Retiree

Benefit Guide

Effective July 1, 2025

Welcome to your 2025 Benefit Guide

Important Information 3
Employee Benefit Website 3
Open Enrollment Online Instructions 4
Medical Insurance Information 7
Medical Plans-Aetna 8
HDHP & HSA Info 10
Medical Plan Premiums 12
Aetna Plan Information 13
Physician Search 13
Aetna Medication Information 13
Medication Search & Mail Order Information ... 14
Aetna Health App 15
Aetna Core 16
Aetna Tools and Programs 18
Dental Plan 20
Voluntary Vision Plans 22
Notices 23
Contact Information 32

Your benefits are important and we are committed to providing you a choice of affordable, comprehensive plans. This Benefit Guide was created to help you understand our plans. Please take time to learn about each plan and choose the plans that are best for you and your family.

If you have any questions regarding our employee benefit plans, please contact the district office.

Ron Wilson
Superintendent

If you (and/or your dependents) 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 pages 30-31 where Notice of Creditable Coverage begin for more details.

Important Information

Open Enrollment

Open Enrollment is the one time per year you may start, stop or change who is insured on your insurance plans. Any requests after Open Enrollment to start, stop or change who is insured must be due to a Qualifying Life Event.

Qualifying Life Events

After your initial eligibility date and other than the annual open enrollment period, you may only change your benefit election and covered dependents within 31 days following a Qualifying Life Event including:

- Birth or adoption of a dependent child;
- Marriage, legal separation, annulment, or divorce;
- Death of spouse and/or dependent;
- Dependent's loss of eligibility;
- Termination or commencement of spouse's employment with health care coverage offered or open enrollment;

Healthcare Reform

Due to Healthcare Reform:

- The individual mandate became effective on 01/01/2014
- For tax year 2025, if you don't have coverage the fee/penalty no longer applies. This is subject to change if different legislation is passed.

Healthcare Reform Exchanges:

- Full Time Employees: If you are eligible for benefits at USD 489 Hays, and buy coverage through a Federal or State Exchange- you and your family will not qualify for a subsidy through the Exchange.
- Part Time Employees: If you are eligible for benefits at USD 489 Hays, and buy coverage through a Federal or State Exchange- you and your family may qualify for a subsidy through the Exchange. Contact a State Exchange navigator for additional information.
- Federal and State Medicaid programs offer low cost or free medical coverage to individuals and families with limited incomes. Your eligibility will depend on your state, income, and family size. For more info visit: www.healthcare.gov.

Who is Eligible?

Employee

All active employees meeting the eligibility criteria.

Dependents

As an employee eligible to enroll in the group insurance plans, you may elect certain options for your dependents. Eligible dependents include:

- Your legal spouse;
- Your dependent child or step child up to age 26 for the medical plan and for dental;
- Any child placed with you for adoption or for whom you have legal guardianship;
- Any unmarried, disabled child of any age who resides with you, medically certified as disabled prior to his/her 26th birthday and primarily dependent upon you for support;
- Any eligible child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

Employee Benefit Information Website

You can access the benefit website 24/7 from any computer. Open your internet browser and enter:

https://c2mb.ajg.com/usd489hays/home/

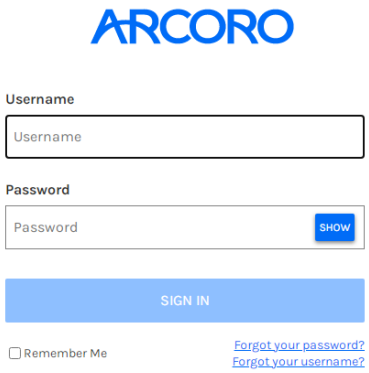
Open Enrollment Online Instructions

***All retirees are required to complete the online enrollment even if you waive all of the benefits.**

***Please note that spouse/dependent's Social Security Numbers are required.**

1 Login

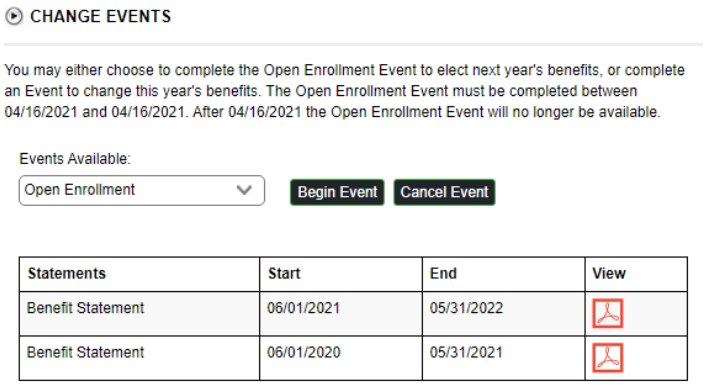
- Go to www.infinityhr.com
- Enter User ID and Password.
- Your UserID is your last name + last 4 digits of your Social Security number
- If you don't remember it, click "Forgot your password/ username"



*To access this system you must have a valid account created for you. If you have forgotten your login information, and you have a valid email address on file, you can click the appropriate link below the login button, and your information will be sent to you.

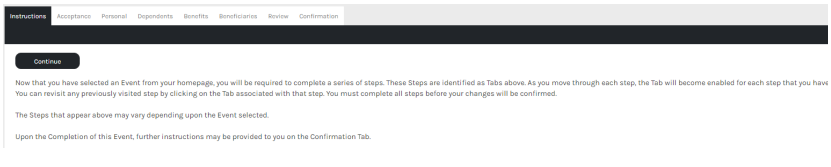
2 Click "Begin Event" on Homepage

- Review Homepage
- The Drop Down should say " Open Enrollment"
- Then click "Begin Event"

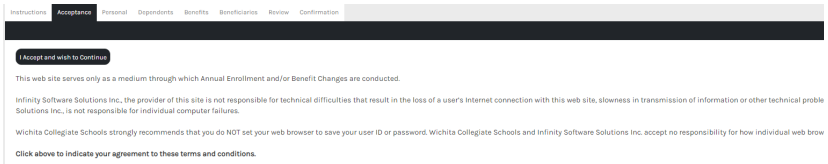


3 Authorization Pages

- Click "Continue"

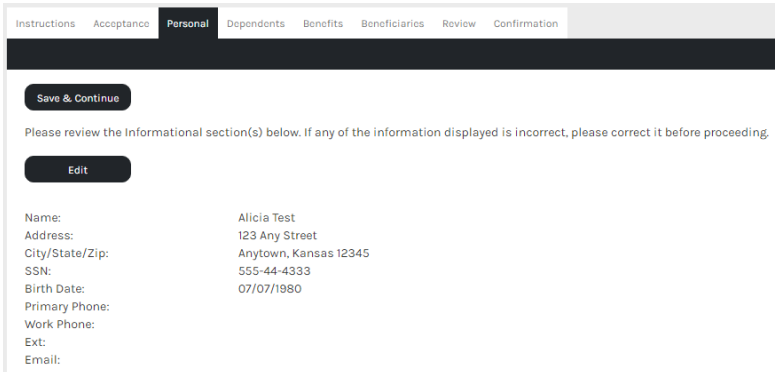


- Click "I Accept…"



4 Confirm Personal Info

- Review personal information.
- To make a change, click "Edit" and enter your information.
- When finished, click "Save and Continue".

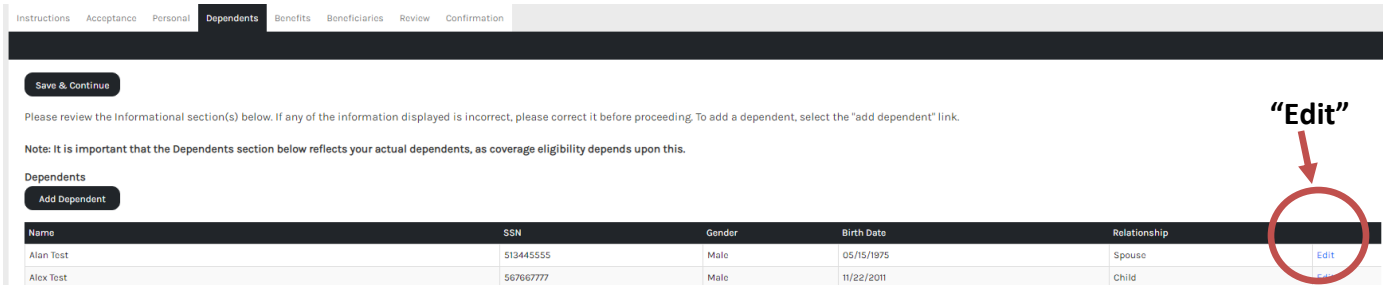


Open Enrollment Online Instructions

***Please note that spouse/dependent's Social Security Numbers are required.**

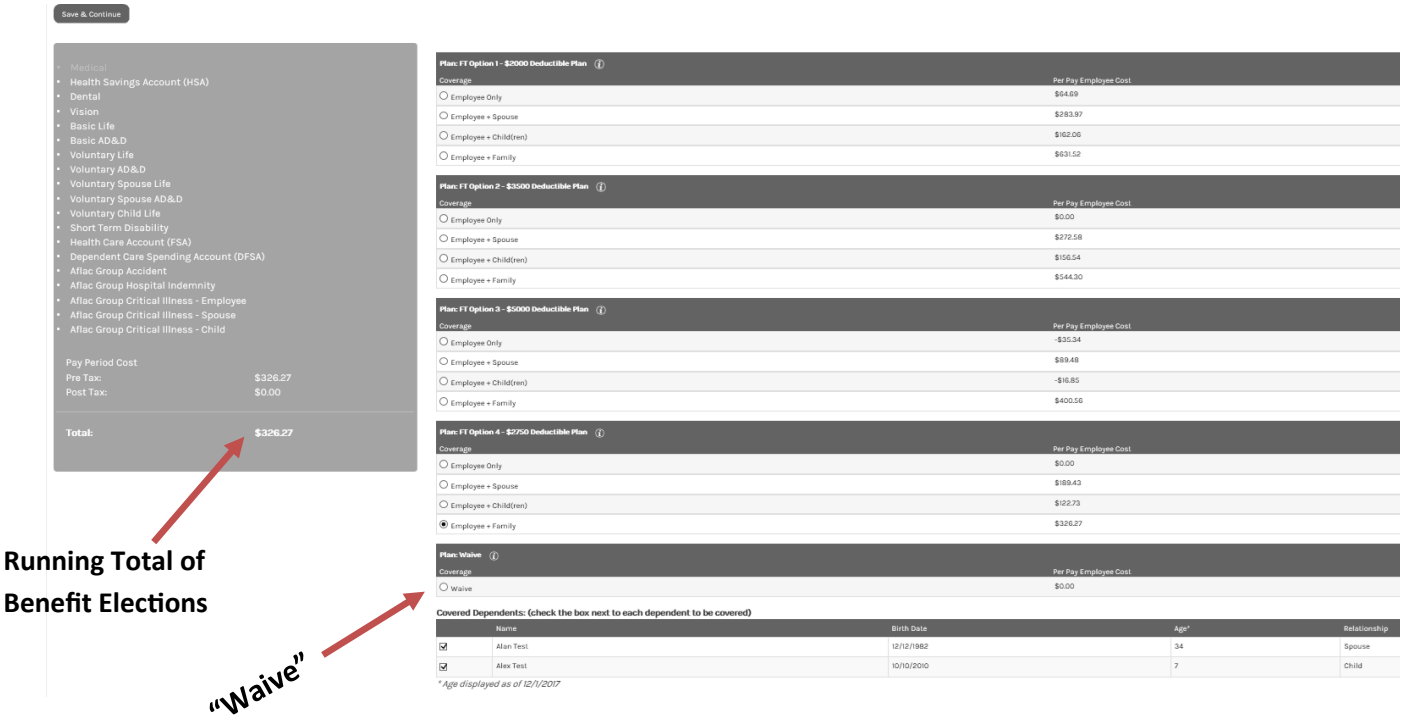
5 Confirm Spouse and/or Dependent Info

- Review information.
- To make a change, click "Edit" on the far right and enter your information.
- In order to add a spouse and/or dependents to a benefit, they must be entered here. To do this click "Add Dependent".
- When finished, click "Save and Continue".



6 Benefit Selections

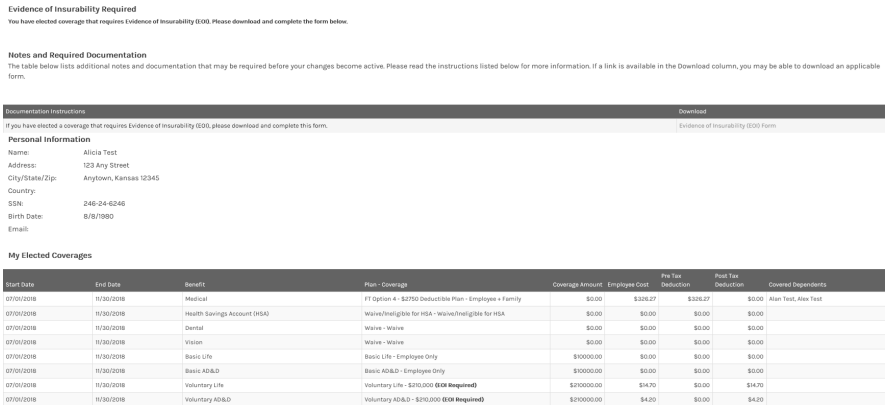
- Make an election or select "Waive" for each benefit.
- Click "Save and Continue" to complete each benefit screen and you will automatically be moved to the next benefit.



Open Enrollment Online Instructions

7 Review

- Review information on Review Step.
- Click “Save & Confirm” to confirm your enrollment.



Evidence of Insurability Required

You have elected coverage that requires Evidence of Insurability (EOI). Please download and complete the form below.

Notes and Required Documentation

The table below lists additional notes and documentation that may be required before your changes become active. Please read the instructions listed below for more information. If a link is available in the Download column, you may be able to download an applicable form.

Documentation Instructions	Download
If you have elected a coverage that requires Evidence of Insurability (EOI), please download and complete this form.	Evidence of Insurability (EOI) Form

Personal Information

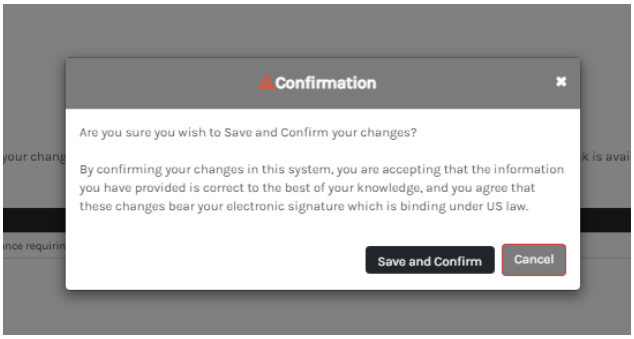
Name: Alicia Test
Address: 123 Any Street
City/State/Zip: Anytown, Kansas 12345
Country:
SSN: 246-24-6246
Birth Date: 8/8/1980
Email:

My Elected Coverages

Start Date	End Date	Benefit	Plan - Coverage	Coverage Amount	Employee Cost	Pre Tax Deduction	Post Tax Deduction	Covered Dependents
07/01/2018	11/30/2018	Medical	FT Option 4 - $2750 Deductible Plan - Employee + Family	$0.00	$326.27	$326.27	$0.00	Alan Test, Alex Test
07/01/2018	11/30/2018	Health Savings Account (HSA)	Waive/Ineligible for HSA - Waive/Ineligible for HSA	$0.00	$0.00	$0.00	$0.00	
07/01/2018	11/30/2018	Dental	Waive - Waive	$0.00	$0.00	$0.00	$0.00	
07/01/2018	11/30/2018	Vision	Waive - Waive	$0.00	$0.00	$0.00	$0.00	
07/01/2018	11/30/2018	Basic Life	Basic Life - Employee Only	$10000.00	$0.00	$0.00	$0.00	
07/01/2018	11/30/2018	Basic AD&D	Basic AD&D - Employee Only	$10000.00	$0.00	$0.00	$0.00	
07/01/2018	11/30/2018	Voluntary Life	Voluntary Life - $210,000 **(EOI Required)**	$210000.00	$14.70	$0.00	$14.70	
07/01/2018	11/30/2018	Voluntary AD&D	Voluntary AD&D - $210,000 **(EOI Required)**	$210000.00	$4.20	$0.00	$4.20	

8 Confirm

- A popup will appear asking if you are sure, click “Save and Confirm”.
- Then click “Return to my Homepage” and Log Out.
- On the your Homepage, you can view and print your “Benefit Statement”.



Your enrollment is complete! You can log in and make changes until the close of open enrollment, just make sure to go through to the end and confirm!

Medical Insurance Information

Insurance Terms

Copay or Copayment is an amount you pay for a covered medical service. Copays are usually paid at the time you receive the service.

Deductible is the amount you pay 100% before the insurance company begins to pay.

Out-of-Pocket Limit is the total amount you pay for covered services during a benefit year. These are the amounts you pay for copays, deductibles and coinsurance.

In-Network Providers contract with the insurance company and charge discounted fees. In-network providers or contracting providers apply to HMO, POS and PPO organizations.

Out-of-Network Providers do not contract with the insurance company. Non-contracting providers will probably bill you for the difference between the out-of-network provider's charge and the insurance company's "allowed" amount. You are responsible for the difference and this amount can be significant.

Primary Care Provider (PCP) are usually family practice physicians or pediatricians who are responsible for monitoring and coordinating all your medical care. If you are insured on a POS plan, you must coordinate all care through your PCP. If you need to see a Specialist, the PCP will provide you with a written referral before seeing the Specialist.

Specialists are physicians who have additional education and training for a specific condition. Examples of specialists are dermatologist, urologist, cardiologist, orthopedic surgeon, endocrinologist, ophthalmologist, thoracic surgeon, pulmonologist and obstetrician, to name a few.

Generic Prescriptions

What are generic drugs? Generic drugs are identical to brand-name prescription drugs in dosage, safety, strength, quality and performance. Generics have the same active ingredients. In-active ingredients such as color or flavor may be different. This means you can save money without sacrificing quality.

What are brand-name drugs? Name-brand drugs are medications protected by a patent. This means the manufacturer who created the drug, has the sole right to sell it for a period of time. When the patent expires, other manufacturers can then apply to the FDA to sell generic versions of the drug.

What's the difference? The cost of Generic drugs are usually much less than brand-name drugs. Generic drugs cost less for one reason: drug manufacturers spend a lot of money on researching, developing, marketing and advertising brand-name drugs. Manufacturers of generic equivalents do not have these expenses and the savings are passed on to you.

Generic Drug Programs Several stores offer discount prescription programs offering a variety of generic drugs at a low price. The prescriptions included on each store's list may vary. Check it out. You may be able you to save some money.

Walgreens Walmart Dillons

This is not an endorsement of any store's discount prescription program. Additional stores have similar plans.

Tips to Saving Money

Be Smart - If your employer offers two or more medical plans, learn what your out of pocket cost will be for each plan and how much each plan will cost you. Then choose the plan best meeting your needs. You might be throwing money away by choosing the wrong medical plan.

Prevention - An annual routine physical might save your life and a bunch of money. An annual checkup allows your doctor to run lab tests to see if you have any health issues.

Over There - If medical coverage is available where your spouse works, you might save money by splitting your coverage between both employers. Many employers pay a higher percentage of the premium for single coverage.

Free Advice - Pharmacists know a lot about prescription drugs, so talk to yours about the drugs you take. Your pharmacist might be able to suggest a less expensive alternative you can ask your physician about and save money.

Urgent vs Emergency - Consider going to an Urgent Care Center instead of the Emergency Room. Urgent Care Centers are similar to doctors offices and are much less expensive.

Medical Plans—Aetna

Deductible accumulators reset as of July 1, 2025 for a 12 month period.

Plan year: 07/1/2025 - 06/30/2026 **Deductible Period: 07/01/2025 - 06/30/2026**

	Option 1 - OAMC $2,500 Deductible Plan	Option 2 - OAMC $3,500 Deductible Plan
PCP Office Visits **Walk-in Clinics**	$0 Copay $0 Copay	$30 Copay $30 Copay
Routine Eye Exams **(1 exam per 12 months)**	100% Covered	100% Covered
Specialist Office Visits	$40 Copay after deductible	$60 Copay after deductible
Teladoc (Page 18)	General Medicine: $0 Copay Specialist: $40 Copay after deductible Behavioral Health: $40 Copay	General Medicine: $30 Copay Specialist: $60 Copay after deductible Behavioral Health: $60 Copay
Preventive Services	100% of the allowed amount as specified by Health Care Reform	100% of the allowed amount as specified by Health Care Reform
Diagnostic Laboratory **Diagnostic X-ray/Complex Imaging**	100% coverage Deductible then 100% coverage	20%, deductible waived 20% after deductible
Emergency Services Urgent Care Center Hospital Emergency Room	$40 Copay after deductible $200 Copay after deductible (copay waived if admitted)	$60 Copay after deductible 20% after deductible
Deductible - per plan year	$2,500 Individual $5,000 Family	$3,500 Individual $7,000 Family
Coinsurance	None	20%
Out of Pocket Maximum - Includes Deductible and Copays	$3,500 Individual $7,000 Family	$5,000 Individual $10,000 Family
Lifetime Benefit	Unlimited	Unlimited
Benefit Period	Plan Year	Plan Year
Inpatient Hospital	$250 Copay after deductible	$250 Copay after deductible
Outpatient Hospital	Deductible then 100% coverage	20% after deductible
Mental Health Services Inpatient Outpatient	 $250 Copay after deductible $40 Copay after deductible	 $250 Copay after deductible $60 Copay after deductible
Retail Prescription Drugs Tier 1 Tier 2 Tier 3 Preferred Specialty Non-Preferred Specialty	 20% Coinsurance up to $50 40% Coinsurance up to $55 60% Coinsurance 40% Coinsurance to a Max of $100 40% Coinsurance to a Max of $100	 20% Coinsurance up to $50 40% Coinsurance up to $55 60% Coinsurance 40% Coinsurance to a Max of $100 40% Coinsurance to a Max of $100

This summary assumes eligible medical services are provided by contracting providers.

The benefits shown in this guide are only a summary of the benefits and do not include all the plan's limitations, exclusions, preauthorization requirements and conditions of coverage. Not all services are covered by your health plan. Refer to your plan's summary plan description, insurance company's master policy or certificate of insurance for a complete description of covered benefits.

Medical Plans—Aetna

Deductible accumulators reset as of July 1, 2025 for a 12 month period.

Plan year: 07/1/2025 - 06/30/2026 **Deductible Period: 07/01/2025 - 06/30/2026**

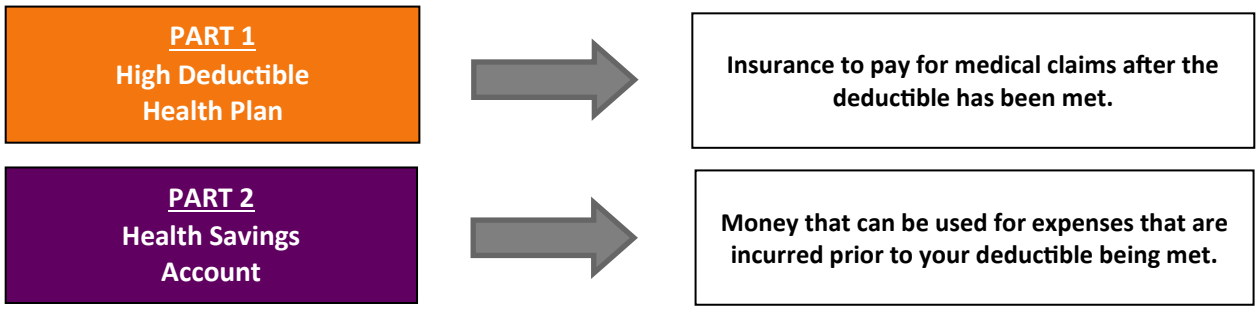
	Option 3 - OAMC $5,000 Deductible Plan	Option 4- OAMC $3,500 High Deductible Plan
PCP Office Visits **Walk-in Clinics**	$20 Copay $20 Copay	20% after deductible 20% after deductible
Routine Eye Exams **(1 exam per 12 months)**	100% Covered	100% Covered
Specialist Office Visits	$40 Copay after deductible	20% after deductible
Teladoc (Page 18)	General Medicine: $20 Copay Specialist: $40 Copay after deductible Behavioral Health: $40 Copay	20% after deductible
Preventive Services	100% of the allowed amount as specified by Health Care Reform	100% of the allowed amount as specified by Health Care Reform
Diagnostic Laboratory **Diagnostic X-ray/Complex Imaging**	100% coverage Deductible then 100% coverage	20% after deductible 20% after deductible
Emergency Services Urgent Care Center Hospital Emergency Room	$40 Copay after deductible $200 Copay after deductible (copay waived if admitted)	20% after deductible 20% after deductible
Deductible - per plan year	$5,000 Individual $10,000 Family	$3,500 Individual $5,600 Family
Coinsurance	None	20%
Out of Pocket Maximum - Includes Deductible and Copays	$6,000 Individual $12,000 Family	$5,000 Individual $10,000 Family
Lifetime Benefit	Unlimited	Unlimited
Benefit Period	Plan Year	Plan Year
Inpatient Hospital	$250 Copay after deductible	20% after deductible
Outpatient Hospital	Deductible then 100% coverage	20% after deductible
Mental Health Services Inpatient Outpatient	$250 Copay after deductible $40 Copay after deductible	20% after deductible 20% after deductible
Retail Prescription Drugs Tier 1 Tier 2 Tier 3 Preferred Specialty Non-Preferred Specialty	20% Coinsurance up to $50 40% Coinsurance up to $55 60% Coinsurance 40% Coinsurance to a Max of $100 40% Coinsurance to a Max of $100	20% Coinsurance after deductible 40% Coinsurance after deductible 60% Coinsurance after deductible 40% Coinsurance after deductible to a Max of $100 40% Coinsurance after deductible to a Max of $100

This summary assumes eligible medical services are provided by contracting providers.
The benefits shown in this guide are only a summary of the benefits and do not include all the plan's limitations, exclusions, preauthorization requirements and conditions of coverage. Not all services are covered by your health plan. Refer to your plan's summary plan description, insurance company's master policy or certificate of insurance for a complete description of covered benefits.

Health Savings Account Info

High Deductible Health Plan & Health Savings Account

If you enroll in Option 4, the Qualified High Deductible Plan, you can open an HSA account at Astra Bank which is the district's designated financial institution.



HEALTH SAVINGS ACCOUNT (HSA) ADVANTAGES:

- You own the account and it stays with you if you should leave employment with USD 489.
- All contributions and earnings on the account are tax free.
- You are fully vested in the account immediately.
- If you retire or leave employment the account stays with you.
- Balances in the account roll-over from year to year with no aggregate maximum—you do not lose the money.

QUALIFIED MEDICAL EXPENSES:

Deductibles	Prescriptions	Orthodontics	Breast Pumps & Accessories
Copays	Dental Expenses	Glasses/Contacts	Chiropractic Care
Coinsurance	Vision Expenses	Ambulance/ER Services	Long Term Care Services
OTC Medications: Written prescriptions will no longer be required for Over the Counter (OTC) drugs, including items like Tylenol, Claritin, Tamiflu, etc. when purchased with an FSA or HSA.			
Menstrual Care Products: Menstrual care products, including items like tampons, pads, cup, etc. are now eligible expenses under an FSA or HSA.			

For more information, refer to IRS Publication 969: **https://www.irs.gov/pub/irs-pdf/p969.pdf**

For a complete list of eligible expenses referred to in publication 969, you can visit: **https://www.irs.gov/taxtopics/tc502**

Please Note:

⇒ The USD 489 District does not contribute to your Health Savings Account

⇒ Once you are enrolled in any part of Medicare, you are no longer eligible to contribute to your Health Savings Account.

Health Savings Account Q & A

1. **Who can have an HSA?** The individual must be:
   1)covered by a HDHP (only Option #4);
   2)not covered under other health insurance;
   3)not enrolled in Medicare; and
   4)not another person's dependent.
2. **Where can I open an HSA?** Astra Bank is the district's designated financial institution.
3. **When do I see the tax savings?** When you do your taxes at the end of the year, it will be an above the line deduction, therefore your taxable income is reduced by the amount you contributed to your HSA.
4. **If I switch jobs, do I lose my money?** No. The money in your HSA is yours. Whatever money you contribute to your HSA is yours, just like if you had a bank savings account. If you do not use all your HSA money during the year, it will roll over to the next year.
5. **How much can I contribute to my HSA account?** In 2025, with single coverage, you can contribute up to $4,300 per year and if two or more are insured, you can contribute up to $8,550 per year. Age 55+ can contribute an additional $1,000. Limits apply.
6. **What are some examples of HSA qualifying expenses?** HSA qualifying expenses include doctor office visits, prescription drugs, eye exams, glasses, contact lenses, chiropractors, laser eye surgery and birth-control prescriptions, to name a few. There are many more eligible items you can pay for with HSA money. You can get a list of covered expenses at www.irs.gov.
7. **What happens if I lose my health insurance?** You may continue to use your HSA money to pay for eligible expenses, even if you do not have a qualifying health insurance plan, but you cannot keep contributing money to your HSA.
8. **Can I use my HSA money to pay for my premiums?** HSA money can pay for health insurance premiums if you are collecting Federal or State unemployment benefits or are paying COBRA premiums.
9. **What if I need medical care in another country?** You can use your HSA money for the same medical expenses anywhere in the world.
10. **Can I withdraw my HSA money if I need to?** Yes, but the withdrawal is taxable and you will pay a 20% penalty for non-qualifying withdrawals.
11. **When I die, do I lose my HSA money?** No. You can name a beneficiary to receive your HSA money.
12. **How much does it cost to set up an HSA?** This depends on the bank or credit union you choose. Most usually have a one time set up fee, monthly fee, debit card fees, printed check fees, and overdraft fees. Shop around for the lowest fees.
13. **Can my HSA be used for dependents not covered by the health insurance?** Generally, yes. Qualified medical expenses include unreimbursed medical expenses of the account holder, his or her spouse, or dependents, even if they are not insured by a qualified HDHP.
14. **Do I need to keep any records when I use my HSA?** Although some financial institutions track the use of the HSA for you, it is a good idea to keep your own records. It is your responsibility to track the use of your HSA account and you may be required to show proof of your expenditures to the IRS. We recommend you designate a place to store all your receipts so they are available when you need them.
15. **What if I do not use all of the money in my HSA account by the end of the year?** All the money deposited in your HSA, but not spent during the year, rolls over to the next year. HSA's do not have a "use or lose it" provision. You have the option of accumulating money in your HSA to pay for future eligible expenses and never pay taxes on the money.
16. **Can I deposit additional money into my HSA account without going through payroll?** Yes, you can make deposits directly to your HSA, but you will not have the advantage of a pre-tax deposit until you file your income taxes. It is your responsibility to remember to claim these direct deposits on your income tax return.
17. **Will my bank notify me if I have exceeded my allowable contribution amount?** No, it is your sole responsibility to keep track of the amounts deposited and spent from your account.

IMPORTANT

You should open your HSA account prior to the effective date of your Qualified High Deductible Health Plan (QHDHP). Medical costs incurred after your HDHP is effective, but before your HSA account is established, cannot be paid with money deposited in your HSA account.

Retiree Premiums

-USD 489's covered Medical Plan is Option 2

Retirees capped at $575.81 district contribution					
	Option 1	Option 2	Option 3	Option 4	Dental
Member Only	$ 366.39	$ 305.91	$ 239.68	$ 254.62	$41.80
Member and Spouse Only	$ 1,308.60	$ 1,187.63	$ 1,055.17	$ 1,085.04	$82.70
Member and Child(ren) Only	$ 1,139.00	$ 1,028.92	$ 908.38	$ 935.56	$104.16
Member and Family	$ 1,732.59	$ 1,584.41	$ 1,422.14	$ 1,458.73	$161.35

Retirees capped at $500.00 district contribution					
	Option 1	Option 2	Option 3	Option 4	Dental
Member Only	$ 442.20	$ 381.72	$ 315.49	$ 330.43	$ 41.80
Member and Spouse Only	$ 1,384.41	$ 1,263.44	$ 1,130.98	$ 1,160.85	$ 82.70
Member and Child(ren) Only	$ 1,214.81	$ 1,104.73	$ 984.19	$ 1,011.37	$ 104.16
Member and Family	$ 1,808.40	$ 1,660.22	$ 1,497.95	$ 1,534.54	$ 161.35

Retirees capped at $400.00 district contribution					
	Option 1	Option 2	Option 3	Option 4	Dental
Member Only	$ 542.20	$ 481.72	$ 415.49	$ 430.43	$ 41.80
Member and Spouse Only	$ 1,484.41	$ 1,363.44	$ 1,230.98	$ 1,260.85	$ 82.70
Member and Child(ren) Only	$ 1,314.81	$ 1,204.73	$ 1,084.19	$ 1,111.37	$ 104.16
Member and Family	$ 1,908.40	$ 1,760.22	$ 1,597.95	$ 1,634.54	$ 161.35

Aetna Physician Search

It is important for you to verify each of your medical providers are *"contracting providers"* prior to each service. Your out of pocket cost will be substantially lower if you receive services from contracting providers.

Find A Doctor, Facility or Urgent Care

How to find:

1. Go to www.aetna.com/docfind
2. "Continue as a Guest" (right side of page) or if you are already registered, log in (left side of page)
3. Under "Select a Plan" enter plan name to narrow list or scroll down until you see the desired network. Plans are subcategorized with different like headers.

   Under: "**Aetna Open Access Plans**"

   Choose: "**Managed Choice POS (Open Access)**"

6. Search or select a category (ex. Primary Care Physician or Urgent Care)

Aetna Member Website

Aetna's Member Website gives you access to tools and resources to help you manage your benefits. All of your plan information and cost-saving tools are in one place. After your coverage effective date, you can register at **www.aetna.com** and then log in anytime.

You can use the site for the following:

- Search for providers & walk-in clinics
- Change your Primary Care Physician
- View & sort claims
- Get coverage details
- Compare costs
- Get treatment options
- Find pharmacies & Order medicine
- Start a wellness program
- View discounts & perks

Aetna Medication Information

Choose Generic

Taking a generic is an easy way to reduce your out-of-pocket costs. They are as safe and effective as their brand-name counterparts and often cost less. Your plan sometimes requires you to use a generic drug when one is available. This could help you get the best coverage. You and your doctor may still decide that you want to get the brand-name version of a drug. If so, your doctor will write "DAW" on your prescription. This stands for "Dispense as written." In this case, your pharmacist will only fill your prescription with the brand-name drug.

Please know that if a generic is available and you choose to get the brand instead, you'll pay the difference in cost between the brand and the generic. Plus, you'll pay the applicable plan copay. This could result in a significant increase in your out-of-pocket expenses. The out-of-pocket cost difference between the generic and brand may not be applied to your deductible or your out-of-pocket max.

If you want to try a generic version, please talk to your doctor about changing your prescription. If you cannot tolerate the generic or have had an adverse reaction, talk to your doctor about requesting an exception.
Generic drugs are as safe as brand-name drugs! While you may pay less with generics, you won't lose out on quality. U.S. Food and Drug Administration (FDA)-approved generic drugs must be equivalent to the brand-name drug.

Aetna Medication Information

Medication Search

You and your doctor can search for a drug, find out if it's covered and see what tier it falls under. You can also see if there are alternatives that cost less. Make sure your doctor knows that you pay more for 2-4 tier drugs. The formulary list is subject to change throughout the year.

Take these steps:

1. Visit **www.aetna.com/formulary.**
2. Scroll down to "**Choose your plan"**; Select **"2025"** as the plan year; Select **"Advanced Control Plans - Aetna"**
3. Click "Search to see if drug is covered" and search prescription drug name or open the **Aetna Drug Guide.**
4. This is where you can see what tier your drug falls under and where you can learn more about the types of drug coverage reviews your drug requires such as precertification, step therapy or quantity limits.

CVS Caremark Home Delivery (Mail Order)

Maintenance medications may be filled and refilled using CVS Caremark Home Delivery. You can get up to a 90-day supply sent to your home or any location you choose. Shipping is quick, confidential and standard shipping is free!

Step 1 - Ask your doctor to write TWO prescriptions.

Prescription #1: Is for a one-month supply. Fill it at a local retail pharmacy. With this short-term supply, you will have enough of your medicine on hand to see you through until your first Aetna CVS Caremark Home Delivery order arrives.

Prescription #2: Is typically for a 90-day supply (with three refills). Send this one to Aetna Rx Home Delivery.

Step 2 - Choose one of these ways to submit your order:

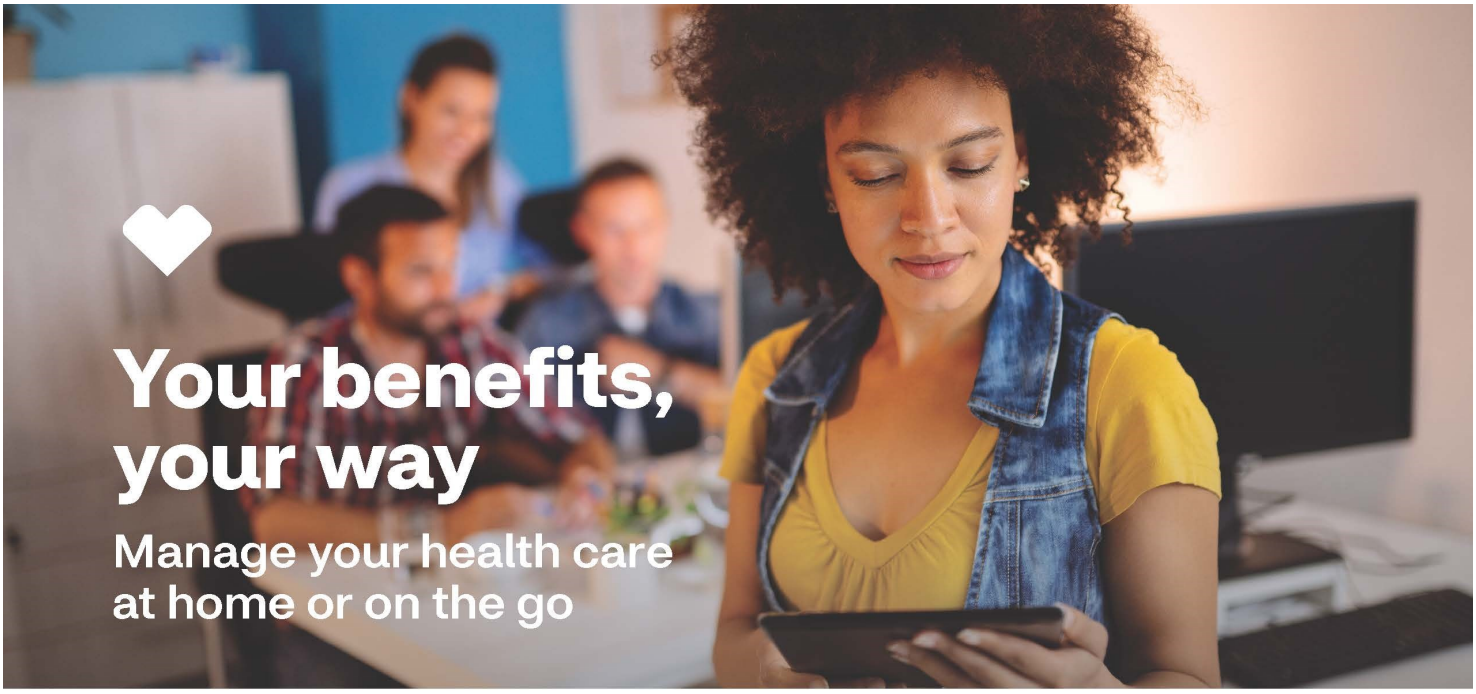
- Online—Log in to your secure member website. There you can add or remove prescriptions.
- Phone—Call us 24/7 at 1-888-792-3862
- Mail— Mail your Rx to us with a completed order form. You can find the form on your secure member website. The mailing address is on the form.

Your doctor can send an electronic prescription (e-prescribe) to CVS Caremark Mail Service Pharmacy. Give your doctor this number, (NPI: 1881952851), to send your prescription to us.

Things to keep in mind!

- We'll need to hear from you before we ship you refills. This is called Ship Consent and is a required step for Medicare prescriptions.
- Let us know your preferred method of payment. We'll need this information to process your order in a timely manner.
- You can only get the amount of medication that your doctor prescribes. Ask your doctor to write a 90-day prescription. Your plan may have quantity limits on your medication that may determine how much you get per month.
- We may substitute a generic version for a brand name medicine, unless your doctor writes "dispense as written." Generic drugs are clinically equivalent to brand-name medication but often cost you less.

Aetna Health App



Stay on top of your benefits

- Review your benefits and what's covered.
- Track your spending.
- View claims on your member website.
- See your ID card online.
- Get cost info before you get care.*

Connect to care

- Find in-network providers, including virtual care.
- Locate walk-in clinics and urgent care centers near you.
- See reviews of providers.

Get started today

Visit **MyAetnaWebsite.com** to register for your member website.

Get the **Aetna Health℠ app** by texting **"AETNA"** to **90156** to receive a download link. Message and data rates may apply.**

— OR —

Scan the QR code to download the **Aetna Health℠ app**.

*Estimated costs are not available in all markets or for all services. We provide an estimate for the amount you would owe for a particular service based on your plan at that very point in time. It is not a guarantee. Actual costs may differ from an estimate for various reasons including claims processing times for other services, providers joining or leaving our network or changes to your plan. Health maintenance organization (HMO) members can only get estimated costs for doctor and outpatient facility services.

Terms and Conditions: **Aet.na/Terms. Privacy Policy: **Aetna.com/legal-notices/privacy.html**. By texting 90156, you consent to receive a one-time marketing automated text message from Aetna® with a link to download the Aetna Health℠ app. Consent is not required to download the app. You can also download by going to the Apple® App Store® or Google Play.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Aetna.com

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aetna®

Better health starts here

Check in with yourself

How are you feeling these days? Maybe you're not sleeping well. Or it's been a while since you've visited the dentist. Taking a health assessment can tell you how you're doing — and what steps you can take to feel better. And it only takes a few minutes to complete.

Taking a health assessment can help you:

- Find ways to **improve your health**
- **Prevent health problems** before they occur
- **Learn helpful tips** for living a healthier life
- **Understand your health** better with a detailed report

Just log in to your member website at **Aetna.com** and select "Well-being Resources."

Aetna.com

97.03.347.1 (1/21)

aetna®

AHYW-CORE DIGITAL COACHING-MEMBER

A path to health that works for you

No matter what your health goals are, our digital coaching tools can help you achieve them. You can work on things like being more active, losing weight, eating better and more.

Digital coaching provides:

- Fun games, quizzes and videos
- Small bites of helpful information
- Access to group coaching classes
- Daily activities that can help you keep moving forward

Visit your member website at **Aetna.com** and select "Well-being Resources."

Aetna.com
97.03.345.1 (1/21)

aetna®

Aetna Tools and Programs

Concierge Service

A concierge is here to help. Simply call the number on your Aetna ID card or log in to your secure member website at **www.aetna.com**.

A concierge can assist you with:

- Asking a question about a diagnosis
- Learning about your coverage
- Selecting a doctor
- Planning for upcoming treatment

Think of the concierge as your personal assistant for healthcare. Your concierge will:

- Find solutions that fit your needs
- Show you how to use the online tools to make the decisions that are right for you.
- Assist you in scheduling appointments
- Find network providers based on your needs

Your concierge can show you how to estimate your costs before you make an appointment. You can find out what it would cost to see a network doctor versus an out-of-network doctor. You can also learn the difference between inpatient and outpatient care as well as the difference in cost.

Call 800-501-9837 to speak with a concierge • Monday - Friday 8 a.m. - 6 p.m.

Human Resources is also a resource for questions or concerns regarding a claim that is already in progress.

24-Hour Nurse Line

With the 24-Hour Nurse Line, you can speak to a registered nurse about health issues that are on your mind — whenever you need to. While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

Call a registered nurse 24/7 as many times as you need and there is no cost: 1-800-556-1555

Member Payment Estimator

MEDICAL COST SAVING

Get real-time personalized cost estimates based on providers negotiated rates, members plan and generated using claims adjudication.

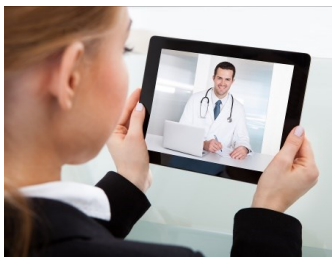
- Compares cost and quality for up to 10 in-network providers at once using real time data
- Includes 650 medical services, tests & procedures.
- Allows you to plan ahead & decide where to go for care

Using the Estimator:

1. Log in to the Aetna member website and select **"Find Care and Pricing"** (towards the center of the page)
2. Enter the type of service that you would like an estimate for.

Aetna Tools and Programs

Teladoc (Virtual Services)



Telemedicine is an alternative to in-person doctor visits. You can see a doctor anytime, anywhere, virtually!

- Available 24/7
- Less time away from work
- The cost is a copay which is billed to you! You pay with a credit card, debit card, FSA card or PayPal just like you would normally.
- Board-certified physicians treat many conditions by phone or video
- Consultation includes diagnosis and recommended treatment, including prescriptions (if appropriate)

WHEN TO USE TELEMEDICINE?

Everyday Care

- Cold/Flu
- Fever
- Migraine
- Sinus Infection
- Allergies
- Stomach Pain
- Pink Eye
- Ear Infection
- Sore Throat

Dermatology

Upload images of a skin issue & get a custom treatment plan within 2 days for things like Eczema, Acne, Rashes and more!

Mental Health Care

Talk to a therapist 7 days a week -
(7am - 9pm local time)

TO GET STARTED:

1) Set up your account
2) Request a Consult
3) Provide Medical History

Teladoc.com/Aetna
Facebook.com/Teladoc
Teladoc.com/mobile
1-855-Teladoc (835-2362)

TELADOC.

Aetna Maternity Program

This program helps members give their babies a healthy start. You'll learn about what to expect before and after delivery, early labor symptoms, newborn care and more.

When you join the program:

- Receive materials on prenatal care, labor and delivery, newborn care, and more.
- Get information for Dad or partner.
- Take our pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy. You'll also get a small gift if you complete the survey and enroll in the program by your 16th week of pregnancy.
- If you smoke, you can join our nicotine-free Smoke-Free Mom-to-Be® program. You'll get educational materials and support from one of our nurses to help you quit smoking for good.
- Maternity Support Center: This no-cost resource is available through your member website and offers information about the maternity journey. Whether you are planning for baby, already pregnant or post delivery, it is personalized for you.

If you have questions, call toll-free 1-800-272-3531

Dental Plan

Included in your Dental Plan:

1 Right Start 4 Kids (RS4K)

The Right Start 4 Kids program removes the cost barriers for dental care by providing children 12 and under 100% coverage, with no deductible, for all services covered under the plan, excluding orthodontics, when an in-network dentist is seen.

**If an out-of-network dentist is seen, the underlying contract applies.*

2 Unlimited Cleanings

Your plan allows for unlimited cleanings. This includes regular/prophylaxis cleanings and periodontal maintenance cleanings. Cleanings are not subject to your deductible but they count toward your maximum benefit.

Calendar Year Deducible: 01/01/2025 - 12/31/2025. Deductible will reset each January

	Enhanced (PPO)	Basic (Premier)	
Diagnostic & Preventive	**100%**	**100%**	**No Deductible – 100% Payment** Oral examinations - 2 times per calendar year Diagnostic x-rays - bitewings once each 12 months/ full mouth once each 5 years Prophylaxis - Unlimited Fluoride applications - up to age 19, 2 times per calendar year Space Maintainers - dependent children under age 14 Sealants - one per lifetime per tooth for dependents under age 16
Basic Services	**80%**	**60%**	**After Deductible – 80% /60% Payment** Emergency exam - 1 per plan year for treatment of pain Oral surgery – including extractions and oral surgery Fillings Endodontic – root canals Periodontics – treatment of diseases of the gums
Major Services	**50%**	**40%**	**After Deductible – 50%/40% Payment** Special Restorative – crowns Prosthodontics – includes bridges and dentures
Deductible			$50.00 per person per calendar year $150.00 maximum per family per calendar year Basic & Majors Services are combined to meet the deductible
Maximum			$1,700.00 per person per calendar year (For all covered services, excluding Diagnostic & Preventive)
Orthodontics	**50%**	**50%**	Includes Ortho appliances & treatment, interceptive and corrective, for dependent children under age 19
Orthodontics Maximum			$1,000.00 per dependent, per lifetime

Your Coinsurance will increase for services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis or preventive oral exam, you will qualify for the Enhanced Benefit Level. The plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis & preventive oral exam. Routine prophylaxes and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

The dental summary assumes eligible dental services are provided by contracting providers. See the plan document for more information.

Dental Plan

Retiree Dental Only Premiums: (Without Medical Insurance)	
Coverage:	**Retiree Premiums**
Employee	$41.80
Emp + Spouse	$82.70
Emp + Child(ren)	$104.16
Family	$161.35

***See page 12 for Retiree Dental rates with Medical**

Find a Dentist

To find contracting Delta Dental providers:

1. On the internet, go to: **www.deltadentalks.com** and click on "Find a Dentist"
2. Select the "Specialty" and under "Your Plan" select:

   Enhanced Benefits: "Delta Dental PPO"

   Basic Benefits: "Delta Dental Premier"
3. Click "Find Dentists"

**If you receive dental services from a non-contracting provider, the benefits will be substantially less.*

Delta Dental Tools

To access or set up your online account, go to www.deltadentalks.com and click "member". From here you can log in or register.

You can:

- View your benefits and print an ID card
- Use the Delta Cost Estimator to estimate procedure costs
- Review your claims
- Access Member Perks

Ways to Save

- Use Delta Premier contracting dentists to receive the most benefit from your dental plan.
- Protect your teeth – brush and floss at least once per day.
- Ask your dentist for a Pre-Treatment Estimate prior to treatments and/or procedures. A treatment plan is usually submitted by a dentist for Delta Dental to review and provide an estimate of benefits before treatment starts. This can help a member budget for dental procedures and predict their out-of-pocket costs.

Voluntary Vision Plans

Benefits below run on a Calendar Year, January 1st to December 31st	Plan 1: Exam + Materials	Plan 2: Materials Only
Annual Eye Exam	Subject to $200 maximum	Not Covered
Lenses (per pair) Single Vision Bifocal Trifocal Lenticular Progressive	Subject to $200 maximum	Subject to $200 maximum
Frames	Subject to $200 maximum	Subject to $200 maximum
Deductibles	$0	$0
Benefit Maximum	$200 per Calendar Year	$200 per Calendar Year
Contact Lenses	Subject to $200 maximum	Subject to $200 maximum

Monthly Premium:

Employee Only	$15.44	$11.20
Employee + Spouse	$27.68	$22.04
Employee + Child(ren)	$25.44	$19.68
Family	$39.04	$30.36

How to use your Vision Plan:

1. Select an eye doctor of your choice - No network requirement!
2. Pay the doctor for all services
3. Submit a claim to Reliance Standard for reimbursement **within 60 days of the date of service.**

*Dependents are covered up to age 26

Extra Eyewear Savings at Walmart Vision Centers:

Plan members may receive up to 15% off eyewear frames and lenses purchased at any Walmart Vision. To receive the eyewear savings identification card, plan members can visit reliancestandard.com/dental-vision and sign-in (or create) a secure member account. Members must present the Eyewear Savings Card at time of purchase to receive the discount.

Notices

SUMMARY OF COBRA BENEFITS

A temporary extension of health benefits may be available In certain instances where coverage under the plan would otherwise end. Please refer to the COBRA Notice previously provided to review your rights and obligations under the continuation of coverage provisions of the law. Covered individuals experiencing a qualifying event may continue coverage as outlined in the chart below. Your coverage will be billed directly from the insurance company at the group rate plus a 2% administrative fee. The health, dental and vision may be continued under COBRA.

Qualifying Event	Qualified Beneficiary	Number of Months
Employee terminates employment or hours reduced.	Employee and all covered dependents.	18
Employee loses coverage because the employer files for Chapter 11 bankruptcy.	Employee and all covered dependents.	18
The employee becomes disabled.	Employee and all covered dependents.	29
The employee becomes eligible for Medicare due to age while on COBRA.	All covered dependents.	36
The employee's death.	All covered dependents.	36
Divorce or legal separation.	All covered dependents.	36
Dependent child no longer qualifies as a dependent (e.g., reaches the maximum dependent age).	Dependent child upon reaching the maximum dependent age.	36

HIPAA Special Enrollment Rights

USD 489 Hays Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the USD 489 Hays Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Employee Services at 785-623-2400 or employeeservices@usd489.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Patient Protections Disclosure

The USD 489 Hays Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Aetna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Aetna at 800-501-9837 or www.aetna.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Aetna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Aetna at 800-501-9837 or www.aetna.com.

Newborns' and Mothers' Health Protection Act

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

Notices

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

USD 489 Hays is committed to the privacy of your health information. The administrators of the USD 489 Hays Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Employee Services at 785-623-2400 or employeeservices@usd489.com.

Women's Health & 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 the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Option 1 - OAMC $2,500 Deductible Plan (Individual: coinsurance none and $2,500 deductible; Family: coinsurance none and $5,000 deductible)

Plan 2: Option 2 - OAMC $3,500 Deductible Plan (Individual: 20% coinsurance and $3,500 deductible; Family: 20% coinsurance and $7,000 deductible)

Plan 3: Option 3 - OAMC $5,000 Deductible Plan (Individual: coinsurance none and $5,000 deductible; Family: coinsurance none and $10,000 deductible)

Plan 4: Option 4 - OAMC $3,500 High Deductible Plan (Individual: 20% coinsurance and $3,500 deductible; Family: 20% coinsurance and $5,600 deductible)

If you would like more information on WHCRA benefits, please contact our Employee Services Department at 785-623-2400 or employeeservices@usd489.com.

Notices

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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: 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+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Notices

GEORGIA – Medicaid	INDIANA – Medicaid
GA 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-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

Notices

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2024, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Notices

Notice of Creditable Coverage

Important Notice from USD 489 Hays

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with USD 489 Hays 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. **USD 489 Hays has determined that the prescription drug coverage offered by the medical plan 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 to December 7th.

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current USD 489 Hays coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current USD 489 Hays coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with USD 489 Hays 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 USD 489 Hays changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this 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).

Date:	**July 01, 2025**
Name of Entity/Sender:	**USD 489 Hays**
Contact—Position/Office:	**Amy Beckman - Employee Services Director**
Office Address:	**323 West 12th Street**
	Hays, Kansas 67601
	United States
Phone Number:	**785-623-2400 ext. 151**

Contacts

Aetna		**Download the Aetna Mobile App!**
Concierge Phone:	1-800-501-9837	· Find in-network doctors & facilities
Rx Phone:	1-888-792-3862	· Access your ID card
Website:	www.aetna.com	· Review claims & coverage

Delta Dental of Kansas		**Download the Delta Dental App!**
Member Services:	Local: 316-264-4511 1-800-234-3375	· Find in-network dentists
Website:	www.deltadentalks.com/Subscribers	· Access your ID card · Review claims & coverage

Reliance Standard	
Customer Service:	1-800-351-7500
Website:	www.reliancestandard.com

Gallagher Benefit Services	
Phone:	316-977-9779
Fax:	316-685-5520
Website:	www.ajg.com
Email:	Wichita.GBS.Info@ajg.com

Helpful Tools:

GoodRx		**Download the GoodRx Mobile App!**
Good Rx collects & compares prices from over 70,000 pharmacies. You can also find discounts and print free coupons.		
Website:	www.goodrx.com	

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