Aides, Paras, & Classroom Support

Employee Benefit Guide

Effective July 1, 2024

Welcome to your 2024 Benefit Guide

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 49-50 where Notice of Creditable Coverage begin for more details.

***ALL EMPLOYEES ARE REQUIRED TO COMPLETE THE ONLINE ENROLLMENT EVEN IF YOU WAIVE ALL OF THE BENEFITS.**

The District provides a wide range of employee benefits for you and your dependents and encourage you to thoroughly evaluate your needs and the needs of your family before enrolling or declining to participate in any of the benefit plans. This Benefit Guide contains a overview of some elements of the employee benefit plans sponsored by USD 489 Hays.

This Guide is intended to provide a summary of the main features of our benefits package. It is much shorter and less technical than the legal documents and contracts that govern our benefits. We have made every effort to make sure the information in this Guide is accurate; however, in the case of any discrepancy, the provisions of the legal plan documents and insurance certificates will govern.

Each plan may be amended or terminated at the sole discretion of the District. Nothing in this guide is intended to guarantee employment of any employee with the USD 489 Hays.

If you do not enroll at your first opportunity, you may only be able to enroll during an annual open enrollment period or during a special enrollment period. Since your premiums are paid through a Section 125 Plan, you will not be able to terminate coverage until the next open enrollment period, unless you terminate employment or have a qualified Election Change Event. If you have questions, contact the your HR Department.

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 2024, 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/

Eligibility Information

Benefit	Eligibility Requirements	Additional Information
Medical/Prescription/Dental Plans (District Contribution)	30+ hours per week	Beginning of the month after 30 days of employment
Medical/Prescription/Dental Plans (Partial District Contribution)	30+ hours per week	Beginning of the month after 30 days of employment
Health Savings Account	30+ hours per week Must enroll in HDHP	Beginning of the month after 30 days of employment
Vision Plan	30+ hours per week	Beginning of the month after 30 days of employment
District Paid Life Insurance/ Voluntary Life Insurance	18.75+ hours per week	Beginning of the month after 30 days of employment
Health Flexible Spending Account	30+ hours per week	Beginning of the month after 30 days of employment OR open enrollment
Dependent Care Spending Account	30+ hours per week	Beginning of the month after 30 days of employment OR open enrollment
3-1 Supplemental Plan	30+ hours per week	Beginning of the month after 30 days of employment
Legal Shield	30+ hours per week	Beginning of the month after 30 days of employment
403b, 457, Roth 403b	30+ hours per week	Payroll period following enrollment
KPERS	18.75+ hours per week	Beginning first day of employment
KPERS Group Life Insurance	18.75+ hours per week must be eligible for KPERS	Through KPERS, beginning first day of employment (1 1/2 x salary)
Sick Leave & Personal Leave	30+ hours per week	Beginning 30 days after first day of employment (adjusted for budgeted

Open Enrollment Online Instructions

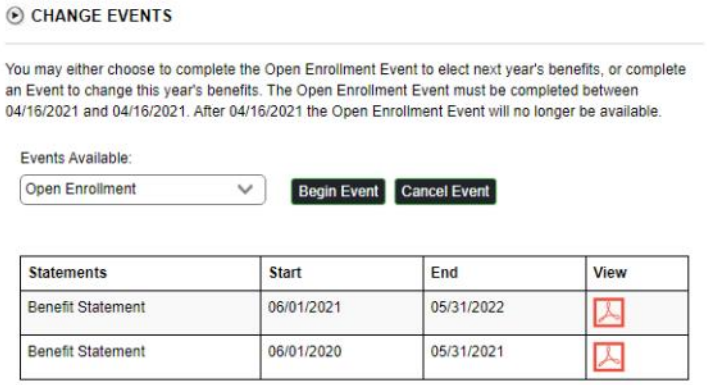
***ALL EMPLOYEES ARE REQUIRED TO COMPLETE THE ONLINE ENROLLMENT EVEN IF YOU WAIVE ALL OF THE BENEFITS.**

1 Login to ARCORO/INFINITY HR site

- **Go to https://identity.arcoro.com/Account/Login**
- **Choose the box on the left (Benefits) and click the arrow**
- 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"

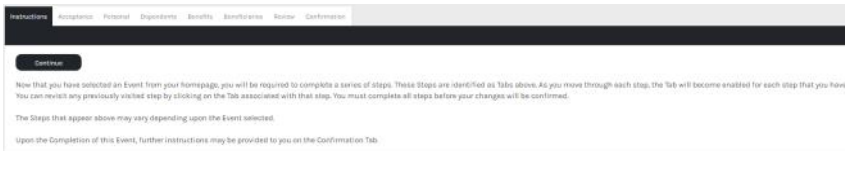
*To access this system you must have a valid account created for you. If you have forgotten your login information, and you have a valid email address on file, you can click the appropriate link below the login button, and your information will be sent to you.

2 Click "Begin Event" on Homepage

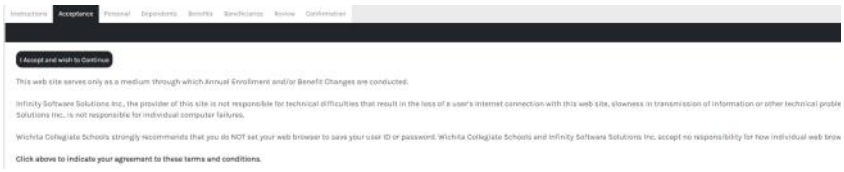


- Review Homepage
- The Drop Down should say " Open Enrollment"
- Then click "Begin Event"

3 Authorization Pages

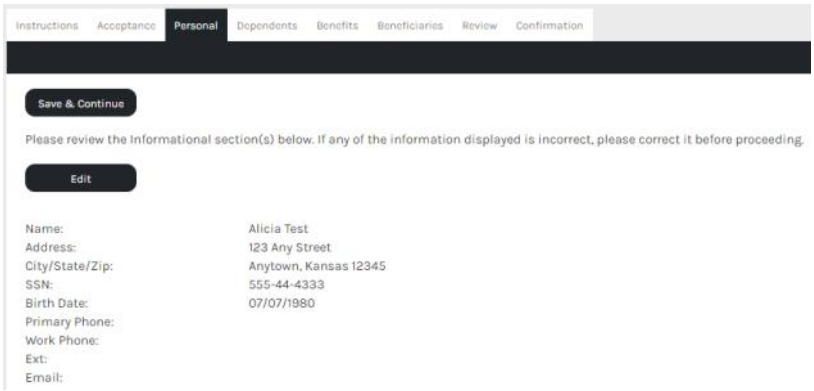


- Click "Continue"



- Click "I Accept…"

4 Confirm Personal Info



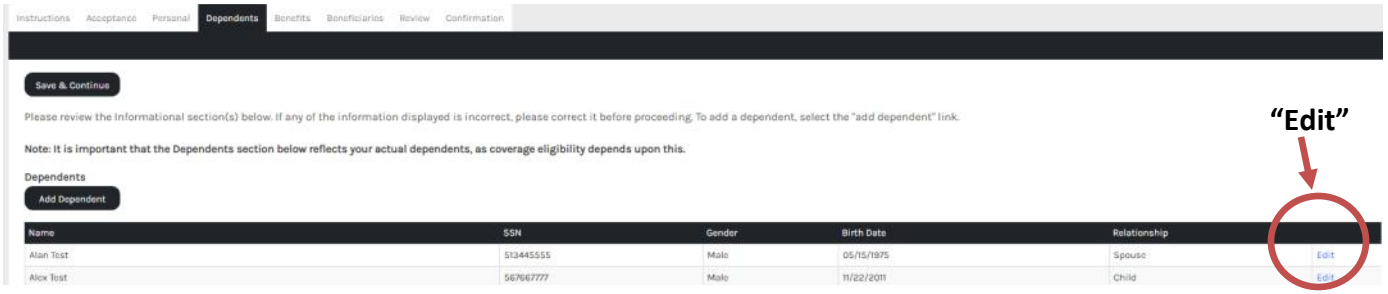
- Review personal information.
- To make a change, click "Edit" and enter your information.
- When finished, click "Save and Continue".

Open Enrollment Online Instructions

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

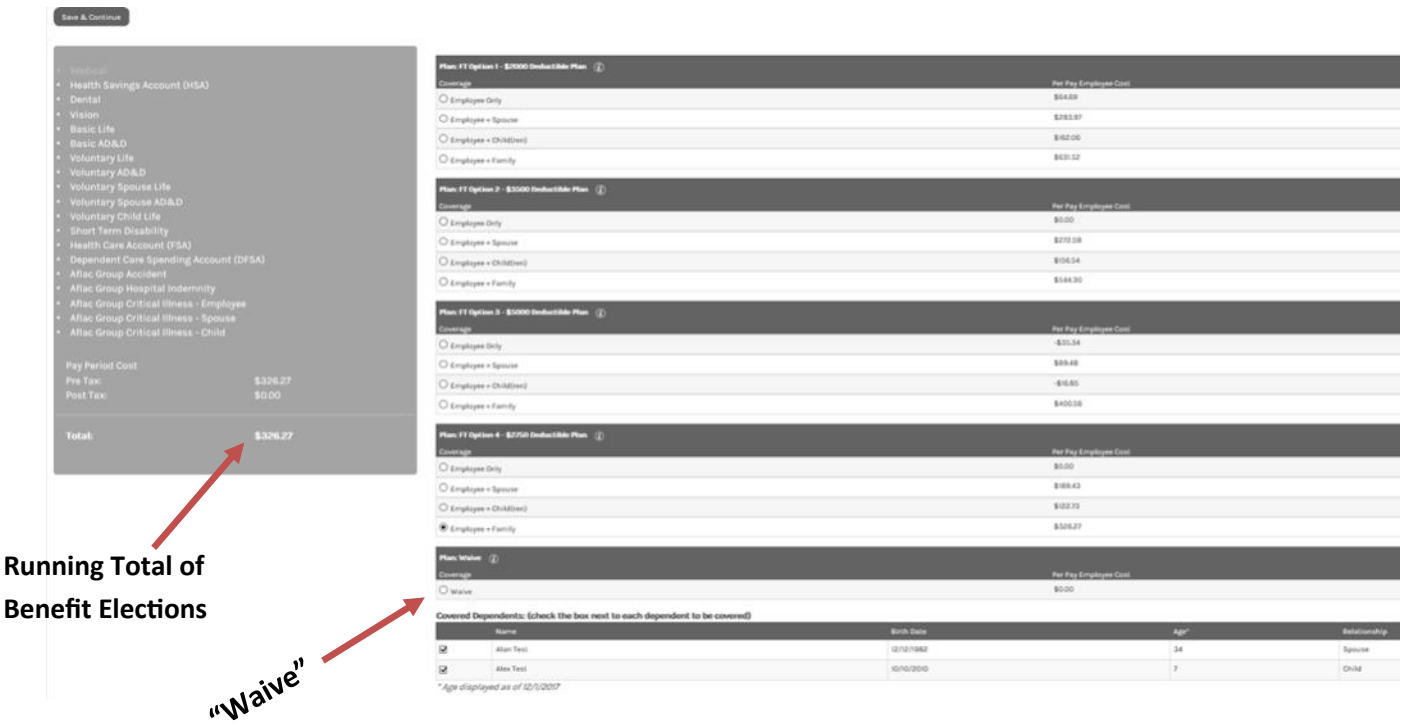
5 Confirm Spouse and/or Dependent Info

- 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.

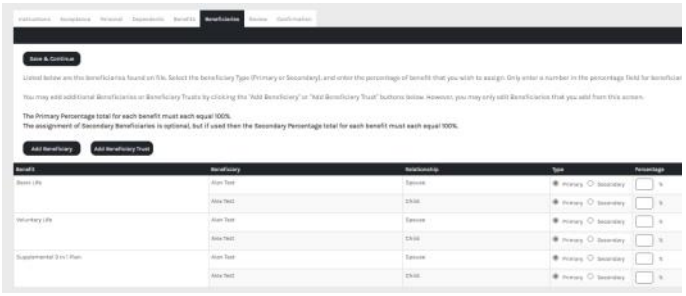


If you elect Option 4, the High Deductible Health Plan, you will also need to PRINT and COMPLETE the HSA Packet. If you have previously completed this packet and the information is still correct, you don't need to complete it again. The form is located on the top of the HSA election page and needs to be returned to the District Office.

Open Enrollment Online Instructions

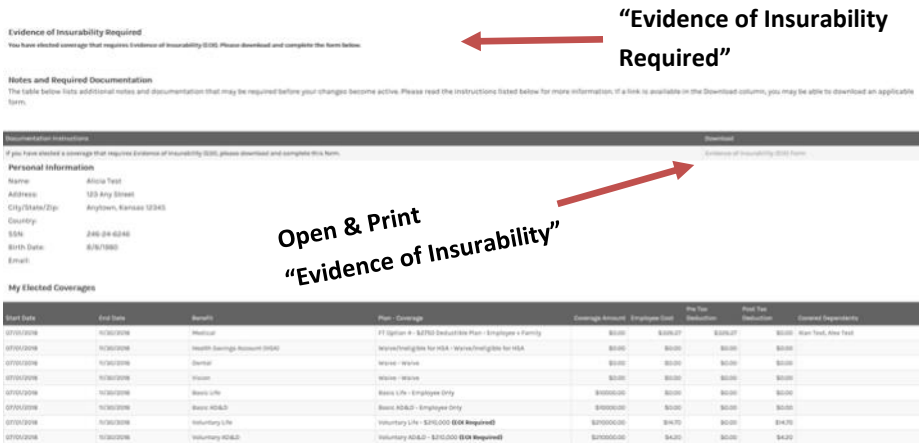
7 Enter Beneficiaries

- Select a Primary Beneficiary for each benefit. If you need to add a beneficiary, click “Add Beneficiary” and complete the information. You can add multiple beneficiaries, however the total percentage must equal 100%.
- Repeat if you choose to enter a Contingent Beneficiary. If not, leave “Primary” clicked and enter 0.
- When finished, click “Save and Continue”.



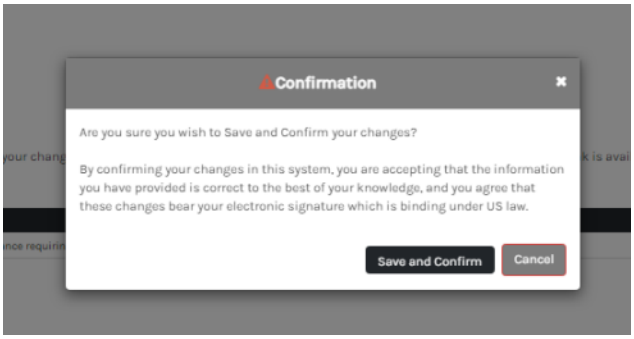
8 Review

- Review information on Review Step.
- Click “Save & Confirm” to confirm your enrollment.
- It will tell you if you selected a benefit that requires Evidence of Insurability (EOI). You will need to complete this form and return to HR. The EOI form is located on the employee benefit website.



9 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.

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.

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.

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

Walgreens Walmart Dillons

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, 2024 for a 12 month period.

Plan year: 07/1/2024 - 06/30/2025 **Deductible Period: 07/01/2024 - 06/30/2025**

	Option 1 - OAMC $2,000 Deductible Plan	Option 2 - OAMC $3,500 Deductible Plan
PCP Office Visits **Walk-in Clinics**	$20 Copay $20 Copay	$20 Copay $20 Copay
Routine Eye Exams **(1 exam per 12 months)**	100% Covered	100% Covered
Specialist Office Visits	$40 Copay after deductible	$40 Copay after deductible
Teladoc (Page 19)	General Medicine: $20 Copay Specialist: $40 Copay after deductible Behavioral Health: $40 Copay	General Medicine: $20 Copay Specialist: $40 Copay after deductible Behavioral Health: $40 Copay
Preventive Services	100% of the allowed amount as specified by Health	100% of the allowed amount as specified by Health
Diagnostic Laboratory **Diagnostic X-ray/Complex Imaging**	Covered 100% Deductible then 100% coverage	Covered 100% Deductible then 100% coverage
Emergency Services Urgent Care Center Hospital Emergency Room	 $40 Copay after deductible $200 Copay after deductible	 $40 Copay after deductible $200 Copay after deductible
Deductible - per plan year	$2,000 Individual $4,000 Family	$3,500 Individual $7,000 Family
Coinsurance	None	None
Out of Pocket Maximum - Includes Deductible and Copays	$3,500 Individual $7,000 Family	$4,000 Individual $8,000 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	Deductible then 100% coverage
Mental Health Services Inpatient Outpatient	 $250 Copay after deductible $40 Copay after deductible	 $250 Copay after deductible $40 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, 2024 for a 12 month period.

Plan year: 07/1/2024 - 06/30/2025 **Deductible Period: 07/01/2024 - 06/30/2025**

	Option 3 - OAMC $5,000 Deductible Plan	Option 4- OAMC $3,200 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 19)	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**	Covered 100% 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	 20% after deductible 20% after deductible
Deductible - per plan year	$5,000 Individual $10,000 Family	$3,200 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 Office visits which does apply the copay	 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

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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. **In order to get the district match you will be required to contribute a minimum monthly contribution of $50.** **You will also need to complete the HSA Packet** and return it to the district office so that they can make payroll contributions on your behalf.

STOP

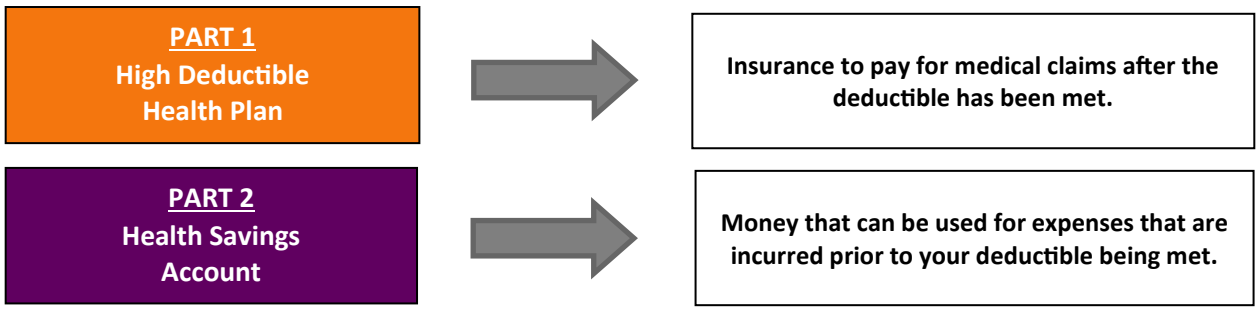
You MUST open a HSA account in order to benefit from Employee and District monthly contributions.

1. **Enroll in HDHP**
2. **Open HSA account at Astra Bank**
3. **Deliver HSA packet to Payroll office.**

Full Time Employee	
Employee Only:	$53 per month
Two or more persons:	$58 per month

** The total annual contribution of USD 489 and the employee combined, can not exceed the Federal Maximum.*

HOW IT WORKS:



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 are not 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 eligible expenses under an FSA or HSA.			

*See IRS publication 502 for a full list of eligible expenses.

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?** District contributions and your payroll deducted contributions are Pre-Tax. Contributions made outside of that will be an above the line deduction when you do your taxes at the end of the year.
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 2024, with single coverage, you can contribute up to $4,150 per year and if two or more are insured, you can contribute up to $8,300 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.

Medical Deductions

Aetna Option 1 - $2000 Deductible Plan			
Plan Tier	Total Monthly Premium	District Contribution for FT Emp	Full Time Employee Deduction
Employee Only	$942.20	$ 675.00	$ 267.20
Emp + Spouse	$1,884.41	$ 854.00	$ 1,030.41
Emp + Child(ren)	$1,714.81	$ 854.00	$ 860.81
Family	$2,308.40	$ 854.00	$ 1,454.40

Aetna Option 2 - $3500 Deductible Plan			
Plan Tier	Total Monthly Premium	District Contribution for FT Emp	Full Time Employee Deduction
Employee Only	$881.72	$ 675.00	$ 206.72
Emp + Spouse	$1,763.44	$ 854.00	$ 909.44
Emp + Child(ren)	$1,604.73	$ 854.00	$ 750.73
Family	$2,160.22	$ 854.00	$ 1,306.22

Aetna Option 3 - $5000 Deductible Plan			
Plan Tier	Total Monthly Premium	District Contribution for FT Emp	Full Time Employee Deduction
Employee Only	$815.49	$ 675.00	$ 140.49
Emp + Spouse	$1,630.98	$ 854.00	$ 776.98
Emp + Child(ren)	$1,484.19	$ 854.00	$ 630.19
Family	$1,997.95	$ 854.00	$ 1,143.95

Aetna Option 4 - $3200 HDHP - Health Savings Account				
Plan Tier	Total Monthly Premium	District Contribution for FT Emp	Full Time Employee Deduction	Full Time District Contribution to HSA
Employee Only	$830.43	$ 675.00	$ 155.43	**$ 53.00**
Emp + Spouse	$1,660.85	$ 854.00	$ 806.85	**$ 58.00**
Emp + Child(ren)	$1,511.37	$ 854.00	$ 657.37	**$ 58.00**
Family	$2,034.54	$ 854.00	$ 1,180.54	**$ 58.00**

**** Employees are required to make a minimum monthly contribution of $50 to a Health Savings Account in order to be eligible for the District Contribution, in which case a Health Savings Account must be established at Astra Bank. Once this information is received in our Payroll Department, the deductions will begin.**

DISCLAIMER: THE BOARD CONTRIBUTION IS SUBJECT TO CHANGE BASED ON NEGOTIATIONS.

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
2. Click "Find a Doctor"
3. Under "Guests" select "Plan from an employer"
4. Under "Continue as a Guest", enter your location (zip code, city, county, or state) and then click Search
5. 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 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** and click "Find a Medication"
2. Scroll down to "**Choose your plan"**; Select **"2024"** 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.

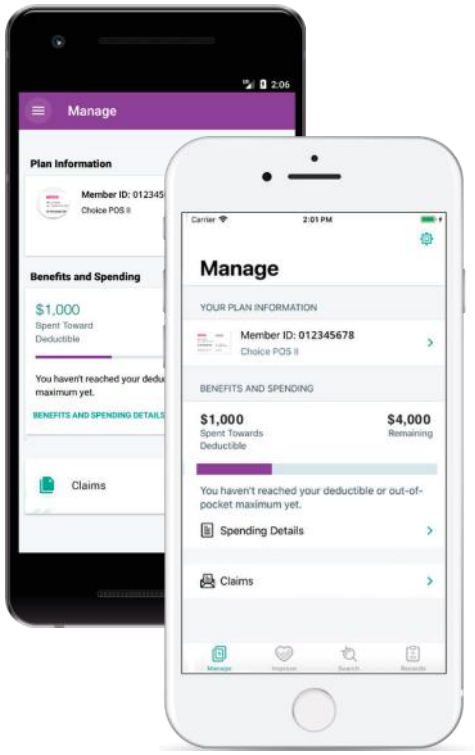
Things to keep in mind!

- 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

Staying healthy is important. So is keeping track of your benefits. But with everything else you have going on, managing it all can be a challenge.

The Aetna Health app can help. From finding a doctor and estimating costs to tracking progress on your personal health goals, the app is your all-in-one resource for information and inspiration.



- **View benefits & pay claims for your whole family**
- **Search for providers, procedures & medications**
- **Get cost estimates before you get care**
- **Access your ID card whenever you need it**
- **Get recommended health actions on your profile**

Text **"AETNA"** to **90156**
to receive a link to download the Aetna Health℠ app.

(Message and data rates may apply.*)

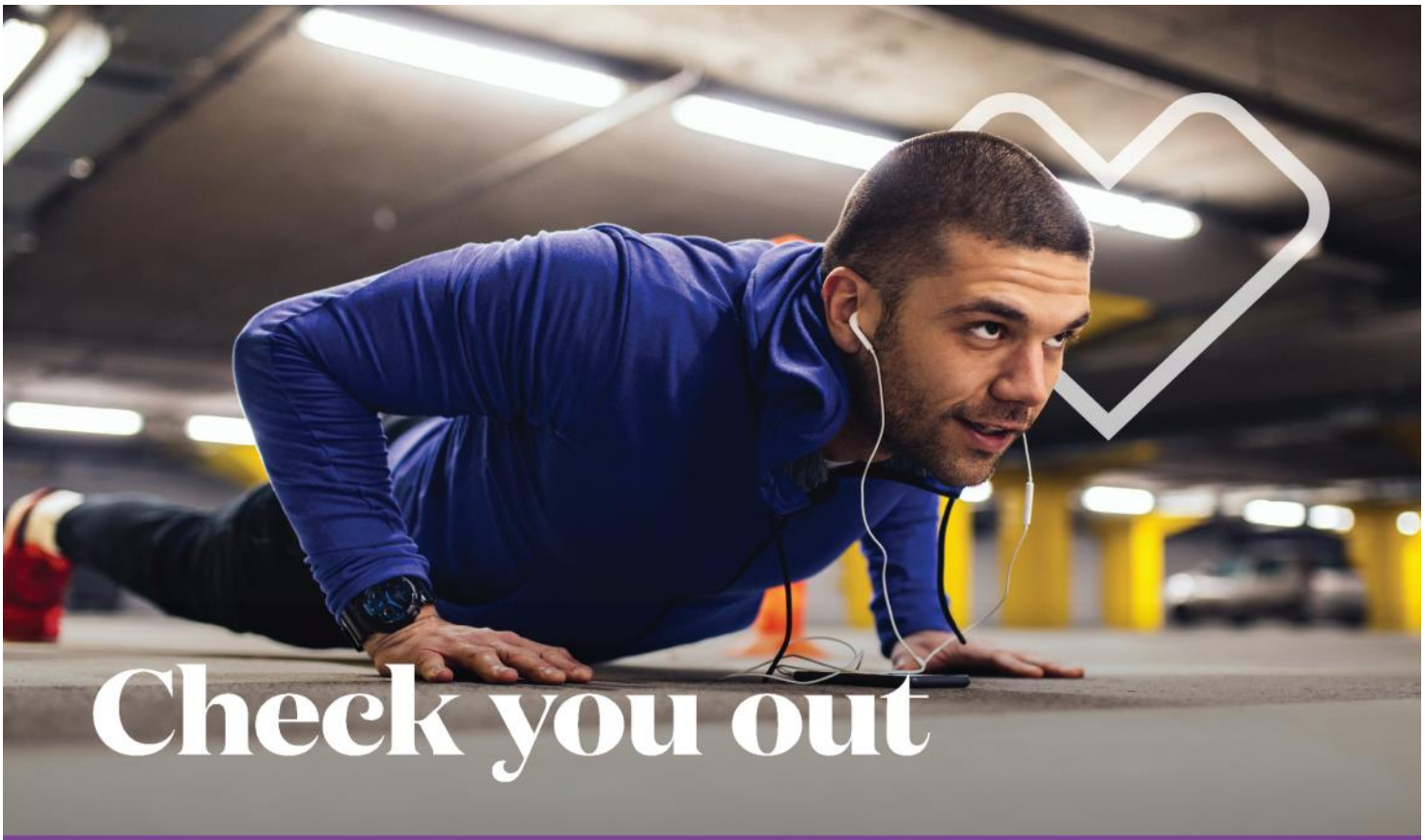
Download on the App Store | GET IT ON Google Play

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 you receive your Aetna ID Card, 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



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

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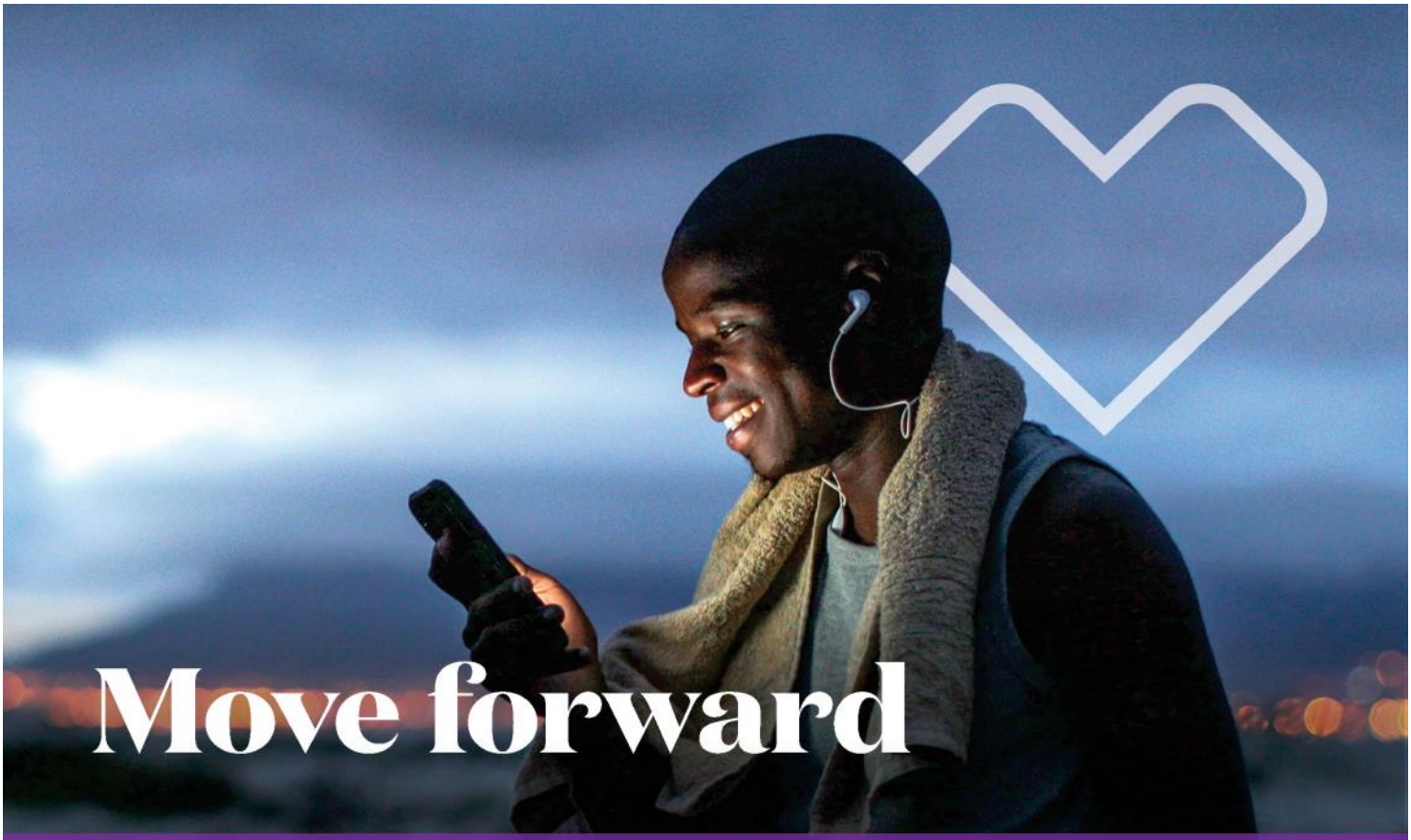
AHYW-CORE DIGITAL COACHING-MEMBER



A smart way to live healthy

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
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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 assistance 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

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: 01/01/2024 - 12/31/2024. 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

Monthly Dental Premiums for Employees Enrolled in District Medical			
Plan Tier	**Total Monthly Premium**	**District Contribution for FT Emp**	**Full Time Employee Deduction**
Employee Only	$40.19	$25.22	$14.97
Emp + Spouse	$79.52	$38.31	$41.21
Emp + Child(ren)	$100.15	$60.08	$40.07
Family	$155.14	$86.47	$68.67

Monthly Dental Premiums for Employees NOT Enrolled in District Medical			
Plan Tier	**Total Monthly Premium**	**District Contribution for FT Emp**	**Full Time Employee Deduction**
Employee Only	$40.19	$0.00	$40.19
Emp + Spouse	$79.52	$0.00	$79.52
Emp + Child(ren)	$100.15	$0.00	$100.15
Family	$155.14	$0.00	$155.14

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		
Fit & Follow Up Exams	Subject to $200 maximum	Subject to maximum
Elective	Subject to $200 maximum	Subject to $200 maximum
Medically Necessary	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:

*Dependents are covered up to age 26

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.**

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.

RELIANCE STANDARD

Basic Life Insurance

The Basic Employee Life Insurance program is provided at no cost to ensure all our employees have some level of financial protection. This plan includes Accidental Death and Dismemberment benefits equal to the Basic Life Insurance amount.

You designate a beneficiary, the person who will receive your insurance money in the event of your death. You should review your beneficiary designation to make sure it is up to date.

Life Insurance Benefit $10,000

AD&D Benefit $10,000

Features:

- Air Bag Benefit
- Seat Belt Benefit
- Waiver of Premium

Benefit Reduction Due to Age:

Age 65 original benefit reduces to 65%
Age 70 original benefit reduces to 40%
Age 75 original benefit reduces to 20%

Value Added Services:

Bereavement Counseling Service

- No cost to you
- 100% Confidential
- Available 24/7 365 days a year

Toll-Free number: 1-800-961-3007
Administered by Health Management Systems of America

Travel Assistance Service

Through your group coverage with Reliance Standard, you automatically receive travel assistance services provided by On Call International (On Call) when traveling more than 100 miles from home.

Pre-Trip Assistance

- Passport/visa requirements, currency exchange rates, health hazard advisory, etc…

Emergency Medical Transportation

- Emergency evacuation, return of vehicle, return of mortal remains, etc…

Emergency Personal Services

- Urgent message relay, Legal assistance, translation services, etc…

Medical Services Include:

- Medical referrals, Case monitoring, Rx assistance and eyeglasses replacement

Toll-Free number: 1-800-456-3893

RELIANCE STANDARD

Voluntary Life Insurance

If you need additional Life Insurance coverage, you may purchase Term Life and Accidental Death & Dismemberment insurance for yourself, spouse and children. The AD&D amount will be the same as the Life amount you elect.

You may elect coverage up to the Guaranteed Issue amounts when you are first eligible to enroll. Late enrollees will have to complete a medical questionnaire (EOI), unless it's the approved open enrollment amount.

	Benefit Amount	Guaranteed Issue Amount
Employee	Minimum of $10,000 to a Maximum of $300,000 (Increments of $10,000) *Not to exceed 5 times salary*	**$200,000**
Spouse	Minimum of $5,000 to a Maximum of $150,000 (Increments of $5,000) *Not to exceed 50% of employee amount*	**$50,000**
Child(ren)	$10,000	**$10,000**

Features:

- Accidental Death & Dismemberment is included equal to the Life amount at no additional cost;
- Coverage is Portable if notification is made within 31 days.
- Air Bag & Seat Belt Benefit
- Waiver of Premium

Benefit Reduction Due to Age

(applicable to employee & Spouse coverage)

Age 65 original benefit reduces to 65%

Age 70 original benefit reduces to 40%

Age 75 original benefit reduces to 20%

During Open Enrollment:

- Employees can increase their existing coverage by $50,000 up to the **Guarantee Issue amount** without answering medical questions.
- Employees can enroll for $50,000 without answering any medical questions (if they haven't been previously declined).

Medical Questionnaire/EVIDENCE OF INSURABILITY (EOI) IS REQUIRED FOR:

- Newly Eligible Employees or Spouses requesting coverage over the Guaranteed Issue Amount
- Employees that have previously waived coverage and enroll for more than $50,000 during Open Enrollment
- Spouses that have previously waived coverage and enroll during open enrollment (any amount)
- Open Enrollment Employee coverage increases over $50,000
- Open Enrollment Spouse coverage increases (any amount)

***To complete your EOI, click the link in Arcoro and this will take you to Reliance Standard's EOI Form**

RELIANCE STANDARD

See Benefit Summary for Exclusions.

Voluntary Life Insurance

Employee Benefit Amount:

- Amounts exceeding the Guarantee Issue Amount ($200,000) will require Evidence of Insurability
- Open Enrollment: Enrollments or Increases in excess of $50,000 will require Evidence of Insurability

Employee Monthly Premiums

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$10,000	$0.60	$0.60	$0.70	$0.90	$1.20	$1.80	$3.00	$4.80	$6.20	$10.20	$22.20
$20,000	$1.20	$1.20	$1.40	$1.80	$2.40	$3.60	$6.00	$9.60	$12.40	$20.40	$44.40
$30,000	$1.80	$1.80	$2.10	$2.70	$3.60	$5.40	$9.00	$14.40	$18.60	$30.60	$66.60
$40,000	$2.40	$2.40	$2.80	$3.60	$4.80	$7.20	$12.00	$19.20	$24.80	$40.80	$88.80
$50,000	$3.00	$3.00	$3.50	$4.50	$6.00	$9.00	$15.00	$24.00	$31.00	$51.00	$111.00
$60,000	$3.60	$3.60	$4.20	$5.40	$7.20	$10.80	$18.00	$28.80	$37.20	$61.20	$133.20
$70,000	$4.20	$4.20	$4.90	$6.30	$8.40	$12.60	$21.00	$33.60	$43.40	$71.40	$155.40
$80,000	$4.80	$4.80	$5.60	$7.20	$9.60	$14.40	$24.00	$38.40	$49.60	$81.60	$177.60
$90,000	$5.40	$5.40	$6.30	$8.10	$10.80	$16.20	$27.00	$43.20	$55.80	$91.80	$199.80
$100,000	$6.00	$6.00	$7.00	$9.00	$12.00	$18.00	$30.00	$48.00	$62.00	$102.00	$222.00
$110,000	$6.60	$6.60	$7.70	$9.90	$13.20	$19.80	$33.00	$52.80	$68.20	$112.20	$244.20
$120,000	$7.20	$7.20	$8.40	$10.80	$14.40	$21.60	$36.00	$57.60	$74.40	$122.40	$266.40
$130,000	$7.80	$7.80	$9.10	$11.70	$15.60	$23.40	$39.00	$62.40	$80.60	$132.60	$288.60
$140,000	$8.40	$8.40	$9.80	$12.60	$16.80	$25.20	$42.00	$67.20	$86.80	$142.80	$310.80
$150,000	$9.00	$9.00	$10.50	$13.50	$18.00	$27.00	$45.00	$72.00	$93.00	$153.00	$333.00
$160,000	$9.60	$9.60	$11.20	$14.40	$19.20	$28.80	$48.00	$76.80	$99.20	$163.20	$355.20
$170,000	$10.20	$10.20	$11.90	$15.30	$20.40	$30.60	$51.00	$81.60	$105.40	$173.40	$377.40
$180,000	$10.80	$10.80	$12.60	$16.20	$21.60	$32.40	$54.00	$86.40	$111.60	$183.60	$399.60
$190,000	$11.40	$11.40	$13.30	$17.10	$22.80	$34.20	$57.00	$91.20	$117.80	$193.80	$421.80
$200,000	$12.00	$12.00	$14.00	$18.00	$24.00	$36.00	$60.00	$96.00	$124.00	$204.00	$444.00
$210,000	$12.60	$12.60	$14.70	$18.90	$25.20	$37.80	$63.00	$100.80	$130.20	$214.20	$466.20
$220,000	$13.20	$13.20	$15.40	$19.80	$26.40	$39.60	$66.00	$105.60	$136.40	$224.40	$488.40
$230,000	$13.80	$13.80	$16.10	$20.70	$27.60	$41.40	$69.00	$110.40	$142.60	$234.60	$510.60
$240,000	$14.40	$14.40	$16.80	$21.60	$28.80	$43.20	$72.00	$115.20	$148.80	$244.80	$532.80
$250,000	$15.00	$15.00	$17.50	$22.50	$30.00	$45.00	$75.00	$120.00	$155.00	$255.00	$555.00
$260,000	$15.60	$15.60	$18.20	$23.40	$31.20	$46.80	$78.00	$124.80	$161.20	$265.20	$577.20
$270,000	$16.20	$16.20	$18.90	$24.30	$32.40	$48.60	$81.00	$129.60	$167.40	$275.40	$599.40
$280,000	$16.80	$16.80	$19.60	$25.20	$33.60	$50.40	$84.00	$134.40	$173.60	$285.60	$621.60
$290,000	$17.40	$17.40	$20.30	$26.10	$34.80	$52.20	$87.00	$139.20	$179.80	$295.80	$643.80
$300,000	$18.00	$18.00	$21.00	$27.00	$36.00	$54.00	$90.00	$144.00	$186.00	$306.00	$666.00

Voluntary Life Insurance

Spouse:

- Amounts exceeding the Guarantee Issue Amount ($50,000) will require Evidence of Insurability
- Open Enrollment: Enrollments or Increases will require Evidence of Insurability

Spouse Monthly Premiums (Use Employee's Age)

Benefit Amount	Age 18-24	Age 25-29	Age 30-34	Age 35-39	Age 40-44	Age 45-49	Age 50-54	Age 55-59	Age 60-64	Age 65-69	Age 70+
$5,000	$0.30	$0.30	$0.35	$0.45	$0.60	$0.90	$1.50	$2.40	$3.10	$5.10	$11.10
$10,000	$0.60	$0.60	$0.70	$0.90	$1.20	$1.80	$3.00	$4.80	$6.20	$10.20	$22.20
$15,000	$0.90	$0.90	$1.05	$1.35	$1.80	$2.70	$4.50	$7.20	$9.30	$15.30	$33.30
$20,000	$1.20	$1.20	$1.40	$1.80	$2.40	$3.60	$6.00	$9.60	$12.40	$20.40	$44.40
$25,000	$1.50	$1.50	$1.75	$2.25	$3.00	$4.50	$7.50	$12.00	$15.50	$25.50	$55.50
$30,000	$1.80	$1.80	$2.10	$2.70	$3.60	$5.40	$9.00	$14.40	$18.60	$30.60	$66.60
$35,000	$2.10	$2.10	$2.45	$3.15	$4.20	$6.30	$10.50	$16.80	$21.70	$35.70	$77.70
$40,000	$2.40	$2.40	$2.80	$3.60	$4.80	$7.20	$12.00	$19.20	$24.80	$40.80	$88.80
$45,000	$2.70	$2.70	$3.15	$4.05	$5.40	$8.10	$13.50	$21.60	$27.90	$45.90	$99.90
$50,000	$3.00	$3.00	$3.50	$4.50	$6.00	$9.00	$15.00	$24.00	$31.00	$51.00	$111.00
$55,000	$3.30	$3.30	$3.85	$4.95	$6.60	$9.90	$16.50	$26.40	$34.10	$56.10	$122.10
$60,000	$3.60	$3.60	$4.20	$5.40	$7.20	$10.80	$18.00	$28.80	$37.20	$61.20	$133.20
$65,000	$3.90	$3.90	$4.55	$5.85	$7.80	$11.70	$19.50	$31.20	$40.30	$66.30	$144.30
$70,000	$4.20	$4.20	$4.90	$6.30	$8.40	$12.60	$21.00	$33.60	$43.40	$71.40	$155.40
$75,000	$4.50	$4.50	$5.25	$6.75	$9.00	$13.50	$22.50	$36.00	$46.50	$76.50	$166.50
$80,000	$4.80	$4.80	$5.60	$7.20	$9.60	$14.40	$24.00	$38.40	$49.60	$81.60	$177.60
$85,000	$5.10	$5.10	$5.95	$7.65	$10.20	$15.30	$25.50	$40.80	$52.70	$86.70	$188.70
$90,000	$5.40	$5.40	$6.30	$8.10	$10.80	$16.20	$27.00	$43.20	$55.80	$91.80	$199.80
$95,000	$5.70	$5.70	$6.65	$8.55	$11.40	$17.10	$28.50	$45.60	$58.90	$96.90	$210.90
$100,000	$6.00	$6.00	$7.00	$9.00	$12.00	$18.00	$30.00	$48.00	$62.00	$102.00	$222.00
$105,000	$6.30	$6.30	$7.35	$9.45	$12.60	$18.90	$31.50	$50.40	$65.10	$107.10	$233.10
$110,000	$6.60	$6.60	$7.70	$9.90	$13.20	$19.80	$33.00	$52.80	$68.20	$112.20	$244.20
$115,000	$6.90	$6.90	$8.05	$10.35	$13.80	$20.70	$34.50	$55.20	$71.30	$117.30	$255.30
$120,000	$7.20	$7.20	$8.40	$10.80	$14.40	$21.60	$36.00	$57.60	$74.40	$122.40	$266.40
$125,000	$7.50	$7.50	$8.75	$11.25	$15.00	$22.50	$37.50	$60.00	$77.50	$127.50	$277.50
$130,000	$7.80	$7.80	$9.10	$11.70	$15.60	$23.40	$39.00	$62.40	$80.60	$132.60	$288.60
$135,000	$8.10	$8.10	$9.45	$12.15	$16.20	$24.30	$40.50	$64.80	$83.70	$137.70	$299.70
$140,000	$8.40	$8.40	$9.80	$12.60	$16.80	$25.20	$42.00	$67.20	$86.80	$142.80	$310.80
$145,000	$8.70	$8.70	$10.15	$13.05	$17.40	$26.10	$43.50	$69.60	$89.90	$147.90	$321.90
$150,000	$9.00	$9.00	$10.50	$13.50	$18.00	$27.00	$45.00	$72.00	$93.00	$153.00	$333.00

Eligible Dependent Child(ren):

- Age 6 months to 20 years of age (26, if full-time student): $10,000
  (Birth to 6 months: $500)
- One rate & benefit amount for all eligible children in family
- Employee or spouse must be insured, in order to elect coverage for children; Only one insured spouse may cover children.

Child Monthly Premium

Benefit Amount	Premium
$10,000	$1.80

Short Term Disability Plans

How long can you go without a paycheck?

What are your chances of becoming disabled and unable to work? One in four 20 year-olds today will become disabled before they retire. Freak accidents are NOT usually the culprit. Back injuries, cancer, heart disease and other illnesses cause the majority of long-term absences.

Are you prepared if it happens to you? If you are like most employees, you do not have disability insurance or enough emergency savings. The average long-term disability claim lasts 31 months.

Reliance Standard is offering voluntary disability plans to take away the worry of not being able to work and bring home a paycheck.

Benefit Amount:

- 66.67% of your income replaced - tax free
- Maximum Weekly Benefit of $1,600
- Two options to choose from:
  - ♦ **OPTION 1** 14 day waiting period - benefits payable for 24 weeks
  - ♦ **OPTION 2** 30 day waiting period - benefits payable for 22 weeks

Features:

- **Maternity covered as any other illness**
- **Partial Disability Benefit Included**

Limitations:

- Pre-existing Limitation: Any sickness or injury for which the insured person received treatment within 3 months prior to the effective date won't be covered for the first 6 months of the policy. Pre-Ex also applies to benefit increases.

New Enrollments are not required to complete a medical questionnaire (EOI); however, the benefit is subject to the pre-existing limitation.

	Rate per $10 benefit
Option 1	$0.66
Option 2	$0.39

To calculate your monthly payroll deduction, use the formula indicated below:

(Round all numbers to the nearest whole number)

1. Enter your **Weekly Earnings**, not to exceed $2,400 1._____
2. **Multiply** your weekly earnings (Line 1) by **0.667** 2._____
3. **Multiply** the amount on Line 2 by **$0.66 for Option 1** or **$0.39 for Option 2**. 3._____
4. **Divide** the amount on Line 3 by 10 and enter the amount on Line 4 to get your monthly payroll deduction. 4._____

Actual deductions may vary slightly due to rounding.

RELIANCE STANDARD

3-1 Supplemental Plan

The Supplemental Health Plan is three plans rolled into one – Hospital Indemnity, Critical Illness and Accident!

This plan provides benefits to help cover additional or unexpected medical costs. The benefits pay directly to you and are not tied to the medical plans. Coverage is Guaranteed Issue which means there are no medical questions!

Accident Plan

The Accident Plan provides benefits to help cover the costs associated with unexpected medical bills. When you have an accident – the costs add up quickly! The plan pays you the benefit regardless of any other insurance and it is 24 Hour Coverage, on or off the job!

Emergency Care Benefits	
Ambulance Transportation	$100 Ground; $500 Air
Emergency Treatment	$150
Diagnostic Examination	$100 per CT/MRI scan
Initial Physician Office Visit	$50
General Treatment Benefits	
Initial Hospital Admission	$500
Initial ICU Hospital Admission	$1,000
Hospital Confinement/ICU Confinement	$200 per day, 365 days maximum/$400 per day, 30 days maximum
Rehabilitation Facility Confinement	$50 per day, 30 days maximum
Follow-Up Physician Office Visit	$50
Transportation	$300, if more than 100 miles from residence
Lodging	$100 per day up to 30 days, if more than 100 miles from residence
Specified Injury & Treatment Benefits	
Fractures	To $2,500 Non-Surgical; To $5,000 Surgical repair
Dislocations	To $1,600 Non-Surgical; To $3,200 Surgical
Burns	To $800 for 2nd degree burns; To $6,400 for 3rd degree burns; Skin Graft – 25% of benefit payable for burns
Blood/Plasma/Platelets	$200
Coma/Concussion	$5,000/$100
Dental Injury	$150 for Crown; $50 for Extraction
Eye Injury	$100 for removal of foreign object; $200 for surgical repair
Lacerations	To $400
Transitional Benefits	
Medical Appliances/Prosthesis	$100/$1000 for two or more, $500 for one
Physical Therapy	$25 per session, 6 sessions maximum
Paralysis Benefits	$10,000 quadriplegia; $5,000 paraplegia/hemiplegia
Surgery Benefits	$100 for Exploratory; $300 for Knee Cartilage; $1,000 for Abdominal or Thoracic; $500 for Ruptured Disc; To $600 Tendon, Ligament, Rotator Cuff

3-1 Supplemental Plan

Critical Illness Plan

A group Critical Illness Plan helps prepare you for the added costs of battling a specific critical illness. As the recovery process begins, most people begin to worry about the bills that have piled up. Our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness.

Employee:	$5,000	**Guaranteed Issue:** Coverage is guaranteed issue which means you don't have to qualify or answer medical questions to get coverage!
Spouse:	$5,000	
Children:	$1,250	

Basic: 100% of Amount of Insurance	Coma Alzheimer's Heart Attack Major Organ Failure Motor Neuron Diseases: (ALS, Lou Gehrig's)	Stroke Parkinson's Multiple Sclerosis Ruptured Cerebral Life Threatening Cancer Cartoid/Aortic Aneurism
Partial: 25% of Amount of Insurance **Partial: 5% of Amount of Insurance**	Coronary Disease, Carcinoma in situ Skin Cancer	
Benefit Waiting Period	30 Days	
Lifetime Maximum Benefit	1000% of the Amount of Insurance	
Subsequent Occurrence Benefit (Different Category*)	100% of Benefit (6 months apart)	
Recurrence Benefit (Same Category*)	50% of Benefit (12 months apart)	
Pre-Ex Limitation	Any sickness or injury for which the insured person received treatment, consultation, care or services, in the 12 months just prior to the effective date won't be covered for the first 12 months of the policy.	
Family Medical Leave/Portability	Included/Included	
Age Reduction	50% at age 70	
Wellness (Health Screening) Benefit	$50 per person per calendar year (Up to 4 benefits per family)	

Tests Eligible for Wellness Benefit:

ALT / AST (liver function test)	Bone density testing (DEXA scan)	CA 125 (blood test for ovarian cancer)	CEA (blood test for colon cancer)	CA 15-3 (blood test for breast cancer)
Biopsy for cancer	Bone marrow testing	Fasting blood glucose test	Echocardiogram	Flexible sigmoidoscopy
Blood test for triglycerides	Colonoscopy	Chest X-ray	Electrocardiogram	Genetic tests
Hemoccult stool analysis	Hepatitis/HIV screening	Stress test	Mammography	Pap test
PSA (blood test for prostate cancer)	Serum cholesterol test (HDL and LDL)	Serum Protein Electrophoresis (blood test for myeloma)	Skin cancer screening	Ultrasound screening

If you cancel the existing Aflac Group Critical Illness and enroll in the 3-1 plan, the Pre-ex Limitation is waived.

3-1 Supplemental Plan

Hospital Indemnity Plan

The Hospital Indemnity Plan Provides benefits to help cover the costs associated with a hospital stay.

Hospital Room & Board Benefits	
Room & Board Benefit per Day (180 Daily Benefits per Coverage Year)	$100
Hospital Admission Benefit	
One Daily Benefit per Coverage Year (Admission/Observation must be 23 hours or more)	$1,000
Non-Insurance Services	
On-Call Travel Assistance	Included

NO PRE-EXISTING CONDITION EXCLUSIONS ON HOSPITAL INDEMNITY!

3-1 PLAN FEATURES & ELIGIBILITY:

- Maternity Feature:
  When a covered member is admitted to the hospital and delivers a baby, the admission/daily benefit is paid for the newborn as well as the mother.
- Benefits are paid regardless of any other insurance
- **24 Hour Coverage**
- Includes On Call Travel Assistance
- Employee and Spouse must be under age 70 to enroll
- Children are eligible up to age 26
- HSA Compliant

3-1 Supplemental Plan Monthly Premiums	
Employee	$27.62
Employee + Spouse	$54.06
Employee + Child(ren)	$44.86
Family	$71.42

RELIANCE STANDARD

Flex Spending Accounts

The Flexible Spending Account Plan allows you to convert a portion of your taxable income into a non-taxable employee benefit. Since you pay for these items before taxes, your take-home pay increases because federal and state income tax, FICA and Medicare tax are not deducted from your paycheck.

A **Premiums Savings Plan** allows you to pay your share of eligible insurance premiums on a pre-tax basis from your payroll. Since these are pre-tax from your payroll they are not eligible to be reimbursed under the Flex Spending Account. You may not stop the deductions or change how you enroll in these plans unless you have one of the below status changes.

- Termination of employment
- Spouse changes jobs
- Birth or adoption of a child
- Child no longer eligible
- Change of marital status
- Death of a dependent

FLEXIBLE SPENDING ACCOUNT

Each year you must elect to participate in the Flexible Spending Account. You estimate the amount of eligible expenses you and your dependents will likely incur, and from this amount, determine how much you would like to set aside in the Flexible Spending Account. Eligible health expenses must be incurred during the plan year, from July 1, 2024- June 30, 2025.

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

For employees that will be contributing to a Health Savings Account, you will have the option to participate in a Limited Purpose Flexible Spending Account. It works the same, except that you can contribute pre-tax dollars to pay for **Dental and Vision expenses only.**

Maximum: $3,200 per year pre-tax

CARRY OVER

For the 2024 –2025 Plan Year, up to $640 of unused amounts in a current plan year's health flexible spending account (FSA) can be "carried over" to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following plan year. **For the 2023-2024 Plan Year, the Carry Over is $610.*

For example, if an employee has $640 of unspent funds at the end of the plan year, this amount would carry over and be available for the next plan year. The carry over amount doesn't count toward the annual maximum limit. Also, you can carry over $640 for more than one year, according to the IRS. ***Any balance over $640 will be forfeited.***

Example:

FSA unspent money as of **06/30/24** that will carry over:	Amount elected for **07/01/24—06/30/25:**	Total available balance as of **07/01/24:**
$610	$3,200	$3,810

FSA unspent money as of **06/30/25** that will carry over:	Amount elected for **07/01/25—06/30/26**:	Total available balance as of **07/01/25**:
$640	$3,200	$3,840

RUN-OUT PERIOD:

Plan participants also have an extended time after the end of the plan year to submit receipts for reimbursement. You can only get reimbursed for claims with a date of service during the previous plan year. The run-out period goes for 75 days after the plan year ends so all claims must be submitted by 09/15/2024.

07/01/24—06/30/25 FSA Plan Year	07/01/24—09/15/24 Run Out Period (Reimbursements for claims that occurred during the plan year)

Flex Spending Accounts

QUICK FACTS:

- You **do not** have to be enrolled in a medical plan to participate in a FSA!
- In most cases, you can use your FSA money to pay for expenses incurred by your spouse and dependents (up to age 26).
- You can only use your FSA money to pay for expenses with a date of service within the plan year.
- The amount you contribute from your paycheck cannot be changed up or down during the year unless you have a qualified election change event.

SURENCY FLEX BENEFITS CARD is a special-purpose Visa® Card that gives you an easy, automatic way to pay for eligible expenses. The Benefits Card lets you electronically access the pre-tax amounts set aside in your **Surency FSA accounts**. Use it when paying for eligible expenses at a provider or merchant that accepts Visa Cards and uses an inventory control system. These transactions may be automatically substantiated, meaning you don't have to file a claim and may not have to submit a receipt. However, always keep all documentation for tax purposes or in case Surency requests further documentation.

Keep your receipts in the event that further validation is needed. Make sure receipts include the following information:

→ **Patient's Name**. The name of the person who received the service or for whom the item was purchased. For retail store purchases, this information may be excluded.

→ **Provider's Name**. The provider that delivered the service or the merchant where the item was purchased.

→ **Date of Service**. The date when services were provided or the item was purchased.

→ **Type of Service**. A detailed description of the service provided or item purchased. A bag tag is sufficient for prescriptions.

→ **Cost**. The amount paid for the service or product and/or the portion that is not reimbursed through your insurance carrier.

DID YOU PAY OUT-OF-POCKET FOR AN ELIGIBLE EXPENSE?

Submit a claim to get paid back using money from your account. There are three ways to submit a claim:

1. SURENCY FLEX APP	2. MEMBER ACCOUNT	3. PAPER CLAIM FORM
Download the Surency Flex mobile app and submit the claim by taking a photo of your receipt.	Log into your Member Account at Surency.com to upload your receipt.	Visit Surency.com to download a paper claim form. Complete and return to Surency.

EMPLOYMENT TERMINATION:

If an employee terminates employment, the FSA debit card will become inactive as of the date of termination. The employee then has 75 days to file claims for reimbursement. The claims must have a date of service on or before their termination date.

Flex Spending Accounts

Most expenses applied to the deductible, coinsurance or copay of your health benefit plan can be submitted for reimbursement. Consider depositing money in the Flexible Spending Account so you can pay those expenses with tax-free dollars. Questions? Call **866-818-8805 or visit Surency.com** to view a complete list of eligible expenses.

COMMON FSA ELIGIBLE EXPENSES

Abortion	Contraceptives	Lead-Based Paint Removal	Prosthesis
Acupuncture	Crutches	Learning Disability	Psychiatric Care
Adult Diapers	Dental Treatment	Lifetime Care Payments	Psychoanalysis
Alcohol/Drug Treatment	Denture Adhesives/Repair	Long-Term Care	Smoking Deterrents
Ambulance	Denture Pain Relief/Cleansers	Medical Conferences	Splints & Casts
Artificial Limb/Teeth	Diabetes Testing/Supplies	Medical Information Plan	Sterilization
Athletic Care	Diagnostic Devices	Mileage for medical trips	Sunscreen (SPF 15 or over)
Bandages	Eyeglasses (Prescription & Reading)	Nursing Home	Surgery
Birth Control Pills	Fertility Enhancement	Nursing Services	Telephone (Hearing Impaired)
Blood Pressure Monitors	Guide Dog	Optometrist	Therapy
Body Scan	Hearing Aids (& Batteries)	Organ Donors	Thermometers
Braille Books & Magazines	Home Care	Orthodontic Fees (braces)	Transplants
Breast Pumps & Supplies	Home Improvements	Orthopedic Supports	Transportation (Medical)
Breast Reconstruction	Hospital Services	Osteopath	Vasectomy
Capital Expenses	Hot/Cold Therapy Packs	Ovulation Kits	Vision Exams
Car (Special Hand Controls)	Infertility Treatments	Oxygen	Weight Loss (Program Fees)
Catheters	Laboratory Fees	Physical Therapy	Wheelchair
Chiropractor	Lactation Expenses	Pregnancy Test Kit	Wig (Hair Lost Due to Disease)
Contact Lenses/Solutions	Lasik Eye Surgery	Prescription Medicines	X-rays/Diagnostic Testing

OTC Medications: Written prescriptions are not 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 eligible expenses under an FSA or HSA.

INELIGIBLE FSA EXPENSES

Burial/Funeral Expenses	Fitness Programs	Maternity Clothes	Tanning
Cosmetic Procedures	Future Medical Services	Medicine (from Outside U.S.)	Teeth Whitening
Dance Lessons	Health Club Dues	Nutritional Supplements/ Vitamins (Over-the-Counter)	Toiletries (Toothbrush, Toothpaste, etc.)
Diapers/Diaper Service	Household Help	Piercings	Veterinary Fees
Electrolysis/Hair Removal	Illegal Treatments	Sunglasses (non-prescription)	Warranties (for Eyeglasses or Hearing Aids)
Exercise Equipment (unless prescribed)	Insurance Premiums	Swimming Lessons	Weight-Loss Programs (unless prescribed)

Flex Spending Accounts

DEPENDENT CARE ACCOUNT

A Dependent Care Account reimburses you for eligible dependent care expenses with tax-free dollars. This is a valuable plan for employees with children or dependent parents. **The maximum amount you may set aside is $5,000 per plan year and the deductions are pre-tax.**

Expenses you may claim and be reimbursed with tax-free dollars include:

- Wages paid to a babysitter, whether the care is provided in or outside of your home. However, the babysitter may not be someone you claim as a dependent on your tax return and must be over 18 years of age. Expenses for a babysitter can only be used for services provided during regular working hours. Babysitting costs for social events are not eligible.
- Services of a day care center or nursery school, providing the center complies with state and local laws.
- Cost for care at facilities away from home, such as family day care or adult day care centers, as long as the dependent returns home for at least 8 hours of a 24-hour day.
- Wages paid to a caregiver or home aide for providing eligible care.
- Any other qualified dependent care expenses as defined by the IRS.

Eligible dependents must be under the age of 13, and/or physically or mentally unable to care for themselves and claimed as an exemption on your tax return.

If you participate in a Dependent Care Account, you can elect to have your reimbursements **Direct Deposited**. This is the fastest and easy way to be reimbursed!

RUN-OUT PERIOD:

Plan participants also have an extended time after the end of the plan year to submit receipts for reimbursement. You can only get reimbursed for claims with a date of service during the previous plan year. The run-out period goes for 75 days after the plan year ends so all claims must be submitted by 09/15/2024.

TIPS:

If you participate in a Dependent Care Account, you may contact Surency to complete a **Reoccurring Reimbursement Form.** The completed form will serve as an ongoing receipt for the entire plan year and you won't have to submit a receipt each time you pay the care provider!

The Visa card can only be used with a Dependent Care provider with a properly registered credit card processing system including the four digit Merchant Category Code of 8351 "Child Care Services" or 8299 "Schools and Educational Services". If the merchant's credit card terminal is not setup in this way, the card will not be accepted.

ONLINE ACCOUNT ACCESS

Create a Member Account at Surency.com or download the mobile app!

- Check balances on your Health Care Flexible Spending Account (FSA) & Dependent Care Flexible Spending Account (DC FSA)
- View account activity, payment history and tax statements
- Submit claims for expenses.
- Add or update a bank account to receive direct deposit reimbursements - this is the quickest way to receive reimbursement
- Access account funds to pay yourself back or to pay your doctor
- Report a Surency Flex Benefits Card as lost or stolen

Surency FLEX

Download on the App Store

GET IT ON Google Play

Flex Spending Account Worksheet

Estimate your out-of-pocket medical costs per year

Health insurance deductibles (not paid by insurance)	$ _____
Co-pays (Office Visits and Rx not paid by insurance)	$ _____
Over - the –Counter medications	$ _____
Wheelchair, crutches, medical appliances	$ _____
Medical supplies	$ _____
Mileage related to medical care	$ _____
Other items	$ _____

Total out-of-pocket medical expenses per year: $ _____

Estimate your out-of-pocket dental costs per year:

Examinations and cleanings, x-rays, etc.	$ _____
Braces and retainers, fillings, etc.	$ _____
Orthodontic, implants, inlays, other	$ _____

Total out-of-pocket dental expenses per year: $ _____

Estimate your out-of-pocket vision costs per year:

Lenses, frames	$ _____
Contact lenses & saline solution	$ _____
Prescription sunglasses	$ _____

Total out-of-pocket vision costs per year: $ _____

Total Health Care Expenses (maximum of $3,200 per plan year) $ _____

Total Daycare Expenses ($5,000 maximum per plan year) $ _____

The amount you contribute from your paycheck cannot be changed up or down during the year unless you have a qualified election change event!

Legal Services

LegalShield | IDShield

Payroll Deduction Benefit for Hays USD 489

Scan QR Code for Benefit Overview

Have You Ever

- ☐ Needed your Will prepared or updated?
- ☐ Signed a contract?
- ☐ Received a moving traffic violation?

Are You A Gun Owner--See Gun Owner Supplement Info under details in Above QR Code

- ☐ Worried about being a victim of identity theft?
- ☐ Been concerned about your child's identity?
- ☐ Lost your wallet?

The LegalShield Membership Includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** on unlimited personal issues
- **Letters/Calls** made on your behalf
- **Contracts/Documents Reviewed** up to 15 pages
- **Residential Loan Document Assistance** for the purchase of your primary residence
- **Will Preparation** - Will/Living Will/Health Care Power of Attorney
- **Speeding Ticket Assistance** (15 day waiting period)
- **IRS Audit Assistance** (begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (if named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (available 90 days after enrollment)
- **25% Preferred Member Discount** (bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** for covered situations

The IDShield Membership Includes:

- **High Risk Application and Transaction Monitoring** We can detect fraud up to 90 days earlier than traditional credit monitoring services; we carefully watch all your accounts, reorders, loans and more. If a new account is opened, you will receive an alert.
- **Social Media Monitoring** for privacy concerns and reputational risks
- **Credit Monitoring** continuous credit monitoring through TransUnion
- **Monthly Score Tracker** watch your credit score and map your credit trends
- **Credit Inquiry Alerts** (instant hard inquiry alerts)
- **Consultation** on any cyber security question
- **$3 Million Insurance** (coverage for lost wages, legal defense fees, stolen funds and more)
- **Full Service Restoration & Unlimited Service Guarantee** We don't give up until your identity is restored!
- **24/7 Emergency Access** in the event of an identity theft emergency

Put your law firm and identity theft protection in the palm of your hand with the LegalShield & IDShield Plus mobile apps

Plan	Family Price Monthly	Individual Price Monthly
LegalShield	$18.95	$18.95
IDShield	$18.95	$8.95
Combined	$33.90	$27.90

Prepared for: Hays USD # 489 Legal & ID Shield Overview player.vimeo.com/video/402593265 (2:41 minutes)

Scan QR Code for Estate Planning Video

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bobpilcher58@gmail.com
316-215-5100

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children. IDShield is a product of Pre-Paid Legal Services, Inc. d/b/a LegalShield ("LegalShield"). LegalShield provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see www.idshield.com. All Licensed Private Investigators are licensed in the state of Oklahoma. A $1 million insurance policy is issued through a nationally recognized carrier. LegalShield/IDShield is not an insurance carrier. Certain limitations apply. IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 10 dependents up to the ages 18. It also provides consultation and restoration for dependent children age 18 to 26. This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See plan details for your state of residence for complete terms, coverage, amounts, conditions and limitations.

FLIER_LS+IDS_1895_USA_051519

Legal Shield Gun Owner Supplement

LegalShield is here to protect your gun rights.

Gun Owners Supplement offers the following benefits of protection:

Advice and Consultation

- Gun owner rights
- Carry and license requirements
- Advice on where carrying your concealed firearm is allowed
- Advice on where carrying your firearm is openly allowed
- Recent changes in gun laws

Emergency Access for a Firearm Incident

- 24/7 toll-free access to a provider lawyer for consultation in the event of a covered firearm incident

**Does not include assistance in making, posting, or obtaining bond, bail, or other security required for release.

NFA Gun Trust Services

- One (1) NFA Gun Trust prepared by your provider law firm per membership year for a flat fee of $250

Trial Defense for Gun Related Matters

- Defense of covered civil and criminal lawsuits filed in state or federal court
- 60 total hours for covered lawsuits (20 hours pre-trial and 40 hours trial per plan year)

25% Discount

- As a member, you are entitled to a 25% discount off the provider lawyer's standard hourly rate for additional trial defense services and/or grand jury investigations, related to a covered firearm incident.

In order to enroll in this plan you must have the Legal Plan or the Combo Plan to add this as a supplement.

MONTHLY RATES	INDIVIDUAL
Gun Owner Supplement	$12.95

LegalShield

*** Covered lawsuit is a criminal or civil lawsuit arising from a firearm incident involving a covered person in a place where the covered person is legally permitted to possess and carry (concealed or open) his/her firearm. Appeals and trial court decisions are not included. This is a general overview of your legal plan coverage for illustration purposes only. See a plan contract for complete terms, coverage, amounts, conditions, and exclusions.

Employee Assistance Program

What is an EAP?

Provided by BHS, your Employee Assistance Program (EAP) provides you and your household members with free, confidential, in-the-moment support to help with personal or professional problems that may interfere with work or family responsibilities.

What Happens When You Call the EAP?

A Care Coordinator (master's level clinician) will confidentially assess the problem, assist with any emergencies and connect you to the appropriate resources. The Care Coordinator may resolve your need within the initial call; assess your need as a short-term issue, which can be resolved by an EAP counselor within the available sessions; assess your need as requiring long-term care and assist with connecting you to a community resource or treatment provider available through your health insurance plan.*

Common Reasons to Call Your EAP

Relationships	Life Events	Risks	Challenges
Boss/Co-worker	Birth/Death	Burnout/Anger	Daily responsibilities
Customers	Health/Illness	Depression/Anxiety	Financial/Legal
Friends	Marriage/Divorce	Suicidal thoughts	Parenting
Spouse/Kids	Promotion/Retirement	Substance abuse	Stress/Conflict

PROGRAM FEATURES:

Program Cost

This is a FREE benefit provided and paid for by your employer at no cost to you.

Confidentiality

BHS follows all federal and state privacy laws. When you speak with us, you can trust that your conversations and information will be kept completely confidential.

Information about your problem cannot be released without your written permission.

Available 24/7

Services are available 24-hours a day, 7-days a week via a toll-free number.

Help is just a phone call away.

Call or text to access services.

800-327-2251

MyBHS Portal

The mobile-friendly MyBHS customer portal provides access to more than 500,000 tools and resources on a variety of well-being and skill-building topics.

Features:

- Program Information
- Access to Live Chat
- Announcements
- Assesments
- Café Series Webinars
- Training Center
- Calculator
- Legal Forms
- News & Tips
- And more...

ACCESS THE MYBHS PORTAL ONLINE OR VIA THE APP.

Portal.BHSonline.com

Username: **USD489**

Download on the App Store

GET IT ON Google Play

Employee Assistance Program

WORK LIFE SERVICES

CHILDCARE

BHS provides up-to-date, carefully screened, national resources and referrals for a range of childcare needs including:

- Adoption and Special Needs
- Before and After School Programs
- Family Daycare and Group Homes
- Nanny and Au Pair Services
- Nurseries and Preschools
- Summer Camps

ELDERCARE

BHS provides up-to-date, national resources and referrals for a range of eldercare needs including:

- Home-Based Services: Nutrition, Meals on Wheels, Cleaning and Repair
- Housing: Retirement Communities, Subsidized Housing
- In-Home Care: Medical and Nursing Rehabilitation Services
- Inpatient Services: Nursing Homes, Intermediate Care Facilities, Respite Care and Assisted Living Facilities
- Older Adult Services: Support/ Advocacy Groups, Volunteer Opportunities and Adult Day Care
- Transportation Services

LEGAL

When faced with a legal matter, simply contact BHS and you will be connected to an attorney with expertise specific to your needs. Legal benefits under the program include:

- Free 30-minute consultations
- In office or telephonic with local plan providers
- Each consultation must be over a new legal topic
- 25 percent off the attorney's hourly rate when an hourly rate is quoted for services beyond consultation

FINANCIAL

You and your household members can access unlimited telephonic financial counseling, information and education from BHS' team of highly-trained financial counselors. Typical financial matters include:

- Budgeting
- College Funding
- Credit Counseling
- Debt Management and Consolidation
- Retirement Funding

LOCATOR SERVICES

BHS shall provide participants with a resource that allows for searches to be performed based on specific requirements regarding child and eldercare needs. This resource is available through the MyBHS portal.

403b Retirement Plan

403b Retirement Plan with 2% District Matching Contribution

A 403(b) plan allows you to have pretax money automatically deducted from each paycheck and paid into a personal retirement account. USD 489 will match your contribution up to 2% allowing you to put away more money for retirement and at the same time reducing your taxes.

The USD 489 403b plan is administered by Omni – go to OMNI's website www.omni403b.com to set up your account, choose your investments and complete the Salary Redirection Agreement to begin your deduction or to make changes to your current deductions.

After setting up your account with Omni and completing your SRA complete the District match form by going to www.USD489.com > payroll resources to begin receiving the 2% match.

OMNI's Customer Service Number : 1-877-544-6664

OMNI's Website: www.omni403b.com

OMNI & TSACG Compliance Services

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 Faith Lochmann – Human Resources Coordinator at 785-623-2400 Ext. 106 or flochmann@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 1-800-501-9837or 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 1-800-501-9837or 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 Faith Lochmann – Human Resources Coordinator at 785-623-2400 Ext. 106 or flochmann@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 $2,000 Deductible Plan (Individual: coinsurance none and $2,000 deductible; Family: coinsurance none and $4,000 deductible)

Plan 2: Option 2 - OAMC $3,500 Deductible Plan (Individual: coinsurance none and $3,500 deductible; Family: coinsurance none 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 $3,200 High Deductible Plan (Individual: 20% coinsurance and $3,200 deductible; Family: 20% coinsurance and $5,600 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 785-623-2400 Ext. 106 or flochmann@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 January 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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

Notices

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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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 January 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)

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, 2024**
Name of Entity/Sender:	**USD 489 Hays**
Contact—Position/Office:	**Faith Lochmann – Human Resources Coordinator**
Office Address:	**323 W 12th St** **Hays, Kansas 67601-3812** **United States**
Phone Number:	**785-623-2400 Ext. 106**

Contacts

Aetna

Concierge Phone: 1-800-501-9837

Rx Phone: 1-888-792-3862

Website: www.aetna.com

Download the Aetna Mobile App!

- Find in-network doctors & facilities
- Access your ID card
- Review claims & coverage

Delta Dental of Kansas

Member Services: Local: 316-264-4511
1-800-234-3375

Website: www.deltadentalks.com/Subscribers

Download the Delta Dental App!

- Find in-network dentists
- Access your ID card
- Review claims & coverage

Surency FSA & Cobra

Member Services: (FSA & Cobra) 1-866-818-8805

FSA Website: www.myflexaccount.com

FSA Email: flex@surency.com

Download the Surency FLEX Mobile App!

- Check account balance
- View & submit claims
- Submit receipts

Reliance Standard

Customer Service: 1-800-351-7500

Website: www.reliancestandard.com

LegalShield

Contact: Bob Pilcher 316-215-5100

Website: www.bobpilcher.com

Email: Bobpilcher58@gmail.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

Good Rx collects & compares prices from over 70,000 pharmacies. You can also find discounts and print free coupons.

Website: www.goodrx.com

Download the GoodRx Mobile App!

FSAstore

FSAstore is the largest online marketplace for guaranteed FSA-eligible products along with educational resources. You can search eligible items and shop on the website.

Website: www.fsastore.com

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