Benefits Guide

Plan Year Effective 7/1/24-6/30/25

Review the Benefits Presentation using QR Code (left) or link below:

https://www.brainshark.com/usi/vu?pi=zIvzZypLtzjvE7z0

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.

Revised 5.3.24

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Benefits at a Glance

What Benefits does Lake Wales Charter Schools offer?

Lake Wales Charter Schools offers a variety of benefits, some require an employee contribution, and others are provided entirely by the company. Choose any combination of voluntary benefits for you and your eligible dependents from the list below:

- Medical
- Teladoc (included in medical plan)
- Dental
- Vision
- Basic Life and AD&D
- Supplemental Term Life
- Short Term Disability
- Long Term Disability
- Employee Assistance Program (EAP)
- Travel Assistance Program
- Accident
- Critical Illness
- Prepaid Legal
- Identity Theft
- NEW: Beyond Med

We are happy to provide you with this Benefit Guide which summarizes your employee benefits for the 2024-2025 plan year. Lake Wales Charter Schools, Inc. recognizes that benefits are an important part of your total compensation package. Our benefit program provides competitive and valuable benefits for you and your dependents.

This document is not just an enrollment guide. It is a resource for you and your family to use throughout the year. In this guide you will find a summary of each of the benefit plans offered to eligible employees and their dependents. Our benefits program is designed to allow you to choose what works best for your needs and your budget. This information will allow you to make informed decisions regarding the selection and continued management of the services and benefits provided to you as an employee of Lake Wales Charter Schools, Inc.

Eligibility

Who is eligible?

All regular full-time employees are eligible to enroll in the benefit plans on the first of the month following 30 days of employment. To be considered a full-time employee, you must be regularly scheduled to work 30 per week.

Eligible dependents, including legal spouse, children, and step-children may also be enrolled as long as they meet the corresponding requirements for each plan.

Note: Proof of dependent eligibility is required and may be requested when you first enroll and/or if you change coverage mid-year due to a qualifying event.

When Can I Enroll?

- During new hire eligibility period
- During the annual enrollment period
- Within 30 days of a qualifying event

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

What is a Qualifying Event?

- Marriage
- Divorce or legal separation
- Birth or adoption of an eligible child
- Death of spouse or covered child
- Change in a spouse's work status that affects your benefits
- Change in your child's eligibility for benefits
- Receipt of Qualified Medical Child Support Order

When do my Benefits Start?

As a new hire, your benefits become effective on the first of the month following 30 days of full time employment. During annual open enrollment, benefit changes are effective on July 1, except for changes that require Evidence of Insurability approval (i.e., Voluntary Life, Short & Long Term Disability or Critical Illness).

When Will You Start Taking Deductions from my Paycheck?

Deductions will begin the first paycheck in which your benefits become effective.

When Will My Coverage End?

For medical, dental, and vision, coverage will stop on the last day of the month in which employment with the company ends. All other benefits end on the last day of employment.

Why are some benefits deducted pre-tax?

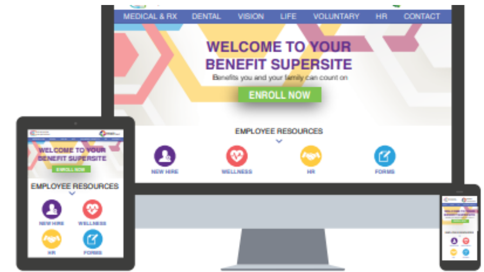
Lake Wales Charter Schools has an IRS Section-125 plan. That means certain eligible benefit premiums are deducted from your paycheck before tax. This lowers the amount of your taxable pay which saves you money.

You must notify Human Resources ***within 30 days of a family status change o****r wait until the next annual enrollment period to make benefit changes.*

important

ENROLLMENT IN "MyBenSite" PORTAL

You will be required to make your elections online in the MyBenSite portal by the due date specified by Human Resources. You can access the portal from any internet connection or mobile web browser (i.e., Google, Safari, etc.) 24 hours a day, 7 days a week.



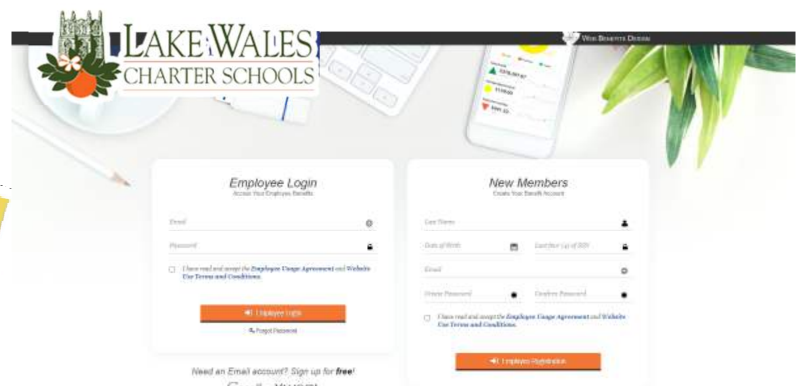
Good news! There will be no paper forms to complete. To begin your enrollment, follow these easy steps:

- ❑ Enter the following address into your internet browser:

https://www.mybensite.com/lwcharterschools/

- ❑ Your user name is your Lake Wales Charter Schools email address (or your email address on file).
- ❑ If you forgot your password just click on the forgot password link.
- ❑ Once logged in, select the **Enroll Now** tab. You will be guided through a series of screens, each taking only a few moments to complete:
  - ✓ **Personal Information** – Please verify that all information is accurate.
  - ✓ **Dependent Information** – Please be sure that all dependents you wish to cover are listed in this section. You must include SSN and dates of birth.
  - ✓ **Benefit Selections** – each page will show you the benefits you are eligible for and the cost "per paycheck". Please either elect or decline each benefit.
  - ✓ **Review and Submit** – this is the final step. Please review your benefit selections and costs. If you wish to make changes to your selections, click the "edit" button to update your information. Once you have completed your review, agree to the terms and hit "Continue". You will then be given the opportunity to print and/or email a Benefits Confirmation Statement for your personal records.

Important: Please have your spouse and/or children social security numbers and dates of birth with you when enrolling in the site. You must list dependents first, otherwise they won't be shown coverage options to include them.



MAKING YOUR SELECTION

There are limited opportunities to enroll and/or make changes to your benefit elections. Make your selections carefully! The choices you make now will be effective through the end of the plan year, as long as you remain eligible.

When you're first hired

The benefits you elect as a newly eligible employee begin on the first day of the month following 30 days of full-time employment.

You are required to make your elections using the MyBenSite portal by the due date specified by Human Resources (also to decline coverage in benefits).

If "DECLINING" benefits, you must decline benefits in the MyBenSite portal.

Refer to the prior page of this guide for instructions to login (or first time register) in the portal. Once registered, be sure to keep your Username and Password. You will need it each year for Open Enrollment.

At Open Enrollment

Open Enrollment is your annual opportunity to enroll or make changes to your elections. Benefits selected during Open Enrollment are effective annually each July 1st unless Evidence of Insurability (EOI) is required.

For 7/24 open enrollment: If you are not making any changes, your current enrollment/declines will ROLLOVER for 7/1/24 (except FSA, you must re-elect).

If you are newly enrolling or making changes/declines at Open Enrollment: This must be done in the online portal (MyBenSite) by the due date specified by Human Resources.

Refer to the prior page of this guide for instructions to login in the MyBenSite portal. If you registered as a new employee simply log in with the same Username and Password. Be sure to keep your Username and Password, you will need it each year for Open Enrollment.

If you have a life event

Some life events allow you to change your coverage during the year. If you experience a life event, **you have 30 days from the date of the event to request changes** and provide any required documentation. Some IRS approved qualifying events are:

- Birth or adoption
- Marriage or Divorce
- Change in employment status or change in coverage under another employer sponsored plan
- Loss or gain of eligibility under Medicare or Medicaid

Log in to MyBenSite to submit your change request following a life event. These requests are subject to verification and approval.

Please note: the IRS does not consider financial hardship a qualifying event to drop coverage.

Medical Insurance – UMR/United

Our medical plan is through UMR using the UMR national Choice network. The chart below provides a brief summary of some common services.

UMR (United "National" Network	Choice Plan (EPO)
Office Visits (PCP/Specialist):	Open Access
In-Network	PCP(+Virtual): $25 copay; Specialist(+Virtual): $50 Teladoc (General/Derm): $5
Out-of-Network	No Benefit
Prescription Drugs:	
In-Network	$10/$35/$70
Out-of-Network	No Benefit
Mail Order Drug Copay	2.5x copay
Emergency Room/Urgent Care	
In-Network	ER: $300 copay UC: $50 copay
Out-of-Network	ER: Same as IN network UC: No Benefit
Lab / Xray /Major Diagnostics (Non-Preventative in Independent Facility)	Preventative covered 100% in network, must be coded as preventative
In-Network	LAB: $0 copay X-Ray/Diag: $0 copay Complex: $300 copay
Out-of-Network	No Benefit
Outpatient Surgery/Services	
In-Network	20% after DED
Out-of-Network	No Benefit
In Patient Hospital & Services	
In-Network	20% after DED
Out-of-Network	No Benefit
Deductible: *Individual / Family*	Accrued Jan-Dec
In-Network	$2000/$4000
Out-of-Network	No Benefit
Co-Insurance after DEDUCTIBLE:	
In-Network	20% after DED
Out-of-Network	No Benefit
Out-of-Pocket Maximum:	Accrued Jan-Dec
Individual / Family	INCLUDES All: DED/Coin/Copays/RX
In-Network	$5000/$10,000
Out-of-Network	No Benefit
Lifetime Maximum Benefit	
In-Network	Unlimited
Out-of-Network	No Benefit

This chart is intended to be an illustration of benefits only. If it conflicts with the Summary Plan Description (SPD), the SPD shall prevail.

Teladoc (for UMR Medical plan members)

Teladoc is the on-demand healthcare solution that gives you access to medical care 24/7 by phone, online video or mobile app. Your spouse and children can also use Teladoc, even if they are not enrolled in the medical plan! Use Teladoc for medical advice and care when:

- √ **Your primary care doctor is not open.**
- √ **You are at home, traveling or do not want to take time off work to see a doctor.**
- √ **You need a prescription or refills.**

Common Conditions Treated			
Allergies	Headaches / migraines	Sinus infections	Urinary tract infections
Bronchitis	Eye/ear infections	Stomach ache or diarrhea	Cold/flu

Benefits of Teladoc

Saves time and money

Quicker recovery from illness

Convenient prescriptions

Choice of consultation method

Great health means peace of mind

By phone

Just call **1-800-Teladoc** (1-800-835-2362)

Online

Simply request a video consultation online at **www.teladoc.com**.

On the go

You can download the Teladoc mobile app by visiting the **App Store** or **Google Play**.

Cost = Less than going to ER, or Urgent Care or your PCP!

Only a $5 copay for a General Medicine (PCP) or Dermatology Consultation!

Highly qualified, experienced doctors

When you use Teladoc, your medical questions will be answered by a highly qualified doctor. Teladoc doctors are:

- **Experienced**—with an average of over 10–15 years in practice.
- **Progressive**—using the latest technology to provide excellent care.
- U.S. **board certified** and **state licensed**.
- **Specially trained** in telemedicine.

Next Steps? How to Use?

First "set up" your account online (www.Teladoc.com) or via the mobile app and follow the prompts. Once completed, you can then contact a Teladoc physician at 1.800.835.2362, or by visiting www.teladoc.com

Medical and Pharmacy Plan Tips

UMR's Provider Networks

Tip: Verify that your provider is 'in-network' BEFORE each visit. Ask the provider: do you participate in the UMR/United "choice" network? (Do not ask: do you "take" UMR insurance?)

To Register as a Member

- Go to the UMR website www.umr.com
- Click on "login/register" (blue button, upper right) and follow the prompts

To Find an IN Network Provider:

- Click on 'find a provider"
- Enter "UMR Choice Plus Network", then enter
- Click on "view providers" (green button, bottom left)
- Click on any of the following: people, places, etc
- Follow prompts to add your zip code and what kind of provider you are looking for

Pharmacy Tips

Use generics when possible for lower costs out of pocket. Always asks your doctor to write DAW on any prescription UNLESS your prescription is a generic drug. By writing "DAW" (dispense as written) or "medically necessary" on your brand or non-formulary drug prescription, it won't be substituted with a generic version at the pharmacy. Get your generic drugs filled at Walmart ($4 each) or $7.50 for 90 days (certain meds) at Publix also check out www.goodrx.com to compare prices! Finally…if it's a new prescription, ask your doctor for samples (especially if the RX is brand or non-formulary tiers)! Remember, you don't get a refund if the RX doesn't work for you!

Important on RX:

Check the UMR drug list (called "formulary list) frequently. The Drug List can change throughout the year but is posted each January and July. Changes to drug list or copay "can" happen during the year when:

- An RX becomes "over the counter,"
- If/when a generic becomes available or
- If an RX is excluded from the RX list entirely

- Some drugs have step therapy, quantity limitations or require pre-authorization…your doctor may need to contact UMR/Optum to submit info on your medical necessity prior to a prescription being filled.
- Specialty or Injectable drugs have additional steps like pre-authorization to receive…check with UMR/Optum for further details.

Questions? Contact UMR:

- Via the UMR website www.umr.com
- Using your smartphone at the mobile website m.optumrx.com
- Via www.optumrx.com
- By phone:
  - Customer Service, Mail Order Pharmacy: 877-559-2955
  - Medical Supplies Pharmacy: 866-208-7707
  - Prior Authorization (Physicians): 800-498-5428 opt 2
  - Pharmacists (Mail Service Customers): 800-788-4863

Dental Insurance – Mutual of Omaha

Lake Wales Charter Schools offers a two PPO dental plans through Mutual of Omaha. Both plans allow you to use in-network or out-of-network benefits. Go to www.dentistsforme.com/mutualofomaha.com to check if your dentist is in the network (choose PPO network) and REGISTER to print a member ID card and to access your dental claims.

Dental PPO	Low Plan	High Plan
Preventive Services:	You'll Pay:	You'll Pay:
In Network	Covered @ 100%	Covered @100%
Out of Network	100%*	100%*
Basic Services:		
In Network	20% after DED	20% after DED
Out of Network	20% after DED*	20% after DED*
Major Services:		
In Network	50% after DED	50% after DED
Out of Network	50% after DED*	50% after DED*
Orthodontia (Child & Adults)		$1500 lifetime Benefit
In Network	No Benefit	50% (no DED)
Out of Network	No Benefit	50% (No DED)*
DEDUCTIBLE	Individual/Family	Individual/Family
In Network	$50/$150	$50/$150
Out of Network	$50/$150	$50/$150
MAXIMUM ANNUAL BENEFIT:		
In Network	$1,000.00 (Includes Preventative Max)	**$1,500.00**
Out of Network	Same as above	Same as above
Wait Periods	NONE when first eligible or if added at open enrollment	
Perks	Rollover Benefit, see note	

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

ROLLOVER Benefit: Both plans have the 'rollover' benefit included. If you have LESS than $500 in claims in the year, Mutual of Omaha will add $350 to your annual benefit the following year if using an in network provider ($250 if using an out of network provider).

Preventative Max (on Low plan only): All preventative care services do "not" accrue toward your annual benefit.

TIP:
If needing "higher cost" services like root canals, perio care, crowns, bridges or dentures: always ask your provider for a "pre-determination" to be done PRIOR to having the service completed.

Although it may mean another visit to the dentist, it will give you an idea of what will be covered by the carrier and no surprises when you receive the bill!

Please review the benefit summary/certificate for further details. Mutual of Omaha

Vision Insurance – Mutual of Omaha

Lake Wales Charter Schools offers a voluntary vision plan through Mutual of Omaha using the EyeMed national network. This vision plan provides coverage both in and out of network, the chart below provides a brief overview. Please review the benefit summary/cert for further details.

Go to www.mutualofomaha.com/vision for a list of in-network vision providers, also register to see your claims, print out an ID card, etc. **Note that no ID cards are issued (or needed), but you can print one only by registering in the member portal.** Just advise the provider that you have Mutual of Omaha coverage (EyeMed network), and the provider will call the provider line to verify your eligibility and coverage.

	In-Network	Out-Network
Lenses		
Single Vision	$10 copay	$40 allowance
Lined Bifocal	$10 copay	$60 allowance
Lined Trifocal	$10 copay	$80 allowance
Lenticular	$10 copay	$80 allowance
Standard Progressive	$70 copay	NA
Other Progressive	$110-$250 copay	NA
Contact Lenses (in lieu of frames/glasses)		
Medically Necessary	$25 copay	$210 allowance
Elective	$150 allowance	$105 allowance
Frames		
	Up to $150 after $25 Copay 15% off the balance	$45 allowance
Exams	$10 copay	$40 allowance
Frequency		
Exam	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 12 months	

Check out the vison discount list for other copay discounts offered by the Vision plan to include lens options, extra glasses, sunglasses and Lasik surgery!

Basic Life & Supplemental Life Insurance

Lake Wales Charter Schools provides all full-time eligible employees an employer paid life insurance benefit. The chart below provides an overview. Please review the benefit summary/cert for further details.

	Basic Life and AD&D Insurance
BENEFIT OUTLINE:	
Employee Life Benefit	$20,000
Employee AD&D Benefit	$20,000
Age Reduction Schedule	Initial benefit reduces to: To 65% at age 65, To 50% at age 70 Coverage terminates at retirement
Conversion	Yes

In addition, eligible employees are offered the option to purchase supplemental term life insurance coverage for self, spouse and child(ren). Spouses and unmarried dependent children may be enrolled as long as the employee also elects coverage. The chart below provides an overview. Please review the benefit summary/cert for further details.

	Supplemental (Voluntary) Life Insurance
BENEFIT OUTLINE:	
Employee Life	Increments of $10,000, 5x salary, max $100,000
Employee Guarantee Issue*	Lesser of 5x salary or $100,000
Spouse Life	Increments of $5,000 up to 100% of employee election, max $50,000
Spouse Guarantee Issue*	$20,000
Child Life	100% of employee election, max to $25,000
Child Guarantee Issue*	Increments of $5k, to max $25,000 (max=25% of EE election)
Benefit Reduction Schedule	Initial benefit reduces to: 65% at Age 65; 50% at Age 70
Conversion	Yes. If your employment ends, you may convert this policy to an individual policy without evidence of insurability. You'll need to contact Mutual of Omaha within 30 days of termination to enroll and pay for your individual policy (directly with Mutual of Omaha)
Portable	Yes. If your employment ends, you may continue this policy for you and dependents without evidence of insurability. You'll need to contact Mutual of Omaha within 30 days of termination to enroll and pay for your individual policy (directly with Mutual of Omaha)

IMPORTANT: Your enrollment in voluntary life insurance has **guaranteed approval** (no medical questionnaire/EOI to complete) **when you first become eligible to enroll in benefits** (after your wait period). **If you decide to enroll later**, it is no longer guarantee issue and you will be required to complete a medical questionnaire (also known as an "Evidence of Insurability" or EOI form). The insurance carrier reserves the right to decline coverage based on medical information obtained on the EOI. **If EOI is submitted, your paycheck contributions for the EOI amount will not be collected until if/when you receive notification that the benefit election is approved. Premium deductions begin on approval date and going forward.**

EMPLOYEE CONTRIBUTIONS: Rates vary based on age and the amount of coverage you elect. Your semi-monthly will be shown in the Web Benefits portal. (Note: spouse age is based on employee age)

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.

Short Term Disability: Employees may purchase Short Term Disability (STD) through payroll deductions, coverage is offered by Mutual of Omaha. You must be actively at work on this day coverage begins. Rates vary based on your salary. Your semi-monthly payroll deductions will be shown in the MyBenSite portal.

important

This is 'guarantee issue" when you are newly eligible for benefits. 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. Premium deductions begin on approval date and going forward

Long Term Disability: LWCS provides an employer paid Long Term Disability benefit for full time eligible. The summary below provides an overview.

	Short Term Disability
BENEFIT OUTLINE:	
Employee Definition	All Eligible FT employees working 40+ hours/week
Benefit Percentage	60%
Minimum Weekly Benefit	$15
Maximum Weekly Benefit	$1200
Elimination Period	14 days for both Accident & Sickness
Duration of Benefit	Up to 26 weeks (including elimination period)
Pre-Existing Condition Limitation	3 months lookback / 12 month wait (if applicable)

	Long Term Disability
BENEFIT OUTLINE:	
Employee Definition	All Eligible FT employees working 40/week
Benefit Percentage	60%
Maximum Monthly Benefit	$6000
Definition of Disability	Loss of Duties and Earnings
Own Occupation Period	24 months
Elimination Period	180 days
Duration of Benefit	Later of age 65 or SSNRA
Pre-Existing Condition Limitation	3 months lookback / 12 month wait (if applicable)

***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.

MUTUAL of OMAHA

Accident & Critical Illness

Employees can enroll in Accident and/or Critical Illness plans offered by Mutual of Omaha. The plans pay "you" directly when a covered accident or condition occurs (see benefit summaries in MyBenSite for what is covered).

Accident Insurance: You can enroll in this when newly eligible **or can add at a later open enrollment without EOI** (evidence of insurability).

Critical Illness: This benefit is 'guarantee issue' if you enroll in when you are newly eligible for benefits.

If you add at a later date, then an EOI form (evidence of insurability) is needed and you are subject to carrier approval. Your paycheck deduction will not begin until you are approved for this benefit.

Accident Insurance

If you and your family are active, chances are, you're no stranger to a hospital emergency room. Even with medical insurance, a fall while bicycle riding or your child's sprained ankle at soccer practice can cost you a bundle in out-of-pocket expenses!

Are you financially prepared for all of the medical and non-medical costs of treatment and recovery from a serious injury? No matter what kind of medical coverage you have, you will have out-of-pocket costs that could really set you back financially.

Mutual of Omaha pays you cash benefits based on your covered injuries, treatments and services. Payments go directly to you, and you can pay for other expenses, such as traveling to the hospital, childcare and lost income from missed work.

Wellness Benefit – if you get an annual wellness screening for tests that can prevent critical illnesses, Mutual of Omaha will pay out $50 per year, per covered individual.

Critical Illness Insurance

Health care costs are on the rise. Even with medical insurance, you're still responsible for co-payments, deductibles and other out-of-pocket costs, so a serious illness could really set you back financially.

If you or a family member was diagnosed with a serious illness, could you handle the extra expenses?

Mutual of Omaha helps protect your savings:

- Critical Illness Insurance supplements your medical plan— **no matter what type of other coverage you have**
- Pays you cash benefits based on each eligible diagnosis
- The cash benefits are paid directly to you — you decide how to use them
- Wellness Benefit – if you get an annual wellness screening for tests that can prevent critical illnesses, Mutual of Omaha will pay out $50 per year, per covered individual

Employees and spouse coverage can choose to elect benefits in $5000 increments, to a max of $20,000. (Spouse coverage can match employee election or less.) Children are included at no charge in the employee coverage, their benefit is 25% of the employee election up to $5000.

Please review the benefit summaries for details and exclusions, it includes payable benefits to you and family members based on illness and/or conditions.

Legal Shield and Identity Theft

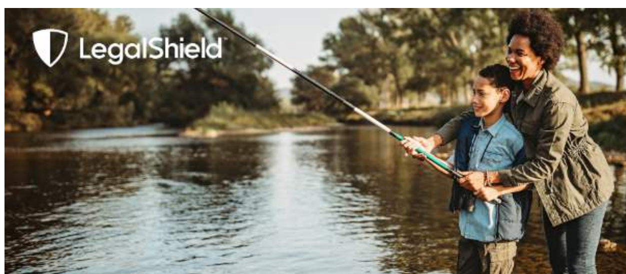
LWCS offers group Legal and Identity Theft plans (payroll deducted). See below for a brief summary on what is coverage on each plan, but refer to the brochure in MyBenSite for further details.

Legal

People need legal coverage without the complexity because life can unpreditable and the law can be complicated. LegalShield created a model for legal coverage in which you know exactly what you are getting and how much your're paying for it. Once you sign up, you can sit back, relax and know you're covered by an entire law firm.

A LegalShield® Membership Includes:

- 24/7 legal access for covered situations
- Mobile App for easy access
- Unlimited Legal advice on personal legal issues
- Letters/calls made on your behalf
- Contracts/documents reviewed
- Preparation of wills/trusts
- Assistance with traffic violations
- Trial defense (if named defendant/respondent in a covered civil lawsuit)
- Speeding ticket Assistance
- IRS audit assistance
- Uncontested Divorce, Separation, Adoption or Name Change (90 days after enrollment)
- 25% Preferred Member Discount (Bankruptcy, criminal charges, DUI, personal injury, etc.
- And more!

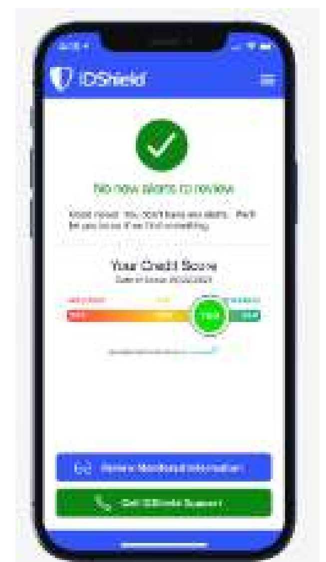


Identity Theft

Protect you and family members against cybercrimes! Consider the IDShield protection plan which offers these benefits:

- Social Media Monitoring
- Dedicated U.S. Licensed Private Investigators
- IDShield Plus Mobile App
- Full Service Restoration to pre-theft status
- $1 million fraud reimbursement
- Continuous Credit Monitoring with one credit bureaus
- Security Monitoring of SSN, credit cards, bank accounts, credit score tracking
- Consultation Services with 24/7 live support for covered emergencies
- $1 Million Service Guarantee. We'll do whatever it takes for as long as it takes to help recover and restore your identity
- And more!

**Always connected.
Always protected.**



Beyond Med

Where health *meets* wellness

A membership program to enhance your most important investment: yourself.

NEW: Weight loss program discounts for non-diabetes! Program includes Telehealth consultation, lab test, RX (for semaglutide) and coaching with nutrition & exercise.

Beyond Med Employee Contributions (24/year)	
Employee Only	$5.00
EE + Family	$10.00

WHY BEYOND MED?

Elevate your health and well-being by getting access to a proprietary network of board-certified doctors and licensed providers at reduced rates on elective and cosmetic services.

- 3,000 + Providers
- 15 Specialties
- 2,500+ Offices
- 400+ Treatments

MEMBER PERKS

Curated Network

Access to thousands of elective and cosmetic providers at reduced rates

Concierge Service

A concierge team to guide you and an easy-to-use mobile application

Unlimited Savings

No waiting periods and no limits to benefit usage (use it as much as you want!)

SAVE ON SERVICES LIKE:

- Acupuncture
- Anti-Aging
- Bariatric
- Chiropractic
- Dermatology
- Fertility
- Hair Restoration
- Hearing
- Mental Wellness
- Med Spa
- Physical Therapy
- Plastic Surgery
- Surgical Vision
- Vein Therapy
- Veterinary
- Weight Loss

INDUSTRY'S LEADING PROVIDERS

FOR MORE INFO, CONTACT US AT INFO@BEYONDMEDPLANS.COM or VISIT WWW.BEYONDMEDPLANS.COM

Beyond Med Plans Inc. ("BMP") is not insurance. BMP provides discounts at certain health care providers for medical services. BMP does not make payments directly to the providers of medical services. BMP members are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with BMP. **Beyond Med Plans Inc. is a licensed Discount Plan Organization** which is administered from 3050 Biscayne Blvd. Suite 904, Miami, FL 33137.

Healthcare Flexible Spending Account (FSA)

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. **For 2024, the IRS limits your healthcare FSA contributions to $3,200.**

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:

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.

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

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.*

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 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

Additional resources:

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:

www.FSAStore.com

Employee Assistance Program (EAP)

Life is not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family. The EAP is available to all full time LWCS employees working 30 or more hours per week. There is ***no cost*** to you for utilizing EAP services .

What to Expect

Information gathered by the EAP is ***confidential*** – the EAP does not communicate with your employer about your situation unless there is a risk of harm to you or others.

Experienced EAP Staff

Master's level professionals who can provide assistance for a variety of personal and professional matters.

- Emotional well-being
- Family and relationships
- Legal and financial
- Healthy lifestyles
- Work and life transitions

EAP Benefits

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Robust network of licensed and/or certified mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

  * Face-to-face visits can also be used toward legal and financial consultations
- Legal assistance and financial services
- Will preparation
- Legal library & online forms
- Resources for:
  - Work/Life balance
  - Substance abuse
  - Dependent and elder care assistance & referral services
- Access to a library of educational articles, handouts and resources via website

important

Don't delay if you need help!
Visit mutualofomaha.com/eap or call 800-316-2796 for a confidential consultation and resource services.

Worldwide Travel Assistance

Lake Wales Charter Schools provides an employer paid life Travel Assistance benefit for full time eligible employees and their dependents. The summary below provides an overview.

Experiencing an emergency while traveling can be especially difficult. Knowing who to call for medical problems, currency exchanges issues or lost luggage is critical. Take comfort in knowing that the Travel Assistance program travels with you worldwide (100+ miles from your home), offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations. Example of what this program can help with is listed below:

Pre-Trip Assistance

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements for foreign countries
- Domestic and international weather forecasts
- Daily foreign exchange rates
- Consulate and embassy locations

Emergency Travel Support Services

- Telephone translation and interpreter services, 24/7 access
- Locating legal services, referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance & bail)
- Baggage: assistance with lost, stolen or delayed baggage while traveling with a common carrier
- Emergency payment and cash: assistance with advance of funds for medical expenses or travel emergencies by coordinating with your credit card company, bank, employer or other sources
- Emergency messages: assistance with recording and retrieving messages between you, family or others at any time
- Document replacement: coordination of credit card, airline ticket or other documentation
- Vehicle return: if evacuation or repatriation is needed, help to return vehicle to company
- And more!

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free: **1-800-856-9947**

Outside the U.S. call collect: **(312) 935-3658**

WORLDWIDE TRAVEL ASSISTANCE

Services available for business and personal travel.

For inquiries within the U.S. call toll free: **1-800-856-9947**

Outside the U.S. call collect: **(312) 935-3658**

Canyon Educational Participant Program

NEW FOR 2024!

Lake Wales Charter Schools is pleased to be a new participant in Grand Canyon University's Canyon Educational Participant (or CEP) program. This program provides members of our school community with a variety of benefits as listed. Check with Human Resources for additional details.

CANYON EDUCATIONAL PARTICIPANT

Canyon Educational Participant (CEP) is a Grand Canyon University program that is designed to benefit teachers, students, parents and leadership of charter and private schools through alliance scholarships, university program scholarships, professional development and more.

CEP OUT-OF-STATE STUDENTS RECEIVE:

SCHOLARSHIPS: Out-of-state high school students graduating from a CEP participant high school, who are fully admissible to GCU, will receive a minimum institutional award package of $2,250 per academic year. The total GCU award package could increase based upon a student's level of academic merit, program of study, registration date and other offers for incoming students, including those related to participation in athletics, pep band, theatre, debate and more.

VIRTUAL LIVE LESSONS: Access to complimentary lessons intended for 11th and 12th-grade high school students, led by a programmatic expert teaching GCU curriculum through a web-hosted presentation.

DUAL ENROLLMENT: CEP high school students have an opportunity to potentially reduce the time to complete a bachelor's degree by taking dual enrollment courses during high school. These courses are offered at $52.50 per credit hour.

TO LEARN MORE ABOUT OTHER SERVICES AND BENEFITS, EMAIL K12ED@GCU.EDU.

CEP STAFF AND SPOUSES RECEIVE:

SCHOLARSHIPS:

- A 15% off tuition scholarship is available to eligible CEP employees employed as paraprofessionals entering an online bachelor's program through the College of Education, a secondary education emphasis degree, a Bachelor of Science in Behavioral Health Science or a bachelor's degree program in applied management, applied human resources management, applied marketing and advertising, applied technology, applied business analytics, applied business information systems or applied entrepreneurship.[1]
- Eligible staff can receive a 10% off tuition scholarship providing savings toward tuition and fees for online undergraduate, graduate or doctoral degree programs along with non-degree single courses and continuing teacher education courses.[2]
- Eligible spouses can receive a 5% off tuition scholarship.[3]

PROFESSIONAL DEVELOPMENT: Get access to GCU's Canyon Professional Development services and applicable discounts, including expert-led professional development, coaching, mentoring, consultation and strategic planning. All fee-based services are specifically customized to meet the needs and goals of our CEP participants.

ADDITIONAL BENEFITS:

JOB BOARD: Access to GCU's online job board to post employment opportunities and search for applicants.

TEST PREPARATION WORKSHOP: Complimentary certification and licensure test preparation workshops for those pursuing careers where state and national testing are required. State-specific test prep options vary by location and availability.

Benefits and services may change and are frequently developed or updated to serve the needs of our participant schools and districts.

If you are interested in learning more about online degree programs, please contact:

- GCU's local University Development Counselor, Javis Mays, Javis.Mays@gcu.edu. The local University Development Manager is Carolina Burdier and can be contacted at Carolina.Burdier@gcu.edu.
- Please note that if you are a current GCU student, the scholarship will apply to all your future classes as long as you are continuously enrolled in the program. The 15% scholarship for paraprofessionals and classified staff is available to new students only.

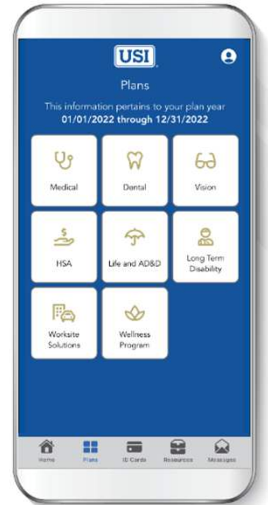
To learn more about GCU, please visit www.gcu.edu

Benefit Mobile App

The "MyBenefits2Go app gives you on-the-go access to all the Lake Wales Charter Schools benefit and insurance plan 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.



Check Out the App

Download the mobile app to your smartphone. Scroll through the intro pages and, when prompted, **enter the code that LWCS provides you with** to see your plan information.

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

Semi-Monthly Payroll Deductions (24pp)

	Medical	Dental Low	Dental High	Vision	Accident	Legal	ID Theft	Beyond Med
EE Only	$0	$0	$7.59	$3.90	$6.48	$10.98	$6.48	$5.00
EE + SP	$383.02	$17.46	$34.63	$7.06	$10.42	$10.98	$11.48	$10.00
EE + Child(ren)	$234.38	$17.82	$35.20	$7.32	$12.77	$10.98	$11.48	$10.00
EE + Family	$593.77	$30.24	$54.44	$11.29	$17.43	$10.98	$11.48	$10.00

Voluntary Life: approx. deductions are shown below, MyBenSite will calculate your paycheck deduction based on your age and election.

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

CHILD(REN) SEMI-MONTHLY PAYROLL DEDUCTION

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

*Check with HR for age 65+ rates

Critical Illness: Employee in 5k increments; Spouse in $5k increments up to 100% of employee election:

Critical Illness	Semi-Monthly (24) Payroll Deductions			
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**
Under Age 30	$1.03	$2.05	$3.08	$4.10
30-39	$1.73	$3.45	$5.18	$6.90
40-49	$3.45	$6.90	$10.35	$13.80
50-59	$6.40	$12.80	$19.20	$25.60
60-69	$12.58	$25.15	$37.73	$50.30
70-79	$22.90	$45.80	$68.70	$91.60

Short Term Disability: approx. 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.

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

CONTACT INFORMATION

Benefit	Carrier	Phone Number	Website
Medical	UMR Group 76-415456	800-826-9781	www.umr.com Network: United "Choice"
Pharmacy/RX	UMR/Optum Group 76-415456	800-826-9781	www.umr.com
TeleHealth	Teladoc	800-835-2362	www.teladoc.com
Dental (PPO)	Mutual of Omaha Group #G000BWCR	877-999-2330	www.mutualofomaha.com/dental
Vision	Mutual of Omaha Group #G000BWCR	833-279-4358	www.mutualofomaha.com/vision
Life & Voluntary Life	Mutual of Omaha Group #G000BWCR	800-775-8805	www.mutualofomaha.com
Short & Long Term Disability	Mutual of Omaha Group #G000BWCR	800-877-5176	www.mutualofomaha.com
Accident & Critical Illness	Mutual of Omaha Group #G000BWCR	888-600-1600	www.mutualofomaha.com
EAP	Mutual of Omaha	800-316-2796	www.mutualofomaha.com/eap
Travel Assistance	Mutual of Omaha	800-856-9947	Email: medservices@assistamerica.com
Legal & Identity Theft	LegalShield	630-479-7043	John Djonlich jdjonlich@legalshieldassociate.com
Discounted Health Services	Beyond Med	844-267-6192	www.beyondmedplans.com
Flexible Spending Accounts	Asure Software	888-862-6272	https://www.mywealthcareonline.com/emangrove/Resources/FSAResources.aspx
HR and Payroll		863-679-6560	
Enrollment Portal	MyBenSite		https://www.mybensite.com/lwcharterschools/
COBRA	Web Benefits	888-600-3440	https://cobra.mybensite.com/enrollee/login

Questions about Benefit Plans? Please contact:

Human Resources
863-679-6560

OR

USI Benefit Resource Center
855-874-0835 BRCsouth@usi.com

Required Annual Employee Disclosure Notices

Important Legal Notices Affecting Your Health Plan Coverage

The Women's Health Cancer Rights Act of 1998 (WHRCA)

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.

Newborns Act Disclosure – Federal

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).

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.

HIPAA Privacy Policy for Self-Funded Plans with Access to PHI

The group health plan is a partially self-funded 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). HIPAA privacy requirements are in place and a copy of the Privacy Policy is available from the Human Resource Department.

Required Annual Employee Disclosure Notices

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 $152 per day (up to a $1,527 cap per request), 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 which 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.

Contact Information

Questions regarding any of this information can be directed to:
Human Resources Dept
407-788-6700 ext 27003

Required Annual Employee Disclosure Notices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Your Information. Your Rights. Our Responsibilities (continued)

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
    - Marketing purposes
    - Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Your Information. Your Rights. Our Responsibilities (continued)

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of Notice: 1/1/2024

Location Disclosure

As a participant in any of the Sentry Management, Inc. health and welfare benefits, you can request any or all of the following documents at anytime. You can contact Human Resources and you will receive a copy of the documents as soon as possible. In addition, you can access these documents 24/7/365 These documents are updated periodically.

1. The Sentry Management, Inc. Wrap Plan and Section 125 Summary Plan Descriptions (SPDs). The SPDs are a summary of all of the material provisions of the health and welfare benefits offered by Sentry Management, Inc.
2. Certificate of Coverage. The explanation of benefits is usually a benefit booklet prepared by the insurance carrier which explains the details of how and which benefits are covered, and which are not.
3. Summary of Material Modifications. If any of the benefits offered by Sentry Management, Inc. are changed in a substantial way, Sentry Management, Inc. will amend the corresponding documents. Sentry Management, Inc. will communicate these changes in the open enrollment materials.
4. Annual and other required disclosures. All required disclosures are contained in our open enrollment materials. If you have any questions about these notices, please let us know.
5. Summary Annual Report (SAR). Sentry Management, Inc. files a Form 5500 for the health and welfare benefits and prepares a SAR. The SAR explains information about what Sentry Management, Inc's paid for benefits in the previous plan year.
6. Initial COBRA Notice. This notice explains your rights under COBRA should you have a qualifying event, including a termination of employment or a reduction in hours.
7. Summary of Benefits & Coverage. This is a document required under the Affordable Care Act. It is a four-page document prepared for each medical plan and enables you to compare each plan side by side.
8. Marketplace Notice. This notice gives you information about the health insurance marketplace.
9. Medicare Part D Notice. This notice informs you about the credibility of Sentry Management, Inc's prescription drug coverage so that you can elect Medicare in a timely manner to avoid potential penalties.
10. Wellness Program Information and Disclosures. This information will explain how Sentry Management, Inc's wellness program works, and what is required to be compliant and receive an incentive.

Required Annual Employee Disclosure Notices

Michelle’s Law Disclosure

Under the ACA, dependent children are covered by the group health plan until age 26. Sentry Management, Inc. group health plans extend 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 Human Resources.

Notice Regarding Wellness Programs

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

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Wellness Program Disclosure

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.

Required Annual Employee Disclosure Notices

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact CIGNA at 800-997-1654, visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

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, 2018. 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

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, 2023, or for more information on special enrollment rights, contact either:

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

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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as February 1, 2014.

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 9.5% 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 Crystal Lewis**.**

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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name		4. Employer Identification Number (EIN)
Lake Wales Charter Schools		59-1625937
5. Employer Address		**6. Employer phone number**
130 East Central Ave.		863-679-6560
7. City	**8. State**	**9. ZIP code**
Lake Wales	FL	33853
10. Who can we contact about employee health coverage at this job?		
Human Resources, LaQuanda Burroughs		
11. Phone number (if different from above)	**12. Email address**	
	laquanda.burroughs@lwcharterschools.com	

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

- As your employer, we offer a health plan to:
    - All employees. Eligible employees are:
        - *Full-time working at least 30 hours per week.*
    - With respect to dependents:
        - We do offer coverage. Eligible dependents are:
            - *Spouse,, unmarried children up to age 26*
- This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

Medicare D -- Annual Disclosure Notice

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 UMR/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. UMR/United Healthcare has determined that the prescription drug overage offered by t Sentry Management under the UMR/United Healthcare options 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 UMR/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 UMR/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 UMR/United Healthcare coverage, be aware that you and your dependents will be able to get this coverage back.

When will you pay a higher premium (penalty) to join a Medicare drug Plan?

You should also know that if you drop or lose your current coverage with UMR/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 UMR/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: July 1, 2024
Name of Entity/Sender: **Lake Wales Charter Schools**
Contact--Position/Office: Human Resources
Address: 130 East Central Ave.
Lake Wales, FL 33853
Phone Number: **863-679-6560**