



2024

Employee Benefit Guide

Roosevelt School
District No 66





About Your Benefits

At Roosevelt School District No 66, we are committed to providing a comprehensive and affordable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your Roosevelt School District No 66 benefits. If you have any questions, feel free to reach out to Christina Wiltshire at **602.243.4822** or christina.wiltshire@rsd66.org.



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Eligibility and Enrollment

You are eligible to participate in Roosevelt School District No 66's benefits if you are a full-time employee working at least 30 hours per week. If you enroll for benefits, you may also cover your:

- Legal spouse
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

You have until the first of the month from your hire date to log on to [Employee Financial Access](#) and enroll. Your benefits begin on the first of the month following your hire date.

Example: If you start with RSD#66 on July 20th, your benefits will begin on August 1st.

If elections are not made prior to the first of the month following your hire date, you will be required to wait until Annual Open Enrollment or until a Qualifying Life Event takes place.

Benefit Website

To access benefit summaries and carrier website and contact information go to <https://c2mb.ajg.com/roosevelt/>.

If you 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 27-28 for more details.

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during open enrollment. You may make mid-year changes to your benefits only if you have a qualifying life event. Examples of qualifying life events include:

- Marriage or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Change in employment status for you or your dependents resulting in the loss/gain of coverage
- A significant change in the cost or coverage of your dependent's benefits
- Change in the cost of dependent care (for dependent care flexible spending accounts only)
- Death of a dependent

You have 30 days from the date of the event to contact the Benefits Specialist and to log on to [Employee Financial Access](#) and make the change. Keep in mind, the changes you make must be directly related to the event.

Benefit Advocate for One on One Benefit Help

Gallagher provides one on one benefit advocacy assistance to all Roosevelt employees and dependents. The Advocates can assist with benefit and claims questions, issues, concerns or difficult situations. English and Spanish support M-F, 8-6pm Arizona Time. Phone: 833.420.1622 or email: BAC.RooseveltElementarySchoolDistAdvocates@ajg.com.

Employee Group Insurance Rates

Effective July 1, 2024 - June 30, 2025



Roosevelt School District pays the total premium costs for the employee under the Classic Gold Plan and HDHP A \$1,600 Plan. Voluntary participation in the Copay Gold Plan (only open to employees that were enrolled in the 23/24SY) and other types of insurance coverage are deducted 9 and 10 Month Employee Deductions will be collected over 21 pay periods Starting on the 4th Pay Period of FY24/25.

12 Month Employee Deductions will be collected over 26 pay periods Starting on the 1st Pay Period of FY24/25.

Please see rates for Medical, Dental and Vision benefit plans listed below for 9, 10, & 12 Month Employees.

Medical - Meritain Health 866-300-8449

HDHP A \$1,600 with Health Savings Account (H.S.A) Plan In addition to contributing the full cost of the employee's annual rate, the district will also contribute \$1902 to each employee's Health Savings Account on a per pay period basis. Contributions to be prorated based on date of hire.

	Employee	Emp + Spouse	Emp + Child(ren)	Emp + Family
Monthly rate.....	\$ 588.50	\$ 1,092.50	\$ 977.50	\$ 1,334.50
Annual rate.....	7,062.00	13,110.00	11,730.00	16,014.00
Paid by RSD.....	7,062.00	7,062.00	7,062.00	7,062.00
HSA Contributions Paid by RSD.....	1,902.00	1,902.00	1,902.00	1,902.00
Paid by Employee.....	0.00	6,048.00	4,668.00	8,952.00
9 & 10 Month Employee Per Paycheck Rate.....	\$0.00	\$ 288.00	\$ 222.29	\$ 426.29
12 Month Employee Per Paycheck Rate.....	\$0.00	\$ 232.62	\$ 179.54	\$ 344.31

Classic Gold Plan

	Employee	Emp + Spouse	Emp + Child(ren)	Emp + Family
Monthly Rate	\$ 761.00	\$ 1,415.00	\$ 1,267.00	\$ 1,729.00
Annual Rate	9,132.00	16,980.00	15,204.00	20,748.00
Paid by RSD	9,132.00	9,132.00	9,132.00	9,132.00
Paid by Employee	0.00	7,848.00	6,072.00	11,616.00
9 & 10 Month Employee Per Paycheck Rate.....	\$0.00	\$ 373.71	\$ 289.14	\$ 553.14
12 Month Employee Per Paycheck Rate.....	\$0.00	\$ 301.85	\$ 233.54	\$ 446.77

Copay Gold Plan only open to employees enrolled in 23/24

	Employee	Emp + Spouse	Emp + Child(ren)	Emp + Family
Monthly Rate	\$ 893.00	\$ 1,660.00	\$ 1,486.00	\$ 2,028.00
Annual Rate	10,716.00	19,920.00	17,832.00	24,336.00
Paid by RSD	9,132.00	9,132.00	9,132.00	9,132.00
Paid by Employee	1,584.00	10,788.00	8,700.00	15,204.00
9 & 10 Month Employee Per Paycheck Rate.....	\$ 75.43	\$ 513.71	\$ 414.29	\$ 724.00
12 Month Employee Per Paycheck Rate.....	\$ 60.92	\$ 414.92	\$ 334.62	\$ 584.77

Dental - Cigna Dental 800-244-6224

Dental HMO Plan

	Employee	Emp + Spouse	Emp + Child(ren)	Emp + Family
Monthly rate	\$ 12.65	\$ 19.54	\$ 22.20	\$ 33.16
Annual rate	151.80	234.48	266.40	397.92
9 & 10 Month Employee Per Paycheck Rate.....	\$ 7.23	\$ 11.17	\$ 12.69	\$ 18.95
12 Month Employee Per Paycheck Rate.....	\$ 5.84	\$ 9.02	\$ 10.25	\$ 15.30

Dental PPO Plan

	Employee	Emp + Spouse	Emp + Child(ren)	Emp + Family
Monthly rate	\$ 25.77	\$ 50.60	\$ 60.21	\$ 80.87
Annual rate	309.24	607.20	722.52	970.44
9 & 10 Month Employee Per Paycheck Rate.....	\$ 14.73	\$ 28.91	\$ 34.41	\$ 46.21
12 Month Employee Per Paycheck Rate.....	\$ 11.89	\$ 23.35	\$ 27.79	\$ 37.32

Vision - Delta Vision 866-800-5457

DeltaVision Platinum Plan

	Employee	Emp + Spouse	Emp + Child(ren)	Emp + Family
Monthly rate	\$ 8.02	\$ 16.06	\$ 15.66	\$ 24.49
Annual rate	96.24	192.72	187.92	293.88
9 & 10 Month Employee Per Paycheck Rate.....	\$ 4.58	\$ 9.18	\$ 8.95	\$ 13.99
12 Month Employee Per Paycheck Rate.....	\$ 3.70	\$ 7.41	\$ 7.23	\$ 11.30



Medical Coverage

You have a choice of three medical plans through Meritain Health using the Banner/Aetna network - the **2 POS** and **1 HDHP plans**. Review the chart below for the amount you will pay for the medical service listed. Refer to the plan SBC for final details.

	Copay Gold Banner Plan		
	Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers
Annual Deductible (Individual/Family)	\$0/\$0	\$0/\$0	\$900/\$2,700
Coinsurance	0%	0%	50%
Annual Out-of-pocket Maximum (Individual/Family)	\$5,080/\$10,160	\$6,350/\$12,700	Unlimited
Office Visits Preventive Care Primary Care Specialist Urgent Care	Covered 100% ⁽¹⁾⁽²⁾⁽³⁾ \$24 Copay \$32 Copay \$40 Copay	Covered 100% \$30 Copay \$40 Copay \$50 Copay	Not Covered 50% after deductible 50% after deductible \$50 Copay +50% after deductible
Emergency Room (Copay is waived if admitted)	\$120 copay/visit (facility)/ \$32 copay/visit (professional & ancillary fees)	\$120 copay/visit (facility)/ \$32 copay/visit (professional & ancillary fees)	\$120 copay/visit (facility)/ \$32 copay/visit (professional & ancillary fees)/ 50% after deductible for Non-Emergency
Inpatient Hospital*	\$200 Copay per admission	\$250 Copay per admission	50% after deductible
Outpatient Hospital*	\$60 Copay	\$75 Copay	50% after deductible

(1)Covered at 100% up to \$300 for routine care. Preventive services covered at 100%.

(2)Flu shots/pneumonia & shingles vaccine covered at 100% (deductible waived).

(3)Routine hearing (1 exam per calendar year) covered after the in-network copay/coinsurance; covered at 50% after deductible out-of-network.

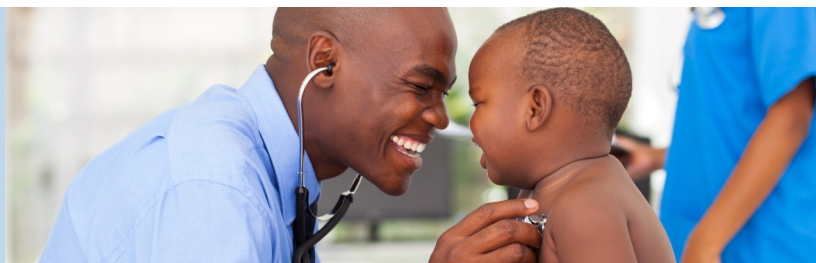
*Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

Terms to Know

- **Copay** - A set dollar amount you pay for a covered health care service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for health care services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the table above, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to www.meritain.com or call **866.300.8449** to find providers in the Meritain Health network.





Medical Coverage

Refer to the plan SBC for final details.

	Classic Gold Banner Plan		
	Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers
Annual Deductible (Individual/Family)	\$240/\$720	\$300/\$900	\$1,200/\$3,600
Coinsurance	15%	15%	50%
Annual Out-of-pocket Maximum (Individual/Family)	\$3,200/\$6,400	\$4,000/\$8,000	Unlimited
Office Visits			
Preventive Care	Covered 100% ⁽¹⁾⁽²⁾⁽³⁾	Covered 100%	Not Covered
Primary Care	\$20 Copay	\$25 Copay	50% after deductible
Specialist	\$38 Copay	\$45 Copay	50% after deductible
Urgent Care	\$38 Copay	\$45 Copay	50% after deductible
Emergency Room	15% after deductible	15% after deductible	15% after deductible
Inpatient Hospital*	\$200 Copay per admission plus 15% after deductible	\$250 Copay per admission plus 15% after deductible	50% after deductible
Outpatient Hospital*	15% after deductible	15% after deductible	50% after deductible

(1)Covered at 100% up to \$300 for routine care. Preventive services covered at 100%.

(2)Flu shots/pneumonia & shingles vaccine covered at 100% (deductible waived).

(3)Routine hearing (1 exam per calendar year) covered after the in-network copay/coinsurance; covered at 50% after deductible out-of-network.

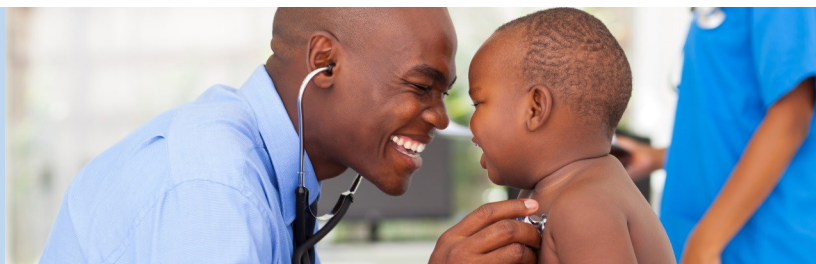
*Preauthorization required for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. See your plan document for a detailed listing.

Terms to Know

- **Copay** - A set dollar amount you pay for a covered health care service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for health care services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered health care services after you reach the deductible. You pay the percentage noted in the table above, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide health care services. In-network providers typically provide services at a lower negotiated rate.

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to www.meritain.com or call 866.300.8449 to find providers in the Meritain Health network.





Medical Coverage

Refer to the plan SBC for final details.

	HDHP A Banner Plan ⁽⁴⁾⁽⁵⁾		
	Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers
Annual Deductible (Individual/Family)	\$1,600/\$3,200	\$2,150/\$4,300	\$2,500/\$5,000
Coinsurance	20%	20%	50%
Annual Out-of-pocket Maximum (Individual/Family)	\$4,500/\$9,000	\$5,500/\$11,000	Unlimited
Office Visits Preventive Care Primary Care Specialist Urgent Care	Covered 100% ⁽¹⁾⁽²⁾⁽³⁾ Deductible / \$20 Copay Deductible / \$30 Copay Deductible / \$40 Copay	Covered 100% Deductible / \$25 Copay Deductible / \$35 Copay Deductible / \$45 Copay	Not Covered 50% after deductible 50% after deductible 50% after deductible
Emergency Room Inpatient Hospital*	20% after deductible \$200 Copay per admission plus	20% after deductible \$250 Copay per admission plus	20% after deductible 50% after deductible
Outpatient Hospital*	20% after deductible	20% after deductible	50% after deductible

(1)Covered at 100% up to \$300 for routine care. Preventive services covered at 100%.

(2)Flu shots/pneumonia & shingles vaccine covered at 100% (deductible waived).

(3)Routine hearing (1 exam per calendar year) covered after the in-network copay/coinsurance; covered at 50% after deductible out-of-network.

(4) Monthly HSA administration fees are paid for by ASBAIT. If participant changes health plans your account may be directly charged up to \$3.95 per month. If an employee leaves the District, the HSA account will be charged \$3.95 per month if your balance is under \$2,500; waived if over \$2,500.

(5) Non embedded deductible - For family coverage, the entire Family Annual Deductible must be met before copay or coinsurance is applied for any individual family member

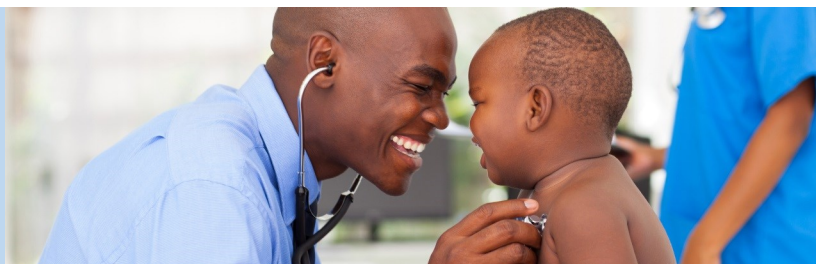
*Preauthorization required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.

HDHP A Facts to Know

- The HDHP A plan requires the deductible to be met prior to the carrier paying for services.
- This plan includes a Health Savings Account (HSA).
- Employees may contribute pre-tax dollars to the HSA via payroll deduction. 2024 contribution limits: Individual \$4,150 or Family \$8,300
- You will always get the best cost savings by using an in-network provider (Banner or Participating).
- When using an out of network provider, they may balance bill for any charges beyond what your carrier will pay as they are not contractually obligated to only accept the carrier payment.

Finding In-network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to www.meritain.com or call **866.300.8449** to find providers in the Meritain Health network.





Medical Coverage

How the Plans Work

Three plans use the Banner/Aetna network and cover 100% of the cost for preventive care services in network, like annual physicals and routine immunizations. The way you pay for care is different with each plan.

With the **HDHP**, you pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible. Once you meet the deductible, you and the plan share the costs (coinsurance) until you reach the annual out-of-pocket maximum. After that, the plan pays for 100% of your claims for the rest of the year. Your paycheck deductions for this plan are lower than the POS plan.

The **POS plans** have copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your annual out-of-pocket maximum. This plan has higher paycheck deductions than the HDHP.



	HDHP	POS Plans
Per-paycheck Cost for Coverage	Lowest	Highest
Annual Deductible	Highest	Lowest
Annual Out-of-pocket Maximum	Highest	Lowest
Using the Plan	Pay less with each paycheck and more when you need care	Pay more with each paycheck and less when you need care
Spending Account Options	Health savings account Limited Purpose FSA Dependent care FSA	Health care FSA Dependent care FSA



Telemedicine

Getting to the doctor when you're sick is never easy. That's why Roosevelt School District offers telemedicine through Teladoc. **You can connect with a U.S. board-certified doctor 24 hours a day, seven days a week by phone or video chat.** Call Teladoc at **1.800.362.2667** if you have a minor physical condition like a cold or fever. To get started, visit mydrconsult.com and register with your Teladoc member ID number (found on the back of your medical ID card).



Prescription Drug Coverage

Prescription drug coverage through Meritain Health is included with all of our medical plans. Review the chart below for the amount you will pay for the prescription drug service listed.

	Coplay Gold / Classic Gold / HDHP A Banner		
	Tier 1 Banner Providers	Tier 2 Participating Providers	Tier 3 Non-Participating Providers
Retail (30-day Supply)			
Generic	\$15 copay per prescription		Not covered
Preferred	20% after deductible (\$25 min, \$80 max)		Not covered
Non-preferred	40% after deductible (\$40 min, \$110 max)		Not covered
Specialty	\$200 copay / \$200 copay / \$200 after deductible		Not covered
Mail-order (90-day Supply)			
Generic	\$30 copay per prescription		Not covered
Preferred	20% after deductible (\$50 min, \$175 max)		Not covered
Non-preferred	40% after deductible (\$80 min, \$225 max)		Not covered

Out-of-Pocket Maximum (Individual / Family):

Coplay Gold: Combined with medical

Classic Gold: Combined with medical

HDHP A Banner: Combined with medical

Coplay Gold / Classic Gold Plans: Deductible does not apply.

HDHP A Plan: Major medical deductible applies.

All plans: Covers up to a 30-day supply (retail prescription or specialty drugs); 90-day supply (retail prescription or mail order). Plan requires pharmacies to dispense generic drugs when available. Mandatory generic provision applies. There is no charge or deductible for preventive drugs.

Generic Drugs

Generic drugs are FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts. If you choose a brand-name drug when a generic drug is available, you will pay the brand-name copay plus the cost difference between the generic equivalent and the brand-name drug.

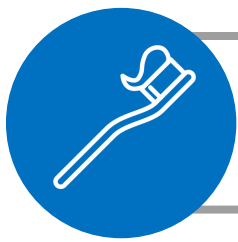
Preferred Drugs

Meritain Health regularly reviews the latest prescription drugs on the market and maintains a list of preferred drugs that are clinically effective and not cost-restrictive. These drugs are available at a lower price than those not included on the list, which are called non-preferred drugs.

Specialty Drugs

Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using Meritain Health's mail-order pharmacy. You can register for mail-order pharmacy by logging on to www.meritain.com.





Voluntary Dental Coverage

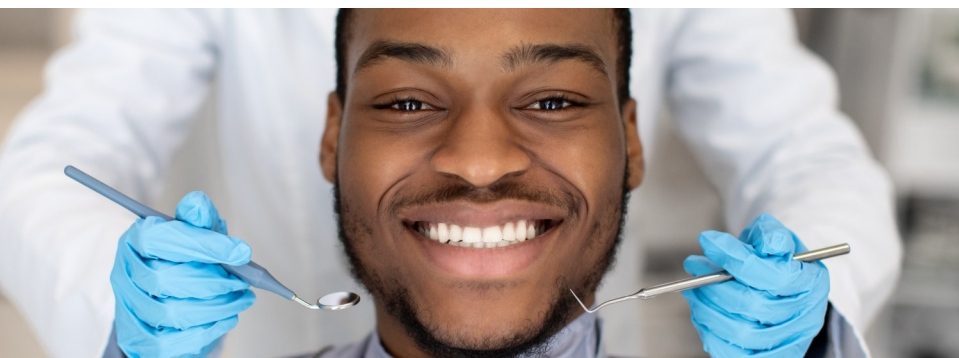
Roosevelt School District No 66 offers two dental plans through CIGNA. Review the chart below for the amount CIGNA will pay for the dental service listed.

	PPO Dental Plan Pays	DHMO Dental Plan*
	In Network and Out-of-Network	In Network
Annual Deductible (Individual/Family)	\$50/\$150	None
Annual Maximum (Per Person)	\$1,000	None
Preventive Care (Routine Cleaning and X-rays)	80%	Office Visit Fee \$5.00 Various copay apply
Basic Services (Fillings, Basic Root Canals)	80% after deductible	Various copay apply
Major Services (Extractions, Crowns)	50% after deductible	Various copay apply
Orthodontia	50% (Adult and Children)	Various copay apply
Orthodontia Lifetime Maximum (Per Person)	\$1,000	N/A

For services provided by a non-network dentist, Cigna Dental will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 80th percentile of all provider submitted amounts in the geographic area. The dentist may balance bill up to their usual fees.

Effective July 1, 2024, implants will be covered in-and out-of-network for those enrolled in the PPO Dental plan.

*Refer to 2024 Pre-Paid Dental Summary on the Roosevelt benefit website for plan and copay information.



Finding In-network Dentists

You pay less for services when you use a dentist in the CIGNA network. You can find an in-network dentist by visiting www.mycigna.com or calling **800.352.6132**.



Voluntary Vision Coverage

Roosevelt School District No 66's vision plan through Delta Vision Administered by EyeMed covers routine eye exams and helps you pay for glasses or contact lenses. Review the chart below for the amount you will pay for the vision service listed.

	Vision Plan	
	In Network	Out of Network
Eye Exam (Once every 12 months)	\$10 copay	Reimburse up to \$30
Lenses (Once every 12 months)		
Single Vision	\$10 copay	Reimburse up to \$25
Bifocal	\$10 copay	Reimburse up to \$40
Trifocal	\$10 copay	Reimburse up to \$55
Standard Progressive	\$75 copay	Reimburse up to \$40
Frames (Once every 12 months)	\$150 allowance plus 20%	Reimburse up to \$75
Contact Lenses (Once every 12 months in lieu of glasses)		
Separate Fitting Allowance	Standard - \$40 allowance; Premium - 10% off retail price;	N/A
Allowance	Conventional - \$150 allowance plus 15%;	Reimburse up to \$120
Medically Necessary	Disposable - \$150 allowance Covered in full	Reimburse up to \$200

You're on the Insight network.

Finding In-network Eye Doctors

For a complete list of providers near you, use the Provider Locator on [EyeMedVisionCare.com](https://www.eyemedvisioncare.com) For customer service, call **866.800.5457**





Spending Accounts

Paying for Health Care

Roosevelt School District No 66 offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	Health Savings Account (HSA)	Limited Purpose Savings Account (LPSFA)	Health Care Flexible Spending Account (FSA)
What medical plan can I choose?	HDHP	HDHP	POS plan
What expenses are eligible?	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses)	Dental and vision care (See IRS publication 502 for a full list of eligible expenses)	Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses)
When can I use the funds?	Funds are available as you contribute to the account	All of the funds you elect for the year are available January 1	All of the funds you elect for the year are available January 1
Can I roll over funds each year?	Yes, funds roll over from year to year and are yours to keep (even if you leave the company or retire)	No, you will lose any funds remaining in your account at the end of the year	No, you will lose any funds remaining in your account at the end of the year
How do I pay for eligible expenses?	With your HealthEquity through Meritain debit card (you can also submit claims for reimbursement online at www.healthequity.com)	With your PayFlex debit card (you can also submit claims for reimbursement online at www.payflex.com) or through the PayFlex Mobile app	With your PayFlex debit card (you can also submit claims for reimbursement online at www.payflex.com) or through the PayFlex Mobile app
How much can I contribute each year?	\$4,150 for individual coverage or \$8,300 for family coverage (this total includes company funding) in 2024	You can contribute up to \$3,200 in pretax dollars to the Limited Purpose FSA in 2024	You can contribute \$3,200 to your health care FSA in 2024
Can I change my contributions throughout the year?	Yes, to change per-paycheck contributions, employee will need to reach out to Benefits Specialists	No, unless you have a qualifying life event, you choose an annual election amount during open enrollment and that amount is taken out of each paycheck in equal increments throughout the year	No, unless you have a qualifying life event, you choose an annual election amount during open enrollment and that amount is taken out of each paycheck in equal increments throughout the year

Note: If you are enrolled in Medicare, by law you are not allowed to contribute to an HSA.

What Are the Tax Implications of an HSA?

Contributions to your HSA reduce your taxable income, and qualified medical expenses are never taxed. All money set aside in an HSA grows tax-deferred until age 65, when funds can be withdrawn for any non-medical purpose at ordinary tax rates, or tax-free when used for medical expenses. You may contribute additional funds to your HSA (\$1,000 per tax year) if you will be 55 years or older (but less than the Medicare Eligibility Age) by December 31. Learn more at www.healthequity.com.





Spending Accounts

Paying for Dependent Care

You can contribute pre-tax dollars into a dependent care FSA to pay for eligible child or elderly care expenses.

	Dependent Care FSA
What is it?	An account that allows you to set aside pre-tax dollars from each paycheck to pay for eligible child or elderly care expenses while you and your spouse work full time
Why should I consider it?	You can lower your taxable income to save some money while you take care of your daycare expenses
What expenses are eligible?	Daycare expenses for your children under age 13 or dependents who are mentally or physically incapable of caring for themselves (including elderly dependents)
When can I use the funds?	Funds are available as you contribute to the account with each paycheck
Can I roll over funds each year?	No, you will lose any funds remaining in your account at the end of the year
How do I pay for eligible expenses?	With your PayFlex debit card (you can also submit claims for reimbursement online at www.payflex.com)
How much can I contribute each year?	You can contribute \$5,000 to your dependent health care FSA in 2024



Important Note

Both the health care and dependent care FSAs have a use-it-or-lose-it rule. You will lose any unused funds at the end of the year.



Life, AD&D and Disability Insurance

Life and AD&D Insurance

Roosevelt School District No 66 provides basic life and accidental death and dismemberment (AD&D) insurance through Standard Insurance Company at no cost to eligible employees. If you want additional coverage for yourself, your spouse, or your children, you can purchase voluntary coverage at our group rates.

	How it Works	Basic Life and AD&D (Company-paid benefit)	Voluntary Life and AD&D (Employee-paid benefit)
Life	Your beneficiaries receive this benefit if you pass away	Class IV: All Other FT EE: 1x Annual Earnings to max \$100,000	<p>You: Increments of \$10,000 up to \$750,000</p> <p>Your spouse: Increments of \$5,000 up to \$250,000 not to exceed 100% of EE's amount</p> <p>Your child(ren): Live birth up to age 25; choice of \$10,000 or \$15,000 not to exceed 100% of EE's amount</p> <p>Vol Life/AD&D—Newly hired employees: guarantee issue up to \$250,000 or 3 times annual earnings, whichever is less when they enroll at initial eligibility</p>
AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	Class IV: All Other FT EE: 1x Annual Earnings to max \$100,000	<p>You: Increments of \$10,000 up to \$750,000</p> <p>Your spouse: Increments of \$5,000 up to \$250,000 not to exceed 100% of EE's amount</p> <p>Your child(ren): Live birth up to age 25; choice of \$10,000 or \$15,000</p>

The cost for Supplemental Life is calculated based on the age of the employee or spouse at the start of the plan's current policy year.

If electing voluntary life outside of initial eligibility, you will need to complete an Evidence of Insurability (EOI) form. The form may be found on the Roosevelt benefit website. The form must be submitted to Standard Insurance Company, do not submit to Roosevelt Human Resources. Your policy is not effective until completion of Standard Insurance Company underwriting review.



Keep Your Beneficiaries Up to Date

To change your beneficiaries, please see Human Resources to update/change your beneficiary. Make sure to keep this person's information updated so your benefit is paid according to your wishes.

Disability Insurance

Roosevelt School District No 66 also provides disability insurance through Voya Financial. This benefit replaces a portion of your income if you become disabled and are unable to work. If electing voluntary disability outside of initial eligibility, you will need to complete an Evidence of Insurability (EOI) form. The form may be found on the Roosevelt benefit website. The form must be submitted to Voya, do not submit to Roosevelt Human Resources. Your policy is not effective until completion of Voya underwriting review.

	How it Works	Who Pays for the Benefit
Voluntary Short-term Disability	You receive 66.67% of your income up to \$1,154 per week. Benefits begin after 7 calendar days of absence from work for illness and injury and continue for up to 26 weeks.	Employee



Additional Benefits

Employee Assistance Program

To help you with personal issues and concerns, Roosevelt School District No 66 provides you and your family with an employee assistance program (EAP) at no cost to you.

Call Alliance Work Partners offered by Alliance Work Partners offered by ASBAIT 24/7 for confidential assistance with personal matters like family, finances, health and work.

Experienced consultants are available to listen and help you find solutions. They can also set up in-person sessions with local behavioral health counselors if needed.

Find more information at www.awpnow.com

Toll Free 800-343-3822

EAP Teen Line 800-334-TEEN (8336)

TDD 800-448-1823



Servicios en español disponibles





Additional Benefits

Accident Insurance

Cleaning the gutters. Yoga class. Soccer practice. Life offers plenty of opportunities for accidental injuries. When an injury happens, Accident Insurance can help. Things to keep in mind about Accident Insurance:

- No medical questions or tests are required for Accident coverage.
- **Employees get an annual Wellness Benefit** of \$50 for completing an eligible health screening test. Your annual benefit amount is \$50. Your spouse’s benefit amount is \$50. The benefit for child coverage is 50% of your benefit amount per child, with an annual maximum of \$100 for all children.
- Benefit payments go directly to you. Use them how you’d like!

Accident Insurance doesn’t replace your medical coverage; instead, it complements it. The benefit payments don’t go out to pay for medical bills or treatments you may need, instead they come in-directly to you-to be used however you’d like. Choose this supplemental health insurance product for added protection if one of the following covered conditions comes your way.

Accident Insurance is a limited benefit policy. It is not health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

What’s covered? See benefit summary for plan details.

Accident Insurance provides a benefit payment after a covered accident that results in the specific injuries and treatments listed in this document. To be eligible, the accident must happen outside of work. Some of the most common treatments and conditions we pay benefits for include:

- ER treatment
- X-rays
- Physical therapy
- Stitches
- Follow-up doctor treatment(s)

Coverage Tier	Monthly Rates
Employee Only	\$6.77
Employee + Spouse	\$14.01
Employee + Child(ren)	\$15.05
Employee + Family	\$22.29



Additional Benefits

Critical Illness

There are more than just medical bills to pay after a heart attack, stroke, or other unexpected covered medical condition. Critical Illness Insurance provides a benefit payment that can help. This document includes benefit information for Critical Illness Insurance. As you explore, keep in mind:

- No medical questions or tests are required for coverage.
- Employees get an annual Wellness Benefit of \$50 for completing an eligible health screening test.
- Benefit payments go directly to you. Use them however you'd like!

Critical Illness Insurance doesn't replace your medical coverage; instead, it complements it. The benefit payments don't go out to pay for medical bills or treatments you may need, instead they come in-directly to you-to be used however you'd like. Choose this supplemental health insurance product for added protection if one of the following covered conditions comes your way.

Critical Illness Insurance is a limited benefit policy. It is not health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

What's covered by Critical Illness Insurance? See benefit summary for plan details.

Critical Illness Insurance provides benefits for the covered conditions and diagnoses shown below. The most common conditions we pay claims for include:

- Heart attack
- Kidney failure
- Stroke
- Coronary artery bypass
- Cancer
- Transplant

Employee/Spouse Coverage Monthly Rates (Child Cost Included)			
Age	\$10,000	\$20,000	\$30,000
Under 25	\$1.80	\$3.60	\$5.40
25-29	\$2.20	\$4.40	\$6.60
30-34	\$3.00	\$6.00	\$9.00
35-39	\$3.60	\$7.20	\$10.80
40-44	\$6.40	\$12.80	\$19.20
45-49	\$7.70	\$15.40	\$23.10
50-54	\$10.60	\$21.20	\$31.80
55-59	\$12.00	\$24.00	\$36.00
60-64	\$16.10	\$32.20	\$48.30
65-69	\$20.50	\$41.00	\$61.50
70+	\$29.20	\$58.40	\$87.60



Additional Benefits

Hospital Indemnity

Out-of-pocket costs from a stay in a hospital or other medical facility can be overwhelming. As expenses add up, Hospital Indemnity Insurance can help. This document includes cost and benefit information for Hospital Indemnity Insurance. As you explore, keep in mind:

- No medical questions or tests are required for coverage.
- **Employees get an annual Wellness Benefit** of \$50 for completing an eligible health screening test. Your annual benefit amount is \$50. Your spouse's benefit amount is \$50. The benefit for child coverage is 50% of your benefit amount per child, with an annual maximum of \$100 for all children.
- Benefit payments go directly to you. Use them however you'd like!

Hospital Indemnity Insurance doesn't replace your medical coverage; instead, it complements it. The benefit payments don't go out to pay for medical bills or treatments you may need, instead they come in—directly to you—to be used however you'd like. Choose this supplemental health insurance product for added protection should a covered hospitalization occur.

Hospital Indemnity Insurance is a limited benefit policy. It is not health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

How does it work? See benefit summary for plan details.

With Hospital Indemnity Insurance, you'll receive a fixed daily benefit if you have a covered stay in a hospital, intensive care unit, or rehabilitation facility that occurs on or after your coverage effective date. Benefit amounts are listed below, and depend on the type of facility and number of days of confinement. Any combination of facility confinement and admission benefits payable includes a limit, please see your certificate for further confirmation. And for a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and any riders.

Coverage Tier	Monthly Rates
Employee Only	\$16.33
Employee + Spouse	\$27.63
Employee + Child(ren)	\$26.62
Employee + Family	\$37.92



Additional Benefits

403b TAX-SHELTERED ACCOUNT



Retirement Plan

Roosevelt School District #66 is proud to offer 403b plans through Valic, Voya, Teacher's Pension, and Security Benefit. The 403b plans allow you to shelter income on a pre-tax basis, which lowers your current year taxable liability and increases savings for retirement.

VALIC

Contact: Mr. Shane Russell

Phone: (602) 674-2600

Fax: (602) 678-0646

shane.russell@valic.com



Contact: Mr. John Bartimoccia

Phone: (602) 759-6737

jbartimoccia@sjj.us.com



Contact: Mr. Ken McCormick

Phone: (480) 462-0436

Fax: (800) 391-5750

kmccormick@tpensions.com



Contact: Ms. Evelyn Contreras

Phone: (480) 482-9242

Fax: (480) 534-5911

evelyn.contreras@lpl.com



Coverage Costs

Monthly Cost for Voluntary Life and AD&D Insurance (per \$1,000 of coverage)

Employee Age	Employee Rate*	Your Spouse's Rate**
<30	\$0.055	\$0.065
30-34	\$0.090	\$0.075
35-39	\$0.100	\$0.085
40-44	\$0.110	\$0.105
45-49	\$0.155	\$0.155
50-54	\$0.235	\$0.235
55-59	\$0.430	\$0.375
60-64	\$0.635	\$0.575
65-69	\$1.175	\$1.005
70+	\$1.865	\$1.705
Dependent Life with AD&D coverage for your child(ren), your monthly rate is \$0.115 per \$1,000, no matter how many children you're covering.		

*Includes a monthly AD&D rate of \$0.015 per \$1,000 of AD&D benefit.

**Includes a monthly AD&D rate of \$0.015 per \$1,000 of AD&D benefit for your

Note: No Age Reductions for Employee or Spouse



Contact Information

Benefit	Vendor	Phone	Website or Email
Medical	ASBAIT	866.300.8449	www.meritain.com
Voluntary Dental	CIGNA	800.Cigna24	www.mycigna.com
Voluntary Vision	DeltaVision	866.800.5457	www.EyeMedVisionCare.com
Health Savings Account	HealthEquity through Meritain	866.346.5800	www.healthequity.com
Flexible Spending Account	PayFlex	844.729.3539	www.payflex.com
Life and AD&D	Standard Insurance Company	800.628.8600	https://standard.com/
Voluntary Life and AD&D	Standard Insurance Company	800.628.8600	https://standard.com/
Voluntary Short Term Disability	Voya Financial	800.955.7736	www.voya.com
Employee Assistance Program	Alliance Work Partners offered by ASBAIT	800.343.3822 Teen line 800.334.8336 TDD 800.448.1823	www.awpnow.com www.alliancewp.com
Voluntary Accident Insurance	Voya Financial	877.236.7564	www.voya.com
Voluntary Critical Illness	Voya Financial	877.236.7564	www.voya.com
Voluntary Hospital Indemnity	Voya Financial	877.236.7564	www.voya.com
Benefit Advocate Center (BAC)	Gallagher Service Center	833.420.1622	BAC.RooseveltElementarySchoolDistAdvocates@ajg.com
Telemedicine	Teladoc	800.835.2362	mydrconsult.com
ASRS	Arizona State Retirement System	602.240.2000	https://www.azasrs.gov/content/contact.us
COBRA	Meritain	800.925.2272	www.meritain.com

Roosevelt School District No 66 Benefit Advocate Center

The Roosevelt School District No 66 Benefit Advocate Center is an employee resource for your company-sponsored health, welfare and insurance benefits. Talk to a representative about your eligibility, enrollment or your current benefits.

- Phone: **833.420.1622**
- Email: BAC.RooseveltElementarySchoolDistAdvocates@ajg.com
- Hours: Monday - Friday, 7 a.m. - 6 p.m. (CT)





Legal Notices

Patient Protections Disclosure

The Roosevelt School District No 66 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, ASBAIT 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 ASBAIT at 866.300.8449 or www.meritain.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from ASBAIT 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 ASBAIT at 866.300.8449 or www.meritain.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: Copay Gold Banner Plan (Individual: 0% coinsurance and \$0 deductible; Family: 0% coinsurance and \$0 deductible)

Plan 2: Classic Gold Banner Plan

Tier 1 - (Individual: 15% coinsurance and \$240 deductible; Family: 15% coinsurance and \$720 deductible)

Tier 2 - (Individual: 15% coinsurance and \$300 deductible; Family: 15% coinsurance and \$900 deductible)

Plan 3: HDHP A Banner Plan

Tier 1 - (Individual: 20% coinsurance and \$1,600 deductible; Family: 20% coinsurance and \$3,200 deductible)

Tier 2 - (Individual: 20% coinsurance and \$2,150 deductible; Family: 20% coinsurance and \$4,300 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 602.243.4822 or christina.wiltshire@rsd66.org.

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).



Legal 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.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268



Legal 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: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178



Legal 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 Rlte 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



Legal Notices

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)



Legal Notices

HIPAA Notice of Privacy Practices

Protecting Your Health Information Privacy Rights

Roosevelt School District No 66 is committed to the privacy of your health information. The administrators of the Roosevelt School District No 66 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 Christina Wiltshire - Employee Benefits Specialist at 602.243.4822 or christina.wiltshire@rsd66.org.

HIPAA Special Enrollment Rights

Roosevelt School District No 66 Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Roosevelt School District No 66 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 Christina Wiltshire - Employee Benefits Specialist at 602.243.4822 or christina.wiltshire@rsd66.org.



Legal Notices

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.



Legal Notices

Notice of Creditable Coverage

Important Notice from Roosevelt School District No 66 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 Roosevelt School District No 66 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. Roosevelt School District No 66 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?

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Roosevelt School District No 66 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.



Legal Notices

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 Roosevelt School District No 66 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).

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Notes



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This benefit summary prepared by



Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.