.50
$10,000	$0.22	$0.25	$0.28	$0.33	$0.39	$0.72	$1.05	$2.11	$2.99
$15,000	$0.33	$0.38	$0.41	$0.50	$0.59	$1.08	$1.58	$3.16	$4.49
$20,000	$0.44	$0.50	$0.55	$0.66	$0.78	$1.44	$2.10	$4.21	$5.98

*Check with HR for age 65+ rates

CHILD(REN) SEMI-MONTHLY PAYROLL DEDUCTION

$5000=	$0.28	$10,000=	$0.55

Disability Insurance

Disability Income Benefits

In the event you become disabled from a non work-related injury or sickness, disability benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Employees may purchase Short Term Disability (STD) through payroll deductions, coverage is offered by United Healthcare. You must be actively at work on this day coverage begins. If you waive or have previously waived STD and would like to apply at a later date, you will need to complete an Evidence of Insurability (EOI) form before coverage is approved.

Long Term Disability is provided to full time employees at no cost through United Healthcare.

***What are pre-existing conditions?**
A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in the 3 months prior to your effective date. The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 months of coverage.

Short Term Disability	United
Definition of Employee	All full time employees
Benefit Percentage	60%
Maximum Weekly Benefit	$1200
Pre Existing Limitation	3/12
Elimination Period	14 day Accident 14 day Sickness (Benefit begins on 15th day)
Duration of Benefit	24 weeks

Age and STD Premium Factor Updated)
<24 = .02250
25-29=.02487
30-34=.02352
35-39=.01983
40-44=.01713
45-49=.01848
50-54=.02118
55-59=.02553
60-64=.03090
65-69=.03795
70+ =.03795

Semi Monthly Payroll Calculation for STD:
Annual Salary x Premium Factor = PP Deduction
Note: if your salary is more than $104,00, use $104,000 to calculation your premium.

Long Term Disability	United
Definition of Employee	All full time employees
Benefit % of Monthly Covered Payroll	60%
Monthly Maximum	$6000
Elimination Period	180 days
Own Occupation	After benefits have been paid for 24 months, you are disabled when the Carrier determines that, due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
Definition of Disability	Unable to perform the material and substantial duties of occupation and 20% or more loss in indexed monthly earnings due to same sickness or injury
Benefit Duration	Reducing Benefit Duration (RBD)/ To age 65/ SSNRA
Pre-Existing Conditions	3/12
Mental Illness Limitation	24 months

Voluntary Products

TransAmerica

The following voluntary benefits are offered by TransAmerica and are designed to provide you additional cash flow to assist with out of pocket medical costs and other bills based on individual needs. :

Accident Advance Insurance
Offsets the cost of unexpected expenses that result from accidents that occur every day. The benefits are paid directly to you, not to your doctor or hospital.

Critical Illness Plus
Provide immediate financial relief from overwhelming expenses of serious illness, such as a heart attack, stroke or organ failure. It pays you a lump sum cash benefit when you are diagnosed with a covered illness easing your financial worries.

Cancer Select Plus
Pays you money to help pay for the high cost of cancer-related treatment, medical expenses and other indirect costs associated with this disease. Pays you, regardless of other health insurance coverage or payments for cancer related expenses.

Hospital Select II
Helps offset your out of pocket expenses include deductible, coinsurance and copays, also services not covered in your group health coverage for Hospitalization and Outpatient surgery.

Transelite (Universal Life Insurance)
Universal life insurance can help safeguard your family members' futures, with benefits that can assist with your initial expenses and their dependent care, living expenses or college tuition. Benefit Highlights: NO physicals or blood work needed, accumulates cash value, guaranteed 3% interest rate, withdrawal and loan options, guaranteed issue coverage.

Trans$ure (Whole Life Insurance)
A whole life policy designed to help provide financial protection for the insured's family, with a death benefit that can be used for final expenses, for college tuition, for living expenses or as an inheritance. It also accumulates cash value (with a minimum 4% interest rate) that can be borrowed against while alive. Benefit Highlights: payroll deducted premiums, accumulates cash value, guaranteed 4% interest rate, loan and withdrawal options.

Trans Select 10 (Group Life Insurance)
Trans Select 10 premiums are scheduled to remain level for ten years and are guaranteed level for the first five years. Premiums may increase annually starting in year 6.

For more details, contact your TransAmerica/ExplainMyBenefits Counselor at 321-296-8060 x2 (indicate that you are employed at Lake Wales Charter Schools.
www.transamerca.com

Flexible Spending Accounts

Healthcare Spending Account

A flexible spending account (FSA) is your personal account funded with your pre-tax dollars to help you save for future healthcare expenses including the copays, deductibles, coinsurance and even vision and dental expenses. You may contribute up to (New) **$2750** for the Jan-Dec plan year.

How does the FSA work?

As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to Social Security (FICA), federal, state, or local income taxes — effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly, depending on your tax bracket. And, as a result of the personal tax savings you realize, your spendable income will increase. See the example:

Example: **Bob and Jane's combined gross income is $30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend $2,000 in adult orthodontia and $3,000 for daycare next plan year, they decide to direct a total of $5,000 into their FSAs.**

	Without FSAs	With FSAs
Gross income:	$30,000	$30,000
FSA contributions:	-5,000	0
Gross income:	$25,000	$30,000
Estimated taxes:		
Federal	$-2,550*	
FICA	$-1,755*	
-2,295		*-1,890*
After-tax earnings:	*21,355*	*25,155*
Eligible out-of-pocket medical and dependent care expenses:	*0*	*-5,000*
Remaining spendable income:	*$20,155*	
	$21,355	
Spendable income increase:	***$1,200***	

**Assumes standard deductions and four exemptions.*
The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.

For further information:
Call or check out the following link for more information and a list of items and services that are eligible: **888-862-6272 or visit: https://www.mywealthcareonline.com/emangrove/resources/fsaresrouces.asps**

Is the FSA Program Right for Me?

It's easy to determine if a FSA will save you money. Prior to enrollment, you will need to determine your annual election amount. Estimate the expenses that you know will occur during the year. These include out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes. If you had $100 or more in recurring or predictable expenses, the accounts can help you stretch your dollars.

Estimated Annual Expenses & Tax Savings	
Total Medical+Vision+Dental Expenses	$
Total Dependent Care Expenses	+
Total Expenses	$
Tax Bracket Percentage (see right)	x
Annual Tax Savings	$
Number of Pay Periods	/
Estimated Savings Amount Per Paycheck	$

Pre-Tax Savings Estimate Table	
Annual Household Earnings	**Estimated Tax Rate**
< $30,000	25%
$30,000—$40,000	29%
$40,000—$70,000	31%
> $70,000	33%

** Based on Social Security, federal, and state income taxes. Rates are estimates based on national averages and may not reflect your actual tax rate.*

IMPORTANT:

- **You must enroll/re-enroll each year to participate.**
- **You must still retain all receipts as you may be asked to substantiate any expenses**

FSA Carryover: This feature allows you to carry forward up to $500 in unused healthcare/FSA funds to the new calendar year which can be used for eligible healthcare expenses. Please remember: *any unused amounts in excess of $500* will be forfeited at the end of the plan year and not carried forward.

Healthcare FSA Debit Card: We are pleased to offer employees the Healthcare FSA debit card that allows you to pay for most qualified expenses without having to worry about paying out of pocket at the time of service.
Examples of reimbursable expenses included (but not limited to): hearing exams and aids, vision expenses and Lasik surgery, orthodontia, chiropractic services, acupuncture, physical therapy, diabetic supplies, AND MORE! Note: Under ACA, over the counter medications are no longer eligible for FSA reimbursement unless you have a doctor's prescription.

Dependent Care FSA

Dependent Care FSA

Dependent Care Spending Accounts are pre-tax, payroll deduction accounts established to reimburse employees for out-of-pocket dependent care expenses. To be considered eligible, dependent care expenses must be incurred by an employee who must arrange for care of an eligible dependent in order to work. For married employees, dependent care must be necessary so that both spouses can work.

Qualifying Dependent

A qualifying dependent is:

- A tax dependent of yours who is under age 13, or
- Any other tax dependent of yours, such as an elderly parent, who is physically or mentally incapable of self-care and has the same principal residence as you
- A spouse who is physically or mentally incapable of self-care and has the same principal residence as you

Your Contribution

The Internal Revenue Service limits the amount you can contribute to a dependent care FSA, up to:

- $5,000 per year, if you are married and filing a joint federal tax return, or if you are a single parent
- $2,500 per year, if married and filing separate federal tax returns

Estimate what your daycare expenses will be for the year, and allocate enough from your pay, up to the allowable contribution, to cover those expenses.

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- · The cost of child or adult dependent care
- · The cost for an individual to provide care either in or out of your house
- · Nursery schools and preschools (excluding kindergarten)
- · Summer Camp

Just remember this: Dependent Care Accounts are "use-it-or-lose-it" funds. Any balance remaining in Dependent Care Accounts at the end of the plan year will be forfeited. That is an IRS requirement. Estimate the amount you want to contribute to your FSA carefully.

For further information:

Call or check out the following link for more information and a list of items and services that are eligible:
888-862-6272 or visit:
https://www.mywealthcareonline.com/emangrove/resources/fsaresrouces.asps

www.FSAStorecom

Check out this site, it's a one stop shop stocked exclusively with FSA-eligible products and services…so there are no guessing games as to what "is and isn't" reimbursable.

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

Benefit Resource Center

BRCSouth@usi.com | Toll Free: 855-874-0835

Required Annual Employee Disclosure Notices

The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery, to less than 48 hours, and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

1. Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
2. Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
3. Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage;
4. Require a mother to give birth in a hospital; or
5. Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires Lake Wales Charter Schools to notify you, as a participant or beneficiary of the Lake Wales Charter Schools Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical compilations of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Required Annual Employee Disclosure Notices - Continued

Medical Plans Offered effective 7/1/20 (Non-Grandfathered):

For eligible employees, the health plans offered by LWCSI meet the Affordable Care Act (ACA) requirements that qualify the plans as affordable and meet specific federal guidelines (referred to as Minimum Essential Coverage or MEC) set by the ACA.

If you are an employee not eligible for benefits (in your waiting period for benefits, a part-time, seasonal or variable hour employee), or do not have access to other coverage, you may qualify for reduced premiums through a Marketplace plan. You can visit **www.healthcare.gov** to determine if you, and/or your family qualify for subsidies under the Health Insurance Marketplace in your state.

HIPAA Privacy Policy for Fully-Insured Plans with no Access to PHI

The group health plan is a fully-insured group health plan sponsored by the "Plan Sponsor". The group health plan and the plan sponsor intend to comply with the requirements of 45 C.F.R. §164.530 (k) so that the group health plan is not subject to most of HIPAA's privacy requirements.

I. No access to protected health information (PHI) except for summary health information for limited purpose and enrollment / dis-enrollment information.

Neither the group health plan nor the plan sponsor (or any member of the plan sponsor's workforce) shall create or receive protected health information (PHI) as defined in 45 C.F.R. §160.103 except for (1) summary health information for purpose of (a) obtaining premium bids or (b) modifying, amending, or terminating the group health plan, and (2) enrollment and dis-enrollment information.

II. Insurer for group health plan will provide privacy notice

The insurer for the group health plan will provide the group health plan's notice of privacy practices and will satisfy the other requirements under HIPAA related to the group health plan's PHI. The notice of privacy practices will notify participants of the potential disclosure of summary health information and enrollment / dis-enrollment information to the group health plan and the plan sponsor.

III. No intimidating or retaliatory acts

The group health plan shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights , filing a complaint, participating in an investigation, or opposing any improper practice under HIPAAA.

IV. No Waiver

The group health plan shall not require an individual to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment or eligibility. If such an action should occur by one of the plan sponsor's employees, the action shall not be attributed to the group health plan.

Michelle's Law

Under the ACA, dependent children are covered by the group health plan until age 26. Lake Wales Charter School's group health plan extends dependent coverage beyond the ACA requirements, to age 26, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

To obtain more information, contact person listed at the end of this summary.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 30 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

Required Annual Employee Disclosure Notices - Continued

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 January 31, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://dhhs.nh.gov/ombp/nhhpp Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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

Required Annual Employee Disclosure Notices - Continued

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: https://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

To see if any other states have added a premium assistance program since January 31, 2018, 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

Medicare Part D Notice of Creditable Coverage

Medicare Part D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with United Healthcare and about your options under Medicare's prescription 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.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription 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. United Healthcare has determined that the prescription drug overage offered by the Welfare Plan for Employees of Lake Wales Charter Schools under the United Healthcare option are, on average for all plan participants, expected to pay out as much as the 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.

You should also know that if you drop or lose your coverage with United Healthcare and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current United Healthcare coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current United Healthcare coverage, be aware that you and your dependents will be able to re-enroll in our program during the next open enrollment period.

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 United Healthcare 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 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 our office for further information (see contact information below). 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 United Healthcare 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 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 notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	7/1/2020
Name of Entity/Sender:	**Lake Wales Charter Schools, Inc.**
Contact--Position/Office:	Dr. Julio Acevedo, Human Resources Director
Address:	130 E. Central Avenue Lake Wales, Florida 33853
Phone Number:	**863-679-6560**

Health Insurance Marketplace Coverage Options

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

In 2014, a new way to buy health insurance was introduced: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment -based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. You can get coverage through the Marketplace for 2019 if you qualify for: 1) a special enrollment period, 2) are applying for Medicaid or 3) the Children's Health Insurance Program (CHIP). Here are some important dates each year:

November 1, 2019:	Open enrollment for marketplace health insurance coverage begins
December 15, 2019:	Last day to enroll or change 2020 marketplace coverage plan
January 1, 2020:	Marketplace coverage begins

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Human Resources Department.

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

[1] An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.