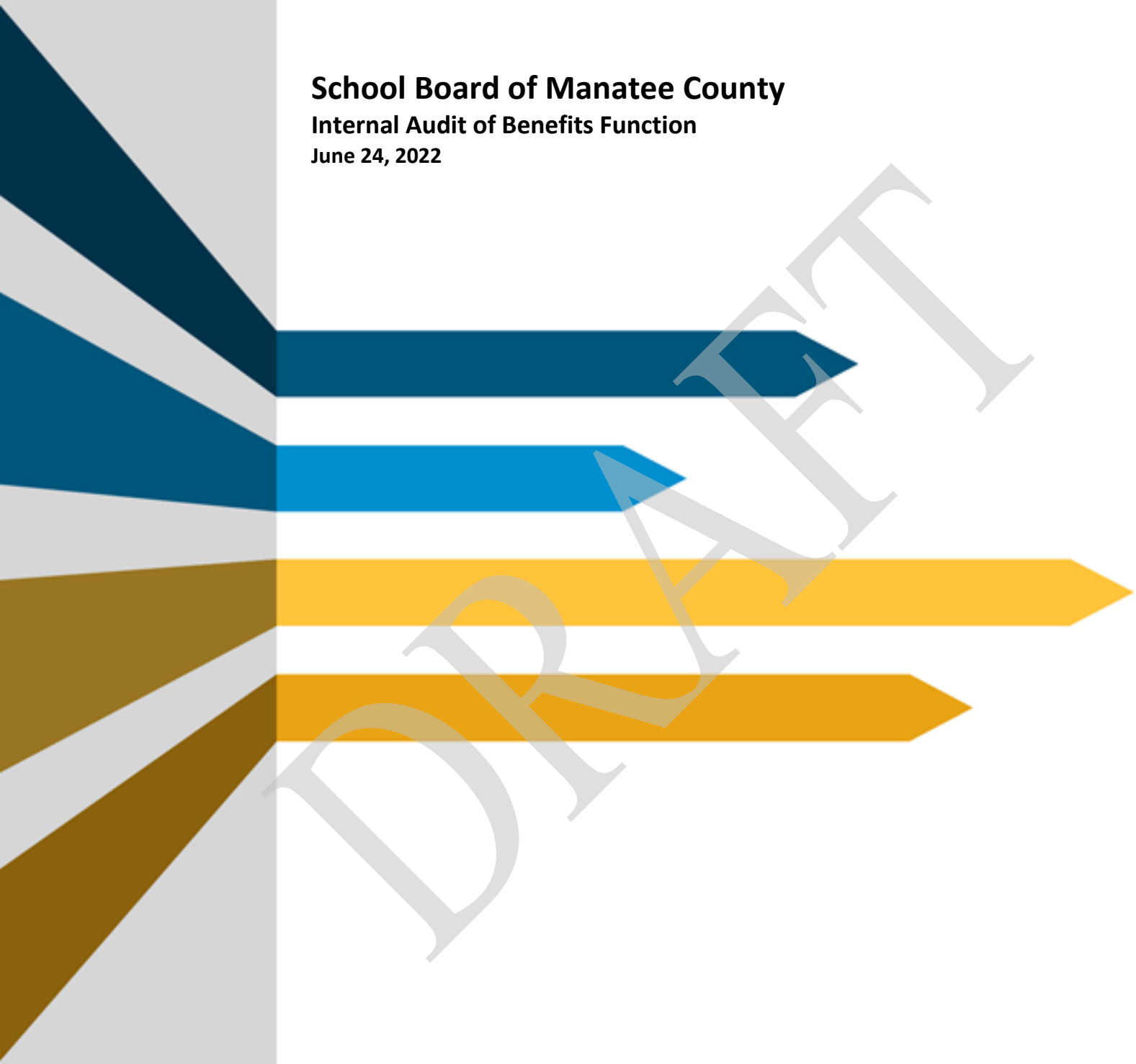
School Board of Manatee County

Internal Audit of Benefits Function

June 24, 2022



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June 24, 2022

Audit Committee and School Board of
Manatee County
215 Manatee Ave. W.
Bradenton, FL 34205

Pursuant to the approved 2021/2022 internal audit plan, we hereby submit the Internal Audit of Benefits Function. We will be presenting this report to the Audit Committee at the next scheduled meeting on July 7, 2022.

Our report is organized in the following sections:

Executive Summary	This provides a summary of the observations and testing results related to our internal audit of Benefits
Background	This provides an overview of the components of the benefits function.
Objectives, Scope, and Methodology	The internal audit objectives and focus are expanded upon in this section as well as the period of our methodology and areas evaluated.
Testing & Results	This section documents the testing performed and results of our internal audit procedures.
Exhibit A	2022 Benefits Guide

We would like to thank all those involved in assisting the Internal Auditors in connection with this audit.

Respectfully Submitted,

Carr, Riggs & Ingram, LLC
Internal Auditors

The internal audit of the benefits function was included in the 2021/2022 Internal Audit Plan. The benefits function received a Risk Rating of Low during the five year Internal Audit Risk Assessment conducted in 2020. We previously reviewed various aspects that related to Human Resources during the Payroll Audit and Personnel Audit. This included IRS and FRS deductions, vacation time, and retired and deceased employee unused vacation and sick time payouts. Therefore, this review focused on elected benefits as it relates to the benefits function. We interviewed personnel, conducted walkthroughs, obtained documentation of benefits and reports, and performed testing to determine whether the Benefits Department functions are operating effectively, efficiently and with appropriate internal controls and in compliance with applicable laws, rules, and regulations.

We evaluated risk of the benefits function and developed an internal audit program that addressed the following related functions:

Benefits Governance
Compliance with State Statute
Benefit Vendor Records
Benefit Elections
Benefit Deductions
System and Organization Control (SOC) Reports

Overall the specific operating controls evaluated during this audit (noted above) as it relates to the Benefits Department is rated as Satisfactory. There is an established committee that meets monthly to provide governance over employee benefits. The District's self-insured medical plan is in compliance with the requirements of State Statute 112.08 F.S. as attested to by the Florida Office of Insurance Regulation (OIR). Employee elections are properly deducted based on the premiums published in the Benefits Guide and match vendor records when applicable. The specific test steps, can be found at Appendix A. The following is a summary of the areas that should be addressed:

- ***Vendor Records (Benefits-1)*** ***High*** **–** Our reconciliations of the *Active Employee Roster* from PeopleSoft to the eligibility records of the benefit vendors for medical, dental, and vision resulted in the following discrepancies:

Benefit (Provider)	Number Participants Billed April 2022	Number Discrepancies	% Accounts Discrepancy	Financial Impact Total	Comments
Medical (Meritain)	4,741	31	0.65%	$3,241.88	Administrative Fees
Dental (MetLife)	4,051	12	0.30%	$6,503.07	Premiums Paid
Vision (VSP)	3,458	9	0.26%	$1,955.39	Premiums Paid
				$ 11,700.34	**Total**

Note: Financial impact for medical is based on administrative fees (tested April invoice) since transition to Meritain in 2022. Financial impact for dental and vision are for those total premiums paid for plans since termination of those individuals by the District.

Benefit (Provider)	April Impact	April Invoice Amount	% Impact April Invoice
Medical (Meritain)	$810.47	$126,569.09	0.65%
Dental (MetLife)	$541.33	$234,804.32	0.23%
Vision (VSP)	$113.45	$62,097.16	0.18%
Total	**$1,465.25**	**$423,470.57**	**0.35%**

Since claims paid for medical are from the self-funded plan, we inquired for the 26 discrepancies identified above related to terminated employees, if there were any claims filed or paid for these individuals. There were 4 plans that had claims filed during 2022 relating to these 26 individuals, which resulted in 24 claims filed. Not all claims resulted in payments. The total payments were $169.78. Also, 4 of the 24 claims are currently pending for a total of $53,174 (one of which is $52,775).

Recommendations were made that Management should perform the following:

1. Contact the benefit vendors to recover any administrative fees, premium fees, or paid claims for plans that were not eligible per the District's records.
2. The District should inquire about any additional claims or pending claims with the benefit vendors to ensure claims are not paid. This would include inquiring about paid medical claims for those identified in our testing prior to transition to Meritain while benefits were administrated by Blue Cross Blue Shield.
3. The District should implement a reconciliation process when transition to a new benefit vendor or changes in benefit offerings to ensure clean records at start of coverage.
4. The District should implement a monthly reconciliation process between the vendor records and District records to identify any terminated employees and/or new hires to identify any discrepancies. This should be conducted for any benefit that the vendor maintains a list of eligible participants and bills the District based on the vendor records.
5. All vendor record reconciliation processes should include retiree and COBRA participants.

- ***System and Organization Controls (SOC) Reports (Benefits-2)*** *Low*- A SOC report is a verifiable auditing report which is performed by a Certified Public Accountant (CPA) designated by the American Institute of Certified Public Accountants (AICPA). The purpose of a SOC examination is to report on the effectiveness of an organization's internal controls and safeguards they have in place while providing independent and actionable feedback; financial statement auditors use them to reduce audit procedures, and sophisticated users of service organizations push for them as confirmation that systems are secure and data is protected. The District does not review SOC reports for benefit vendors. Vendors could lack adequate and effective internal controls and safeguards. Additionally, there could be key Complementary User Entity Controls that the District is unaware of or has not adequately addressed. Reviews should be performed of vendors' SOC Reports at time of selection and on an ongoing basis. The SOC reports are normally prepared on an annual basis and therefore

should be reviewed annually. This should be performed by the Benefits Department in conjunction with the Information Technology Department. The District should also consider implementing the SOC review process with other departments.

Critical	Such an issue would be expected to receive immediate attention from Management, but must not exceed 30 days to remedy from the final Audit Report date.
High	Such an issue would be expected to receive urgent corrective action by Management, and must be completed within 60 days of final Audit Report date.
Moderate	Such an issue would be expected to receive corrective action from Management, and must be completed within 90 days of final Audit Report date.
Low	Such an issue does not warrant immediate attention but requires corrective action by Management, and must be completed within 120 days of final Audit Report date.

APPENDIX A

BACKGROUND

The Benefits Department is located within the Finance Department. The Benefits Department consists of 10 employees and is led by the Benefits Administrator who reports directly to the Associate Superintendent of Finance. Per the *2022 Benefits Guide* (Exhibit A), the District provides a robust benefits package to eligible employees that allows employees to choose the coverage which best fits their and their family's needs. The benefit plan year runs from January through December. The following benefits are offered to employees:

HEALTH & WELL-BEING
- Medical and Prescription Plans
- Critical Illness Insurance
- Accident Insurance
- Hospital Indemnity Insurance
- Dental Insurance
- Vision Insurance
- Flexible Spending Accounts

INCOME SECURITY
- Basic Term Life and Accidental Death and Dismemberment (AD&D) Insurance
- Supplemental Life and Accidental Death and Dismemberment (AD&D) Insurance
- Short-Term Disability Insurance
- Long-Term Disability Insurance

LIFESTYLE
- Identity Theft Protection
- Employee Assistance Program
- Wellness Program
- Legal Insurance

As part of benefit offering evaluations and cost saving measures, the District implemented nine new vendors during the 2022 open enrollment:

1. Meritain Health
2. Ventegra (pharmacy manager) included in employee premiums
3. Quantum Health (MyQHealth concierge service, also cost included in employee premiums)
4. MetLife Legal Plan
5. MetLife Critical Illness
6. MetLife Accident
7. MetLife Hospital Indemnity
8. Norton Identity Theft Protection
9. WEX (medical and dependent FSA)

Governance of benefits is conducted through the Healthcare Insurance Committee (HIC). The HIC meets monthly, publishes an agenda, and documents meetings and topic discussions through minutes. Employees self-enroll in the elected benefits in PeopleSoft. Tables are built in PeopleSoft based for each benefits and associated premiums. The Benefits Analyst loads these into PeopleSoft as they are updated and should match those published in the *Benefits Guide*. Deductions are then

calculated using the tables in PeopleSoft for each payroll run. Currently benefits are deducted from 22 pay periods. The District is in the process of developing a calendar for the 2022/2023 school year to ensure that benefit deductions occur from full paychecks. In years past, there were times that deductions occurred on partial or "skinny" paychecks at the start of the school year. This was due to the various contract start dates of positions. This new process is viewed as an improvement and to eliminate the need for any adjustments to deductions at the start of the school year.

The medical plan is self-insured and administered by Meritain Health (Meritain). Meritain is a subsidiary of Aetna and is one of the nation's largest administrators of health benefits. The previous plan administrator for the District was Blue Cross Blue Shield. A monthly administration fee is charged by Meritain based on enrollment. Premium payment deductions are taken out of the employee paychecks for the employee portion and the calculated District portion of the premium is also applied to the check. The total premiums (employee and District) are computed for each payroll run and then transferred to a trust account. Meritain invoices the District for the monthly administration fee and claims that were approved.

Dental and vision benefits are administered by the respective vendors Metlife (dental) and VSP (vision). Billing from the vendor is based on monthly premium funded from deductions from employees' paychecks. These vendors maintain an eligibility list of employees based on scheduled secure files that are sent from the District. Claims filed are reviewed by these vendors and paid directly to the service providers.

For other vendors, such as Lincoln Financial (short and long term disability) and Securian (life and AD&D) claims or filings are administered by the District. Billing for these types of vendors is based on a template completed by the Benefits Department. The vendor will send the template for the month and the Benefits Department will perform queries in PeopleSoft of employees with elected benefits. The Department will then complete the template and submit the invoice to accounts payable for payment. As far as the self-administration, if a claim came through, for instance, involving life insurance, Securian would reach out to the District to inquire about coverage for the individual. The District would then confirm coverage to the vendor for the benefit to be paid out.

In addition to active employees, benefits can also be provided to terminated employees through COBRA or for retired employees. For COBRA, premium payments for applicable covered benefits are made from the individual to the vendor WEX. WEX will then send the funds, less administrative fee, to the District. The District will then include in the premium payment to the vendor. For retired employees, the retired employees can either direct pay (ACH payment from a checking account to the District) or withhold from their Florida Retirement System (FRS) paycheck. For FRS withholds, the District provides a list and the deduction amounts to FRS for the amount to withhold, and then FRS will then send the funds to the District. Reconciliations for COBRA and ACH funds are performed by the Finance Department and FRS Deductions by the Benefits Department.

Depending on the benefit, employee information is either provided on a regular basis to the vendor or the District only provides the number of plans at the time of billing. There is an automated SFTP (SSH File Transfer Protocol) process to produce files daily. This provides the Benefits Department the flexibility to have the files available to send to the vendor when needed. The District has been provided Pretty Good Privacy (PGP) keys to encrypt (2048 bit) and sign files. The District also initiates from SDMC the "puts" and "get" – meaning the District does not give the vendors access to their server. Should a file need to be retrieved, SDMC would get it from the vendor's server.

OBJECTIVE

To determine whether certain benefit functions are operating effectively, efficiently and with appropriate internal controls and in compliance with applicable laws, rules, and regulations.

SCOPE

Our internal audit scope included benefit activities for the current plan year of 2022 and 2021/2022 school year.

METHODOLOGY

We evaluated the budget functions to determine the associated risk. We interviewed District Management, read available policies and procedures, and previously issued reports and District-wide Risk Assessment to develop our audit program. We tested the following benefit areas:

- Benefits Governance
- Compliance with State Statute
- Benefit Vendor Records
- Benefit Elections
- Benefit Deductions
- System and Organization Control (SOC) Reports

TESTING & RESULTS

Benefits Governance

Governance of benefits is conducted through the Healthcare Insurance Committee (HIC). The HIC is chaired by the Deputy Superintendent of Finance and comprised of Manatee Education Association (MEA) and American Federation of State, County and Municipal Employees (AFSCME) union members as well as Non Bargaining Members. The HIC meets monthly, publishes an agenda, and documents meetings and topic discussions through minutes. Also attending meeting are benefit vendors and Aon, which provides the District with benefits consulting and actuarial services for the self-insured medical plan. Per the HIC agenda, desired outcomes of the Committee are as follows:

- Foster an environment where all participants are engaged and are comfortable sharing their thoughts as it pertains to the duties of the HIC.
- Collaborative discussion regarding Benefits for the School District

The HIC reviews various reports and discusses benefits coverage and costs. The District has not raised premiums since 2016. Per discussions with management throughout this audit, various cost saving measures have been made to delay a raise in premiums. This included the transition to Meritain along with other benefits and plan changes as well as the transition to new vendors for the 2022 plan year.

We were provided with and reviewed HIC meeting minutes for the last 15 months. The HIC met monthly and discussed a variety of topics that included benefit offerings, costs, evaluation and selection of vendors and reserve balances. Meetings also covered topics such as the selection of new vendors and the conversion from Blue Cross to Mertiain for medical benefit administration. The HIC regularly discusses the self-insured reserve as well as ways to manage costs. As noted in the background section, due to rising health care costs and the fact that premiums have not been raised since 2016, the District has had to implement measures for cost savings.

Florida Statute 112.08

Florida Statute 112.08 – Group insurance for public officers, employees, and certain volunteers; physical examinations states the following as it relates to self-insured plans:

After implementation of an approved plan, each local governmental unit or consortium shall annually submit to the Office of Insurance Regulation a report which includes a statement prepared by an actuary who is a member of the Society of Actuaries or the American Academy of Actuaries as to the actuarial soundness of the plan. The report is due 90 days after the close of the fiscal year of the plan. The report shall consist of, but is not limited to:

1. *The adequacy of contribution rates in meeting the level of benefits provided and the changes, if any, needed in the contribution rates to achieve or preserve a level of funding deemed adequate*

to enable payment of the benefit amounts provided under the plan and a valuation of present assets, based on statement value, and prospective assets and liabilities of the plan and the extent of any unfunded accrued liabilities.

2. *A plan to amortize any unfunded liabilities and a description of actions taken to reduce unfunded liabilities.*
3. *A description and explanation of actuarial assumptions.*
4. *A schedule illustrating the amortization of any unfunded liabilities.*
5. *A comparative review illustrating the level of funds available to the plan from rates, investment income, and other sources realized over the period covered by the report with the assumptions used.*
6. *A statement by the actuary that the report is complete and accurate and that in the actuary's opinion the techniques and assumptions used are reasonable and meet the requirements and intent of this subsection.*
7. *Other factors or statements as required by the office in order to determine the actuarial soundness of the plan.*

Aon performed the actuarial services and provided the report and accompanying documents to the Florida Office of Insurance Regulation (OIR) for the plan year ending 6/30/2021. The Actuarial Certification issued by Aon states "Based on our review of plan experience, current premium levels, the positive surplus funds on Form OIR-B2-574, Line 5, we consider the Plan to be actuarially sound."

We were provided with the letter from the Florida Office of Insurance Regulation (OIR) that confirms that the OIR reviewed the annual report submitted to the OIR, including the statement of the plan's actuarial soundness. The letter from the OIR further states that the liabilities and assets appear to produce adequate positive support, and the filing was accepted to be in compliance with the requirements of 112.08 F.S. No exceptions noted.

Vendor Records

Monthly billing for the major benefits offered for medical (administration fee Meritain), dental (MetLife), and vision (VSP) are based on the eligibility maintained by the respective vendors. As there is not a reconciliation process in place to verify eligibility of participants with the vendors' records, we performed reconciliations between the Active Roster of employees in PeopleSoft and reports from the each vendor. This testing focused on ensuring that billing from vendors, and coverage, were for active employees or other appropriate status.

There were also a number of employees that were not on the PeopleSoft *Active Employee Roster* due to timing as terminations will at times lag when being processed by the benefit vendors. This is an expected occurrence in the benefits process in which adjustments are made the following month. We did see comments on the invoices from vendors for adjustments based on termination and additions from previous periods. There were both retirees and terminated employees on COBRA that are not on the PeopleSoft *Active Employee Roster*. We further inquired and tested these participants to ensure vendor records matched District records.

Therefore we focused on those discrepancies identified through the reconciliations performed in this audit which were a result of terminated employees that continued to appear as eligible on the vendor side and resulted in continued administration fees or premium payments to the vendor. We obtained responses from the Benefits Department, as well as other information such as claims filed/paid, and quantified estimated impact to the District. We noted the following exception as it relates to vendor records:

Vendor Records (Benefits -1) High

Condition: We performed a 100% reconciliation between the *Active Employee Roster* from PeopleSoft to each of the eligibility records of participants for the benefit providers for medical, dental and vision. Our reconciliation resulted in the following discrepancies:

Benefit (Provider)	Number Participants Billed April 2022	Number Discrepancies	% Accounts Discrepancy	Financial Impact Total	Comments
Medical (Meritain)	4,741	31	0.65%	$3,241.88	Administrative Fees
Dental (MetLife)	4,051	12	0.30%	$6,503.07	Premiums Paid
Vision (VSP)	3,458	9	0.26%	$1,955.39	Premiums Paid
				$ 11,700.34	**Total**

Note: Financial impact for medical is based on administrative fees (tested April invoice) since transition to Meritain in 2022. Financial impact for dental and vision are for those total premiums paid for plans since termination of those individuals by the District.

Benefit (Provider)	April Impact	April Invoice Amount	% Impact April Invoice
Medical (Meritain)	$810.47	$126,569.09	0.64%
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Vision (VSP)	$113.45	$62,097.16	0.18%
Total	**$1,465.25**	**$423,470.57**	**0.35%**

Since claims paid for medical are from the self-funded plan, we inquired relating to the 26 discrepancies identified if there were any claims filed or paid for these terminated employees. There were 4 plans that had filed claims during 2022 relating to these 26 individuals identified above, which resulted in 24 claims filed. Not all claims resulted in payments. The total payment was $169.78. Also, 4 of the 24 claims are still pending for a total of $53,174 (one of which is $52,775).

Impact: As noted above, the estimated financial impact (less pending claims) was $10,354.58 in fees and premiums and $169.78 in paid claims. Also, 4 of the 24 claims are still pending for a total of $53,174 (one of which is $52,775).

Criteria: Vendor records should reflect eligible plan participants.

Cause: There is not a monthly or implementation reconciliation process in place that compares active employees as recorded by the District to the eligibility records of the benefit vendors**.** Additionally, the retiree and COBRA reconciliations do not include comparison to vendor records.

Recommendation: Management should perform the following:

1. Contact the benefit vendors to recover any administrative fees, premium fees, or paid claims for plans that were not eligible per the District's records.
2. The District should inquire about any additional claims or pending claims with the benefit vendors to ensure claims are not paid. This would include inquiring about paid medical claims for those identified in our testing prior to transition to Meritain while benefits were administrated by Blue Cross Blue Shield.
3. The District should implement a reconciliation process when transition to a new benefit vendor or changes in benefit offerings to ensure clean records at start of coverage.
4. The District should implement a monthly reconciliation process between the vendor records and District records to identify any terminated employees and/or new hires to identify any discrepancies. This should be conducted for any benefit that the vendor maintains a list of eligible participants and bills the direct based on the vendor records.
5. All vendor record reconciliation processes should include retiree and COBRA participants.

Management Response: The district has reached out to vendors to recover administrative fees, premium fees, or paid claims for plans that were not eligible per the District's records. Additionally, outreach has been made on pending claims and assurances were made that pending claims would not be paid. Meritain will refund any paid fees that occurred within the past 90-days. A monthly reconciliation process has been created between the vendor records and District records to identify any terminated employees and/or new hires to identify any discrepancies. The district is working with Agitech to ensure clean records are provided at the start of any new coverages.

Additionally, Ticket: #75445 was created requesting Agitech revisit the file structure/layout against vendor specifications. The District will still need to determine if the files to MetLife Dental, VSP vision and Meritain allow addition of a termination date. Currently, members are supposed to drop off the eligibility files if no longer active in PeopleSoft.

Responsible Party: Tracy Moore

Estimated Completion Date: 7/31/2022

Benefits Elections and Deductions

We tested a total of 45 employees that elected various benefits offered by the District and tested for the following attributes:

a. Amount deducted from employee paycheck agrees to premiums in the *Benefits Guide* or proper calculations

b. Coverage elected by employee agrees to coverage recorded by benefit vendor

The sample size of employees for each benefit was based on the number of enrollees and type of benefit. 25 of the 45 selected were those that had all three coverages of medical, dental, and vision as these are higher cost premiums and coverage elections are provided to the vendor. Additionally, the District funds a portion of the medical benefit which is based on the selected coverage of the employee. The remaining 20 selections were based on number of participants of each benefit as follows:

Under 1000 – 1 selection
1001-2000 – 2 selections
2001 - 3000 – 3 selections
3001 - 4000 – 4 selections
4001 - 5000 – 5 selections

As part of our review, we also compared the Rate Tables in PeopleSoft to those published in the *Benefits Guide* for medical, dental, and vision, as well as any other applicable benefit. For those in which deductions are based on elected coverage driven by dollar amount, such a supplemental life or long and short term disability, we recalculated the deduction. We obtained documentation and reports from vendors to verify the coverage matched the elected coverage in PeopleSoft. Based on our review, no exceptions were noted.

SOC Reports and Vendor Portal Access

SOC Reports

System and Organization Controls, better known as the SOC framework, was developed by the American Institute of CPAs (AICPA). A SOC report is a verifiable auditing report which is performed by a Certified Public Accountant (CPA) designated by the American Institute of Certified Public Accountants (AICPA). The purpose of a SOC examination is to report on the effectiveness of an

organization's internal controls and safeguards they have in place while providing independent and actionable feedback; financial statement auditors use them to reduce audit procedures, and sophisticated users of service organizations push for them as confirmation that systems are secure and data is protected. A SOC 1 report is for organizations whose internal security controls can impact a customer's financial statements, such as payroll, claims, or payment processing companies. SOC 1 reports can assure customers that their financial information is being handled securely. SOC 2 reports help organizations demonstrate their cloud and data center security controls.

Both SOC 1 and SOC 2 are attestation reports, where management attests that certain security controls are in place. An independent CPA firm is brought in to verify those claims and either agree or disagree. Both SOC 1 and SOC 2 also offer Type I and Type II reports. Type I reports evaluate an organization's controls at a single point in time. The goal is to determine whether the controls put in place are designed correctly. A Type II report examines how well those controls perform over a period of time (typically 3-12 months). Type II reports demonstrate the effectiveness of the controls.

The vast majority of SOC audit reports include Complementary User Entity Controls (CUEC) since they are generally integral to the design and operating effectiveness of the control environment. CUECs state all controls within a service organization's systematic processes that rely on the user entity for implementation and function. User entities are accountable for the performance of CUECs and if a user entity does not consistently perform CUECs as stated in the SOC, its vendor may ultimately be unable to deliver contracted control objectives.

Per discussion the Benefits Administrator and the Chief Technology Officer (CTO), the District does not review SOC reports for benefit vendors. The District has created a very comprehensive *Information Technology Cyber Incident Response Team and Risk Assessment Guide* to document IT and cyber policies, plans, forms, contacts, etc. Although SOC reports are reviewed as part of the IT Risk Assessment process as it relates to technology vendors, this has not yet been practice for vendors such as those that provide benefits.

At the request of this audit, the Benefits Administrator worked with Aon to request and obtain SOC reports from the benefit vendors. We were provided with SOC reports and documentation for those that AON was able to obtain. In reviewing the available SOC reports, there are CUECs within the reports that state controls should be in place for the entity user (District) such as ensuring access is restricted to the vendor's system/portal, data integrity, and ensuring security is in place at the entity user. A common CUEC control is vendor portal access. We reviewed the District associates that have access to the various benefits vendor portals without exception. However, we noted the following exception:

***SOC Report Review** Low*

Condition: The District does not review SOC reports for benefit vendors.

Impact: Vendors could lack adequate and effective internal controls and safeguards. Additionally, there could be key Complementary User Entity Controls that the District is unaware of or has not adequately addressed.

Criteria: Reviews should be performed of vendors' SOC Reports at time of selection and an ongoing basis.

Cause: There is not a review process implemented for review of SOC reports for benefit vendors.

Recommendation: The District should obtain and review the SOC reports and any other applicable or appropriate documentation to ensure benefit vendors have adequate and effective controls in place as well as the applicable key CUECs. The Benefits Department should work with the IT Department to review SOC reports and incorporate this process as part of the *Information Technology Cyber Incident Response Team and Risk Assessment Guide.* The District should also consider implementing the SOC review process with other departments.

Management Response: The Benefits Department will work with the IT Department to review SOC reports and incorporate this process as part of the Information Technology Cyber Incident Response Team and Risk Assessment Guide.

Responsible Party: Tracy Moore

Estimated Completion Date: 7/31/2022

BE WELL.

SAVE WELL.

LIVE WELL.

2022

EMPLOYEE BENEFIT GUIDE

SCHOOL DISTRICT OF MANATEE COUNTY, FLORIDA
A Tradition of Excellence

INDEX

THE BENEFITS WE OFFER

The School District of Manatee County (SDMC) provides a full range of coverage that protects you financially and helps you build a secure future. As a new employee of SDMC, you become eligible for our benefit offerings the first day of the second month following your date of hire. Our benefit plan year runs from January through December.

HEALTH & WELL-BEING

- Medical and Prescription Plans
- Critical Illness Insurance
- Accident Insurance
- Hospital Indemnity Insurance
- Dental Insurance
- Vision Insurance
- Flexible Spending Accounts

INCOME SECURITY

- Basic Term Life and Accidental Death and Dismemberment Insurance
- Supplemental Life and Accidental Death and Dismemberment Insurance
- Short-Term Disability Insurance
- Long-Term Disability Insurance

LIFESTYLE

- Identity Theft Protection
- Employee Assistance Program
- Wellness Program
- Legal Insurance

Log in to
https://launchpad.classlink.com/manateeschools,
click on the Peoplesoft ESS tile and
select Benefits Enrollment.

WHO WE COVER

Employees: MEA bargaining unit employees must work a minimum of 20 hours per week for Health Insurance and Flexible Benefits and 15 hours per week for Life Insurance. All other employees must work a minimum of 30 hours per week for Health Insurance, 20 hours per week for Flexible Benefits, and 15 hours per week for Life Insurance.

Dependents:

- Your legal spouse
- Your children up to age 26
- Your children ages 26 to 30 for medical, dental, and vision plans as allowed by Florida law
- Your children over age 26 who are not able to support themselves due to a physical or mental disability

Eligible children include biological children, legally adopted children, stepchildren, and children for whom you have been appointed a legal guardian or for whom the court has issued a Qualified Medical Child Support Order (QMCSO).

PAYING FOR YOUR BENEFITS

Some benefits are provided to you at no cost. The cost of other benefits, such as medical, is shared by you and SDMC. Additional benefits, such as dental, vision, and Supplemental Life Insurance are paid for by you at discounted group rates. Having benefit options available means you can build a benefits program that meets your needs and your lifestyle.

BENEFIT	WHO CONTRIBUTES?	TAX BASIS
Medical/Prescription	SDMC & Employees	Pre-Tax
Dental	Employees	Pre-Tax
Vision	Employees	Pre-Tax
Basic Life and AD&D	SDMC	Post-Tax
Hospital Indemnity	Employees	Post-Tax
Critical Illness	Employees	Post-Tax
Accident Insurance	Employees	Post-Tax
Supplemental Life	Employees	Post-Tax
Short-Term Disability	Employees	Post-Tax
Long-Term Disability	Employees	Post-Tax
FSAs	Employees	Pre-Tax
Retirement Savings 401(k)	Employees	Pre-Tax

DID YOU KNOW?

Medical debt currently affects 1 in 4 individuals.

Make sure you choose the correct health plan.

National Patient Advocate Foundation 2021

MEDICAL INSURANCE

Health care needs are different for everyone. We offer three medical plan options so you can choose the coverage level best-suited to your needs and budget.

All three plans are administered by MyQHealth and give you access to the same network of high-quality medical providers. The difference is that each plan carries different premiums and out-of-pocket costs. The Bronze HMO Plan requires you to use in-network providers, while the Gold and Silver PPO Plans allow you to visit providers both in- and out-of-network.

BRONZE HMO PLAN **SILVER PPO PLAN** **GOLD PPO PLAN**

WHICH PLAN IS RIGHT FOR YOU?

Balance your premium cost with the amount you expect to spend on medical services. If you're healthy and don't expect to have many doctor visits, you can reduce your upfront cost by choosing a lower premium plan. If you require a lot of care and need to limit out-of-pocket expenses, a higher premium plan might make sense.

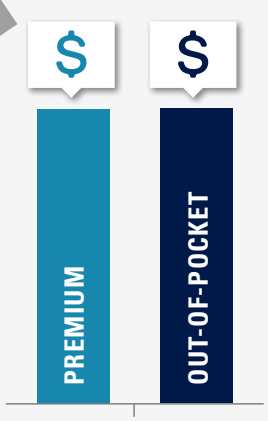
BRONZE HMO PLAN

This plan has the lowest premiums but the highest out-of-pocket costs and only covers in-network providers.

Best if you are...

using doctors who are already in the network and expect to receive most of your care close to home.

SILVER PPO PLAN



This plan balances a lower premium with higher out-of-pocket costs.

Best if you are...

healthy, but want to balance your risk because you're getting older, have a condition like high cholesterol, or have a big family.

GOLD PPO PLAN

This plan has the highest premiums but the lowest out-of-pocket costs.

Best if you are...

going to require plenty of medical care in the coming year, such as having a baby.

MAKING CHANGES DURING THE YEAR

Choose your benefits carefully. Medical, dental, vision, and Flexible Spending Account contributions are made on a pre-tax basis and IRS regulations state that you cannot change your pre-tax benefit options during the year unless you have a Qualified Life Event. Qualified Life Events include:

- Marriage or divorce;
- Death of your spouse, or dependent;
- Birth or adoption of a child;
- Your spouse terminating or obtaining new employment (that affects eligibility for coverage);
- You or your spouse switching employment status from full-time to part-time or vice versa (that affects eligibility for coverage);
- Significant cost or coverage changes; or
- Your dependent no longer qualifies as an eligible dependent.

You must notify and submit any applicable forms and/or documentation to the Benefits Department within **30 days of the event**. The Benefits Administrator will review your request and determine whether the change you are requesting is allowed. Only benefit changes which are consistent with the Qualified Life Event are permitted.

MYQHEALTH

When you need help navigating your health care, you can access MyQHealth. MyQHealth Care Coordinators can work with you and your doctors to ensure you receive the best possible care and avoid unnecessary out-of-pocket fees. They can provide guidance and support when you need help with medical claims, insurance coverage, benefits questions, finding in-network providers, and more. Coordinators and Personal Care Guides will be available from 8:30 a.m. to 10:00 p.m. ET, Monday through Friday. Your dedicated member website and mobile app are available 24 hours a day, seven days a week. To access MyQHealth call **1-855-497-1307** or visit **www.manateebenefits.com**.

TELADOC

Teladoc gives you access to a national network of U.S. board-certified doctors by phone, video, or mobile app. Doctors are available 24/7/365 to treat many common non-emergency medical conditions.

Teladoc services are available for a $15 copay under the Bronze Plan, a $10 copay under the Silver Plan, and a $5 copay under the Gold Plan.

- Cold, flu, and sinus infections
- Nausea, vomiting, and urinary tract infections
- Asthma, allergies, and rashes
- Headaches and migraines
- Stress, anxiety, and depression
- Trauma and grief counseling

To access Teladoc, call **1-800-Teladoc (835-2362)**, visit **www.teladoc.com**, or download the mobile app.

WHAT'S YOUR BEST FIT?

Here's a look at how one family found the plan that is the best fit for them.

SUTTON FAMILY

Typical family with some risk

Ages: Cyrus, 48; Emily, 44; Devin, 13; and Bettina, 12

Lifestyle: Devin and Bettina both play soccer; Devin is an avid skateboarder

Medical Status: Cyrus has high blood pressure and high cholesterol; Emily is a breast cancer survivor

Financial Risk Factors: Heart and cardiovascular disease; Injury risk from sport activities (skateboarding is a very high-risk activity)

BEST FIT: A plan with lower out-of-pocket costs makes sense because of Cyrus's risk factors and the chances of injury for the kids. Cyrus can also reduce the financial risk with Critical Illness and Accident coverage.

MEDICAL PLAN SUMMARY

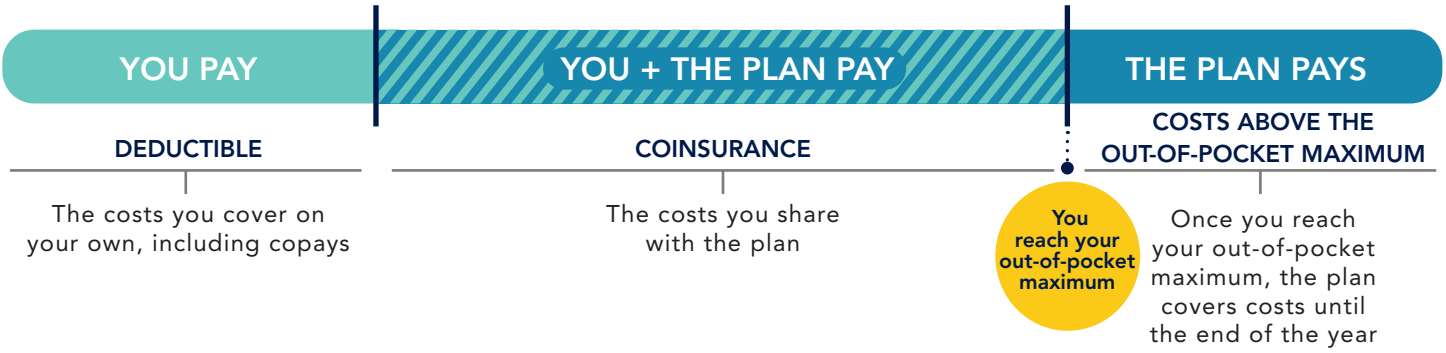
Below is a brief overview of the coverage available under each plan.

	BRONZE HMO PLAN	SILVER PPO PLAN		GOLD PPO PLAN	
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Single/Family	$2,500/$5,000	$1,500/$3,000	$3,000/$6,000	$1,000/$2,000	$2,000/$4,000
Out-of-Pocket Maximum Single/Family	$5,000/$10,000	$4,000/$8,000	$8,000/$16,000	$3,000/$6,000	$6,000/$12,000
Coinsurance	30%	20%	50%	10%	50%
Primary Care Visit	$30 copay	$25 copay	50% after ded.	$10 copay	50% after ded.
Specialist Visit	$60 copay	$50 copay	50% after ded.	$20 copay	50% after ded.
Preventive Care	Covered 100%	Covered 100%	50% coins.	Covered 100%	50% coins.
Acupuncture	$60 copay	$50 copay	50% after ded.	$20 copay	50% after ded.
Teladoc	$15 copay	$10 copay		$5 copay	
Lab and X-ray Services	Covered 100%	$0 copay	50% after ded.	$0 copay	50% after ded.
Imaging (CT/PET Scans, MRIs)	30% after ded.	20% after ded.	50% after ded.	10% after ded.	50% after ded.
Hospital Inpatient	$300 copay	$250 copay	50% after ded.	$200 copay	50% after ded.
Outpatient Surgery	30% after ded.	20% after ded.	50% after ded.	10% after ded.	50% after ded.
Emergency Room	$1,200 copay	$1,000 copay		$800 copay	
Urgent Care	$60 copay	$50 copay	$50 copay	$20 copay	$20 copay

NOTE: *Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.*

Remember: Getting care from an in-network medical provider always saves you money.

HOW YOUR MEDICAL PLAN WORKS



For a full list of medical terms you should know, go to www.benefitsquest.com/terms-to-know.

PRESCRIPTION PLAN

All three medical plans include prescription drug coverage through Ventegra. Prescriptions may be filled at an in-network pharmacy or through the mail order service. We encourage you to create an account at MyVentegra.com to find in-network pharmacies and medication prices. **Walgreens is an excluded pharmacy.**

Costco Specialty Services is also available to provide customized pharmacy services for specialty drugs. Free delivery of your medication to your home or doctor's office is included.

	BRONZE HMO PLAN	SILVER PPO PLAN		GOLD PPO PLAN	
	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Retail – 30-day Supply					
Generic Preferred Brand Non-preferred Brand	$10 copay $30 copay $60 copay	$10 copay $30 copay $60 copay	Not covered Not covered Not covered	$10 copay $30 copay $60 copay	Not covered Not covered Not covered
Mail Order – 90-day Supply					
Generic Preferred Brand Non-preferred Brand	$25 copay $75 copay $150 copay	$25 copay $75 copay $150 copay	Not covered Not covered Not covered	$25 copay $75 copay $150 copay	Not covered Not covered Not covered

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 premiums in future years. Here are tips on how you can help lower the cost of health insurance:

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!

METLIFE 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 pays a full lump sum benefit directly to you 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.

COVERED ILLNESSES INCLUDE:

- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant
- Kidney Failure
- Coronary Artery Bypass Graft*
- COVID-19*

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

PLAN FEATURES

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

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

Payroll Deduction: Premiums are paid through convenient payroll deductions.

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

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 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.

The policy/certificate of coverage or its provisions, as well as covered illnesses, may vary or be unavailable in some states. The policy/certificate of coverage has exclusions and limitations which may affect any benefits payable.

**The coverage pays 50% of the face amount of the policy once per lifetime for coronary artery bypass surgery and 25% of the face amount of the policy once per lifetime for COVID-19.*

METLIFE ACCIDENT INSURANCE

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

Accident Insurance 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.

The benefit amount is calculated based on the type of injury, its severity, and the medical services 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.

Payroll Deduction: Premiums are paid through convenient payroll deductions.

24/7 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.

Health Screening Benefit: The plan provides a $75 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 costs including his deductible and coinsurance.

HOW SAM'S ACCIDENT BENEFIT WAS CALCULATED:

MEDICAL SERVICE	SAMPLE BENEFIT
Emergency Room	$ 200
Fracture Benefit	$ 1,000
Broken Tooth Benefit	$ 200
Physician Follow-Up Visits (2)	$ 200 ($100 per visit)
Physical Therapy Visits (6)	$ 300 ($50 per visit)
TOTAL SAMPLE BENEFIT	$1,900

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.

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

METLIFE HOSPITAL INDEMNITY INSURANCE

Receive payments to help cover the cost of a hospital stay.

If you are admitted into a hospital, it doesn't take long for the out-of-pocket costs to add up. Hospital Indemnity Insurance pays benefits directly to you if you are admitted into a hospital for care or childbirth. Benefits are paid even if you have other coverage.

You receive a benefit as soon as you are admitted and then an additional benefit based on the number of days you are confined to the hospital. The benefit increases if you are admitted and confined to an intensive care unit or inpatient rehabilitation unit.

HOW HOSPITAL INDEMNITY INSURANCE WORKS

Cindy is admitted to the hospital for treatment of COVID-19. Over the course of her illness, she spends 14 days in the hospital, including four days in an intensive care unit and six days in an inpatient rehabilitation unit. Thankfully, Cindy's condition improves, and she is well enough to return home. She uses her Hospital Indemnity Insurance to help cover her medical bills, so she can focus on what matters most – making a full recovery.

HOW CINDY'S HOSPITAL INDEMNITY BENEFIT WAS CALCULATED:

MEDICAL SERVICE	SAMPLE BENEFIT	TOTAL
Hospital Admission	$1,000 per admission	$1,000
Hospital Confinement	$200 per day (4 days)	$800
Intensive Care Unit	$200 per day (4 days)	$800
Inpatient Rehabilitation Unit	$200 per day (6 days)	$1,200
TOTAL SAMPLE BENEFIT		$3,800

This scenario does not reflect the benefits of a specific Hospital Indemnity Insurance plan schedule. The benefits are generic benefits for the purposes of this example to show how the benefit total of a Hospital Indemnity 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.

PLAN FEATURES

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

The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable.

***NOTE**: You cannot contribute to a Health Savings Account if you elect Hospital Indemnity Insurance.*

METLIFE DENTAL PLANS

Your dental health is an important part of your overall wellness. You may choose from two dental insurance plans through MetLife.

	DENTAL LOW PLAN	DENTAL HIGH PLAN
Calendar Year Maximum Per Person	$1,000	$2,000
Annual Deductible Single/Family	$50/$100	$50/$100
Preventive Services Exams, Cleanings, X-rays (3 Cleanings per Every 12 Months)	100%	100%
Basic Services Fillings, Extractions	50%	70%
Major Restorative Services Crowns, Bridgework, Dentures	40%	50%
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	$1,500 Covers children only	$1,500 Covers adult ortho for employee and spouse, and covers children to age 19

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. Your dental plan covers 3 cleanings every 12 months.

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.

VSP VISION PLANS

SDMC offers two vision plan options through Vision Service Plan (VSP). Benefits include eye exams, affordable options for prescription glasses or contacts, and discounts for laser vision correction. To find a network provider, call **1-800-877-7195** or visit **www.vsp.com**.

	VISION BASIC PLAN	VISION PREMIUM PLAN
Eye Exam	$10 copay Every 12 months	$10 copay Every 12 months
Frames	$15 copay, then $170 allowance Every 24 months	$15 copay, then $170 allowance Every 12 months
Lenses Single Vision, Lined Bifocal, and Lined Trifocal Lenses	$15 copay Every 12 months	$15 copay Every 12 months
Contact Lenses (instead of glasses)	$150 allowance Every 12 months	$150 allowance Every 12 months
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

5 TIPS FOR A LIFETIME OF HEALTHY VISION

1. **Schedule yearly eye exams.** Visiting your ophthalmologist regularly helps you see your best, protect your sight, and even detect serious health conditions such as diabetes.
2. **Protect your eyes against UV rays.** No matter what the season, it is important to wear sunglasses. When selecting and purchasing sunglasses, be sure to confirm they offer 100% UVA/UVB protection.
3. **Give your eyes a break from digital devices.** Digital screens emit a specific type of blue and violet light which can negatively impact eye health and cause digital eye strain.
4. **Quit smoking.** Smoking increases your risk of developing macular degeneration, optic nerve damage, and cataracts.
5. **Practice safe wear and care of contact lenses.** Keep them clean and follow your optometrist's recommendations for use and wear.

WEX FLEXIBLE SPENDING ACCOUNTS (FSAs)

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

Flexible Spending Accounts allow you to put aside money for important expenses and help you reduce your income taxes at the same time. SDMC offers two types of accounts – a Health Care FSA and a Dependent Care FSA.

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. You can use your FSA debit card to pay for eligible expenses at the point of sale, or you can pay out-of-pocket and submit a claim form for reimbursement.

USE IT OR LOSE IT! IRS rules require that you forfeit any money left in your account after the claims submission deadline. However, the IRS allows you to roll over up to $550 of unused Health Care FSA funds from one year to the next.

ANNUAL MAXIMUM CONTRIBUTION	
Health Care FSA	$2,850
Dependent Care FSA	$5,000 ($2,500 if you are married and file 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.

ITEMS YOU MIGHT NOT REALIZE ARE HEALTH CARE FSA ELIGIBLE:

- Sunscreen
- Heating and cooling pads
- First aid kits
- Shoe inserts
- Travel pillows
- Motion sickness bands

Go to www.benefitsquest.com/fsa for a complete list of covered expenses.

SECURIAN LIFE AND AD&D 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. SDMC provides Basic Term Life Insurance and offers additional options to give you the ability to assemble a complete Life Insurance portfolio.

BASIC TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SDMC provides Basic Term Life and Accidental Death and Dismemberment (AD&D) coverage at no cost to you and enrollment is automatic.

BASIC TERM LIFE	The benefit is equal to 1x your contracted salary, up to a maximum of $750,000.
ACCIDENTAL DEATH AND DISMEMBERMENT	If you are seriously injured or lose your life in an accident, you will be eligible for a benefit equal to your Basic Term Life coverage.

SUPPLEMENTAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You may also choose to purchase Supplemental Life and AD&D Insurance in addition to the company-paid benefit. Coverage options are available for you, your spouse, and your children.

EMPLOYEE	1 to 5x your contracted salary rounded to the next higher $1,000 to a maximum of $750,000 (combined with Basic Life). Guaranteed Issue up to 3x salary, Evidence of Insurability (EOI) required for 4x or 5x salary.
SPOUSE	Up to $20,000, cannot exceed 100% of employee coverage (Basic and Supplemental Life combined)
CHILDREN UP TO AGE 26	$10,000

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?

DID YOU KNOW?

In 2019, the number of Americans receiving disability payments was about 8.1 million. More than half were between the ages of 18 and 64.

Social Security Administration, Disability Insurance, 2019

LINCOLN FINANCIAL DISABILITY INSURANCE

Your ability to bring home a paycheck is your most valuable asset. 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.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

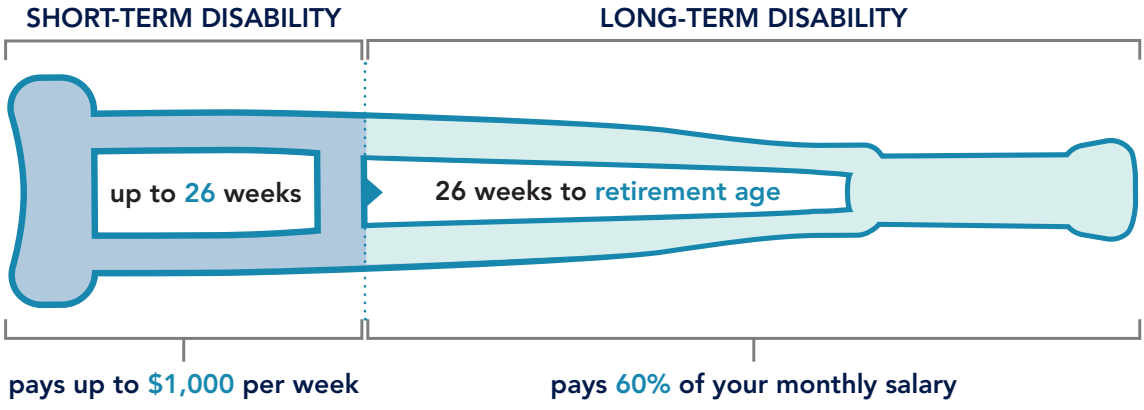
You are eligible to purchase Voluntary Short-Term Disability Insurance to replace a portion of your income if a qualified non-work related illness or injury prevents you from working for an extended period of time.

Benefits begin on the 15th day following an injury or sickness, and the plan pays up to $1,000 in weekly benefits for up to 26 weeks. Benefits are offset by any workers compensation benefits.

VOLUNTARY LONG-TERM DISABILITY INSURANCE

You are also eligible to purchase Voluntary Long-Term Disability Insurance to protect your finances when your disability continues beyond the period covered by the Short-Term Disability plan.

Benefits begin after 180 consecutive days of a qualified non-work related illness or injury and provide you with 60% of your monthly salary up to a maximum of $7,500 per month.



The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable.

NORTON LIFELOCK IDENTITY 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 that monitors multiple gateways into your identity and credit and alerts you of fraudulent activity.

PROTECTION SERVICES INCLUDE:

- Credit Reports and Monitoring
- Dark Web Monitoring
- Bank Account Takeover Alerts
- Stolen Wallet Protection
- Credit Application Alerts
- Sex Offender Registry Reports
- Data Breach Notifications
- USPS Address Change Verification
- Social Media Monitoring
- 24/7 Live Member Support
- Full-Service Identity Restoration Services

DID YOU KNOW?

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

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

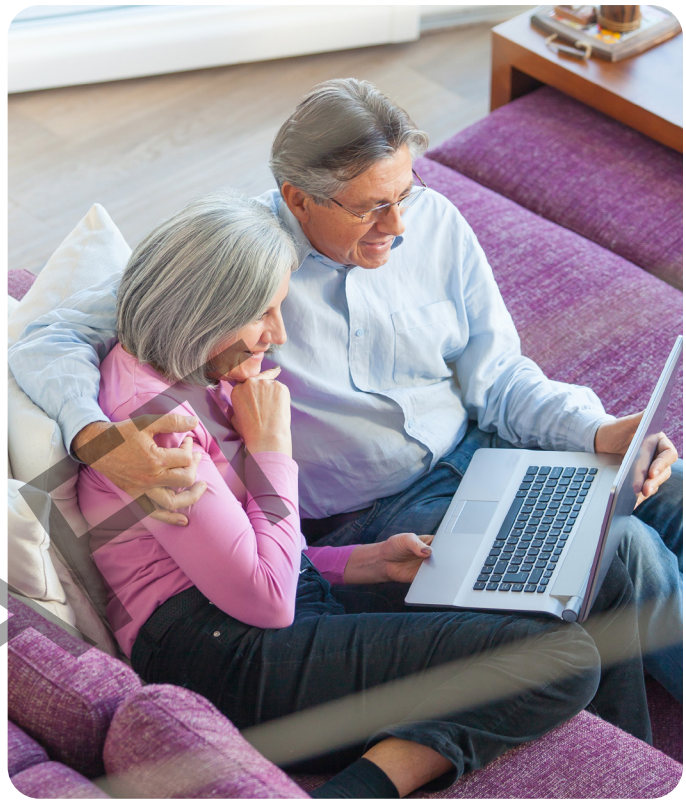
HOW BIG OF AN ISSUE IS IDENTITY THEFT?

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

Identity Fraud Study, Javelin Strategy & Research, 2020

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM

Balancing the demands of work, family, and personal needs can be challenging, especially during uncertain times. SDMC knows how important it is to have access to support when you need it most. Our Employee Assistance Program (EAP) is available at no cost to you and your family members and provides confidential counseling and resources to help you with concerns such as:



- Anxiety and depression
- Grief and loss
- Substance abuse
- Financial and legal concerns
- Relationship and family matters
- Parenting
- Work-related issues
- Child and elder care

PLAN FEATURES

- Provided at no cost to you and your household members
- Includes up to 5 counseling sessions per problem per year
- Confidential services provided by licensed professionals
- Available 24/7/365

To access the EAP, call **1-866-553-1848** or visit **www.guidanceresources.com** (Web ID: Manatee).

WellYOU

WellYOU is the School District of Manatee County's employee wellness program. The wellness program aims to connect employees to the most appropriate resources that instill a better understanding of and means to address key determinants of health and well-being. Pillars of well-being are healthy eating, physical activity, drug-free living, stress management and mental well-being, disease management, personal safety, and social connections.

For more information, contact Shelly Smith, Health and Well-Being Educator at **1-941-708-8770 ext. 41054** or **smiths5@manateeschools.net**.

METLIFE LEGAL INSURANCE

Legal Insurance provides you and your covered family members with access to a network of participating attorneys who can help with a wide range of legal matters. Attorneys are available in person, by phone, or by email. You'll also have access to helpful online tools and resources.

COVERED LEGAL SERVICES

- Consumer Protection – small claims assistance, consumer credit agreements
- Financial Matters – debt collection defense, personal bankruptcy, tax audit representation
- Document Preparation – affidavits, deeds, mortgages
- Family Law – divorce, prenuptial agreements, adoption, guardianship
- Real Estate Matters – sale or purchase of a home, landlord/tenant matters
- Traffic and Criminal Matters – juvenile court defense, traffic ticket defense
- Wills and Estate Planning – trusts, wills, powers of attorney
- And more!

PLAN FEATURES

- You'll have a nationwide network of participating plan attorneys from which to choose.
- There are no deductibles, copays, claim forms, or usage limits when using a plan attorney.
- You can also use a non-plan attorney and be reimbursed for covered services according to a set fee schedule.
- You can consult with your attorney on the phone or in person. You'll also have access to online tools and resources.

For more information, visit **legalplans.com** or call **1-800-821-6400**.

2022 BENEFITS PLAN PREMIUMS

Below are the employee contribution amounts for benefits effective January 1 through December 31, 2022. See your benefits guide for plan details and enrollment instructions.

Please note: Effective January 1, all employees regardless of their pay frequency will have benefit deductions from 22 paychecks. If you are a 26-paycheck employee, you will have 4 checks throughout the year that will not have benefit deductions.

MEDICAL PLANS

PER-PAYCHECK DEDUCTIONS	BRONZE HMO PLAN	SILVER PPO PLAN	GOLD PPO PLAN
	22 PAYCHECK	22 PAYCHECK	22 PAYCHECK
Employee Only	$17.45	$34.91	$55.64
Employee + Spouse	$212.18	$259.09	$303.27
Employee + Child(ren)	$87.27	$158.18	$200.73
Family	$280.91	$382.36	$448.36

DENTAL PLANS

PER-PAYCHECK DEDUCTIONS	LOW PLAN	HIGH PLAN
	22 PAYCHECK	22 PAYCHECK
Employee Only	$14.06	$24.38
Employee + Spouse	$26.83	$45.98
Employee + Child(ren)	$29.63	$50.50
Family	$42.41	$71.83

VISION PLANS

PER-PAYCHECK DEDUCTIONS	BASIC PLAN	PREMIUM PLAN
	22 PAYCHECK	22 PAYCHECK
Employee Only	$4.81	$6.61
Employee + Spouse	$9.62	$13.24
Employee + Child(ren)	$11.81	$16.45
Family	$16.54	$23.01

SHORT-TERM DISABILITY INSURANCE

RATE PER $10 OF WEEKLY COVERED BENEFIT	
Employee Only	$0.750

LONG-TERM DISABILITY INSURANCE

RATE PER $100 OF COVERED PAYROLL	
Employee Only	$0.578

LEGAL INSURANCE

PER-PAYCHECK DEDUCTIONS	22 PAYCHECK
Employee + Family	$8.18

IDENTITY THEFT PROTECTION

PER-PAYCHECK DEDUCTIONS	22 PAYCHECK
Employee Only	$4.90
Family	$9.26

ACCIDENT INSURANCE

PER-PAYCHECK DEDUCTIONS	22 PAYCHECK
Employee Only	$3.45
Employee + Spouse	$6.78
Employee + Child(ren)	$8.21
Family	$9.64

CRITICAL ILLNESS INSURANCE

PER-PAYCHECK DEDUCTIONS
Rates are calculated based on age, tobacco use, amount of coverage elected, and other such factors, and will be provided at the time of enrollment.

HOSPITAL INDEMNITY INSURANCE

PER-PAYCHECK DEDUCTIONS	22 PAYCHECK
Employee Only	$14.57
Employee + Spouse	$27.34
Employee + Child(ren)	$20.59
Family	$33.35

SECURIAN LIFE INSURANCE

CHILD LIFE	$2.54 for $10,000 coverage
SPOUSE LIFE	$5.65 for $20,000 coverage
SUPPLEMENTAL LIFE	$0.1325 per $1,000 of coverage

As of 1/26/2022

NOTE: *Every effort has been made to ensure the information in this document is accurate. However, if there is any inconsistency between this document and the applicable plan documents, the official plan documents will always govern.*

In the event there are medical rate changes because of the collective bargaining process, additional information will be provided for 2022 changes.

CONTACT INFORMATION

BENEFIT	CARRIER	WEBSITE/EMAIL	PHONE NUMBER
Medical and Pharmacy	MyQHealth	www.manateebenefits.com	1-855-497-1307
Telemedicine	Teladoc	www.teladoc.com	1-800-Teladoc (1-800-835-2362)
Critical Illness, Accident, and Hospital Indemnity	MetLife	www.metlife.com	1-800-638-5433
Dental	MetLife	www.metlife.com	1-800-942-0854
Vision	VSP	www.vsp.com	1-800-877-7195
Flexible Spending Accounts	WEX	benefitslogin.wexhealth.com	1-866-451-3399
Life and AD&D Claims	Securian	www.securian.com	1-866-293-6047
Supplemental Life Claims	Securian	www.securian.com	1-866-293-6047
Short-Term Disability Claims	Lincoln Financial	www.mylincolnportal.com Registration code: SDMC-EE	1-800-713-7384
Long-Term Disability Claims	Lincoln Financial	www.mylincolnportal.com Registration code: SDMC-EE	1-800-713-7384
Identity Theft Protection	Norton LifeLock	NortonLifeLock.com	1-800-416-0599
Employee Assistance Program	ComPsych	www.guidanceresources.com Web ID: Manatee	1-866-553-1848
Wellness Program	WellYOU	smiths5@manateeschools.net	1-941-708-8770, ext. 41054
Legal Plan	MetLife	legalplans.com	1-800-821-6400

If you have any questions regarding eligibility, benefit plans, or enrollment periods or would like additional information, contact the Benefits Department at 1-941-708-8770, extension 41061.

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

Benefits Department
215 Manatee Ave W
Bradenton, FL 34205

If you have any questions, please contact the Benefits Department at **1-941-708-8770, extension 41061**.

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. Please reference page 4 for applicable deductible and coinsurance. If you would like more information on WHCRA benefits, call your Benefits Department at **1-941-708-8770, extension 41061**.

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.

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 SDMC 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. SDMC has determined that the prescription drug coverage offered by the Medical Plan through Ventegra, 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 SDMC 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.

From the local pharmacy, 30-day supply:

- **Generic Drugs** **$10**
- **Brand Name Drugs** **$30**
- **Non-Formulary Drugs** **$60**

From the Mail Order Pharmacy, 90-day supply:

- **Generic Drugs** **$25**
- **Brand Name Drugs** **$75**
- **Non-Formulary Drugs** **$150**

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 SDMC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE:

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through SDMC 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**)

Date: October 2021
Name of Entity/Sender: School District of Manatee County
Contact: Benefits Department
Address: 215 Manatee Ave W, Bradenton, FL 34205
Phone Number: **1-941-708-8770, extension 41061**
Fax Number: **1-941-708-8679**

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

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

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

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

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/childhealth-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurancebuy-program
HIBI Customer Service: 1-855-692-6442

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: https://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.indianamedicaid.com
Phone 1-800-403-0864

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/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

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

MISSOURI – Medicaid
Website: https://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

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

NEVADA – Medicaid
Medicaid Website: https://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: https://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: https://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

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

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

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

RHODE ISLAND – Medicaid and CHIP
Website: https://www.eohhs.ri.gov/
Phone: 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: https://www.dss.sd.gov
Phone: 1-888-828-0059

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

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

VERMONT– Medicaid
Website: https://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
Website: https://www.mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

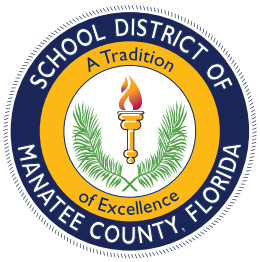
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

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

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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



***NOTE**: This statement is intended to summarize the benefits you receive from the School District of Manatee County. The actual determination of your benefits is based solely on the plan documents provided by the carrier of each plan. This summary is not legally binding, is not a contract, and does not alter any original plan documents. For additional information, please contact the Human Resources department.*