Your Life...
Take care of it.

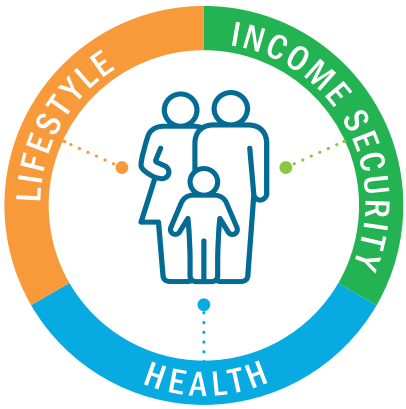
Open Enrollment is October 12 – November 7, 2022

2023 Benefit Enrollment Guide

Plan Year January 1, 2023 – December 31, 2023

SARASOTA County Schools

Open Enrollment is October 12 – November 7



Now is the time to focus on you.

Your physical, emotional, and financial health are important, especially during challenging times. The School Board of Sarasota County (SBSC) cares about you and your overall wellbeing. That's why we offer a comprehensive benefits package that can help provide you with the stability and security to be prepared for the unexpected.

Open Enrollment is the time to add or change benefits for the 2023 Plan Year. We understand how important it is to have resources to help make the best decisions for you and your family. Review your options presented in this benefits guide, compare plans, and choose what works best for you.

Attend a session with a Benefits Counselor to help make choices that reflect your changing benefits needs and goals.

How to Enroll New Hires and Open Enrollment

Open Enrollment: October 12 – November 7, 2022. Please follow instructions on how to access the Benefit Guide and enroll in benefits.

How to Access the 2023 Benefit Enrollment Guide

1. **STEP ONE**: Go to www.sarasotacountyschools.net/benefits
2. **STEP TWO:** First time users must first register to create your username and password. If you participated in Open Enrollment last year, you may have already registered. If you forgot your username and password, please use the click on "forgot username or password"
3. **STEP THREE:** **Login** with your username and password.

NOTE: This will be your only opportunity to enroll in FSA and make changes to your benefits for 2023 (unless a qualifying event occurs). We recommend that you review your dependent coverage and beneficiary designations.

If you and/or your dependent have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 25 for more detail.

Pathways to Health

Pathways to Health will take effect January 1, 2024. Employees who choose to participate will need to have a preventative well exam completed by June 30, 2023. Since it may take several months to get an appointment with your provider, employees are encouraged to schedule an appointment early. Employees will not be required to send in any paperwork or proof of the exam unless requested. To read more about the program and the implementation timeline **click on this link**.

New Hire Enrollments

New Hires are eligible to enroll in benefits the later of their board appointed date or start date. Benefits coverage will become effective the 1st of the month following enrollment. Payroll deductions begin two pay periods before the effective date of coverage. Please see Appendix A: Frequently Asked Questions on page 23.

Section 125 and Benefit Election Changes

Under Section 125 of the Internal Revenue Service (IRS) code, you are allowed to pay for certain group insurance premiums using pretax dollars. This means your premium deductions are taken before federal income and Social Security taxes are calculated. Depending on your tax bracket, your savings could be significant.

Please make your benefit elections carefully, especially if you choose to waive medical coverage, because your pretax elections will remain in effect until the next Plan Year, unless you experience a qualifying change in status. These include, but are not limited to:

- Marriage or divorce (legal separation is not considered a qualified event)
- Birth or adoption of a child
- Death of spouse or other dependent
- A spouse's employment begins or ends
- Dependent's eligibility status changes due to age, student status, marital status, or employment
- You or your spouse experience a change in work hours that affect benefit eligibility
- Gain or loss of other group coverage

You must make the changes within 30* days of your qualified status change. Any benefit changes must be consistent with the event. For example, if you get married, you may add your spouse to your current medical coverage, but you may not switch medical plans. All benefit changes must be approved by Risk Management.

**60 days if you, your spouse, or eligible dependent child loses coverage under Medicaid or a State Children's Health Insurance Program (S CHIP) or becomes eligible for state provided premium assistance.*

Medical Insurance

Healthcare needs are different for everyone. Our medical plan offers multiple options so you can choose the coverage level best suited to your needs and budget. SBSC offers four medical insurance plans — two Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs) through **Florida Blue**. Before choosing a plan, please review the medical plan comparison chart to see each plan's major provisions. Prescription coverage is provided through **Express Scripts** and is included in each medical plan. You will receive two cards: one from Florida Blue and one from Express Scripts. More information about prescription coverage is on page 7.

What's the Right Plan for You?

The Low Plans offer lower payroll deductions, but have higher out of pocket costs for deductibles, copays and/or coinsurance. The High Plans offer higher payroll deductions but have lower out-of-pocket costs. When evaluating the plans, you should consider how often you will use the plan, plus your payroll deductions.

BlueCare HMO Plans

Enrolling in an HMO entitles you to receive care from physicians, hospitals, and other high quality providers who participate in the plan's network. You will need to select an in-network Primary Care Physician (PCP) who will help you manage all aspects of your health care. You can find an in-network PCP at www.floridablue.com under "Find a Doctor." Like all HMOs, there is no coverage for services from out-of-network providers, except for qualified emergencies.

BlueCare PPO Plans

A PPO is a group of providers (hospitals, and other medical facilities) who agree to provide services at discounted rates. A significant difference between an HMO and a PPO is that a PPO allows you to use providers who are not in the network. When you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use an out-of-network provider, you are subject to a deductible and coinsurance, as well as any charges that are higher than what is considered reasonable and customary by Florida Blue. This means you may pay substantially more out-of-pocket. Accessing out-of-network services may also subject you to plan limitations that might be avoided when you receive care from in-network providers who will help you manage all aspects of your health care. You can find a PCP at www.floridablue.com under "Find a Doctor."

Reasonable and Customary Amounts

Reasonable and customary amounts are the fees insurance carriers consider appropriate for a medical expense based on the typical rates charged by other providers for comparable service within the provider's zip code. If you go to an out-of-network provider who charges more than the allowable amounts established by the insurance carrier, the provider may bill you for the remaining balance.

Medical Insurance Rates

Florida Blue – Low HMO (BlueCare Plan)			
	Monthly Plan Cost	Employee Cost Per Month	Employee Cost Per Pay (24)
Employee Only	$667.24	$0.00	$0.00
Employee + Spouse	$1,387.87	$667.40	$333.70
Employee + Child(ren)	$1,262.01	$541.54	$270.77
Family	$1,934.23	$1,213.76	$606.88

Florida Blue – High HMO (BlueCare Plan)			
	Monthly Plan Cost	Employee Cost Per Month	Employee Cost Per Pay (24)
Employee Only	$720.47	$0.00	$0.00
Employee + Spouse	$1,498.46	$777.99	$389.00
Employee + Child(ren)	$1,362.68	$642.21	$321.11
Employee + Family	$2,088.43	$1,367.96	$683.98

Florida Blue – Low PPO (BlueOptions Plan)			
	Monthly Plan Cost	Employee Cost Per Month	Employee Cost Per Pay (24)
Employee Only	$501.45	$0.00	$0.00
Employee + Spouse	$1,042.17	$321.70	$160.85
Employee + Child(ren)	$947.46	$226.99	$113.50
Employee + Family	$1,452.54	$732.07	$366.04

Florida Blue – High PPO (BlueOptions Plan)			
	Monthly Plan Cost	Employee Cost Per Month	Employee Cost Per Pay (24)
Employee Only	$894.99	$0.00	$0.00
Employee + Spouse	$1,860.15	$965.16	$482.58
Employee + Child(ren)	$1,691.07	$796.08	$398.04
Employee + Family	$2,592.60	$1,697.61	$848.81

Definitions

Copayment and Coinsurance

A copayment (copay) is the fixed dollar amount you pay for certain in-network services. In some cases, you may be responsible for coinsurance after a copay is made.

Coinsurance is the percentage of covered expenses shared by the employee and the plan. In some cases, coinsurance is paid after the insured meets a deductible. For example, if the plan pays 90% of an in-network covered charge, you pay 10%.

Annual Deductible

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. Some services, such as office visits, require copays and do not apply to the deductible. This is an annual calendar year deductible.

After you meet your deductible, the plan pays for a percentage of eligible expenses (coinsurance) until you meet your out-of- pocket maximum. If you receive services from an out-of-network provider, the plan pays a lower percentage of coinsurance. Refer to your health care plan summaries for more information.

Out-of-Pocket Maximum

Some plans feature an out-of-pocket maximum, which limits the amount of coinsurance you will pay for eligible health care expenses. Once you reach that maximum, the plan begins to pay 100% of eligible expenses. There may be separate in and out-of-network annual out-of- pocket maximums. Copays, deductible and coinsurance accumulate towards your out of pocket maximum.

2023 Medical Plan Summary

Benefits	Low HMO BlueCare HMO	High HMO BlueCare HMO	Low PPO BlueOptions PPO		High PPO BlueOptions PPO	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible *(Single/Family)*	$500 / $1,500	$250 / $750	$1,500 / $4,500		$500 / $1,500	
Coinsurance	0%	0%	20%	40%	10%	30%
Annual Out-of-Pocket Maximum[1] *(Single/Family)*	$2,000 / $4,000	$1,500 / $3,000	$3,500 / $10,500		$2,000 / $6,000	
Physician Services *PCP Office Visits*	$25 copay	$20 copay	20% after deductible	40% after deductible	$25 copay	30% after deductible
Specialist Office Visits	$50 copay	$40 copay	20% after deductible	40% after deductible	$50 copay	30% after deductible
Teladoc	$20 copay	$15 copay	$25 copay	N/A	$20 copay	N/A
Teladoc Mental Health	$0 copay	$0 copay	$0 copay	N/A	$0 copay	N/A
Preventive Care *Adult Wellness, Routine ObGyn*	Covered 100%	Covered 100%	Covered 100%	40%, waived deductible	Covered 100%	30%, deductible waived
Mammograms	Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%	$300 copay; 30% after deductible
Well Child Care	Covered 100%	Covered 100%	Covered 100%	40%, waived deductible	Covered 100%	30%, deductible waived
Facility Services (including Maternity) *Inpatient*	$200/day (days 1-5); after deductible, Max. $1,000 per admission	$200 per admission after deductible	$150 copay; 20% after deductible	$300 copay; 40% after deductible	10% after deductible	$300 copay; 30% after deductible
Outpatient Surgery	$200 copay after deductible	$100 copay after deductible	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Ambulatory Surgery Center	$0 after deductible	$100 copay	20% after deductible	40% after deductible	$100 copay	30% after deductible
Emergency Room[2]	$150 copay after deductible	$150 copay after deductible	$50 copay; 20% after deductible	$50 copay; 20% after deductible	$150 copay after deductible	$150 copay after deductible
Urgent Care	$50 copay after deductible	$40 copay after deductible	20% after deductible	20% after deductible	$25	$25 copay after deductible
Diagnostic Services *Independent Clinical Lab*	Covered 100%	Covered 100%	20%, deductible waived	40% after deductible	Covered at 100%	30% after deductible
Advanced Imaging[3]	0% after deductible	0% after deductible	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Durable Medical Equipment	0% after deductible	0% after deductible	20% after deductible	40% after deductible	10% after deductible	30% after deductible
Home Health Care	0% after deductible unlimited	0% after deductible unlimited	20% after deductible, 20 visit max	40% after deductible, 20 visit max	10% after deductible, 20 visit max	30% after deductible 20 visit max
Mental/Nervous and Substance Abuse *Inpatient Services*	Covered 100%	Covered 100%	Covered 100%	40%, deductible waived	Covered 100%	30% deductible waived
Outpatient Services	Covered 100%	Covered 100%	Covered 100%	40%, deductible waived	Covered 100%	30% deductible waived
Outpatient Therapy *Physical, Occupational, Speech, Chiropractic*	$50 copay	$40 copay	20% after deductible	10% after deductible	10% after deductible	30% after deductible
Therapy Limits	Varies by service, see certificate	Varies by services, see certificate	Varies by services, see certificate		Varies by services, see certificate	

[1] *Out-of-Pocket Maximum includes deductible, copayments, and prescription drug costs.*
[2] *Copay waived if admitted.*
[3] *Services performed in an Independent Diagnostic Testing Facility. Tests performed in hospitals may have higher cost share.*

Prescription Coverage

Pharmacy Vendor Express Scripts, Inc.

To review participating pharmacies, the drug formulary list and drug exclusions, please visit www.express-scripts.com/NTLPLSNTLPRFF for the **Express Scripts** Formulary/Exclusion List and Pharmacy. Use Express Scripts, your plan's mail order pharmacy, for up to a 90-day supply of medication for 2x your retail copay. If you take a daily maintenance medication to treat a chronic condition such as arthritis, asthma, high cholesterol, blood pressure, heart conditions or contraceptives — it's a great way to save time and money. Refills are easy by phone and online. Free shipping for standard delivery direct to your home or work. Please call Express Scripts for questions or speak with a pharmacist at **1-855-502-8558**, available 24/7.

	Low HMO BlueCare HMO	High HMO BlueCare HMO	Low PPO BlueOptions PPO		High PPO BlueOptions PPO	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail – 30-day supply						
Generic[1] Preferred Brand Non-preferred Brand	$20 $40 $60	$20 $40 $60	$20 $40 $60	50% 50% 50%	$20 $40 $60	50% 50% 50%
Mail Order – 90-day supply						
Generic[1] Preferred Brand Non-preferred Brand	2x retail copay	2x retail copay	2x retail copay	50%	2x retail copay	50%

[1] *To preview participating pharmacies and drug formulary list/exclusions, visit* www.express-scripts.com/NTLPLSNTLPRFF.

If enrolled in the SaveonSP program you will have a $0 copay/out-of-pocket for certain Specialty prescriptions covered under the program. If not enrolled you will be responsible for the copay listed on the SaveonSP Drug List* **www.saveonsp.com. *For more information call SaveonSP at 1-800-683-1074.*

Controlling Health Care Costs

The rising cost of health insurance is a concern for all of us. Keeping costs to a minimum contributes to lower premiu

Use network providers.
You will receive a higher level of benefits if you use providers who participate in the network.

Request generic rather than brand name prescription drugs.
Generic medications, while just as effective, are considerably less expensive.

Consider seeing your family physician rather than a specialist.
Family physicians can often provide the same level of care for a variety of illnesses and conditions.

Exercise and maintain a proper diet.
The healthier you are, the less vulnerable you are to disease, reducing doctor's visits and prescription medicines.

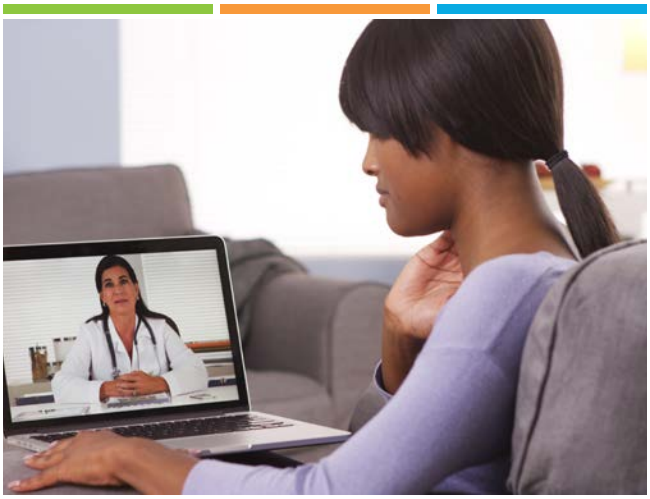
If we become more aware consumers, we can each do our part to lower the cost of health care!

No matter which medical plan you choose, you have convenient access to telemedicine!

Teladoc®

Quality care at your convenience 24/7. Speak to a licensed doctor by web, phone, or mobile app in under 10 minutes! Schedule a doctor visit, manage your medical history, or send a prescription to your nearest pharmacy.

Doctors will diagnose, treat, and prescribe medication for a wide range of conditions such as cold and flu, sinusitis, upper respiratory infections, mental health, and more!



Set Up Your Account

- **Online:** Teladoc.com and click "Set up account."
- **Mobile App:** Download the app and click "Activate account." Visit Teladoc.com/mobile to download the app.
- **Call Teladoc:** Teladoc can help you register your account by calling **1-855-835-2362**.

How Teladoc Works

STEP ONE: CONTACT TELADOC 24/7/365

Access to Teladoc's nationwide network of board-certified physicians is available via phone, video or mobile app.

STEP TWO: SPEAK WITH A PHYSICIAN

A physician will review the patient's medical history and contact them within minutes. Copay is lower than your Primary Care Physician office visit copay.

STEP THREE: RESOLVE THE ISSUE

A physician will diagnose and prescribe medication, if medically necessary, electronically to the pharmacy of choice.

TELADOC PHYSICIANS ARE:

- U.S. board-certified in internal medicine, family practice, emergency medicine, behavioral health or pediatrics
- State licensed
- U.S. residents who average 20 years of experience.

Healthcare Bluebook.

With Healthcare Bluebook, you'll save hundreds to thousands of dollars on medical procedures by choosing Fair Price™ (green) facilities for your care. Plus, you'll get paid to save! Every time you shop for eligible procedures in Healthcare Bluebook and use a Fair Price™ (green) facility for your care, you'll earn a reward.* It's easy!

1 EASY SETUP

On your PC, laptop and tablet:
Log in to Healthcare Bluebook and bookmark the search page for quick access.

On your mobile phone:
Download the app.
Download the app and log in so you'll have Bluebook with you anytime you need to schedule a procedure.

App Store | Google play

2 USE HEALTHCARE BLUEBOOK TO SHOP FOR CARE

Use the Healthcare Bluebook website, mobile app, or phone support to shop for a **Fair Price™** (green) facility for your procedure. Then schedule your appointment.

Always check network status before scheduling.
Always check the Florida Blue network for network status. There may be providers in HCBB that are not in the Florida Blue network.

3 GO GREEN TO GET GREEN

1. Shop for your procedure using **Healthcare Bluebook**
2. Use a **Fair Price™** (green) facility of your choice
3. Earn up to a $1500 reward on eligible procedures

No forms or extra steps required. It's automatic!

Dependents also eligible for rewards. Please allow 60-90 days for processing.

Up to a $1500 Reward per procedure

Visit healthcarebluebook.com/cc/SarasotaSchools
or call **1-800-875-9717**
Mobile Code: **SCS**

Top Rewardable Procedures

Full list at https://www.healthcarebluebook.com/cc/SarasotaSchools/rewards

Cataract Surgery - $150	Laparoscopic Cholecystectomy - $500
Colonoscopy - $150	Lithotripsy - $350
CT Scans - $100	MRIs - $100
Doppler Exam of the Heart - $75	Remove Tonsils & Adenoids - $350
Ear Tubes - $350	Shoulder Arthoscopy - $350
Heart Echo Imaging - $75	Sleep Study - $125
Heart Perfusion Imaging - $150	Upper GI Endoscopy - $150
Knee Arthroscopy - $350	

Always check Fair Price and Reward status in Healthcare Bluebook and confirm in-network status with your provider.

Flexible Spending Accounts (FSAs)

Reduce your tax bill while putting aside money for health and dependent care needs.

Flexible Spending Accounts (FSAs), through **WEX**, allow you to put aside money for important expenses and help you reduce your income taxes at the same time. SBSC offers two types of accounts – a Health Care FSA and a Dependent Care FSA. Please call **WEX** Benefits at **1-833-CALL-WEX (225-5939)** or visit **https://www.wexinc.com/login/benefits-login/** for more information.

You must actively re-enroll in the FSAs each year. You are not automatically enrolled.

HEALTH CARE FSA

Deductibles, copays, prescription drugs, medical equipment, etc.*

DEPENDENT CARE FSA

Babysitters, daycare, day camp, home nursing care, etc.

How Flexible Spending Accounts Work

1. Each year during Open Enrollment, you decide how much to set aside for FSA expenses. Your full contribution amount will be available for use on your benefit effective date.
2. Your contributions are then deducted from your paycheck on a pre-tax basis in equal installments throughout the calendar year for use on qualified expenses.
3. The WEX debit card is the fastest and most convenient way to pay for eligible expenses. The debit card makes it easy to access funds in your pre-tax benefits accounts, reducing your out-of-pocket costs. At many merchants, it also simplifies the way expenses are verified for eligibility, possibly removing the need to submit paperwork for substantiation. If you use your debit card for a 2023 claim, the funds will pull out of the current Plan Year.

USE IT OR LOSE IT RULE

Based on IRS rules, the plan requires you to use all of the money in your account(s) by the end of the Plan Year, December 31, 2023 and submit claims for reimbursement by March 31, 2024 or you will lose the remaining balance.

Annual Maximum Contribution	
Health Care Flexible Spending Accounts	$3,050
Dependent Care Flexible Spending Account	$5,000 ($2,500 if married and filing separate tax returns)

Please note that these accounts are separate. You cannot use money from the Health Care FSA to cover expenses eligible under the Dependent Care FSA or vice versa.

Deadline for Submitting Claims

You have until March 31, 2024 to submit claims for expenses incurred in 2023. After March 31, 2024 any money remaining in your FSA(s) will be forfeited. If you terminate employment during the Plan Year, you may submit claims up to 90-days after your termination for expenses incurred during the portion of the Plan Year preceding your termination date.

Dental Plan

Dental coverage is provided through **Delta Dental Insurance Company**. You can visit any dentist you choose, but you may pay less out of pocket when you visit a Delta Dental PPO or Premier dentist. To find a provider, call **1-800-521-2651** or visit www.deltadentalins.com.

Dental Care Cost Estimator

The Dental Care Cost Estimator provides estimated cost ranges for common dental care needs. Log into your account at www.deltadentalins.com to get a personalized estimate of how much you'll pay for you next dentist visit.

Save with PPO

Visit a dentist in the PPO network to maximize your savings. These dentists have agreed to reduced fees, which leaves more money in your pocket. Find a PPO dentist at www.deltadentalins.com.
Under a table of allowance plan, each procedure has an "allowance," or set amount that Delta Dental will pay (if no deductibles or maximums apply). If your dentist charges over the allowance, you will be responsible for the remaining amount.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at www.deltadentalins.com. This useful service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more. Delta also has a mobile app that you can download to a mobile device.

Dental Plan Rates

	Per Pay Period
Employee Only	$0.00
Employee + One	$11.93
Employee + Two or more	$27.27

What Does Preventive Dental Care Typically Cover?

Preventive care can save you money later on procedures that are more urgent, complex, and costly.

Routine dental checkups and cleanings should be scheduled every six months. Your dentist may recommend more frequent or fewer visits, depending on your dental health history.

Professional fluoride treatments can be a key defense against cavities. Professional fluoride treatments have significantly more fluoride than tap water or toothpaste, and take only minutes to apply.

Dental sealants go a step beyond fluoride by providing a thin, coating to the surface of your teeth. Most dental plans cover sealants as preventive care for children under 18 on their first and second molars.

X-ray images of your mouth may be taken to better evaluate your oral health. These images provide a more detailed look inside your teeth and gums.

Vision Plan

SBSC offers vision coverage through the **Humana Insight Network**. The vision plan offers you flexibility to see any provider. When you choose an in-network provider, you receive services at a predetermined fee. If you select an out-of-network provider, you will pay the eye care provider, and then file the claim for reimbursement based on the plan's reimbursement schedule. Benefits include eye exams, affordable options for prescription glasses or contacts, and discounts for laser vision correction.

Benefits include periodic eye exams, plus lenses and frames or contacts. Plan features include:

- Care and testing benefits for diabetics
- Retinal Imaging coverage with a member copay
- $10 exams every 12 months
- $15 materials charge for frames and/or single vision lenses
- Lenses or contact lenses every 12 months
- Frames every 24 months
- $120 contact lenses allowance is available in place of the exam and eyeglasses

Once you enroll, you will receive an ID card to present to your network Humana provider. To find a network provider, call **1-877-398-2980** or visit **www.myhumana.com**.

Vision Plan Rates

	Per Pay Period
Employee Only	$0.00
Employee + Family	$5.00

Humana's Network Extends Online

Humana is changing the way benefits work — because online purchases of prescription glasses is projected to increase by 15% over the next 10 years. And now that **Glasses.com** and **Contactsdirect.com** are in Humana's network, you can go online to buy glasses anytime, from anywhere. And the best part is that you can use their in-network benefits.

Glasses.com

- Snap and send a picture of the prescription – or have **Glasses.com** call the provider for it.
- Lenses available for most prescriptions (including progressives and multifocals).
- Orders fulfilled and shipped the following day – and it's free!
- All supported by the award winning photorealistic and geometrically accurate 3D virtual "try-on" app for iPad and iPhone.

Contactsdirect.com

- Visit **contactsdirect.com**.
- Select your lenses from a wide selection of top selling brands.
- In-network vision benefits instantly apply to your purchase price.
- Contact lenses will ship as soon as the prescription is verified – most even ship the same day!

Disability Insurance

Your ability to bring home a paycheck is one of your most valuable assets. We help you protect it.

If an injury or illness kept you out of work and prevented you from earning a paycheck, how would you cover your bills and other household expenses? Disability Insurance provides income protection, paying benefits you can use to offset out-of-pocket expenses and make up for lost wages.

Did You Know?

It's estimated that 1 in 4 20-year-olds will experience a disability for 90 days or more before they reach age 67.

Social Security Administration, Disability Insurance, Facts 2021

Long-Term Disability Insurance

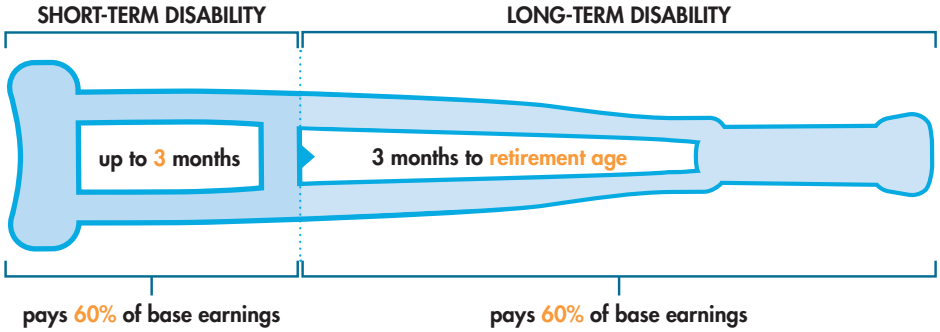
SBSC provides all employees, at no charge, Long-Term Disability insurance through **The Standard**. Long-Term Disability insurance benefits are provided after 90 days of a qualified disability. The plan pays 60% of your basic monthly earnings up to a monthly maximum of $10,000. The maximum benefit period is the latter of your normal retirement age or a sliding scale, based upon the age at which your disability began. That means you will have a steady income stream to help pay your bills during your disability.

Visit the MyBenefits website standard.com to register and for more information. For questions or to obtain a claim application call **1-800-368-1135**.

Voluntary Short-Term Disability Insurance

Short-Term Disability Insurance, through **Aflac**, replaces a portion of your income if an injury or illness forces you out of work for an extended period of time. Employees may elect coverage up to 60% of their salary up to a maximum of $5,000 per month during Open Enrollment on a Guaranteed Issue basis. This covers disability due to off-the-job covered injuries on the first day following an injury or seven days following a covered illness. Partial disability benefits allow a transition period before returning to full-time employment. Maximum benefits duration is three months. For additional information, please call **1-800-433-3036** or visit www.aflacgroupinsurance.com.

Within the first nine months of the effective date of coverage Aflac will not pay benefits for a disability that is caused by, or occurs as a result of, pregnancy or childbirth. Disability due to complications of pregnancy will be covered to the same extent as a covered sickness.



Life Insurance

Always be there financially for your loved ones.

Your family depends on your income for a comfortable lifestyle and for the resources necessary to make their dreams a reality. Life Insurance ensures your family's future is financially secure if you're no longer there to provide for them. SBSC provides Basic Term Life Insurance, through **The Standard** and offers additional options to give you the ability to assemble a complete Life Insurance portfolio. For more information, please call **1-800-858-5420**.

Basic Term Life Insurance

SBSC provides Basic Term Life coverage at no cost to you and enrollment is automatic.

Basic Term Life	The benefit is $50,000. The benefit will be reduced by 50% on the policy anniversary date (January 1) following the date you attain age 70.

Voluntary Term Life Insurance

You may also purchase voluntary term life as a supplement to the basic term life benefit through **The Standard**. You pay 100% of the cost for voluntary term life insurance and deductions are withheld on an after-tax basis. Coverage is available for yourself and your eligible dependents.

Employee	Increments of $10,000 up to $300,000; new hires are eligible for a guaranteed issue amount of $300,000.
Spouse	Increments of $5,000 up to $150,000, not to exceed 50% of the employee's voluntary coverage amount; newhires are eligible for a guaranteed issue amount of $50,000.
Child(ren)	Increments of $5,000 or $10,000 covers all of your dependent children up to age 26 who are unmarried and fully dependent upon you for support; coverage is guaranteed issue for all employees. $5,000 of coverage costs $0.30 per pay and $10,000 of coverage costs $0.60 per pay.

An individual may not be covered as an employee and a dependent. If your spouse or child is a benefit-eligible employee of School Board of Sarasota County, do not elect dependent life insurance for them, as benefits would not be payable. You must be actively at work on the effective date of coverage.

Open Enrollment Opportunity 2023

Employee	During Open Enrollment, you may increase your employee term life insurance on a guaranteed issue basis by one $10,000 increment. More than $10,000 increment increase will require a Evidence of Insurability (EOI).
Spouse	Employees can increase their spouse's coverage on one $5,000 increment provided the resulting amount of insurance does not exceed the guarantee issue maximum of the lesser of $50,000 or 50% of the employee's voluntary life amount. Elections in excess of the guarantee issue amount will require EOI.

How Much Life Insurance Do You Need?

Many financial experts recommend you have at least five to eight times your household income in Life Insurance. To calculate the level sufficient to cover your needs, you should consider your current income and how much it costs to maintain your family's standard of living. You should also consider your current expenses and your family's future financial needs such as the following:

Current Expenses
- Home Mortgage/Rent
- Car Payments
- Credit Card Debt
- Other Debt

Future Needs
- Child Care
- College Tuition
- Spouse's Retirement
- Routine Household Expenses

After you add your financial responsibilities, how does the sum compare with your current coverage? To estimate your insurance needs use our online calculator at **standard.com/life/needs**.
Please call **1-800-858-5420** or visit **standard.com** for additional information.

Whole Life Insurance

Whole Life Insurance, through **Allstate Benefits**, completes your family's protection, providing a cost-effective benefit for final expenses such as funeral costs, credit card debt, and medical bills. As long as premiums are paid, this policy will not expire, and premiums will not change due to your age. It also includes optional riders which provide accelerated death benefits for terminal conditions and "living benefits" (care for chronic conditions). For additional information, please call **1-800-521-3535** or visit www.allstate.com.

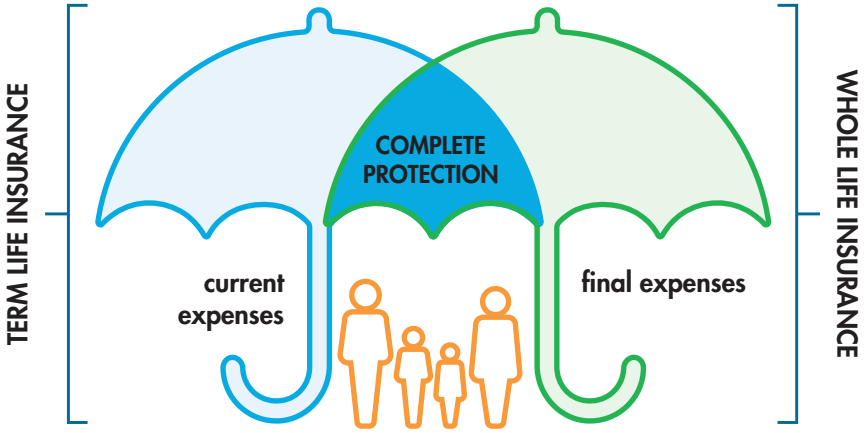
The premium cost for this benefit is determined by your age and the amount of coverage you elect. Locking in a lower premium now will help you save money in the future.

Employee	Guaranteed Issue* amounts of $10,000, $20,000, $30,000, $50,000, $100,000, or $150,000 without having to answer health questions if you enroll when you are first eligible. OE increments allowed.
Spouse	Guaranteed Issue* amounts of $10,000, $20,000, $30,000 without having to answer health questions if you enroll when you are first eligible. **NOTE**: Employee must enroll for spouse to enroll.
Child(ren)	Guaranteed Issue amounts of $10,000 without having to answer health questions, if you enroll when you are first eligible. **NOTE**: Employee must enroll for child(ren) to enroll.

*** Exclusions and limitations still apply**

Plan Features

- **Guaranteed Issue:** No physical exams are required to apply for coverage (although health questions may be asked if you decline insurance the first time it is offered to you.
- **Family Coverage:** Purchase coverage for yourself, your spouse, your children.
- **Portable Coverage:** Take your policy with you if you leave the company or retire.
- **Coverage for Your Needs:** You can purchase the precise amount of coverage that is right for your needs.
- **Policy Builds Cash Value:** As the policy builds cash value, you can eventually use it to make premium payments or to pay urgent expenses while you are still alive.



Group Whole Life Insurance benefits are provided under form GWLP or state variations thereof, underwritten by American Heritage Life Insurance Company. The coverage has exclusions and limitations. Allstate Benefits is the marketing name for American Heritage Life Insurance Company (Home Office, Jacksonville, FL), a subsidiary of The Allstate Corporation.

Why We Offer Additional Supplemental Medical Benefits

Did You Know?

Americans spend an average of $5,000 a year on out-of-pocket health care costs.

Bureau of Labor Statistics Consumer Expenditures Survey 2020

Medical insurance does not prevent all of the financial strain of a major illness or injury. Many families don't have enough in their savings to cover the deductible and coinsurance of a major medical event. Supplemental medical benefits can help cover this out-of-pocket financial exposure for a reasonable cost.

The benefits are paid directly to you, allowing you to use the funds however you choose. You receive the full benefit even if you have other insurance. SBSC offers Critical Illness and Accident Insurance.

Critical Illness Insurance

You can protect yourself from the unexpected costs of a serious illness.

Even the most generous medical plan does not cover all of the expenses of a serious medical condition like a heart attack or cancer. Critical Illness Insurance, through **Aflac Group**, pays a full lump sum benefit directly to you, (unless otherwise assigned) if you are diagnosed with a covered illness that meets the plan criteria. The benefit is paid in addition to any other insurance coverage you may have. For additional information, please call **1-800-433-3036** or visit www.aflacgroupinsurance.com.

Covered Illnesses include:

- Multiple Sclerosis
- Benign Brain Tumor
- Parkinson's Disease
- Alzheimer's Disease
- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant
- End Stage Renal (Kidney) Failure
- Coronary Artery Bypass Surgery*
- COVID-19*

Health Screening Benefit

The plan provides a $50 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam, total cholesterol blood test, mammogram, lipid panel and more.

Plan Features

- **Guaranteed Acceptance:** There are no health questions or physical exams required.
- **Family Coverage:** You can elect to cover your spouse and children.
- **Portable Coverage:** You can take your policy with you if you change jobs or retire.

How Critical Illness Insurance Works

When Marco had a heart attack, he was grateful his doctors were able to stabilize his condition. He learned there was some permanent damage to his heart. He began to see his costs adding up quickly. The good news is Marco received a lump sum payment of $10,000 to help cover these expenses from the Critical Illness coverage he elected during Open Enrollment.

**This is a brief product overview only. The plan(s) has limitations and exclusions that may affect benefits payable. Coverage and benefits may vary by state. Refer to the plan(s) for complete details, limitations, and exclusions.*

*** The coverage pays 25% of the face amount of the policy once per lifetime for coronary bypass surgery and COVID-19.*

Group Accident and Critical Illness Insurance is underwritten by Continental American Insurance Company (CAIC), a proud member of the Aflac family. CAIC is not licensed to solicit business in New York, Guam, Puerto Rico, or the Virgin Islands. For groups sitused in California, group coverage is underwritten by Continental American Life Insurance Company. For groups sitused in New York, coverage is underwritten by Aflac of New York. AGC2201242 EXP 9/23

Accident Insurance

Major injuries are painful. But the financial impact of the medical treatment doesn't have to be.

Accident Insurance, through **Aflac Group**, pays benefits directly to you if you suffer a covered injury such as a fracture, burn, ligament damage, or concussion. Benefits are paid even if you have other coverage. For additional information, please call **1-800-433-3036** or visit www.aflacgroupinsurance.com.

The benefit amount is calculated based on the type of injury, its severity, and what medical services are required in treatment and recovery. The plan covers a wide variety of injuries and accident-related expenses, including:

- Injury Treatment (fractures, dislocations, concussions, burns, lacerations, etc.)
- Hospitalization
- Physical Therapy
- Emergency Room Treatment
- Transportation

Plan Features

Guaranteed Acceptance: There are no health questions or physical exams required.

Family Coverage: You can elect to cover your spouse and children.

Full Coverage: Benefits are paid for accidents that happen on and off the job.

Portable Coverage: You can take your policy with you if you change jobs or retire.

Sickness Rider: You and your family are eligible for Hospital Admission/ Confinement/Intensive Care benefits.

Health Screening Benefit

The plan provides a $50 benefit per covered person per calendar year if you or your covered dependents complete a covered health screening test such as a physical exam, total cholesterol blood test, mammogram, lipid panel and more.

How Accident Insurance Works

Sam trips playing basketball. He breaks his arm and chips a tooth which require a trip to the emergency room, physician follow-up visits, and physical therapy.

Fortunately, Sam has Accident Insurance which helps cover his medical plan coverage costs including his deductible and coinsurance.

How Sam's Accident Benefit Was Calculated:

MEDICAL SERVICE	SAMPLE BENEFIT
Emergency Room	$ 300
Fracture Benefit	$ 500
Broken Tooth Benefit	$ 400
Physician Follow-Up Visits (2)	$ 200 ($100 per visit)
Physical Therapy Visits (6)	$ 540 ($90 per visit)
Total Sample Benefit	**$1,940**

This scenario does not reflect the benefits of a specific Accident Insurance plan schedule. The benefits are generic benefits for the purposes of this example to show how the benefit total of an Accident Insurance plan is calculated. The plan offered to you may provide different benefit amounts and may not cover all services. See the plan details for the benefit schedule for the plan offered to you.

Lifestyle Benefits

ID Theft Protection

Digital thieves constantly discover new ways to extract your personal information, open credit accounts in your name, sell your sensitive data on the dark web, and take over your financial accounts. We offer comprehensive Identity Theft Protection from **Lifelock** that monitors multiple gateways into your identity and credit and alerts you of fraudulent activity.

Protection Services Include:

- Credit Reports and Monitoring
- Court Records Monitoring
- Bank Account Takeover Monitoring
- Criminal Bookings Monitoring
- Credit Application Monitoring
- Sex Offender Monitoring
- Real Time Authorization Notifications
- Change of Address Monitoring
- Child Social Security Number Monitoring
- Full Service Identity Restoration Services
- Social Security Number Trace
- Device Security

Did You Know?

A child's Social Security number gives ID thieves a fraudulent "clean slate."

Monitor you child's credit report as often as your own.

For more information, visit https://www.lifelockbusinesssolutions.com/EmployeeBenefits/BenefitPremier or call **1-800-607-9174**.

How Big of an Issue is Identity Theft?

13 MILLION	**Consumers who were victims of identity fraud in 2019**
$16.9 BILLION	**Total of the victims' financial losses**
39%	**Percentage of families that knew the person who committed identity fraud against them**
73%	**Percentage of victims where fraudulent accounts were opened at financial institutions where they already had accounts**

Identity Fraud Study, Javelin Strategy & Research, 2020

Wellness Benefits

The Employee Wellness mission is to decrease the health risks of employees while empowering them to be active, involved, conscientious health care consumers. The Employee Wellness program encourages employees to take responsibility for enhancing their own well-being, decreasing their risks for acute and chronic illness and premature death, knowing when to seek appropriate care for medical problems, and acquiring knowledge tools for achieving high level wellness.

The Employee Wellness Program provides a balanced and proactive program to employees to improve their individual health through a variety of District and site-based programs throughout the year. The program address topics such as weight management, fitness, and preventative screenings.

Prevention Pays Incentive Program

Active, board-appointed employees may participate in the Prevention Pays incentive program and may be eligible for up to a $100 incentive for completing a preventative wellness exam and other wellness activities. The Prevention Pays incentive form is located on the Employee SharePoint site or by visiting the Employee Wellness website at https://www.sarasotacountyschools.net/Page/1381.

Employee Wellness Screenings and Programs

- **Free biometric screenings**
- **Free health related seminars and workshops**
- **Free fitness classes**
- **Free flu shots**
- **Free dermatology exams**
- **Free mammograms**
- **Free smoking cessation classes**

Employee Wellness also connects employees to programs within the community so they can be active and have a variety of options. As a Florida Blue member, employees have access to a network of gyms through the "Fitness Your Way by Tivity Health" program.

Get fit and stay healthy by participating in other wellness programs, such as weight-loss challenges, step challenges, and fitness classes provided throughout the year in varying locations. Attend one of the Employee Health Fairs to learn more from benefits providers, participate in health and wellness seminars, attend free screenings, and get information from community partners who specialize in Wellness. The health fairs are held annually on District professional days in fall and spring. The fall 2022 health fair will include health screenings and in-person benefit enrollment.

Florida Blue members have access to free personalized health coaching sessions with a registered nurse to assist with making healthy lifestyle choices. Contact Next Steps by calling **1-800-477-3736 x54837** or emailing at **nextsteps@floridablue.com**.

For more information on Employee Wellness and to view available programs, visit the Employee Wellness website at https://www.sarasotacountyschools.net/Page/1381.

Employee Assistance Program (EAP)

At no cost to you, SBSC provides an EAP and Work Life Services through **Humana**. An EAP offers short term counseling up to three sessions per year to help you and your household members manage everyday life issues that can affect you at home and at work. Assistance and counseling are available in person or by telephone.

EAP professionals are available to assist you with:

- Everyday needs and life events
- Weight control
- Emotional concerns
- Family Relationship
- Smoking Cessation
- Coping with a serious illness
- Sleeping difficulties
- Loss of a loved one
- Eating disorders
- Workplace concerns

SBSC understands that job satisfaction and higher productivity are best achieved when employees' personal needs are being met, and when their work and personal lives are in balance. That's why SBSC offers you EAP and Work Life Services to help meet your unique personal needs and life events.

What is Work-Life?

Work-Life offers extensive assistance, information, and support to help you achieve a better balance between work, life, and family to help make your life easier. You can access information and self-search locators to find resources and providers that can help you with:

- Convenience services
- Housing options
- Childcare
- Financing college
- Home ownership
- Moving and relocation
- Finding colleges and universities
- Free 30-minute consultations with attorney and financial counselor
- Adoption, pregnancy, and infertility
- Adjusting to retirement
- Locating services and care for older adults
- Pet care
- Child development
- Recreational activities
- Services and education for children with special needs
- And much, much more

Access is easy and confidential! 24 hours day, seven day a week. Call **1-866-440-6556** (TTY:711) or visit humana.com/eap and username and password, both **scs**.

Retirement

Florida Retirement System (FRS)

SBSC is a participant in the **Florida Retirement System** (FRS). All eligible employees are automatically enrolled in FRS and will contribute a required 3% of their salary to the FRS. The district also contributes to the FRS on your behalf at a rate that is dependent on your position classification. The FRS offers you two retirement plans, the Investment Plan and the Pension Plan.

All FRS members will have access to an easy to use retirement planning solution through a digital advisor service, **GuidedChoice**. GuidedChoice is an independent advisory firm whose sole purpose is to give you tailored, unbiased investment advice to help you reach your retirement goals. Both FRS Investment Plan and Pension Plan members will be able to get professional advice on how to allocate investments through the GuidedChoice Advisor Service at no cost. You can use this service for your Investment Plan account, as well as any other supplemental retirement account you or your spouse may have (for example, your 457, 403(b), IRAs) to provide a complete view of your retirement savings.

GuidedChoice will provide a clear picture of what you can expect in retirement based on how you're currently invested and how much you're saving. You'll then receive a personalized, actionable recommendation on how to adjust your investments to help meet your goals from there. The advice can easily be implemented with just a click of a button. You will even be able to run scenario modeling to answer those difficult questions like,"*Do I need to save more?*" and "*When can I really retire?*" Start by accessing the Advisor Service directly through www.MyFRS.com or by calling the MyFRS Financial Guidance Line at **1-866-446-9377** Option 2 (or TRS 711).

New Hires

New Hires that are also new to the FRS will get communications from FRS informing you that you have an 8-month election period to choose a plan to participate in, if you do not make a choice by the end your election window you will be defaulted to the Investment Plan. To help you choose the correct plan that's right for you, please visit the website ChooseMyFRSplan.com or by calling the MyFRS Financial Guidance Line at **1-866-446-9377**.

Drop Program

The **Deferred Retirement Option Program** (DROP) is a voluntary retirement program that is available only to **Florida Retirement System** (FRS) Pension Plan members who qualify for normal retirement. As a participant of DROP, you begin accumulating your retirement benefits while delaying your termination of employment for up to 60 months from the date you first reach your normal retirement date or your eligible deferral date. If you are employed as K–12 instructional you may defer drop until a future date indefinitely and still participate for the full 60 months.

Drop Participation Requirements

Regular Class — Retirement for employees enrolled in FRS before 7/1/2011 eligibility is 30 years of service or age 62, whichever comes first. If you were enrolled in FRS after 7/1/2011 eligibility is 33 years of service or age 65 whichever comes first.

Special Risk Class — Retirement for employees enrolled in FRS before 7/1/2011 eligibility is 25 years of service or age 55 whichever comes first. If you were enrolled in FRS after 7/1/2011 eligibility is 30 years of service or age 60 whichever comes first.

Service Credit

Service credit with FRS is based on your employment contract period for a fiscal year (7/1– 6/30). You will earn service credit for each month you work in your contracted work year. You may be able to purchase service time from another employer's retirement plan, out-of-state service or time lost from an approved leave of absence. For more information on DROP or Service Credit, please contact the FRS at www.MyFRS.com or by calling the MyFRS Financial Guidance Line at **1-866-446-9377** or Risk Management at ext. 32318.

Florida Schools Retiree Benefits Consortium

Medicare eligible retiree benefits is administered through the **Florida School Retiree Benefits Consortium** (FSRBC). Plans available through FSRBC are retiree-focused.

Pre 65 Retirees — Prior to turning 65 you will receive communication about future medical, dental, and vision options available through the FSRBC.

Post 65 Retirees — When you become Medicare eligible, your medical, dental, and vision coverage with the School Board will end. You will have the option to enroll in plans under the FSRBC for medical, dental, vision. To enroll in a Medicare medical plan, contact the **FSRBC Medicare Customer Service Center** at **1-833-686-0983** or go online at www.myfsrbc.bswift.com.

Dental and Vision plans are also available through **Humana**. You can call Humana directly to enroll at **1-877-589-4051** or go to www.myfsrbc.com and click on the Dental/Vision page for more information on how to enroll online.

Voluntary Retirement Plans

401(k) Retirement Plan

Building a healthy financial future is just as important as taking care of your health needs today. SBSC offers eligible employees a Voluntary 401(k) and Roth 401(k) retirement savings plan options.

You may enroll at any time during the year by contacting **Prudential Retirement Services**. You may contribute a minimum of $20 per pay, up to the maximum annual deferral limit (including any contributions you make to a 403(b) plan or other qualified retirement plan). Employees 50 and older may also make catch-up contributions.

To enroll or get more information, contact Prudential Retirement Services at **1-877-778-2100** or **www.prudential.com/online/retirement**

You may also contact the Plan Representative, Tony Madera, Benefits Consultant of Gallagher Retirement Services, Inc. at **1-570-407-3208**.

EMPOWER

Prepare for Your Retirement Today!

Click HERE to Enroll
Follow Steps Under New User

- **Guaranteed fixed interest account**
- **Several investment fund options**
- **Access to a Financial Advisor**
- **Backed by a Global Financial Leader**
- **Financial Wellness Tools and Resources Accessibility**

403(b), Roth 403(b) & 457(b) Retirement Savings Plans

SBSC offers Voluntary 403(b), Roth 403(b) and 457(b) retirement savings plans through authorized providers. Authorized providers are listed below:

American Century Services, LLC – Plan Number 800000045	1-800-345-3533 ext. 48113
AXA Equitable Life Insurance Company	1-800-727-0276
IPX Franklin Templeton Funds	1-844-362-6844
National Life Group	1-800-543-3794
Plan Member Services	1-800-874-6910
ReliaStar Life – Subsidiary of VOYA Financial	1-877-882-5050
Security Benefit Group	1-800-888-2461
The Legend Group – A Lincoln Investment Co	1-888-883-6710
VALIC	1-800-426-3753
VOYA Financial	1-800-584-6001

- **All Providers in one place**
- **Enroll in minutes**
- **Guaranteed interest options**
- **Many fund options**
- **Several service based options**
- **Financial Advisors**
- **No-Load mutual fund options**

Click HERE to Enroll

National Life Group · PlanMember Services · American Century Investments · AIG Retirement Services · EQUITABLE · SECURITY BENEFIT · VOYA FINANCIAL · FRANKLIN TEMPLETON INVESTMENTS · LINCOLN INVESTMENT

Frequently Asked Questions

1. **How are the payroll deductions for dependent coverage handled?**

   The premiums are deducted the month prior to the effective date of the coverage (e.g., coverage is effective September 1; premiums are deducted in August). If you elect to cover your eligible dependents on any benefit, 100% of the cost will be deducted from your paycheck the month prior to the effective date of the coverage. Typically, the payroll cut-off date is 3-5 days before your pay date. If you complete your enrollment after the designated payroll cut-off date, it will not be possible to deduct your premium prior to the effective date of the coverage. As a result, it will be necessary to retroactively deduct your premium during the next payroll cycle.

2. **Do I need to notify Risk Management on the birth of a newborn?**

   The birth of a newborn is not automatically covered if you do not add the child to your benefits. If you want to have the newborn covered by your benefits you must report the life event online within 60 days of the birth (or adoption). The newborn will then be enrolled in the same plans as the employee as the event does not allow for a plan change. If the baby is added within 30 days of the birth (or adoption) then the first 30 days of coverage will be at no cost. If you miss the 30 day deadline you can still add the newborn, you will just have to pay the premiums back to the date of birth. If you add the baby to any other coverages (dental/vision/dependent life) those are always at cost and must be added within 30 days of birth (or adoption).

3. **Do I have to continue the newborn coverage past 30 days?**

   Yes, you may only drop a dependent from coverage if you have a documented Qualifying Event that meets the IRS requirements.

4. **I am taking a Leave of Absence, what is going to happen to my benefits?**

   Your benefits are going to end at the end of the month following the month in which you were last in an active paid status. For example, if you take an unpaid leave of absence not covered by FMLA effective February 5th your benefits will end March 31st.

5. **I am returning to work from a leave of absence in which my benefits ended, do I need to re-enroll in benefits or will they be reinstated according to what I had previously?**

   You must re-enroll in your benefits whenever there is a break in your district provided coverages. You will re-enroll in your benefits online following the same process outlined for New Hires.

6. **I am resigning, what is going to happen to my benefits?**

   Your benefits are going to terminate at the end of the month in which you were last actively in a paid status for your primary job. For example, if your last day actively in a paid status for your primary position is June 2nd, and you resign on July 29th, your benefits will be retroactively terminated effective June 30th. Any voluntary benefit premiums that were deducted prior to cancellation will be refunded through a final payroll process.

Contact Information

Benefit	Phone Number	Website
RISK MANAGEMENT Medical and Retirement Dental, Vision, Life, Disability, FSA Workers' Comp, Aflac, 401(k), 403(b), 457(b)	1-941-927-9000 Julie Miller x32318 James Cecchini x32317 Sabine Flesch x32316 Fax: 1-941-927-7475	www.sarasotacountyschools.net/benefits
DEPENDENT ELIGIBILITY DOCUMENTS	Fax: 1-941-927-7475	Email: riskmanagement@sarasotacountyschools.net or upload to benefit system at www.sarasotacountyschools.net/benefits
EMPLOYEE WELLNESS PROGRAM	1-941-927-9000 Erin Singerman x31363	www.sarasotacountyschools.net/benefits
MEDICAL HMO and PPO Florida Blue On-site Representative Martina Olson	1-800-664-5295 1-941-927-9000 x32314	www.floridablue.com
PHARMACY Express Scripts, Inc. (ESI)	1-855-502-8558	www.express-scripts.com
TELEMEDICINE Teladoc	1-855-835-2362	www.Teladoc.com
MEDICAL PRICE and QUALITY TRANSPARENCY SOLUTION Healthcare Bluebook	1-800-875-9717	healthcarebluebook.com/cc/SarasotaSchools
DENTAL Delta Dental Insurance Company	1-800-521-2651	www.deltadentalins.com
VISION Humana Insight Network	1-877-398-2980	www.humana.com
LONG TERM DISABILITY INSURANCE The Standard	1-800-368-1135	standard.com
BASIC AND SUPPLEMENTAL LIFE INSURANCE The Standard	1-800-858-5420	
FLEXIBLE SPENDING ACCOUNT WEX, Inc.	1-866-451-3399	www.wexinc.com
ID THEFT PROTECTION LifeLock	1-800-416-0599	lifelock.com
WHOLE LIFE INSURANCE AllState	1-800-521-3535	www.allstate.com
SHORT-TERM DISABILITY INSURANCE, CRITICAL ILLNESS, ACCIDENT AFLAC	1-800-433-3036	www.aflacgroupinsurance.com
EAP AND WORK-LIFE SERVICES Humana	1-866-440-6556 (TTY:711)	www.humana.com/eap
401(k) and ROTH 401(k) Empower (formerly Prudential)	1-877-778-2100	www.prudential.com/online/retirement
403(b), ROTH 403(b), and 457(b) Authorized Providers	See provider listing on page 22 & website www.sarasotacountyschools.net/benefits	

Enrollment Center

Call **1-800-290-8155** to speak with a Benefit Counselor 9 a.m. – 6 p.m. (ET), Monday - Friday.

Questions?

For more information, visit **www.sarasotacountyschools.net/benefits**

IMPORTANT NOTICES

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. School Board of Sarasota County (SBSC) reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

REMINDER OF AVAILABILITY OF PRIVACY NOTICE

This is to remind plan participants and beneficiaries of the SBSC Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and disclosed protected health information (PHI). You can obtain a copy of the SBSC Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

Name of Entity/Sender: The SBSC, Florida Contact: Risk Management

Address: 1960 Landings Blvd.

Sarasota, FL 34231

Phone Number: 1-941-927-9000

If you have any questions, please contact the SBSC Human Resources Office at 1-941-927-9000.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the same deductibles and coinsurance apply as other medical and surgical benefits your group medical contract provides. If you would like information on WHCRA benefits, call your plan administrator at 1-941-927-9000.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT DISCLOSURE

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact SBSC at 1-941-927-9000.

for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Your Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with SBSC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. SBSC has determined that the prescription drug coverage offered by the ExpressScripts Medical Plan through FloridaBlue is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through 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 SBSC coverage will be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with SBSC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SBSC 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 for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.

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: 1-800-772-1213 (TTY: 1-800-325-0778)

Name of Entity/Sender: SBSC, Florida Contact: Risk Management

Address: 1960 Landings Blvd.

Sarasota, FL 34231

Phone Number: 1-941-927-9000

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

YOUR ERISA RIGHTS

As a participant in the SBSC **benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as**

amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued 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 or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules. Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a 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 because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

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, the court may order you to pay these costs and fees. This should occur if the court finds your claim frivolous.

Assistance with Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website:

https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices

Or you may write to the:
Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at:
1-866-275-7922. You may also visit the EBSA's web site on the Internet at: https://www.dol.gov/ebsa.

SECTION 125 AND BENEFIT ELECTION CHANGES

Under Section 125 of the Internal Revenue Service (IRS) code, you are allowed to pay for certain group insurance premiums using pretax dollars. This means your premium deductions are taken before federal income and Social Security taxes are calculated. Depending on your tax bracket, your savings

could be significant. Please make your benefit elections carefully, especially if you choose to waive medical coverage, because your pretax elections will remain in effect until the next Plan Year, unless you experience a qualifying change in status. These include, but are not limited to: marriage or divorce (legal separation is not considered a qualified event), birth or adoption of a child, death of spouse or other dependent, a spouse's employment begins or ends, dependent's eligibility status changes due to age, student status, marital status, or employment, you or your spouse experience a change in work hours that affect benefit eligibility, gain or loss of other group coverage.

You must make the changes within 30* days of your qualified status change. Any benefit changes must be consistent with the event. For example, if you get married, you may add your spouse to your current medical coverage, but you may not switch medical plans. All benefit changes must be approved by Risk Management. *60 days if you, your spouse, or eligible dependent child loses coverage under Medicaid or a State Children's Health Insurance Program (CHIP) or becomes eligible for state provided premium assistance.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage.

It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

•You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

•The parent-employee dies;

•The parent-employee's hours of employment are reduced;

•The parent-employee's employment ends for any reason other than his or her gross misconduct;

•The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

•The parents become divorced or legally separated; or

•The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: SBSC Human Resources or COBRA Administrator.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice will lose his or her right to elect COBRA.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours. You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension. You must provide notice immediately to the Risk Management office.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Other Coverage Options Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

For further information regarding the plan and COBRA continuation, please contact:

Name of Entity/Sender: The SBSC, Florida
Contact: Risk Management

Address: 1960 Landings Blvd.

Sarasota, FL 34231

Phone Number: 1-941-927-9000

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/healthinsurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website:https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: https://www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://www.dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://www.healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: https://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA-Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, 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