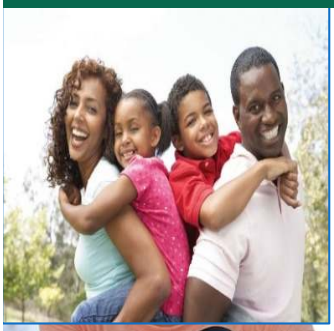


LAKE WALES CHARTER SCHOOLS

Benefits Guide

Plan Year Effective 7/1/23-6/30/24

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

https://www.brainshark.com/usi/vu?pi=zJmzsVliezYbgnz0

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 5.17.23

Table of Contents

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

We are happy to provide you with this Benefit Guide which summarizes your employee benefits for the 2023-2024 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.*

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.

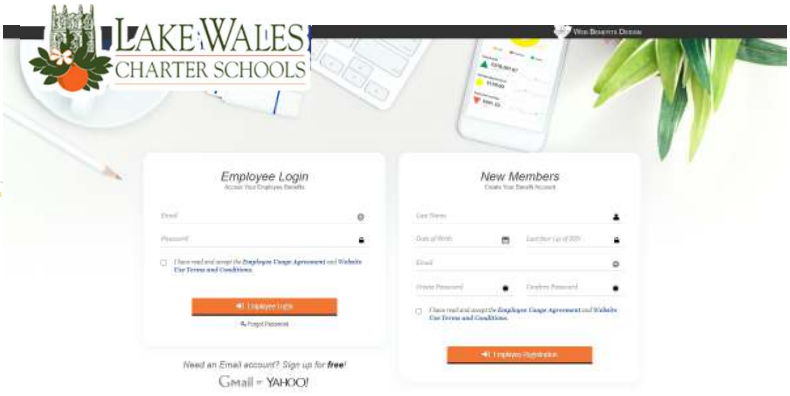
Good news! There will be no paper forms to complete. To begin your enrollment, follow these easy steps:

- ❑ 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 7/23 open enrollment: If you are not making any changes, your current enrollment/declines will ROLLOVER for 7/1/23.

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!

TELADOC.

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	

Please review the benefit summary/certificate for further details. MUTUAL of OMAHA

*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!

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!

MUTUAL of OMAHA

Basic Life and AD&D

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
Wavier of Premium (if disabled)	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions. Should this policy change to another carrier and you are disabled, you'll need to continue the policy directly with Mutual of Omaha for the life benefit to remain in place.
Living Care/Accelerated Benefit	75% of the amount of life insurance benefit is available to you if you are terminally ill, but not to exceed $10,000
Conversion	Yes

Mutual of Omaha

Voluntary Term Life Insurance

All full time eligible employees are offered the option to purchase term life insurance coverage through a group plan. 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.

	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)

*Guaranteed Issue

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. **Important: If you enroll under EOI, your paycheck contributions will not be collected until if/when you receive notification that the benefit election is approved. Premium deductions begin on approval date and**

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)

MUTUAL of OMAHA

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.

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.

important

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 unpredictable 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.

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. You may contribute up to **$3050 for the July 2023 – June 2024 plan year.**

How does the FSA work?

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

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 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.FSAStorecom

Employee Assistance Program (EAP)

Life's 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

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

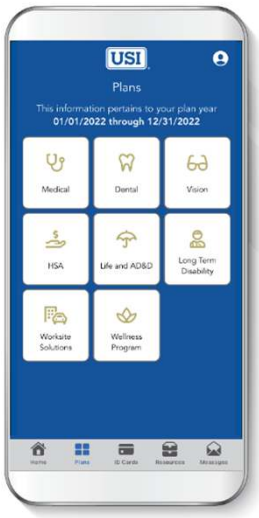
Services available for business and personal travel.

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

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

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 HI 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
EE Only	$0	$0	$7.59	$3.90	$6.48	$10.98	$6.48
EE + SP	$325.97	$17.46	$34.63	$7.06	$10.42	$10.98	$11.48
EE + Child(ren)	$199.29	$17.82	$35.20	$7.32	$12.77	$10.98	$11.48
EE + Family	$507.06	$30.24	$54.44	$11.29	$17.43	$10.98	$11.48

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	David Frack	863-808-2245	d_frack@yahoo.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/lwchartersschools/
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

The Newborns' and Mothers' Health Protection Act of 1996

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

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

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

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

Women's Health and Cancer Rights Act of 1998

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

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

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

Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

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

Enforce your Rights

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

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

Assistance with your Questions

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

Required Annual Employee Disclosure Notices - Continued

Medical Plans Offered effective 7/1/23 (Non-Grandfathered):

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

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

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

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

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

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

II. Insurer for group health plan will provide privacy notice

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

III. No intimidating or retaliatory acts

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

IV. No Waiver

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

Michelle's Law

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

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

Notice of Special Enrollment Rights

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

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

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

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

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

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

Required Annual Employee Disclosure Notices - Continued

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or **dial 1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://dhhs.nh.gov/ombp/nhhpp Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

Required Annual Employee Disclosure Notices - Continued

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

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

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

Medicare Part D Notice of Creditable Coverage

Medicare Part D

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with UMR 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 has determined that the prescription drug overage offered by the Welfare Plan for Employees of Lake Wales Charter Schools under the UMR option are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You should also know that if you drop or lose your coverage with UMR 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 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 coverage, be aware that you and your dependents will be able to re-enroll in our program during the next open enrollment period.

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

You should also know that if you drop or lose your current coverage with UMR 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 changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call **1-800-MEDICARE (1-800-633-4227).** TTY users should call **1-877-486-2048.**

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

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	7/1/203
Name of Entity/Sender:	**Lake Wales Charter Schools, Inc.**
Contact--Position/Office:	Human Resources
Address:	130 E. Central Avenue Lake Wales, Florida 33853
Phone Number:	**863-679-6560**